China–WHO
Country Cooperation Strategy

2013–2015
Bridging the past
Towards a new era of collaboration
Country Cooperation Strategy

China–WHO

2013–2015
Bridging the past
Towards a new era of collaboration
Contents

iii Foreword

iv Abbreviations and acronyms

v Executive summary

1 Section 1: Introduction

2 Section 2: Health and development challenges and national response

15 Section 3: Development cooperation and partnerships

16 Section 4: Review of WHO cooperation over the past CCS cycle

18 Section 5: The strategic agenda for WHO cooperation

25 Section 6: Implementing the strategic agenda: Implications for the entire Secretariat

27 Annex
Foreword

The Government of the People’s Republic of China and the World Health Organization (WHO) have worked together for decades to improve the health of people throughout China. With a common vision of health priorities as identified in the previous China—WHO Country Cooperation Strategy collaboration between China and WHO has been beneficial to both parties and to the wider world.

In response to China's rapidly changing social, economic and health context, and drawing on China's national plans and health challenges, WHO and the Ministry of Health developed this new China—WHO Country Cooperation Strategy (CCS) to bridge the period from 2013 to 2015, thus aligning the CCS with China’s 12th Five-Year Plan for National Economic and Social Development (2011—2015) and the United Nations Development Assistance Framework, as well as WHO policies and frameworks.

Led by the Ministry of Health and WHO, a series of consultations shaped this new CCS. Beginning with a review of past collaboration and current challenges, the consultations included the Ministry of Health and other Government agencies, the United Nations System in China, other multilateral and bilateral health partners, and WHO at all three levels of the Organization.

The China—WHO CCS (2013—2015) has four Strategic Priorities for collaboration:

• Strengthen health systems towards universal health coverage;
• Reduce morbidity and mortality from major diseases of public health importance and from risks to health and health security;
• Reduce inequities in health in the western region of China through subnational public health action; and
• Contribute to strengthening global health through supporting the collaboration of China in the global health arena.

With the Strategic Priorities, Focus Areas and Strategic Approaches identified in this CCS, WHO and China cooperation aims to further strengthen the national health-care system to meet the needs of the Chinese people and ensure the equity and quality of health services. We also seek to draw on our accumulated experience and expertise to improve health throughout China and the world.

In a spirit of partnership and solidarity, this strategy serves as a key tool to guide cooperation between the Government of China and WHO. We are confident that implementation of this CCS will contribute to significant improvements in the health of the people of China.

Dr Chen Zhu
Minister of Health
People’s Republic of China

Dr Shin Young-soo
Regional Director for the Western Pacific
World Health Organization
EXECUTIVE SUMMARY

The WHO Country Cooperation Strategy (CCS) is a medium-term strategic vision for the World Health Organization’s cooperation with a given Member State in support of the country’s national health policies, strategies and plans. The first CCS for China covered 2004–2008 and was later updated for 2008–2013.

This document further updates the current (2008-2013) CCS for China in order to adapt WHO’s role in the rapidly changing country and brings the time frame into conformity with China’s 12th Five-Year Plan for Health Sector Development (2011–2015) and the United Nations Development Assistance Framework 2011–2015. This bridging CCS covers a relatively short time period from 2013 to 2015.

China has a population of more than 1.3 billion people. In the past 50 years, there has been a significant demographic change, including a decreasing fertility rate, an ageing population and an increased number of migrant workers. Great strides in improving people’s health have been made since the founding of the People’s Republic of China in 1949. Despite overall achievements, there are large variations between urban and rural areas, between population groups and between geographic areas. During the last 20 years, China’s total health expenditure has increased more than 30-fold. It accounted for 5.1% of the gross domestic product (GDP) in 2011. There are differences in per capita health expenditure between urban and rural China.


With successful economic development, China’s status as a beneficiary of development aid is changing. With changes to China’s status in the aid environment, WHO in China is constrained by limited flexible funding, which requires tough choices and sharpened focus on strategic priorities for WHO work and staffing in China. However, WHO’s comparative advantage comes from its rich global technical network, including WHO Headquarters, regional and country offices, and WHO collaborating centers. There is still a clear need for China and WHO to further strengthen collaboration for mutual benefit. WHO will continuously provide necessary support to China through renewed CCS strategic agendas and realignment of its resources.

The priorities for China–WHO collaboration for 2013–2015 are underpinned by an analysis of the current context in China and the likely evolution of that collaboration in coming years, priorities of the Government as stated in the 12th Five-Year Plan for Health Sector Development (2011–2015), comparative advantages of WHO and lessons learnt during implementation of the current CCS. The priorities also take account of China’s commitments as a WHO Member State and ongoing agreements that have been negotiated between WHO and China. Described below are the four Strategic Priorities of WHO collaboration with China for 2013–2015.

Strategic Priorities (2013–2015)

1. Strengthen health systems towards universal health coverage.

WHO will support the Government to strengthen health systems development towards universal health coverage to ensure that all people have access to promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.

2. Reduce morbidity and mortality from major diseases of public health importance and from risks to health and health security.

China’s capacity for managing communicable diseases has advanced considerably. China–WHO future collaboration will focus on specific areas. With regards to noncommunicable diseases, collaboration will be provided in the context of the National Plan for Noncommunicable Disease Prevention and Control 2012–2015. WHO will also support the strengthening of risk assessment, preparedness, surveillance and response for emergency events in line with the commitments contained in the International Health Regulations (2005) and the Asia Pacific Strategy for Emerging Diseases (APSEd) to enhance capacity in health security.

3. Reduce inequities in health in the western region of China through subnational public health action.

WHO will support the implementation of national health priorities and promote the achievement of the Millennium Development Goals (MDGs) at the subnational level through the Western Area Health Initiative (WAHI). In the initiative’s first phase, Guangxi Zhuang Autonomous Region, Chongqing Municipality and Shaanxi Province have been selected as pilot locations. The experience and lessons learnt from the pilot locations will be distilled and documented for dissemination to other western provinces.

4. Contribute to strengthening global health through supporting the collaboration of China in the global health arena.

WHO is well placed to support China in building its capacity in priority programme areas in which China can best add value to global health.

The refocus of priorities and the changing circumstances of both China and WHO have implications for the role of WHO and its presence in the country, including the staffing structure of the WHO Country Office, the support of other levels of WHO, and the allocation of resources in support of the work and the office.

The WHO Secretariat, the Government of China and local authorities will review the CCS near the end of its cycle.
The Country Cooperation Strategy (CCS) is a medium-term strategic vision for the World Health Organization’s cooperation with a given Member State in support of the country’s national health policies, strategies and plans. The first CCS for China covered 2004–2008 and was later updated for 2008–2013.

This document updates the current (2008–2013) CCS for China in order to adapt WHO’s role in the rapidly changing country, and brings the time frame into conformity with China’s 12th Five-Year Plan for Health Sector Development (2011–2015) and the United Nations Development Assistance Framework (UNDAF) 2011–2015. This Bridging CCS (BCCS) covers a relatively short time period from 2013 to 2015. A new CCS, building on this BCCS, will be prepared for 2016–2020 to further update priorities and align the time period to be covered with China’s next plan for health development.

