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Section B: The MCH Counties Program in China: An Experience of Scaling Up During a Period of Economic Reform and Restructuring of PHC

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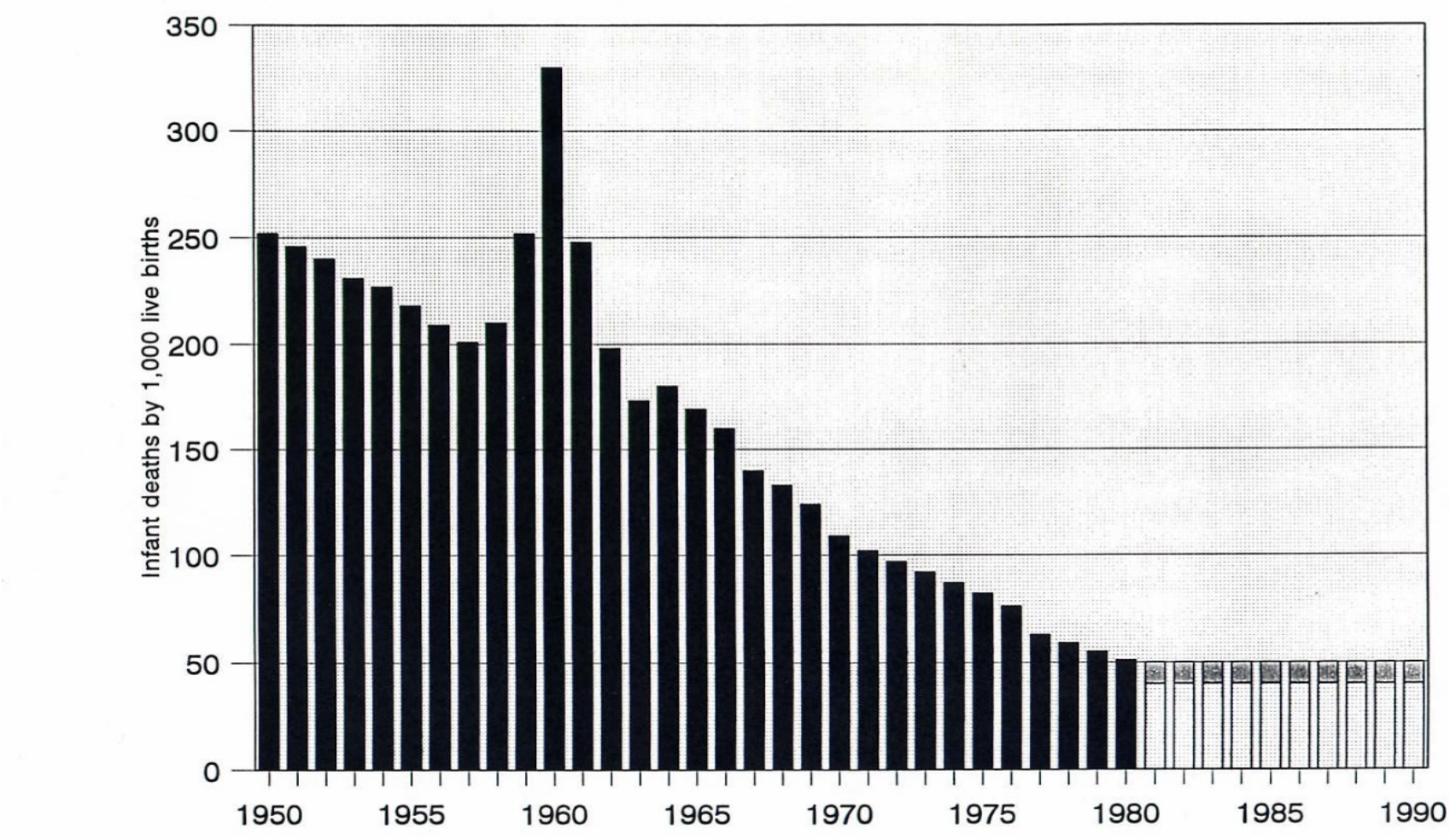
Changes in China's Health System

- **1950-1980**
  - China had developed a model PHC system and made dramatic improvements in health status
- **Late 1970s to mid-1980s**
  - The impact of economic reforms initially benefited mostly rural areas, reducing economic and health disparities between rural and urban areas
- **After the mid-1980s**
  - The reforms mostly benefited urban and coastal regions of China, increasing rural and urban disparities

