**Policy Context**

<table>
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<tr>
<th>Policy Context</th>
<th>Situation Analysis</th>
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</thead>
</table>
| Global strategy on women and children / commitment (PNMCH) | To increase its domestic investment in women and children's health, through new policies and measures, and additional financing;  
To provide basic health care insurance for all through new reforms now being implemented;  
To ensure that new measures that especially benefit rural women reach them, including free breast and cervical cancer screening, hospital birth-delivery subsidies, and free folic acid supplements;  
To implement free hepatitis B vaccination for all children under 15 years old, a national immunization program covering all children;  
To provide free services to prevent mother-to-child transmission (PMTCT) of the HIV virus for all pregnant women;  
To ensure that the government reimburses 90% of medical expenses for rural children who have congenital heart disease or leukaemia. |

| National Health Sector Plan and M&E Plan | Health planning conforms with the system of 5-year plans of PRC. As a key characteristic of centralized, socialist market economy, one plan is established for the whole country, which details economic and social development guidelines for all regions. The term plan was recently changed to guideline. The 12th 5-Year Guideline was approved by the NPC in March 2011. Important goals included addressing inequality, promoting sustainable growth, increasing domestic consumption, and improving social infrastructure and social safety nets. Subsequently, detailed five-year plans are generated by each sector. In 2012, the five-year plan for national health care reform was issued, which details broad directions and goals. Subsequently, a detailed 2012 implementation plan was issued, which identifies specific actions and targets, and the responsible ministry. A detailed set of indicators and data collection systems has been established for monitoring targets set forth under the national health care reform guidelines. The NDRC is responsible for overall monitoring and evaluation, and the MoH as an implementing ministry collects and analyzes the data for reporting. |

**Country team present at the Philippines Accountability Workshop, March 19-20, 2012**

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*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group.*
## COUNTRY ACCOUNTABILITY FRAMEWORK: Scorecard

### KEY:
- **Black** Not present, needs to be developed
- **Red** Needs a lot of strengthening
- **Yellow** Needs some strengthening
- **Green** Already present/no action needed

<table>
<thead>
<tr>
<th>Civil registration &amp; vital statistics systems</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment &amp; Plan</td>
<td>WHO conducted a rapid assessment in 2009. Census conducted in 1995, 2000, and 2005; Vital registration covers about 8% of population; CDC Demographic Surveillance Points (DSP system) conducted among &gt;160 counties; MCH surveillance conducted in 336 counties. There is no interagency coordinating committee. But MCH State Council Office on Women's and Children's development coordinates all aspects of policy for women's and children's health. Hospital reporting of deaths at county level and above is almost complete, but some information may be lost. ICD 10 used in county, provincial, national hospitals. Some regions may not be able to meet quality standards. Incomplete reporting of community births and deaths. CDC conducts verbal autopsies (VA) in approx 200 counties, but incomplete. Vital statistics are published annually in a statistical report, however, data quality assessment is only occasionally conducted and is ad hoc. CDC DSP covers 160 counties.</td>
<td>1. Implement systems to strengthen vital registration and combine vital registration and DSP. 2. Develop a plan to strengthen birth registration. 3. Strengthen interagency coordinating committee involving all key stakeholders. 4. Improve hospital reporting, use electronic reporting system. 5. Training of doctors in ICD 10; regular quality control of certification; improve coding practices. 6. Strengthen community reporting of births and deaths, implement innovative approaches. 7. Strengthen community reporting through use of VA by community workers. 8. Strengthen the analytical capacity of vital statistics office, including data quality assessment. 9. Develop/expand the HDSS system.</td>
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<tr>
<td>Coordinating Mechanism</td>
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<tr>
<td>Hospital reporting</td>
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<tr>
<td>Community reporting</td>
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<tr>
<td>Vital statistics</td>
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<tr>
<td>Local studies for mortality</td>
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### Monitoring of results

<table>
<thead>
<tr>
<th>M&amp;E Plan</th>
<th>M&amp;E Coordination</th>
<th>Health Surveys</th>
<th>Facility data (HMIS)</th>
<th>Analytical capacity</th>
<th>Equity</th>
<th>Data sharing</th>
</tr>
</thead>
</table>

### Situation analysis (strengths, weaknesses/gaps)

There is a comprehensive plan linked to national health care reform, including indicators. Some RMNCH indicators are included, but not all 11 are included. MCH office has built up cooperation with different departments, under the State Council Group for Women's and Children's Development and Rights. MoH CHSI cooperates with universities for monitoring and evaluation of health care reform. The national health services survey (NHSS) is scheduled for 2013, and the MCH surveillance survey will take place in 2012. There is a well-functioning facility reporting system with subnational statistics, and data quality is monitored annually. A sample of MCH institutions is surveyed; small sample of MoH primary level facilities undertaken in 2008 and 2011. Good quality report issued for mid-term review of health care reform, MCH mid-term and final reports produced. Equity stratifiers for key MCH include: income, for women, urban and rural; Equity stratifiers in the census for two indicators of relevance include: LE and birth rates for males/females; MOH is the repository for all MoH information systems; MCH repository is part of the MCH system. Data is not accessible to public.

