GHEN China Case Study Working Paper 1

Health Service Planning and Women's Organisation in Poor Rural China:
The Case of Dafang County, Guizhou Province

Fang Jing, Joan Kaufman and Liu Yunguo

Published by the Institute of Development Studies at the University of Sussex,
Brighton BN1 9RE, UK
Tel: +44 1273 678269; Fax: +44 1273 621202
e-mail: bookshop@ids.ac.uk

ISBN 1 85864 678 2

Abstract

Gender inequality in healthcare is still a concern in poor rural China, despite the national level policies that try to improve the situation. Based on fieldwork conducted in a poor county in south-western China, this paper examines local health service planning and women's organisation. It explores approaches to increasing women's participation in local health planning so as to enhance the responsiveness and accountability of health facilities to women's needs and thus lead to the improvement of gender equity in health. The findings show that county and below county level health authorities and service institutions have little space to make local health plans, due to the centralised and top-down planning approach in China. The limited planning power is further constrained by the extreme insufficient financial resource in poor counties. Target-oriented responsibility management system has been used by the upper-level government to ensure the accomplishment of important health indicators that are defined and planned by the upper levels of government since the late 1980s. The fulfilment of these indicators imposes an 'unfunded mandate' on poor counties. Health authorities and institutions exploit the opportunity provided by the market to generate income to fulfil their obligation, which leaves little space for them to respond to local women's needs. There is no institutional arrangement to bring local health needs, particularly women's needs into the decision-making process. This further exacerbates the non-responsiveness of health institutions to local needs. The 'All China Women's Federation' is the sole legitimate women's organisation in the county and it cannot be claimed as a representative organisation of rural women. However, its constitution indicates it has potential to develop into a real representative organisation and although it did not participate in local health planning, its working guideline contains women's health indicators. There is potential to increase women's participation in local health planning by transforming the Women's Federation or creating a new organisation. However, there will still be a long way to go to improve gender equality in health in poor rural China using the approach of women's participation in local health planning.

Preface

The Gender and Health Equity Network (GHEN) is an international partnership of individuals and institutions committed to demonstrating through action research the importance of taking gender equity into account in health policy and programming. GHEN originated with a first phase of work that focused on improving the knowledge base on gender and international health issues. State-of-the-art research reviews on different aspects of gender and health equity and two edited volumes were produced and disseminated. This first phase of work was led by Gita Sen (Harvard Center for Population and Development Studies and Indian Institute of Management, Bangalore) and Piroska Östlin (Karolinska Institute, Stockholm), supported by Asha George (Harvard Center for Population and Development Studies), and was funded by the Rockefeller Foundation and Sida under the auspices of the Global Health Equity Initiative. In 2000 a second phase of activities was agreed, involving an extended partnership including institutions in China, India, Mozambique, the UK, as well as the World Health Organization.

Despite recent research that demonstrates that gender plays a role in creating and maintaining systematic inequalities in health status and access to health resources, very few documented examples of practical efforts to implement gender and health sector planning initiatives exist. Policy makers and practitioners particularly lack information on practical methodologies for improving gender and health equity in specific local contexts. GHEN projects in three countries - China, India and Mozambique – have sought to fill this gap.

The projects are being implemented in contexts where there are clear macro level policy commitments to health equity but difficulties in translating these into programmes of work at lower levels of government, or practical action on the ground. By bringing together policy makers, health providers and users of health services in new partnerships within an action research framework, the GHEN project teams aim to identify practical ways in which policy can be translated into effective action. This Working Paper series reports on work in progress in the GHEN countries. An earlier paper, reporting on work in progress in India, was published under the IDS Working Paper Series: (George, Iyer and Sen 2005).

The following organisations have generously funded GHEN activities:

The Ford, Rockefeller and MacArthur Foundations, the Swedish International Development Cooperation Agency (Sida), and the International Development Research Centre (IDRC). Support has also come from the Global Forum for Health Research and the World Health Organization.