This Bridging CCS (BCCS) 2013–2015 has been developed in accordance with WHO policies, international and national frameworks, and China’s national plans and health challenges. It will guide the work of WHO at all levels, including preparation of the 2014–2015 Programme Budget. Currently, WHO reforms are refining the development of country cooperation strategies with two main purposes in mind: to review each Member State’s needs and to guide the work of the entire Secretariat in support of each country.

Formulation of the BCCS began with a country self-assessment and strategic discussions between the WHO Country Office and the WHO Regional Office for the Western Pacific, followed by a review of work during the first four years of the current CCS (2008–2013). The assessment reviewed the strengths and weaknesses in health development in China, based on data provided in reports, as well as WHO-supported reviews. The assessment revealed weaknesses that required improvement as well as strengths that indicated the potential for China to make regional and international contributions. These exercises and analyses provided evidence-based information used for developing the strategic priority agenda. The BCCS considers opportunities for WHO support to China, as well as opportunities for WHO and China to cooperate for mutual benefit in regional and global initiatives.

The issues included in the BCCS were refined through a process of prioritization using explicit criteria, which took into consideration the interest and capacity of both China and WHO, as well as the availability of resources from and contributions by other health partners. Consultations were conducted with selected key agencies in the Government of China, the United Nations country team, development partners, and key academic institutions from June 2012 to February 2013 (see Annex 1).

This BCCS is intended to be realistic. Considering the expected resource constraints, the Strategic Priorities have been focused on a limited, manageable number of initiatives and programme areas. This will mitigate the risk of responding to the numerous interests and demands, and instead strengthen impact on the highest priorities.

### Health and development challenges and national response

#### 2.1 Country profile

**Demographic profile**

China has a population of more than 1.3 billion people, with approximately 7 million people added annually. In the past 50 years, there has been a significant demographic change, including a decreasing fertility rate, an ageing population and an increased number of migrant workers. An estimated 230 million people are defined as the "floating population", people who live and work in areas other than their registered address. To curb the population growth rate, family planning policies were implemented, which has led to decreasing fertility rates. In 1970 there was an average of 5.5 births per woman, which had fallen to 1.6 births per woman by 2010. In 2011, the sex ratio at birth was 117.8 boys for every 100 girls. In 2010, the population aged 60 years and over was 13% of the total. It is expected that by 2015, this proportion will reach 15%, further increasing to 24% by 2030.
Socioeconomic situation

In the last three decades, China has undergone a remarkable economic transformation. The highly planned and centralized economy of the 1970s has given way to a dynamic market economy. From 1978 to 2011, the average growth rate of the gross domestic product (GDP) was 9.6% in terms of constant value. In 2010, China became the second-largest global economy in terms of GDP. It joined the upper-middle-income country group* in 2010, with GDP per capita income of US$ 4433, yet remains a developing country.

Political and governance structure

The highest lawmaking body of China is the National People’s Congress, which meets annually. The State Council is the chief administrative body, composed of a premier, vice- premiers, state councilors, ministers in charge of ministries and commissions, the auditor-general and the secretary-general. The administrative divisions of China consist of three functional levels of local government: provinces (autonomous regions and municipalities), prefectures (counties, autonomous counties and/or cities) and townships (ethnic townships and/or towns).

Risk of natural disasters and emergencies

China is among the 10 top countries that face the most natural disasters. This is due to climate change and geographic and environmental factors. Deaths due to earthquakes in China were 40% of global earthquake deaths recorded in the 20th century. Disaster prevention and the control of disease outbreaks through capacity-building for preparedness are considered high priorities by the central Government.

2.2 Health status of the population

Overall achievements, but remaining disparities

Great strides in improving people’s health have been made since the founding of the People’s Republic of China in 1949. Life expectancy at birth rose from 35 years before 1949 to 75 years in 2010. At the same time, the maternal mortality ratio (MMR) and the infant mortality rate (IMR) dropped from 1500/100 000 and 200/1000 live births, respectively, before 1949 to 30/100 000 and 13.1/1000 live births, respectively, in 2010.

Despite overall achievements, there are large variations between urban and rural areas, between population groups (e.g. migrants and residents, ethnic groups) and between geographic areas (e.g. east and west). As Figure 1 indicates, the MMR of western China is still higher than eastern and middle China, although there has been an impressive reduction in the last 15 years. In 2011, the IMR in rural areas was reported as 14.7/1000 live births while in urban areas it was 5.8/1000 live births (see Table 1). Figure 2 shows wide gaps in life expectancy by province and the correlation with GDP per capita (see Annex 2).

* The World Bank Income Group: low income, $1,025 or less; lower middle income, $1,026 - $4,035; upper middle income, $4,036 - $12,475; and high income, $12,476 or more.
Transition of disease models

China is experiencing a rapid epidemiological transition. Over the last 20 years, deaths due to communicable diseases have dropped rapidly while deaths due to major noncommunicable diseases (NCDs) have risen sharply. Those epidemiological transitions occur more rapidly in rural China than in urban areas.

Communicable diseases

China has made great progress in the control of communicable diseases at the national level. It is well on the way to eliminating malaria, measles and various neglected tropical diseases (NTD), such as schistosomiasis. However, communicable diseases remain a problem in some western provinces. Disease control efforts for viral hepatitis, tuberculosis and HIV/AIDS remain important issues for China. There are 93 million carriers of hepatitis B in China, with a surface antigen carrier rate of 7.2%. China annually notifies almost 1 million cases of tuberculosis, which is the second-largest killer among the notifiable communicable diseases. Multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) epidemics are a public health concern. By the end of 2011, it was estimated that 780 000 people were living with HIV or AIDS in China. National HIV prevalence is low overall, but higher in some areas and especially in most at-risk populations. China ranks second worldwide in the number of reported rabies-related deaths. Major outbreaks of communicable diseases are always a risk in a large country such as China, as well as the importation of serious non-endemic diseases such as poliomyelitis.

Noncommunicable diseases

Malignant neoplasms, heart diseases, cerebrovascular diseases and chronic lung diseases are major causes of death in China, both in urban and rural areas. According to the national health survey, morbidity of major noncommunicable diseases is rapidly increasing (see Table 2).