### Priority Actions

1. Strengthen the M&E component of the health care reform plan.
2. Review the RMNCH M&E plan(s) and align with the M&E of the national health care reform plan.
3. Build up institutional cooperation.
4. Strengthen M&E coordinating systems.
5. Integrate data and information systems from different departments.
6. Improve on 10 year health survey plans and survey instruments.
8. Strengthen training of grassroots for collecting data.
9. Strengthen analytical capacity, annual compilation of statistics from facilities with data quality assessment.
10. Conduct annual facility survey for data verification and service readiness.
11. Strengthen analytical capacity, involve key institutions; review contents, analyses and presentation.
12. Strengthen annual review systems.
13. Strengthen equity analyses for reviews.
14. Expand on data collection about minority groups.
15. Develop/strengthen national data repository with all relevant data and reports.
16. Strengthen availability of data and include other institutions in data sharing.

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<table>
<thead>
<tr>
<th>Maternal death surveillance &amp; response</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification</td>
<td>A notification policy exists but may not be fully implemented everywhere. Maternal death report and review system in place in hospitals and health facilities, but needs to be strengthened. By 2011, nearly 98% of deliveries occurred in hospital. In the case of a maternal death in a county for example, information is reported to local health authorities and will reach national level within 3 months. ICD (4 codes) generally promoted for use at hospitals nationally. Includes public and private hospitals. Every year, MoH hospital administration and management collects information about quality of hospital care, including MCH. Information is also collected by the MCH department in each province, county and city. However, information is collected but may not be used for policy - both good and bad. In urban areas, reporting occurs. In rural areas, some residents do not report deaths when they occur at home. Reporting could be done by telephone. Communities and counties report to CDC, who use verbal autopsy. The maternal death surveillance and response system is reviewed annually, but could be strengthened.</td>
<td>1. Advocate/develop national policy on maternal death notification.</td>
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<tr>
<td>Capacity to review and act</td>
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<td>2. Strengthen national capacity through training in MDSR.</td>
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<tr>
<td>Hospitals / facilities</td>
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<td>3. Strengthen district capacity through training in MDSR.</td>
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<tr>
<td>Quality of care</td>
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<td>4. Improve reporting by hospitals; Training in ICD certification and coding (links with CRVS).</td>
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<tr>
<td>Community reporting &amp; feedback</td>
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<td>5. Strengthen hospital capacity and practices, including private sector.</td>
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<tr>
<td>Review of the system</td>
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<td>6. Support a regular system of QoC assessments, with good dissemination of results for policy and planning.</td>
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<td>7. Develop/strengthen a community system of maternal death reporting and response, using ICT.</td>
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<td>8. Develop/strengthen a system of maternal death reporting and response initiation by electronic devices.</td>
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<td>10. Develop system of involving communities in review and response.</td>
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<td>11. Support and strengthen review system including dissemination and use of the report.</td>
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<table>
<thead>
<tr>
<th>Innovation and eHealth</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
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</thead>
<tbody>
<tr>
<td>Policy</td>
<td>EHealth strategy developed as a part of the 5-year health information strategy/2011-2015, but content are not so specific. There is connectivity and infrastructure available for health reporting nearly nationwide, with some exceptions in rural and remote areas. Current plan for each village clinic to have a computer. Countries are responsible for reporting health information. Use of web-based reporting is common, including for surveillance and facility-based reporting, but not yet mobile. Data can be provided upon request. Pilots undertaken in specific places and plans are in place to build interoperability capacity. National eHealth coordination mechanisms are being built. Regulations in place for protecting information in general, further related policies may be needed for health.</td>
<td>1. Improve national eHealth strategy with country leadership and broad buy - in. 2. Expand health reporting to villages. 3. Determine the eHealth services required to support the country’s priority programs and goals, particularly with respect to information flows. 4. Determine the eHealth standards and interoperability components required to support eHealth services, applications and infrastructure, as well as to support broader changes to health information flows. 5. Develop and support a strong effective coordination mechanism. 6. Assure health sector, ministerial and government leadership and support. Ensure that the required program development skills and expertise are available. 7. Enforce compliance to data protection policies.</td>
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<tr>
<td>Infrastructure</td>
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<td>Standards</td>
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<td>Governance</td>
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<td>Protection</td>
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## COUNTRY ACCOUNTABILITY FRAMEWORK: Scorecard*