Further information on partners and country studies can be found on the GHEN website at www.ids.ac.uk/ghen Or contact the technical cordination team: Hilary Standing at the Institute of Development Studies: h.standing@ids.ac.uk or Cathy Green: cgreen@healthpartners-int.co.uk

Hilary Standing

Gita Sen

Piroska Ostlin

On behalf of GHEN Partners

List of abbreviations and acronyms

ACWF: All China Women's Federation

CDC: Centre for Disease Control

CHB: County Health Bureau

CMCHH: County Maternal and Child Health Hospital

CMS: Cooperative Medical System

EPI: Epidemic Prevention Immunisation

GHEN: Gender and Health Equity Network

IMR: Infant Mortality Rate

MCH: Maternal and Child Healthcare

MMR: Maternal Mortality Ratio

PRA: Participatory Rural Appraisal

RTIs: Reproductive Tract Infections

THC: Township Health Centre

Acknowledgements

The authors would like to thank Dr Hilary Standing, Ms Cathy Green, Professor Vivian Lin and Dr Anjana Bhushan for their comments and suggestions on the early drafts of this paper.

1 Introduction

Gender equality and empowerment of women is endorsed as part of the Millennium Development Goals. This demonstrates the political will and commitment of the United Nations and its member states towards a more gender-equitable world. In almost all developing countries, women are in a relatively disadvantaged position compared with men in the same socioeconomic group, thus efforts to improve gender equality often take the form of interventions targeted at women as a means towards achieving gender equity. These measures can be encapsulated by the term women's empowerment. In China, women's status and their health, particular maternal health has always been a theme on the agenda of the party-state since the founding of People's Republic of China in 1949. The party-state has made efforts to enhance the status of women in both family and society. In particular, the party-state has issued a number of national policies that grant men and women equal rights and entitlements and promote women's status and development in China. These efforts were intensified after the Fourth World Women's Conference held in Beijing in 1995. It was in that conference that the concept of gender was formally accepted by the Chinese government, despite the fact that official interpretation of the term was 'equality between men and women' (in Chinese: Nan-nu Pingdeng) As a result of these policies and efforts, Chinese women have been employed or participated in various sectors working side-by-side with their male counterparts although not in an entirely equal sense. For positions that involve leadership and decision-making, men are still dominant. Within the health sector, a Maternal and Child Healthcare (MCH) Administration Division and related service facilities were established to specifically take care of women and children's health. Enormous improvement on people's health, including maternal health has been achieved since 1949, as manifested by the major health indicators, such as maternal mortality ratio (MMR), infant mortality rate (IMR) and under-5 mortality rate. For instance, in 2004 the MMR, the IMR and the under-5 children's mortality were 48.3/100,000 live births, 21.5/1,000 live births and 25.0/1,000 live births,[1]

[1] Ministry of Health, 2005, Newsletter on Maternal and Child healthcare and community healthcare, accessed from www.moh.gov.cn/newshtml/11035.htm

respectively. These figures are better than many other countries at a similar economic development level.

Nevertheless, the national level indicators actually mask the inequalities and variations between the rural and the urban, the rich and the poor, the eastern part and the central and western part, and male and female. The inequalities in China in terms of economic and social development levels, including healthcare have been well documented by numerous studies (Chen 1994; Zhao and Gu 1995; Park 1996; Liu 1999; Zhang 1999; Cai 2000; Chen 2000; Huang 2001; Xiang 2001; Li 2002; Wang 2002; Wei 2002; Li 2003; Jones *et al.* 2003). These inequalities have drawn increasing attention and have already been put on the developmental agenda set up by the new generation leadership of the party-state in the 'Sixteen Party Congress', as the goal of building a 'socialist harmonious society'. However, the inequalities between men and women, and boys and girls in healthcare have not yet drawn the same attention as other inequalities. It is the gender inequality in healthcare in poor rural China and the potential approaches for mitigation and improvement that form the focus of this paper.

Although there is not much national level data showing the strong inequality in healthcare between men and women, there have been a number of studies revealing that women still have unmet needs for reproductive health services, particularly in poor rural China. For instance, a study conducted in Yunnan Province in 1994–1997 by two of the authors showed that poor rural women had huge unmet needs for basic reproductive health services, as the existing healthcare system and family planning system that were supposed to provide reproductive health services for women failed to respond to these needs effectively and efficiently (Fang *et al.* 1997; Kaufman and Fang 2002). In that study, both the household survey (n = 1766, in four townships of two counties) and Participatory Rural Appraisal (PRA) showed that 52–81 per cent of women reported various gynaecological symptoms that might suggest the existence of reproductive tract infections (RTIs), and only a few of them sought care, while the survey of health facilities revealed that few village and township health institutions could provide the appropriate diagnosis, treatment and management of common RTIs. The research also showed that a large proportion of women did not have any prenatal care and the majority of women delivered at home attended by untrained personnel, such as family members and neighbours, which caused a high incidence of abnormal conditions, such