Table 2. Trends of major non-communicable disease morbidity (1993 – 2008)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>13.1</td>
<td>14.2</td>
<td>14.3</td>
<td>17.6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>11.9</td>
<td>13.8</td>
<td>21.2</td>
<td>17.6</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.9</td>
<td>3.2</td>
<td>5.6</td>
<td>10.7</td>
</tr>
</tbody>
</table>

Source: China Health Statistics Yearbook 2012

Injuries and accidents

Injury is the chief cause of death among children, youth and within the labour force, with injury mortality rates of 33.93/100 000 for urban people and 56.50/100 000 for rural people in 2011. The top five injuries and accidents leading to death were traffic accidents, suicides, falls, drowning and poisoning. China's rapid growth has been accompanied by a surge in private transport needs and a corresponding increase in the number of motor vehicles, including cars and motorcycles. The increase in motor vehicles, combined with limited public awareness on road traffic safety and insufficient public compliance with road traffic laws, has resulted in a huge toll in road traffic fatalities. The Ministry of Health estimates that there are more than 200 000 road traffic deaths annually.
2.3 Major determinants of health

Health disparities caused by social inequity present challenges for China. The WHO Commission on Social Determinants of Health highlighted in its final report that social context, social position and the conditions of daily life are major causes of ill health.15

Social context determinants

Rapid industrialization, urbanization and globalization

The China Academy of Social Science estimates that China will achieve industrialized society status in 2015-2018. Industrialization and rapid economic development have improved people’s living standards markedly. Meanwhile, rapid industrialization and the exploitation of natural resources have led to air pollution, water contamination, soil pollution and several health problems that can directly increase the prevalence of certain diseases.

The urbanization level of China has increased from 7% in 1949 to 51% in 2011.16 As a result, lifestyles, living conditions, choice of occupation, consumer behaviour and the values of people are undergoing profound changes. Urbanization brings new challenges for health, such as migrant worker health status and their unmet need for health service.

With substantial economic growth, China is deeply engaged in the globalization of trade. Infectious diseases spread without concern for national boundaries. Lessons learnt from the outbreak of the severe acute respiratory syndrome (SARS) prove that disease prevention and control have become a global mission. Lifestyle and other determinants of noncommunicable diseases are also global problems.

Getting old before getting rich

China is quickly becoming an ageing society. Data from the sixth national census in 2010 shows China with a population of 178 million people aged 60 years or above, which accounts for 13.3% of the total population.17 The number increases by 5 million every year. It is estimated that the ageing population will reach 248 million in 2020, accounting for 17.1% of the total population. Meanwhile, there is a huge financial gap for social insurance, such that the overall population is growing old without acquiring adequate financial resources to support themselves in old age, thus the phenomenon one academic calls “getting old before getting rich”. Health insurance and social welfare institutions must improve in response to the rapid ageing of the population.

Social position determinants

Income distribution and poverty

In the past three decades, China has achieved a spectacular reduction in the number of people living in poverty. The number of absolutely poor people in rural China has been reduced from 250 million in 1978 to 35.97 million in 2009. The proportion of people who live on less than US$ 1 per day has been reduced from 46% in 1990 to 10.4% in 2005.18 China’s Human Development Index (HDI)* rose from 0.404 in 1980 (77th among 106 countries measured) to 0.687 in 2011 ranked (101st among 187 countries measured). Among the three components of HDI, the increase in the income index, gross national income (GNI) per capita, was most significant (see Table 3).

Table 3. Human Development Index and its ranking, China, 1980 to 2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Human Development Index</th>
<th>Score</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>0.404</td>
<td>(77)</td>
<td>101</td>
</tr>
<tr>
<td>1990</td>
<td>0.490</td>
<td>(84)</td>
<td>101</td>
</tr>
<tr>
<td>2000</td>
<td>0.588</td>
<td>(93)</td>
<td>101</td>
</tr>
<tr>
<td>2011</td>
<td>0.687</td>
<td>(86)</td>
<td>101</td>
</tr>
</tbody>
</table>

Table 4. Human Development Index, inequity adjusted data, China, 2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Human Development Index</th>
<th>Score</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0.687</td>
<td>94/187</td>
<td>65/135</td>
</tr>
</tbody>
</table>


However, progress has not been equal across all geographic areas and sectors of society, and inequity exists. When adjusted by inequity, HDI and Income Index in 2011 decrease from 0.687 and 0.618 to 0.534 and 0.436 respectively. (See table 4)

Gender

China has had good performance on Gender Inequality Index (GII). The value of GII is 0.223 in 2005, which ranks 34th of 187 countries. But females still have less development opportunities than males in terms of education, employment and political participation. Gender-based violence has serious consequences for women’s health and significantly limits women’s potential to participate fully in society. Rates of female suicide are high compared to those of men.

* The Human Development Index (HDI) is a composite statistic of health, education, and income indices to rank countries into four tiers of human development. It was created by economist Mahbub ul Haq, followed by economist Amartya Sen in 1990, and published by the United Nations Development Programme.
Education

China has high rates of school attendance and has achieved very high literacy rates, both for males and females. However, disparities still exist between urban and rural areas, between regions and between people of different social classes in terms of compulsory education enrolment rates, retention rates and education quality. The population also has a high computer literacy rate and with the widespread introduction of social media, information on food and drug safety can now be rapidly disseminated in the country. This has resulted in the public questioning of government credibility on some issues and has increased the requirement for more transparent information exchange.

Nutrition

China succeeded in reducing the number of underweight children by more than 50% between 1990 and 2005. The consumption of grain is decreasing, while the average daily intake of fruit, meat—especially from domesticated animals—and milk and eggs indicates an upward trend in dietary consumption, both in terms of quality and nutrition. However, consumption of meat, poultry and eggs by the poor and the nutrition of rural pupils and students remain cause for considerable concern. At the same time, obesity of urban children has become a concern.

Migration

Rapid industrialization and urbanization bring huge numbers of people to the cities. The portability across different insurance schemes and different regions is not yet widely established, migrant workers’ use of medical services may be affected. Migrant workers also bear higher risks of occupational diseases.

At the other end, children left in their home villages by their migrant-worker parents also encounter problems, such as low nutritional status, injuries and accidents. The growth retardation and the low birth weight of the “left-behind” children in rural areas in 2009 is approximately 1.5 times higher than those not left behind. In 2010, the number of the left-behind children under 5 years of age in the rural areas of China exceeded 15 million. Meanwhile, left-behind parents have higher incidences of physical and mental impairment than other people.

The circumstances of daily life

Food safety

In recent years, the illegal use of pesticides and veterinary drugs, as well as the fraudulent and illegal addition of or misuse of chemical substances, has gained more public attention and is believed to contribute substantially to the burden of foodborne diseases. Over the last three years (2010–2012), an average of nearly 200 food-related poisoning incidents (defined as more than 30 people haven taken ill or died) were reported in China through the public health emergency online reporting system. These multi-person incidents accounted for more than 6000 foodborne illnesses and 130 deaths per year.

Occupational safety

Over 20,000 cases of occupational diseases were reported each year from 2010 to 2011. From the 1950s to 2010, more than 750,000 cases of occupational diseases were reported, with pneumoconiosis the major occupational disease.

Environmental health

In China, the physical and psychological impacts of air pollution, water shortages, and pollution, road traffic injuries and noise pollution have been recognized as having a negative impact on people’s acute and chronic health status and health sustainability. This has led to concerns that China’s cities pose major environmental health challenges, particularly to those living and working in more deprived circumstances.