Infant Mortality Rate, China, 1950–1990



Source: YOUNG & PROST (1985) p.8 (1959-1980); UNICEF estimates (1981-1990)
Note: these estimates are orders of magnitude
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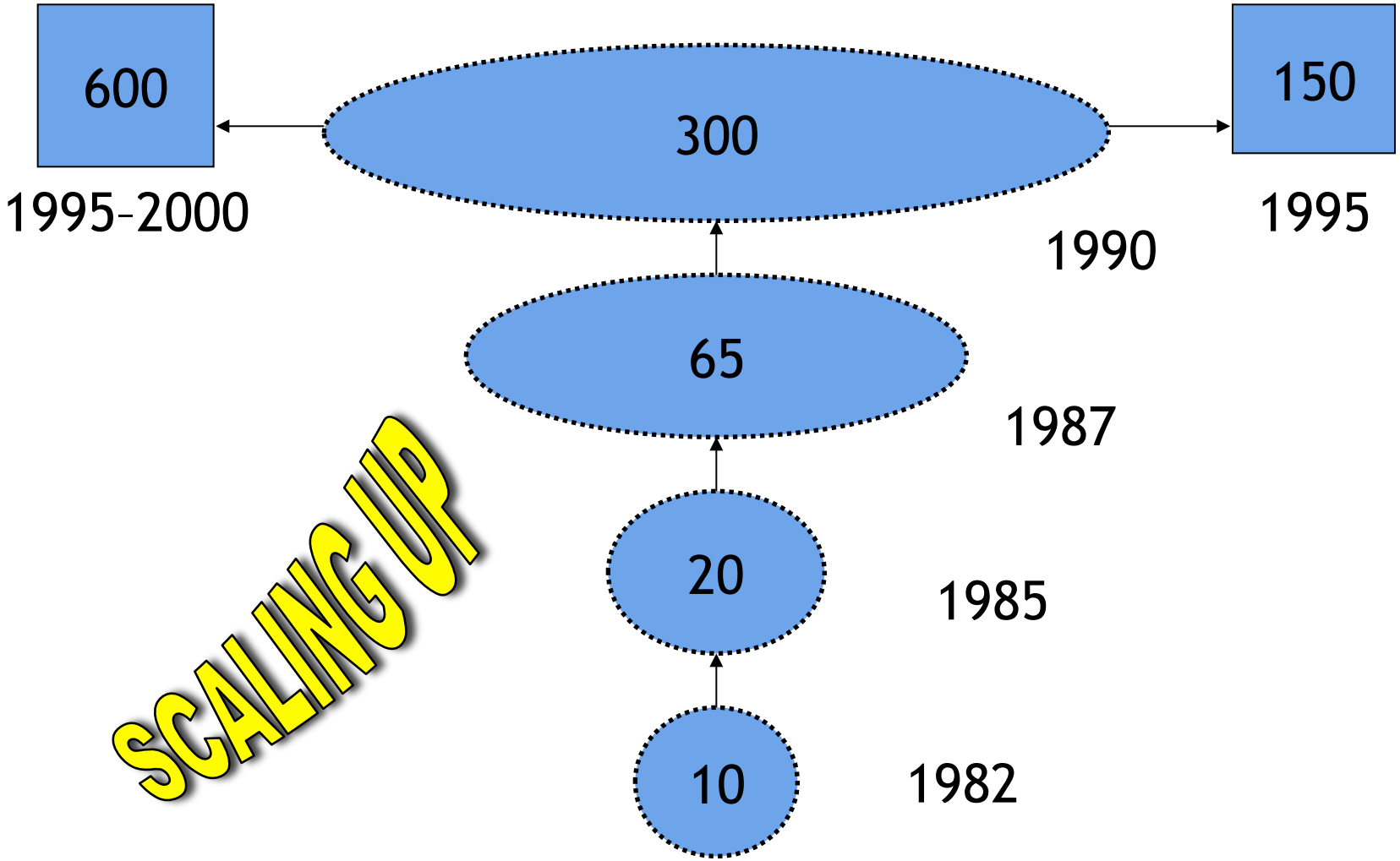
Impact on Rural PHC Systems

- Major changes in the rural PHC system and health status of rural populations occurred starting early in the 1980s
- The number of village and township health workers began to drop
  - For example, over half of the village (barefoot) doctors moved to other professions
- Village health stations were closed, and the use of the remaining ones decreased
- Financing of PHC changed with almost complete elimination of the cooperative health system
  - 90% coverage to 5–10%
- Financial barriers to use the health system became common
  - 40% and 60% couldn't get care for needed outpatient or inpatient services, respectively, in poor areas of China in the 1990s
- The IMR stopped dropping and actually increased in some very poor rural areas

The MCH Counties Program



The MCH Counties Program—Some Lessons Learned

- The first phase: from 10 to 95 counties
  - Intensive community-level planning in the initial counties
  - Commitments made at the county level
  - Expert inputs from academic institutions
  - Comprehensive PHC approach
  - Major demonstration and advocacy impact
  - Important applied research was carried out
  - Program expansion varied
    - Initial scaling-up wasn't very successful

The MCH Counties Program—Some Lessons Learned

- The second phase: 300 high IMR counties
  - Counties selected in all provinces based on IMR, BR, and PCI—concept of "model" revised
  - Key leaders mobilized at all levels
  - Political commitment—"contracts"
  - Provincial level "ownership"
  - Shift from "project" to "program"
  - Avoiding "pilot" mentality—countywide

The MCH Counties Program—Some Lessons Learned

- The second phase: 300 high IMR counties
  - Focus on six integrated interventions
    - Control of diarrheal disease
    - Acute respiratory illness
    - Safe motherhood or maternal care
    - Family planning
    - Nutrition and growth mentoring
    - Care of newborns
  - Different role for academic institutions

The MCH Counties Program—Some Lessons Learned

- The second phase: 300 high IMR counties
  - National level open to new ideas
  - Regionalized, step-wise training
  - Uniform baseline data collected for planning and evaluation
  - Internal and external evaluation

Impact of the MCH Counties Program

- Impact of the MCH counties program on health status and health care: 1989–94
  - IMR reduced 36%
  - MMR reduced 52%
  - CBR reduced 39%
  - Antenatal care (3+ visits) increased 190%
  - Postnatal care increased 147%
  - Percent of hospital deliveries increased 76%
  - Increased priority for MCH
  - Spread beyond the 300 counties
  - Major boost toward year 2000 goals
  - Importance of local “leading groups” and more local flexibility
  - Identified some of the negative effects of economic reforms on health care
  - Good coordination of external agencies

Questions

- What factors in China made the expansion of the MCH Counties Program possible?
- Which of these factors, if any, would be applicable elsewhere?
- How sustainable will the new MCH services be in the current market economy of China?