as vaginal tearing and excess bleeding during and after delivery. Studies that adopted similar methodologies conducted in four poor counties in four different provinces revealed surprisingly similar findings (He *et al.* 2000; Ma *et al.* 2000; Yan, D. *et al.* 2000; Yan, J. 2000). These studies clearly demonstrate that women's unmet needs for basic reproductive health services and the inadequate responsiveness of the health systems to these needs are common in poor rural China. Other studies conducted in central and western part of China also showed that women and men, girls and boys have different access to healthcare and different health outcomes, which is partly reflected by major health indicators such as sex-disaggregated IMR (Li and Zhu 2001; Wei and Hui 2001; Wang 2005).

Thus, efforts are definitely needed to address these issues in order to improve gender equity in healthcare by meeting the specific health needs of women and girls in poor rural China. Consequently, the following questions arise: What are the possible strategies and interventions for improving gender equity in healthcare in the context of poor rural China? The Platform for Action adopted in the United Nations Fourth World Conference on Women calls for women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making (United Nations 1995). International experience, both at theoretical and practical levels, suggests that participation by clients and community can enhance the responsiveness of health system to people's needs, and thus make health service providers more accountable to their clients and community (Cornwall *et al.* 2000; Gaventa *et al.* 2002). The clients' voice is acknowledged as an effective way to strengthen accountability of public service providers (Paul 1991, 1994). We hypothesised that involving women in local health service planning may bring women's voice into the planning process, thus making health facilities and providers more responsive to women's needs. However, how is a local health service plan made, specifically in the context of fiscal decentralisation and subsequent health service delivery marketisation? Who is involved in the process? Does the market economy provide any space for other actors, particularly women's organisations, to participate in local health service planning? What is the situation of women's organisations in poor rural China and is there any organisation that can act as the representative of women to participate in local health planning? The answers to these questions require further research and the answers are also needed if the proposed

approach for improving the responsiveness of the health sector to women's needs is to enhance women's participation in local health planning.

This paper presents an exploratory analysis of these questions based on a study conducted in Dafang County, Guizhou Province, the China case study site of the Gender and Health Equity Network (GHEN, for more information about the China case study, see Kaufman *et al.* forthcoming). The paper describes the health service planning process in county and township level governments and different health institutions, maps the situation of local women's organisations, and analyses possible interventions for improving the responsiveness and accountability of health facilities to women and community. The findings from this paper provide the basis for the interventions that we have been conducting in the sites of the China case study.

2 Methodology

The data used in this paper come from two sources. The published literature (both Chinese and English) and a long-term fieldwork conducted between 2001 and 2004 in Dafang County, where the first author (JF) conducted the fieldwork for her doctoral thesis (Fang 2006), in parallel with the baseline studies conducted for the Gender and Health Equity case study. During that period, the author travelled to Dafang several times to conduct in-depth interviews and observation and collect secondary data including local government and health department documents and records. The field data used in this paper come mainly from in-depth interviews with county leaders; the director of the County Health Bureau (CHB); the head of County MCH Hospital (CMCHH); the heads of 11 township health centres (THC) and other health management staff; the chairwoman and staff of All China Women's Federation (ACWF) at county, township and village levels, as well as some male and female villagers.

The author also visited four townships in the county to interview the heads of township governments in order to understand the township work planning process and the position of health work in their priorities.

In addition, data on county health planning collected from an in-depth interview conducted in another county in Yunnan Province are also used to contrast the data collected in Dafang.

3 Study findings

3.1 General information on Dafang County

Dafang is one of the 88 counties and cities in Guizhou Province. The latter is one of the 31 provinces/autonomous regions in mainland China and is located in the south-western China, with a total area of 176,100 km^2 and a population of 38.69 million (end of 2003) that accounts for around 3 per cent of the total population in China. The province is ranked as number two in mainland China in terms of the numbers of people living under the official poverty line (less than 668 Yuan per capita, per year), which indicates that the province is one of the poorest provinces in China, and it has received financial subsidies from the central government since 1953 (Huang 2001; Xiang 2001). 'Not three feet of flat land, not three days without rain, and not a family with three grams of silver', are the centuries' old Chinese sayings about this impoverished south-west province.