<table>
<thead>
<tr>
<th>Monitoring of resources</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
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</thead>
<tbody>
<tr>
<td>National health accounts</td>
<td>International classification system in place since 1999, data collected from 1990-2010. National Health Development Research Center designated to coordinate, manage, and has budget for implementation. Share of donor funding to total health expenditures (THE) very small. Formal agreements made with different government departments, but not a part of NHA. Coordination with partners is good. National Health Development Research Center designated to coordinate, manage, and access technical advice for implementation. Could strengthen cooperation with other government departments. There is capacity and there are many experts at national level, and at provincial levels. Experts can train provincial level staff. Data conversion takes place. Central database in place. Establish system for data management and queries. Analytical summaries are produced annually, including time series, for policy makers. Indicators are publicly accessible. Some cities may collect data about major public health spending, such as spending on breast and cervical cancer screening, and hospital delivery subsidies, subsidies for folic acid; basic public health package and medical reform spending including MCH projects, and MCH infrastructure.</td>
<td>1. Continued implementation of NHA framework. 2. Need more coordination between ministries. 3. Ensure inclusion of all key stakeholders in resource tracking /NHA. 4. Train staff on system of health accounts 2011; train district and regional staff. 5. Develop /strengthen database for production of NHA. 6. Strengthen analytical capacity in government and other institutions. 7. Ensure that reports and analyses are disseminated. 8. Advocate for /promote use of NHA data in policy making process.</td>
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<td>Compact</td>
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<td>Coordination</td>
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<td>Production</td>
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<td>Analysis</td>
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<tr>
<td>Data Use</td>
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### Review processes

- Reviews
- Synthesis of information & policy context
- From review to planning
- Compacts or equivalent mechanisms

### Situation analysis (strengths, weaknesses/gaps)

Annual reviews are conducted at different levels and key stakeholders are involved. The participants from external stakeholders in limited. Analysis capacity and use of information is limited at county level. National health data including RMNCH are used for annual reviews. For a few important indicators, the sub national level data are not available. Not all key stakeholder involved in the operational planning process.

### Priority Actions

1. Improve capacity on health planning review at lower administrative level.
2. Engage stakeholders from other sectors to be involved in the review process.
3. Strengthening the national MCH surveillance to provide sub-national estimates.
4. Develop/strengthen mechanism to compile all policy / qualitative information to inform annual reviews.
5. Strengthen the use of review results for planning purposes.
6. Ensure greater involvement of all stakeholders.

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**COUNTRY ACCOUNTABILITY FRAMEWORK: Scorecard**

### Advocacy & outreach
- **Parliament active on RMNCH issues**: [ ]
- **Civil Society Coalition**: [ ]
- **Media role**: [ ]
- **Countdown event for RMNCH**: [ ]

### Situation analysis (strengths, weaknesses/gaps)
A commission (comprised of different stakeholders) for reporting on RMNCH is well established. Public forums for information sharing are regularly organized but should be improved in terms of wider involvement of possible partners. Civil societies like Women Union exist and they regularly meet with other stakeholders and government (although they are partially influenced and funded by government). One of the main activities is to advocate for RMNCH, produce evidence-based materials and to disseminate information. Media are involved in disseminating information and messages on RMNCH topics. Media usually report on progress towards implementation of the national commitments towards the Global Strategy. Media receive information and briefings from national bodies. We do not know whether any Countdown event for RMNCH is going to be held during 2012-2014. A country report is produced although there are some missing data (equality).

### Priority Actions
1. Parliamentarians are mobilized to engage in RMNCH accountability, especially on financing.
2. Facilitate the organization of public hearings/forums for sharing of information on RMNCH.
3. Establish/support/strengthen coalition.
4. Support capacity of civil society to synthesize evidence and disseminate messages.
5. Work with the media to strengthen their capacity to report on RMNCH related issues.
6. Work with the media to strengthen their capacity to report on the monitoring the implementation of the Global Strategy.
7. Improve information flows to media.
8. Countdown Coordinating Committee, UN agencies (H4+), and other partners encourage/support national stakeholders to plan national Countdown.

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