Drinking water safety

According to the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation Report, the percentage of the population receiving piped water has risen to 71%, and 69% of the population has access to improved sanitation facilities in rural areas in China. The coverage of piped water has increased in rural areas and the proportion of unsafe drinking-water use is declining. However, the problem still exists. China’s water, both in urban and rural areas, is frequently affected by chemical and waterborne pathogens. Accidents related to water contamination are frequently reported by the media.

Life-style

Behavioural risk factors for noncommunicable diseases such as tobacco use, the harmful use of alcohol, high salt and fat content in diets, and the lack of exercise are prevalent as lifestyles change due to socioeconomic development. There are over 300 million smokers in China, and 740 million people are exposed to second-hand smoke. Results of the 2010 China Chronic Diseases Surveillance Survey show that 8.1% of people over 18 years of age suffer from the harmful use of alcohol, and the rate is higher in rural areas (8.5%) than in cities (7.4%). The survey also indicates that the average daily amount of salt intake in Chinese families is 10.6 grams per person while less than 5.0 grams is recommended, and 83.8% of the population over 18 years of age do not have regular physical exercise in their leisure time. Breastfeeding has many health benefits, including NCD prevention. Currently, only 28% of mothers practice exclusive breastfeeding for their babies in the first six months of life.
2.4 Health system

Health service delivery

As of 2011, China had a total of 954,389 health-care facilities. They include hospitals, primary care institutions, public health institutions and other facilities.* In addition to hospitals, several categories of primary care institutions (district health centres and county hospitals) and public health institutions (maternal and child health centres) also provide in-patient medical care. Among the total of 5.16 million in-patient beds, about 30% was under those categories.

There are marked disparities in in-patient bed density between urban and rural areas, with 6.24 beds/1000 people in urban areas, and only 2.80 beds/1000 people in rural areas. This gap in services is also present for geographic areas (see Table 5).

Table 5. Density of in-patient bed by different regions, 2011

<table>
<thead>
<tr>
<th>Region</th>
<th>Total (beds per thousand population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.81</td>
</tr>
<tr>
<td>East</td>
<td>4.21</td>
</tr>
<tr>
<td>Center</td>
<td>3.52</td>
</tr>
<tr>
<td>West</td>
<td>3.62</td>
</tr>
<tr>
<td>Urban</td>
<td>6.24</td>
</tr>
<tr>
<td>Rural</td>
<td>2.80</td>
</tr>
</tbody>
</table>

Source: China Health Statistical Yearbook, 2012

Health financing

Health expenditure

Over the last 20 years, China’s total health expenditure (THE) has increased more than 30-fold from 74.74 billion RMB in 1990 to 2,426.88 billion RMB in 2011 (about US$ 389.5 billion at current exchange rates). It accounted for 5.1% of GDP in 2011. The proportion of private health expenditure as a percentage of THE rose from 35.7% in 1990 to 59.0% in 2000, but declined again to 34.9% in 2011. Per capita health expenditure in 2011 was 1,801.2 RMB (about US$ 289.10). There are wide differences in per capita health expenditure between urban and rural China.5

Health insurance system

The Urban Employee Basic Medical Insurance (UEBMI), the Urban Residents Basic Medical Insurance (URBMI) and the New Rural Cooperative Medical System (NRCMS) are three basic medical insurance schemes in China. By 2011, more than 1.3 billion people, or more than 95% of the population, had joined the schemes. As mentioned previously in this document, migrant populations often do not have medical insurance in the place of work. An urban–rural medical assistance system has been established, which covers those who are severely ill and have low incomes, the severely disabled, senior citizens from low-income families, and some other groups with special difficulties.5

Health workforce

The total number of the health workforce increased from 6.14 million in 1990 to 8.62 million in 2011. The number of doctors, including assistant doctors, per 1000 population increased from 1.56 in 1990 to 1.82 in 2011.5

However, the health workforce remains a constraint for equitable implementation of quality health services. Firstly, there are huge disparities of human resources across the different geographic regions and areas (see Table 6).

Table 6. Distribution of health personnel (2011) (per 1,000 population)

<table>
<thead>
<tr>
<th>Region</th>
<th>Physicians</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>total</td>
<td>urban</td>
</tr>
<tr>
<td>Total</td>
<td>1.82</td>
<td>3.00</td>
</tr>
<tr>
<td>Eastern Area</td>
<td>2.18</td>
<td>3.36</td>
</tr>
<tr>
<td>Middle Area</td>
<td>1.61</td>
<td>2.79</td>
</tr>
<tr>
<td>Western Area</td>
<td>1.60</td>
<td>2.60</td>
</tr>
<tr>
<td></td>
<td>1.40</td>
<td>2.79</td>
</tr>
</tbody>
</table>

Source: China Health Statistical Yearbook, 2012

* Hospitals include general hospital, traditional Chinese medicine hospital, dental hospital etc. Primary care institutions include district health centres, county hospitals, township hospitals, village clinics etc. Public health institutions include centers for disease control and prevention, maternal and child health centres etc. Other facilities include nursing homes etc.
Essential medicines and technologies

Essential medicines system

The national essential medicine system is seen as an important measure in health reform. In August 2009, the National Essential Medicine List was launched. Effective management is used in selection, production, distribution, use, pricing, reimbursement, monitoring, evaluation and other aspects of essential medicines. Overall, the medicine supply system has been strengthened. Since July 2011, essential medicines have been used in the government-run primary health care facilities with zero-markup drug sales.

Medicine safety

Medicine safety and regulation are important issues in China, as are the irrational use of medicines including the over-prescription of antibiotics, hormones, vitamins and glucose intravenous infusions. Medicine safety also includes issues related to the quality assurance of medicines preparation. In recent years, poor-quality medicines have resulted in a significant number of fatalities and have added to the doubt about the safety of pharmaceuticals in the country. While laws and regulations have improved, implementation of medicine safety supervision in China is still not yet adequate and needs to be strengthened urgently. A competent national drug regulatory authority is the key to ensure drug quality and safety. Over recent years, the capacity of the Chinese national drug regulatory authority, the State Food and Drug Administration (SFDA), has been strengthened in different aspects of drug regulation.

Traditional Chinese medicine

Traditional Chinese medicine (TCM) has been an integral part of the national health-care system in China. The TCM health-care system is composed of general TCM hospitals, TCM special hospitals, the TCM department of a general hospital, community health centres, township hospitals, village clinics, TCM outpatient departments and clinics. The Government promotes “combining TCM and Western medicine for the benefit of consumers” as its national health development strategy. Assuring the quality, safety and efficacy of TCM practices and products is essential to respond to increasing demands from the public and to promote the role of TCM for universal coverage of health service.

Health information system

China has built up a national communicable disease and public health emergencies direct online reporting system (see Figure 3). By 2011, it covered 100% of centres for disease control and prevention, 98% of county and higher-level hospitals and 94% of township hospitals. It helps to identify and report new cases effectively. It also contributes to improving the capacity to detect and respond to outbreaks and public health emergencies and to manage and monitor major communicable diseases in China.