Dafang County has a total area of 3500.75 km^2 and a population of 952,000 (end of 2002) with 36 townships and 499 administrative villages. Dafang is also on the national list of poverty-stricken counties.[2] The per capita net income of farmers in this county was only 1,288 Yuan (US$157) in 2002.[3] According to the provincial statistics, by the end of 2000, the proportion of people living under the poverty line was around 14 per cent of the total population in this county. From 1990 onwards, Dafang County government has been facing serious financial deficits (Fang 2004).

Dafang has a typical health system, as in many other counties in China. There is a County Hospital, a County Traditional Chinese Medicine Hospital, a County MCH Hospital (CMCHH) and a County Centre for Disease Control (CDC) as well as a few other health facilities at county level. Each town/township has a township health centre (THC) except for the county town. Each administrative village has 1–2 health workers who each receive a 30 Yuan

---

[2] There are different types of poverty stricken counties in China. Those identified by the central government as poor counties are called 'national level poor counties' while those identified by provincial governments as poor counties are called 'provincial level poor counties'. The extent of poverty in national level poor counties is more severe than provincial level poor counties.

[3] One dollar was around 8.2 Yuan in 2004.

(US$3.65) subsidy per month from the county government for undertaking preventive care work, and some with medical training certificates operate a clinic simultaneously. In addition to these public health facilities, there are around 400 registered private drug stores and clinics as well as some non-registered informal healthcare practitioners distributed at county, township and village level. By August 2004, there was no cooperative medical system (CMS)[4] or any other rural health insurance scheme in this county; every farmer paid for healthcare out of his or her own pocket.

3.2 Women's status and health status in Dafang

Women's status is a comprehensive theme that can be reflected by different indicators from many angles. Based on the data available, we present a few indicators here. The data from the five census undertaken in 1999 shows that in Dafang there were 227 cadres who were staffed at leadership positions, of whom 207 were men and only 20 were women, while among the total 1,095 professionals, 668 were men and 427 were women. In all other paid positions, the number of men is far beyond those of women. The education gap between men and women in this county is also tremendous, with more men enjoying higher education levels, while women have more illiterate members, and this gap has been enlarged since 1964.

A survey with a sample of 200 households undertaken in three townships of Dafang County in 1998 revealed that 30.77 per cent of married reproductive aged women reported at least one abnormal pregnant symptom; 61.54 per cent reported abnormal conditions during delivery; 40.66 per cent reported abnormal symptoms within one month after delivery and 84.62 per cent of women reported various gynaecological and reproductive tract infections (RTIs) symptoms (Yan, J. *et al.* 2000).

As part of the baseline survey of the GHEN China case study, another survey with 420 households and 838 women was undertaken in four townships of Dafang in October 2003. The

[4] Cooperative medical system is a kind of community level medical prepared scheme in which the collectives and individual peasants contributed certain fees into the scheme, and then the participants could have a proportion of their medical cost reimbursed by the scheme. However, the new CMS started in 2003 in some pilot counties is somehow different with the CMS practised before the economic reform.

survey revealed that 62.4 per cent of married reproductive aged women reported at least one symptom that might suggest abnormal reproductive health conditions. Among them, 32.6 per cent reported vulvae itching or burning; 41.9 per cent reported abnormal discharge; 44.7 per cent reported waist sore or abdominal pain; 23.5 per cent reported abnormal menstruation; 9.1 per cent reported pain during intercourse or bleeding after the intercourse and 14.1 per cent reported pain during urinating. The interval between the two surveys is 5 years, but the findings are similar (see Table 1). These symptoms do not necessarily mean disease but they hint at local women's enormous need for reproductive health services.

Table 1 Reproductive health status of married reproductive aged women in Dafang County

Findings in 1998 (200 households, 3 townships)	**Findings in 2003 (420 households, 4 townships)**
● 30.77% reported at least one abnormal pregnant symptom ● 61.54% reported abnormal conditions during delivery ● 40.66% reported abnormal symptoms within one month after delivery ● 84.62% reported various gynaecological and reproductive tract infections (RTIs) symptoms	● 62.4% reported at least one symptom that might suggest abnormal reproductive health conditions. Among them: – 32.6% reported vulvae itching or burning – 1.9% reported abnormal discharge – 4.7% reported waist sore or abdominal pain – 3.5% reported abnormal menstruation – .1% reported pain during intercourse or bleeding after the intercourse – 4.1% reported pain during urinating

The survey also showed that women's morbidity within 2 weeks before the survey was 162.29/1,000 women, which was significantly higher than men's morbidity 124.02/1,000 men ($\times 2 = 5.19$, $p<0.05$). Women's average duration of illness within two weeks prior to the survey was 6.58 days, while for men it was 5.62 days, suggesting that women's diseases were more serious than men's, although the difference had no statistical significance. Women's chronic disease morbidity was 70.4/1,000 women, which was also statistically significantly higher than men's morbidity 43.6/1,000 men ($\times 2 = 5.84$, $p<0.05$). Compared with men's disease burden indicators, women's all other indicators, such as the days living with illness within two weeks/1,000 women; the average days living with disease within 1 year/ woman; number of people who stayed in bed due to disease within 2 weeks; days staying in bed due to disease

within 2 weeks/1,000 women and the average days staying in bed due to disease within 1 year were higher than men's relevant figures, though some of the differences were not statistically significant (for more information about baseline survey, see Kaufman *et al.* forthcoming).

The life expectancy of Dafang people at birth was 68.4 years in 1999. The maternal mortality ratio (MMR) in Dafang County has decreased rapidly in recent years due to a number of projects aimed to improve MCH in poor rural China. In 1998, the MMR in Dafang was 145.51/100,000 live births, while in 2003 it deceased to 85.37/100,000 live births. At the same time period, the infant mortality rate decreased from 55.71/1,000 live births to 34.15/1,000 live births; the mortality rate under 5 years old decreased from 69.36/1,000 to 46.34/1,000.[5] However, these indicators are still higher than the national average.

Despite the progress made on the major health indicators such as life expectancy, MMR, IMR and under-5 mortality rate, women's morbidity indicators, particularly reproductive morbidity indicators, remain high in this county. This implies that women's health needs, particularly the needs for the diagnosis and treatment of non-life-threatening reproductive health conditions are far from met. Many factors, such as financial constraints, poor access to health services and low health awareness, may contribute to the situation. Among others, the non-responsiveness of the healthcare system to those needs may play an important role.

3.3 Local healthcare planning

3.3.1 The financial plan

The financial situation of Dafang County was called by local officials 'eating finance', which is a metaphor used by local officials to refer to the fact that the financial revenue of the county only managed to cover the salaries of its staff with little left for maintenance and development. Sometimes even salaries could not be paid on time due to the serious financial deficit, and the protracted payment of staff salary was frequent. The budgeting of county government was done according to 'budgeting law' and the 'zero-based' budgeting approach has been employed by the county government given the extremely limited funds. 'Zero-based budgeting'

[5] These indicators are not sex-disaggregated.

means that the county government does not budget funds to any of its departments except for the staff salary, instead, it keeps the funds as a whole, and each department submits its application for funds for any urgent, key and important activities, then based on the degree of priority, importance and urgency, the county government will decide whether to allocate funds to support the activity or not. It is clear that limited funds have to be spent on the central work, such as family planning, social stability, agricultural production, and the implementation of the nine-year compulsory education.[6] As summarised by the director of the County Health Bureau (CHB): 'the central work in Dafang, first is to guarantee eating (refers to salary), second is to ensure the social stability, and the third is development'.