By June 2011, China had a framework for health information system development to build a health information platform composed of national, provincial and prefectural levels, including five applications (public health, medical care, health insurance, drug management and integrated management) and two databases (resident electronic health records and hospital electronic medical records). However, the development of a regional health information system platform has been slow. There is a lack of resource integration and information sharing.

Health leadership and governance

The Ministry of Health (MOH) has overall responsibility within the Government for health matters. However, different aspects of health are now divided into several segments and managed by different ministries. In terms of social health insurance, UEBMI and URBMI are administered by MOH and the Ministry of Human Resources and Social Security (MHRSS), while NRCMS is under MOH. Frontier health and quarantine inspection are functions of the General Administration of Quality Supervision, Inspection and Quarantine. For example, the registration, production, distribution, pricing, bidding and procurement of drugs, as well as reimbursement by insurance, involve several agencies: SFDA, Ministry of Industry and Information Technology, Ministry of Commerce, National Development and Reform Commission, MOH and MHRSS.
2.5 National responses to health challenges

National development process and policies

China released the 12th Five-Year Plan for National Economic and Social Development in March 2011. It sets continuous improvement of people’s lives as one of the seven main objectives over the next five-year period. Within the scope of health development, the plan urges deeper health-care system reforms to meet people’s basic health-care demands.

National health policies, strategies and plans

National health care system reform

Health care system reform was launched fully in 2009 when the Central Committee of the Communist Party and the State Council issued the Opinions on Deepening Reform of the Medical and Health Care Systems. Further, the State Council issued the Implementation Plan for the Recent Priorities of Health Care System Reform (2009–2011). The overall goal of health care system reform is to establish and improve the basic health-care system covering urban and rural residents and provide the people with secure, efficient, convenient and affordable health-care services.

The Government identified five priority areas for reform and established a committee across ministries to coordinate the policy formulation and implementation. The five priorities are:

• accelerating the establishment of the basic medical security system
• establishing a national essential medicines system
• strengthening health services at grass roots level
• promoting the equalization of basic public health services, and
• promoting pilot projects for public hospital reform.

12th Five-Year Plan for Health Sector Development (2011–2015)

The State Council launched the 12th Five-Year Plan for Health Sector Development (2011–2015) and the Plan for Further Strengthening Health Care System Reform (2012–2015). Health development goals for 2015 were set as follows:

• basic medical and health system that covers urban and rural residents will be established;
• basic medical insurance and basic public health services will be made universally available;
• accessibility, quality and efficiency of medical and health services as well as patient satisfaction will increase evidently;
• out-of-pocket payments will be reduced;
• cross-regional gap of health resource allocation and of health status among populations will continuously narrow; and
• average life expectancy will be increased by one year compared with 2010.

In order to achieve those health development goals, four areas of health systems strengthening and seven health priorities are identified. The health system strengthening areas include public health service, medical service, medical insurance and medicine supply systems. Seven health priorities are public health services, food safety and health inspection, medical service management, TCM, health workforce, medical sciences and technology, health information systems, and the health industry.
2.6 China’s contribution to and role in global health

China has made significant contributions to global health by improving the health outcomes of its own population, providing health cooperation to other developing countries, fulfilling international commitments, and engaging in global health technical work and governance.

China’s own health improvement contributes to global health

China has made great achievements in improving the health of its people. It has also made considerable progress in major disease control. China has developed a well-structured health system covering both urban and rural areas. With the development of the county-township-village three-tiered health-care delivery network with NRCMS, and recent health sector reforms, China has rapidly extended coverage of health services and reduced the share of out-of-pocket payments in total health expenditure. The sheer size of the population in China means that any significant improvement in health in China contributes not only as an example of — but also to the magnitude of— global health improvement.

China’s fulfilment of international commitments

China has been seriously fulfilling its international commitments. The Fifty-eighth World Health Assembly discussed and adopted the revised International Health Regulations (IHR 2005) in May 2005. China actively promotes the implementation of IHR 2005 in China. It has also actively responded to international development initiatives, and high-level commitment has been extended to achieve the Millennium Development Goals (MDGs), with all the goals either achieved, or on target to be achieved, by 2015. China also signed the WHO Framework Convention on Tobacco Control (FCTC) in 2005 and is making efforts to implement it.

China’s health cooperation with other countries

China has actively engaged in health cooperation with other countries. It has provided financial and technical support to developing countries, especially in Africa, for decades by dispatching medical teams, donating medical equipment and drugs, building hospitals and other health facilities, and training the health workforce. In recent years, this cooperation has been extended to disease prevention and control programmes, such as malaria control. There is also a trend of multi-player involvement in international health cooperation, with increasing engagement of nongovernmental organizations. China has also engaged in cross-border cooperation, especially in joint responses to health security threats. China–Africa collaboration has been well praised by the international community. It was noted as a best practice for South–South cooperation by United Nations Secretary-General.

China’s role in global health technical work and governance

China, as the largest developing country, plays an important role in international health organizations. It frequently sits on the Executive Board of WHO and has been a board member of the Global Fund to Fight AIDS, Tuberculosis and Malaria since its creation. It is also a member of the UNAIDS Programme Coordinating Board. In the World Health Assembly, China is actively involved in the debate on major global health issues and policy-making. Dr Margaret Chan, from the Hong Kong Special Administrative Region of China, is the first Chinese elected by the World Health Assembly to lead WHO as Director-General. In 2012, China’s assessed contribution to WHO was US$ 14.8 million, making it the eighth-largest contributor to WHO assessed contributions. From 2006 to 2012, the Chinese government has voluntarily contributed US$ 14.66 million to WHO. In addition, China has donated US$ 100,000 (increased to US$ 150,000 in 2012) each year to UNAIDS, and donated a total of US$ 25 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO collaborating centres in China, through their collaborative work and the participation of Chinese experts in WHO meetings, have also contributed to global health work.
3.1 The aid environment in the country

With successful economic development, China’s status as a beneficiary of development aid is changing. According to the Organization for Economic Cooperation and Development, net official development assistance disbursement received by China as percentage of GNI has decreased from 0.12% in 2001 to 0.01% in 2010. The health sector is observing a similar trend. Many development partners in health have recently reduced or withdrawn bilateral support to China.

3.2 United Nations Systems in China

There are currently 21 United Nations System organizations represented in China, including WHO. They work together as part of the United Nations Resident Coordinator system in order to support China in its development.

There are six “theme groups” in the United Nations System in China that operate in support of China’s development. These themes are poverty and inequality, health, climate change and environment, gender, HIV/AIDS, and China’s engagement in the international arena. WHO is the chair of the Theme Group on Health and the co-chair of the Theme Group on HIV/AIDS. The Theme Group on Health includes all health partners, as well as United Nations System organizations, with MOH as co-chair. The Theme Group on Health consists of five working groups: noncommunicable diseases, maternal and child health, health reform, diseases at the animal–human interface, and South–South Cooperation.