CHB is the administration department within county government that is responsible for health work in the county. The CHB could just obtain the salaries of its staff from the county government. Although some small adjustment may be made each year due to the change of staff numbers or the salary increasing, the amount of money coming from the county government to the CHB is basically fixed. As mentioned by the head of Financial Division of the CHB: 'we've got no money to plan, it's only money for salary, so the planning of financial resource here is quite simple.' Prior to 1998, there was 100,000 Yuan allocated from the county government to CHB each year for health work, and half of the funds were allocated by the CHB to township health centres for spending on maternal and child healthcare and anti-epidemic work. Since 1998, there has been no fund above staff salary allocated from county government to the CHB due to the overstressed and deficit budget of the county government. Instead, since 1996, the CHB has been required to hand in money to the county government because the county government considers the CHB as a unit that has income sources. If the CHB fails to hand in the requested funds, it does not get its staff salary from the county government. The amount of funds requested by the county government from the CHB increased yearly: 50,000 Yuan in 1996; 100,000 Yuan in 1997; 50,000 Yuan in 1998; 50,000 Yuan in 1999; 120,000 Yuan in 2000; and 150,000 Yuan in 2001. A total of 6 per cent of the handed in funds has been returned to the CHB since 1998. The major income source of CHB is to issue licences for private clinics and drug stores. The CHB charges each practitioner several

[6] The term central work is used by local people to describe the top priority of their work, which is decided by the upper level governments; or the work that they perceived as the most important one.

hundred Yuan per year for a licence to run a clinic or drug store. By so doing, the CHB could raise around 160,000 Yuan extra-budget revenue. After finishing the requested income generation task, the CHB would use the surplus to maintain its own telephone, vehicles and travel costs, etc. In the last few years, the CHB encountered difficulties in fulfilling the income generation task. It then shifted part of this burden to county level health institutions such as county hospital and CMCHH. Therefore, since 1998; the CHB has actually had no funds to plan but instead, needs to plan how to generate income. However, Dafang County is one of the 71 poor counties that have participated in the World Bank funded Health 8 Project,[7] and it also has a few other health projects funded by the national government or international donors. These projects provide some financial support for the CHB. One CHB staff member said: 'We can not even pay our office telephone bills if we do not have these projects'.

Due to the financial shortfall, the CHB cannot make plans about medical equipment. It only has the authority to approve the application of purchasing large medical equipment by some health facilities; the latter use the income generated from medical services to procure medical equipment.

3.3.2 Human resource planning

The CHB also has no decision-making power to plan new health facilities and human resources. The County Human Resource Quota Committee strictly controls the recruitment of new human resources to any public department in the county. Constrained by the financial difficulty, recruitment has almost been suspended in this county for a few years. The CHB, to some extent, has the power to decide how to use existing human resources, for example, promotion or re-allocation of existing staff. The CHB also has power to decide whether or not to permit a private clinic to open. The CHB in Dafang has adopted a very open policy towards private clinics and drug stores. There are more than 400 clinics and drug stores run by private practitioners in this county. Some doctors working at THC also open their private clinics,

[7] Health 8 project is also called basic rural health service project. It is a comprehensive rural health project supported through a loan from the World Bank, funds from Chinese government and grants from DFID that covers a wider range of rural health service issues, including construction of rural hospitals, training of health service providers and medical assistance for the poor, etc.

usually in the name of a relative or friend. The CHB is aware of this but does not take action to stop them, although it claims that formal staff members of government-owned health institutions are not allowed to conduct private practice.

3.3.3 Healthcare work planning

The contents of county health work can be divided into two parts. One part, such as MCH work and epidemic prevention immunisation (EPI) is non-negotiable and is done by command of the upper level institutions. For this part of the work, the CHB has to manage to meet the required targets. Thus, what the CHB can plan is how to fulfil the targets set by the upper level. For example, one county in Yunnan Province was requested to control its MMR under 50/100,000 live births. In order to achieve this target, the CHB planned a series of strategies, which included: all pregnant women have to give birth at hospitals; village doctors are not allowed to attend birth delivery unless it is an emergency; high-risk pregnant women have to deliver at county level health institutions or comprehensive township hospitals. Another part of the work is relatively flexible, such as clinical work and the management of private health facilities and personnel. For this part of work, the government only provides some guidelines; the CHB has a bigger space to plan what to do and how to do it. However, like the compulsory work, these plans are not equipped with funds.

In fact, it is in the day-to-day administrative management that CHB has the biggest space to plan but CHBs adopt different strategies. For example, the CHB in Dafang requires each THC to put aside a certain amount of money (200–300 Yuan per staff member/year, according to the situation of each THC) from their income. The director of the CHB explained that the purpose behind this request was to strengthen the self-development capacity of THCs. The director said the THC is the key sector of rural health work; therefore he has emphasised the construction and development of THCs since he was appointed as the director. The CHB of another county in Yunnan Province has not set up an income target for THCs. The director said: ‘Setting up an income target is against the nature of health work defined by the Central Government and will conflict with preventive care, so we don’t set up income targets.’ While Dafang CHB adopted an open policy towards private health facilities and practitioners, the

county in Yunnan took a restrictive policy on private practitioners: there were only 18 private health facilities and these private clinics were not allowed to be located in the city or town.