The United Nations System in China and the Government of China jointly agreed upon and launched the United Nations Development Assistance Framework (UNDAF) for 2011–2015. It identified three main priority areas, or UNDAF outcomes, as follows:

- **UNDAF Outcome 1:** The Government and other stakeholders ensure environmental sustainability, address climate change, and promote a green, low-carbon economy.
- **UNDAF Outcome 2:** The poorest and most vulnerable increasingly participate in and benefit more equitably from China’s social and economic development.
- **UNDAF Outcome 3:** China’s enhanced participation in the global community brings wider mutual benefits.

WHO actively participated in the UNDAF development process and has committed to an active role in achieving UNDAF outcomes.
Country Cooperation Strategy

The WHO Representative Office in China was established in 1981. Throughout the years, cooperation between WHO and China has been mutually beneficial. Over the past 30 years, the nature of WHO assistance in China has adapted to the changing social and economic context to address pertinent health needs. In more recent years, WHO has turned its attention to the mounting problems associated with rapid industrialization, urbanization and rising disparities in access to health care and in health outcomes as economic growth surges in China’s transitional economy.

In 2004, MOH and WHO signed a Memorandum of Understanding (MOU) to strengthen health cooperation and exchange, identifying key areas of cooperation, including 1) public health priorities (rural health, prevention and treatment of major diseases, and mechanisms for public health emergency response); 2) control of major communicable diseases (HIV/AIDS, tuberculosis, hepatitis B, schistosomiasis, malaria and other emerging diseases); 3) noncommunicable diseases (including health determinants such as environment, tobacco control and food safety); 4) traditional medicine (including standard setting, quality control and the safe use of TCM in accordance with World Health Assembly policies); and 5) human resources for health. Based on this MOU, WHO developed its CCS for China for 2004–2008.

In 2008, MOH and WHO signed a renewed WHO CCS for 2008–2013 to accommodate the rapidly changing context of China and to address emerging issues. The WHO CCS for China identified four Strategic Priorities and employed seven key approaches to attain those priorities. Four Strategic Priorities were: 1) health systems development through implementation of health sector reforms towards universal access of basic health care services; 2) achievement of health-related MDGs; 3) reducing the high burden of noncommunicable diseases, including work on tobacco control; and 4) addressing emerging public health threats. Seven key approaches were to: 1) support the development or implementation of relevant country health frameworks and policies based on international standards and norms; 2) promote international cooperation and support studies and information exchanges between China and other countries on selected public health issues; 3) provide evidence-based policy advice and technical support; 4) promote the delivery and universal access of essential health interventions for prevention, treatment, care and support; 5) support the strengthening of human resources for health management and development systems; 6) strengthen community-based health services and capacities; and 7) strengthen monitoring, evaluation and surveillance systems.

Overall, supporting national ownership of health investments and capacity-building have been intrinsic to all of these approaches to ensure more sustainable health improvements and results over the long term.

4.2 Review of WHO’s work over the past CCS cycle

A consultation with WHO Country Office staff and WHO’s partners identified areas of WHO strength and weakness. Areas of successful collaboration included health services delivery and financing; regulation of essential medicines and pharmaceuticals; food safety; environmental health; emerging communicable diseases, including core capacity-building required by the International Health Regulations (2005); polio eradication; reduction of chronic hepatitis B infection among children; and substantial reduction in measles incidence.

The consultation highlighted the need to improve efficiency and effectiveness in WHO collaboration, including reducing the large number of small projects funded under assessed contribution funds and the administrative time required for each of the projects. The limited communications capacity of the WHO Country Office and the slow pace of WHO internal working procedures were noted. It was also pointed out that the identified CCS priorities were not always supported by WHO Headquarters and Regional Office technical programmes, warranting an early update of the existing CCS to reflect changed country needs and to ensure that WHO’s collaboration as a whole, including global and regional programmes, coherently reflect China’s needs. Finally, little innovation in financing mechanisms was identified during the consultation.

4.3 Changing context for WHO in China

WHO in China is at a turning point. Over the past decades, financial and human resources available at the WHO Country Office in China have rapidly increased, mainly from voluntary contributions, while funds from assessed contributions have remained at similar levels. With changes in China’s status in the aid environment, WHO in China is constrained by limited flexible funding, which requires tough choices and a sharpened focus on strategic priorities for WHO’s work and staffing in China.

However, WHO’s relative advantage comes from its rich global technical network, including WHO Headquarters, regional and country offices, and WHO collaborating centers. There is still a clear need for China and WHO to further strengthen their collaboration for mutual benefit. WHO will continuously provide necessary support to China though renewed CCS strategic agendas and realignment of its resources.
5.1 Strategic priorities for China-WHO collaboration

To reflect the rapid socioeconomic development and evolved priorities for China-WHO collaboration and better align it with the Government planning cycle, this “bridging” Country Cooperation Strategy (BCCS) lays out a three-year transition from the 2008–2013 CCS to the one that will be prepared for 2016–2020. As such it aims to set up an agenda that will continue in 2016 and beyond, while also phasing out certain areas of work before 2016.

WHO’s collaboration with China needs to focus on specific elements in which WHO’s contribution may be most beneficial, while still retaining some degree of flexibility to respond to the Government’s requests. Overall, this collaboration is related to WHO’s six core functions of (1) providing global health leadership, (2) setting norms and standards, (3) shaping the research agenda, (4) articulating policy options, (5) providing technical support and (6) monitoring health trends.

The priorities for China-WHO collaboration for 2013–2015 described in this section are underpinned by an analysis of the current context in China and its likely evolution in coming years, priorities of the Government of China for health stated in the 12th Five-Year Plan for Health Sector Development, comparative advantages of WHO and lessons learnt during implementation of the current CCS. They also take account of China’s commitments as a WHO Member State and through resolutions of the World Health Assembly and the WHO Regional Committee for the Western Pacific, and ongoing agreements that have been negotiated between WHO and China, for example, the Western Area Health Initiative (WAHI).

This has required a selective approach in determining the priorities for WHO support in the next three years. It is not enough to identify a significant health issue in China. Both China’s capacity and WHO’s capacity must be considered before including these health issues in this strategic plan. We have adopted three criteria for inclusion as a Strategic Priority or Focus Area:

- Identification by Government and by WHO of a specific priority area of intervention;
- WHO added-value in providing support, or comparative advantage over other possible sources of support; and
- Identification of adequate human and financial resources, from any of WHO’s three levels, to ensure WHO’s productive involvement.

Described below are the four Strategic Priorities of WHO collaboration with China for 2013–2015, and within each of these, the main Focus Areas and the Strategic Approaches.

The Strategic Priorities are:

1. Strengthen health systems towards universal health coverage.
2. Reduce morbidity and mortality from major diseases of public health importance and from risks to health and health security.
3. Reduce inequities in health in the western region of China through subnational public health action.
4. Contribute to strengthening global health through supporting the collaboration of China in the global health arena.
5.2 Main Focus Areas, and area-specific strategic approaches

**Strengthen health systems towards universal health coverage**

WHO will support the Government to strengthen health systems development towards universal health coverage to ensure that all people have access to needed promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. WHO’s collaboration with the Government of China will focus on the implementation of national health care system reform, strengthening institutional capacity for comprehensive and quality health services that integrate modern and traditional approaches, and governance and stewardship of the Government.