The planning approach and process differ according to the nature of work. For the part commanded by higher levels, it starts from the provincial level and goes down to township level. Usually, the Deputy County Governor who is responsible for health work and the director of CHB attend the Annual District/Prefecture Health Work Conference, they will sign the health work target contract with the District Health Bureau during the meeting. The target contract is in three parts: MCH work, anti-epidemic work and comprehensive health work. After the conference, the CHB, CMCHH, and county CDC will draft the annual county health work plan based on both the contract and local situation. Then the annual county health work conference will be held to discuss, approve and distribute the targets. During the meeting, the CHB will sign a contract with the CMCHH, county CDC, and each THC. The CMCHH and the County CDC will also sign a contract with each THC. The contents of the contracts include quantitative targets that each contracted unit has to fulfil and the score standards for monitoring and evaluation. Through this process, the targets on MCH work and anti-epidemic work set up by the province are distributed to each district, county and township. The Provincial Health Bureau plans the targets and designs the monitoring and evaluation system and it is for the CHB to plan how to fulfil these targets. For the health work decided by the CHB, it is someone in the health bureau (usually the director) who proposes to do something, and then a meeting in the health bureau will be held to discuss the proposal. If the proposal is approved, it will be in the form of a document, which is distributed to the related units for implementation. Externally funded health projects such as the Health 8 project are designed and planned by outside national and provincial experts; The CHB is sometimes consulted or simply informed.

The director of Dafang CHB said the basis he uses to develop the county health work plan comes from four sources: (1) the health work plan set up by upper levels of government; (2) the county government's annual work plan; (3) new national health policies and strategies; and (4) the local situation. He estimated that half of the county health work consists of finishing the targets set by upper level and half of the county health work is decided by the CHB.

3.3.4 The health service planning of County MCH Hospital (CMCHH)

CMCHH plays an important role in providing reproductive health services for women. Therefore, what it plans to do and how it plans its work will largely affect local women's reproductive health. The CMCHH is under the administrative management of the CHB and technical supervision of the District MCH Hospital so the space for it to plan is even smaller than the CHB. Like the CHB, the CMCHH has no power to decide its personnel and beds, which is determined by the County Human Resource Quota Committee based on the national standard[8]. However, even the national standard cannot be achieved if the county has difficulty in paying the staff salary. In Dafang County, according to the County Human Resource Quota Committee, the CMCHH should have 32 staff, however, it only has 29 staff and is not allowed to add new staff because of the financial constraint.

Prior to 1990, the CMCHH had 50,000 Yuan from the county government each year for its work. The money was reduced and finally stopped in 1998. Since then, there has been no fund at all for MCH work except for the salary for 29 staff. The CMCHH cannot obtain the salary unless it completes the tasks required by the MCH contract and whatever work is requested by the CHB and county government. Therefore, the CMCHH has to use funds generated from its clinical services to support preventive care, monitoring and supervision over lower levels as well as the operation of MCH information system. Furthermore, since 1999, the CMCHH has also had to hand in some money to the CHB. This was 8,000 Yuan in 1999 and 12,000 Yuan in 2000.

The work of Dafang CMCHH includes preventive care, clinical services and projects. Some MCH work is strictly required by the upper level and monitored by detailed quantitative indicators, for example MMR, IMR and hospital delivery rates. The CMCHH can only plan how to complete these indicators. Those tasks are closely related to the implementation of the 'Two Guidelines and One Law' issued by the National Government, which are perceived by the upper level as the central task of MCH system. The two guidelines are the: 'Chinese Women Development Guideline' and 'Chinese Children Development Guideline'; and the one law is the

---

[8] The standard was made by the Ministry of Health in which the numbers of health workers and beds that each county could have were decided based on the number of population. However, this standard did not take into private health facilities account.