<table>
<thead>
<tr>
<th>Main Focus Area</th>
<th>Support the Government to improve health care reform in line with the Plan for Further Strengthening Health System Reform from 2012-2015 and the 12th Five-Year Plan for Health Sector Development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support for the implementation of key areas of health care reform, and building an integrated health-care system.</td>
</tr>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support for the monitoring and evaluation of key areas of health care reform and identification of key barriers to the achievement of desired outcomes and impact.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Focus Area</th>
<th>Support the Government to implement health-care reform in line with the Plan for Further Strengthening Health System Reform from 2012-2015 and the 12th Five-Year Plan for Health Sector Development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support for evidence-based interventions, quality standards and human resources for integrated health service delivery.</td>
</tr>
<tr>
<td>Strategic Approach</td>
<td>Support the development of traditional Chinese medicine as an integral part of a comprehensive health system based on evidence of efficacy, safety and quality.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Focus Area</th>
<th>Support the Government in health care with an emphasis on strengthening primary health care (basic health care) and public hospital reform.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support to build capacities for health planning and financing, health information systems and accountability.</td>
</tr>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support for the regulation, quality assurance and management of medicines, vaccines and health technologies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Focus Area</th>
<th>Support the Government to prevent, control and eliminate targeted communicable diseases, and regional and global initiatives on specific communicable diseases.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support for evidence-based policy-making and legal frameworks in elimination strategies of specific diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Focus Area</th>
<th>Support the Government to reduce the premature burden of noncommunicable diseases and challenges of ageing through a life-course approach.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Approach</td>
<td>Promote advocacy and multisectoral approaches including a health-in-all policies and settings approach to address the social determinants, nutrition, tobacco use and other risk factors of noncommunicable diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Focus Area</th>
<th>Support the Government in the preparedness, surveillance, early warning, assessment, risk communications, epidemiological investigation and response for risks to health security and food safety.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support to implement International Health Regulations (2005) and APSED commitments including capacity-building to reduce cross-border transmission of diseases.</td>
</tr>
<tr>
<td>Strategic Approach</td>
<td>Provide technical and policy support to address food safety and environmental health risks, and preparedness and response in the event of natural disasters.</td>
</tr>
</tbody>
</table>
Reduce inequities in health in western region of China through subnational public health action

WHO will support the implementation of national health priorities (with the focuses identified in 5.2.1 and 5.2.2.) and promote the achievement of the MDGs at the subnational level through WAHI. As the first phase, three provinces or regions (Guangxi Zhuang Autonomous Region, Chongqing Municipality and Shaanxi Province) have been selected as pilot areas. The MOH, provincial authorities and WHO will jointly develop a strategic agenda for implementing national health policies and programmes through a collaborative framework to identify and respond to province-specific conditions and priority health issues. This will be achieved through evidence-based planning and implemented through multisectoral action based on existing platforms such as Healthy Cities and Healthy Villages, with the support of political, academic and health leaders to achieve the goals of extending life expectancy and improving quality of life. The experience and lessons learnt from the pilot provinces will be distilled and documented for dissemination to other western provinces.

**Main Focus Area**
Support WAHI provincial governments in further strengthening health-care system reform.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support WAHI provincial governments in reviewing existing experiences from health-care system reform and further elaborating action plans.</th>
</tr>
</thead>
</table>

**Main Focus Area**
Support WAHI provincial governments in addressing province-specific priority health issues.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support the grassroots-level health facilities in capacity-building of health workforce for integrated and quality health-care service, including traditional Chinese medicine.</th>
</tr>
</thead>
</table>

**Main Focus Area**
Support WAHI provincial governments in strengthening local programme management and coordination capacity to enhance the contribution of the WAHI provinces to national and global health.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support technical institutions to strengthen priority public health programmes, including noncommunicable diseases, maternal and child health.</th>
</tr>
</thead>
</table>

**Main Focus Area**
Support technical institutions for capacity-building in monitoring and evaluation of interventions of public health programmes.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Facilitate cooperation and collaboration of WAHI provincial governments and technical institutions both with other provinces and other countries.</th>
</tr>
</thead>
</table>

Contribute to strengthening global health through supporting the collaboration of China in global health arena

China has accumulated rich experience in developing its health system and improving its people’s health. Important lessons learnt could be shared with countries facing similar challenges. China has the potential of providing more effective cooperation on health with other developing countries through provision of health assistance or joint efforts to control health threats across borders. China, as the largest developing country, plays an important role in global health governance and financing. China could also make its medical technology and products more available at affordable prices to improve global health.

WHO is well placed to support China in building its capacity in priority programme areas in which China can best add value to global health. These areas include knowledge generation and dissemination of experience and lessons learnt by China on health development, improvement of its health cooperation with other countries, greater participation in global health work and governance, and availability of health technology and products for global health.

**Main Focus Area**
Support WAHI provincial governments in addressing province-specific priority health issues.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support WAHI provincial governments in reviewing existing experiences from health-care system reform and further elaborating action plans.</th>
</tr>
</thead>
</table>

**Main Focus Area**
Support China in distilling, documenting and disseminating its experience and lessons learnt in strengthening the health system and in improving health outcomes that are relevant to other countries.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Help China to identify areas where Chinese experiences and lessons are relevant for other countries, especially developing countries.</th>
</tr>
</thead>
</table>

**Main Focus Area**
Support China in improving its bilateral health cooperation and in greater participation in global health work and governance.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support the Government to enhance the effectiveness of external health cooperation, particularly across borders and in Africa, including through new forms of cooperation or/and cooperation with other international organizations.</th>
</tr>
</thead>
</table>

**Main Focus Area**
Support China to make available its health technologies and quality products to contribute to global health.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support China’s capacity-building to apply WHO’s pre-qualification and other internationally recognized standards for its pharmaceutical and biological products.</th>
</tr>
</thead>
</table>

**Strategic Approach**
Provide technical support to distil and document Chinese experiences and lessons and disseminate this knowledge worldwide.

<table>
<thead>
<tr>
<th>Strategic Approach</th>
<th>Support China to transfer appropriate health technologies to other countries to improve global health outcomes.</th>
</tr>
</thead>
</table>
Future collaboration in other health issues

There are many other health priorities in China in which WHO might play a productive role. Any of these might become a part of WHO's core work during the period of this strategic plan and may be supported by any of the three levels of WHO (Country Office, Regional Office and Headquarters) subject to the following:

• identification by Government of a specific priority area of intervention, with a request for further WHO support;
• WHO added-value in providing such support, or comparative advantage, over other possible sources of support; and
• identification of adequate human and financial resources from any of WHO’s three levels to ensure WHO's productive involvement.

5.3 Overall strategic approaches

The overall Strategic Approaches of the collaboration of WHO with China during the period of the BCCS have the following features:

• closely link WHO’s cooperation at the national level to that at the subnational level
• closely link WHO’s cooperation with health sector to that of non-health sectors
• closely link WHO’s cooperation to other partners’ cooperation with Government.

WHO will cooperate with the Government both at the national and subnational levels. At the national level, WHO’s main input is to support the Government to develop health policies and to provide guidance for policy implementation. At the subnational level, WHO will support WAHI to better implement national policies through evidence-based planning and multisectoral action. The experience and lessons learnt in the pilot programme will in turn inform the national decision-making and dissemination in other provinces. This close linking between the national level and subnational levels will make the cooperation more effective.

Addressing social determinants and risk factors of ill health needs engagement of relevant non-health sectors. Effective promotion of “Health in All Policies” is a major challenge to MOH. WHO is taking the lead in addressing the social determinants of health, with its comparative advantage of working globally with other sectors. At the country level, WHO will link its cooperation with MOH to that with non-health sectors and support Government capacity-building in multisectoral action and Health in All Policies. Prevention and control of noncommunicable diseases could be an entry point for this approach.

WHO needs to link its cooperation to the work of other partners at the country level and maximize the synergy between WHO’s actions and the efforts of other partners. WHO will, in particular, use its technical know-how and its convening power to promote the alignment of the action of other partners with the Government priorities so as to create an enabling environment in which other partners can better play to their strengths.

6.1 The role and presence of WHO according to strategic agenda

The refocus of priorities and the changing circumstances of both China and WHO have implications for the role of WHO and its presence in the country, including the staffing structure of the WHO Country Office, the support of other levels of WHO, and the allocation of resources in support of the work and the office.

The role of WHO

During 2013–2015, the role of WHO working in and with China will be shifted towards:

• an increased focus on high-level policy dialogue and technical support for targeted interventions at the national and provincial levels;
• targeted support to WAHI; and
• support to China’s global engagement in health issues.

Presence of WHO

These shifts in the role will require substantial changes in the presence of WHO in China.
A staffing re-structure in the WHO Country Office to align with the CCS

It is expected that core staffing of the Country Office will consist of a limited number of experienced senior international staff who have broad technical and managerial skills, working closely with senior experienced National Professional Officers. The areas of responsibility of these staff members will correspond to the strategic priorities of this BCCS. In addition, international and national professionals will be engaged to meet specific technical priorities according to mutually identified need and available resources. These staff members will often be engaged for a limited duration, depending on needs and resources.

A shift of use of WHO core budget, gradually increasing the share used for supporting WHO core staff and office operations

As the sources of external financial support from bilateral and multilateral donors have steadily declined in China, including those previously provided for WHO staff and activities, a change in use of the WHO core budget is indicated. In the new biennium, according to the joint decision between the two sides, the proportion of budget used to support the core staffing of the WHO Secretariat and the operation of the WHO China Office will be gradually increased.

The short-term technical staff will typically be funded from one of three sources:

- WHO core budget, although this is prioritized for core staff
- funds from external donors (voluntary contributions) where this is available, or
- especially in the case of seconded staff, by Government or by the home institution.

This latter funding modality has not previously been operational in China but is common in many countries, and will be further explored to allow WHO to directly support Government priorities while providing capacity-building and international organization experience to Chinese nationals.

6.2 Using the CCS

The renewed BCCS will guide the WHO Secretariat’s work with China from 2013 to 2015, in particular to:

- guide the work of WHO at all levels, including preparation of the 2014–2015 Programme Budget; and
- identify opportunities for WHO support to China, as well as opportunities for WHO and China to cooperate for mutual benefit in regional and global initiatives.

6.3 Monitoring and evaluation of the CCS strategic agenda

The entire WHO Secretariat, and in particular the WHO Country Office in China, will monitor its contribution within the partnership environment to ensure continuing complementarity with partner contributions.

The WHO Secretariat, the Government of China and local authorities will review the CCS near the end of the CCS cycle.
## Annex 2

### Basic population and health indicators by provinces

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>1.3643 billion</td>
<td>18.47</td>
<td>70.70</td>
</tr>
<tr>
<td>Beijing</td>
<td>22.99 million</td>
<td>16.76</td>
<td>72.56</td>
</tr>
<tr>
<td>Tianjin</td>
<td>9.61 million</td>
<td>18.94</td>
<td>72.56</td>
</tr>
<tr>
<td>Hebei</td>
<td>25.64 million</td>
<td>15.02</td>
<td>74.40</td>
</tr>
<tr>
<td>Shanxi</td>
<td>37.43 million</td>
<td>23.08</td>
<td>69.70</td>
</tr>
<tr>
<td>Henan</td>
<td>46.31 million</td>
<td>16.20</td>
<td>69.10</td>
</tr>
<tr>
<td>Hubei</td>
<td>34.69 million</td>
<td>16.04</td>
<td>71.10</td>
</tr>
<tr>
<td>Hainan</td>
<td>80.50 million</td>
<td>16.22</td>
<td>69.10</td>
</tr>
<tr>
<td>Guangxi</td>
<td>29.19 million</td>
<td>21.96</td>
<td>74.75</td>
</tr>
<tr>
<td>Guangdong</td>
<td>8.77 million</td>
<td>17.90</td>
<td>76.20</td>
</tr>
<tr>
<td>Hunan</td>
<td>46.45 million</td>
<td>14.31</td>
<td>76.49</td>
</tr>
<tr>
<td>Fujian</td>
<td>105.05 million</td>
<td>20.74</td>
<td>74.87</td>
</tr>
<tr>
<td>Jiangxi</td>
<td>65.96 million</td>
<td>18.02</td>
<td>75.08</td>
</tr>
<tr>
<td>Zhejiang</td>
<td>57.58 million</td>
<td>12.61</td>
<td>77.73</td>
</tr>
<tr>
<td>Anhui</td>
<td>44.88 million</td>
<td>12.99</td>
<td>74.33</td>
</tr>
<tr>
<td>Jiangsu</td>
<td>37.20 million</td>
<td>10.70</td>
<td>76.18</td>
</tr>
<tr>
<td>Shandong</td>
<td>59.68 million</td>
<td>10.47</td>
<td>75.10</td>
</tr>
<tr>
<td>Henan</td>
<td>54.63 million</td>
<td>13.55</td>
<td>78.89</td>
</tr>
<tr>
<td>Hebei</td>
<td>54.40 million</td>
<td>20.19</td>
<td>80.18</td>
</tr>
<tr>
<td>Shanxi</td>
<td>13.70 million</td>
<td>11.36</td>
<td>74.83</td>
</tr>
<tr>
<td>Heilongjiang</td>
<td>27.49 million</td>
<td>16.16</td>
<td>76.38</td>
</tr>
</tbody>
</table>

* Basic population and health indicators by provinces include population, % under 15, and life expectancy for the year 2010.

** Life Expectancy includes both male and female populations.

MRR = Maternal Mortality Ratio
GDP = gross domestic product
GRP = gross regional product
N.A. = not available

---

### Endnotes


Country Cooperation Strategy

China — WHO


38 Available from: http://www.aidflows.org