‘Law on Mother and Baby Healthcare’. The typical planning process of CMCHH in Dafang is as follows:

1. The director of CMCHH together with the director of the CHB attends the meeting organised by the District Health Bureau and gets the instructions and targets assigned by the District Health Bureau and District MCH Hospital.
2. The director conveys these instructions and targets to the staff member who is responsible for the paper work at the CMCHH.
3. The staff member drafts the annual working plan based on the new requirement and previous year experience.
4. The director modifies and approves the draft.
5. The director signs the MCH work contract with each THC at the annual county health work meeting. The contract consists of detailed measurable working targets and evaluation methods, which have been developed by the provincial MCH Hospital and practised since the mid-1980s.

It can be concluded that MCH work is very centrally top-down planned and target-oriented; CMCHH has little space to decide what to do. In addition, due to the financial shortfall, the CMCHH has to emphasise the fulfilling of tasks commanded by the upper level and generating income from its clinical services for survival. There is little resource left to spend on other services that are mostly needed by women, such as health education, screening and treatment of reproductive tract infections.

3.3.5 The healthcare planning of township government

Under county government, the township is the lowest level of the administrative hierarchy of Chinese government. As the lowest level of the government, the township has the branch or personnel of each vertical system of the government, such as family planning, education, and agriculture. Each system has its own tasks and targets set up by the corresponding upper level institution. One township governor in Dafang County illustrated the principle of making the township work plan as: ‘Strictly follow the instructions from the upper, and combine the meanings and spirit of upper level policies and documents with local reality to conduct work’.

In recent years, economic development has become the overwhelming task in Dafang; each township has the task of raising a certain amount of income tax, otherwise the salary of the township staff cannot be guaranteed. In addition, family planning is the high priority national policy and all progress made in other work is ignored if the family planning work does not achieve the required targets. This is called 'one ticket decisive power'. These institutional arrangements lay out certain incentives and constraints for township governments to plan their work.

For example, the Liulong Township of Dafang County made the following work plan in 2001:

1. Work priorities: establishing tax bases; trying to increase tax income; controlling the quantity and enhancing the quality of population; ensuring social security and other management work.[9]
2. Strategies: focusing on economic work; putting family planning as a central task; strengthening the construction of party teams;[10] paying attention to social security and comprehensive management; trying to promote other work, such as education and health.

Thus, health is in a much marginalised position in the work plan of township government. One director of a THC said in the annual summary report, delivered by his township governor regarding health work that: 'We followed the upper level instructions to have completed each task.'

Township governments were responsible for providing 60 per cent of the salaries of THC staff and 30 Yuan subsidies per month/village MCH worker. However, the money was usually not allocated in a timely manner in many townships mainly for two reasons. One is the severe financial shortfall. Many townships could not complete the tax income task, which would greatly affect the payment of all township staff, including health personnel. The second reason is that some township governments are dissatisfied with the work done by their THCs, for example, some doctors of THCs run private clinics, and thus the township government postponed the payment of its salary purposely as a kind of sanction against them.

---

9 This refers to any other work whose importance and urgency are suddenly arising.

10 This refers to strengthening Chinese communist party; such as absorbing new party members and conducting more study activities.

Although the extent of township government devoted in health work varies from township to township (Fang 2006), in general health work is almost excluded from the working agenda of township governments. Township governments do not plan health work; and many township governments do not even practise effective management over their THCs, despite the fact that township governments were required to provide 60 per cent of salary for THCs.

3.3.6 The health service planning of a township health centre (THC)

The THC is the only government-owned health facility at township level. Before the reform, THCs were managed by the CHB; the latter had been responsible for the personnel, equipment and funds of THC. After the fiscal decentralisation, township government was made responsible for providing funds for THCs and was also given power to assign people to THCs, although it sometimes consults with CHB. But township governments lack competence to manage issues related to medical knowledge and technology, thus THCs are still under the leadership of the CHB in terms of professional work. However, in 2002 a central policy issued by the Ministry of Health requires that THCs should be managed by the CHB. By the end of 2004, Dafang County had not yet finished this task.

Whether led by township government or by CHB, THCs could only obtain 60 per cent of their staff salaries from governmental budget; they have to earn their operational cost and the other 40 per cent salary through clinical activities. It is clear that there are no funds available from the government budget for THCs to plan their work. Most THCs were struggling hard to earn their salaries and operational cost. However, a few THCs whose clinical service capacity is strong, may have relatively more funds generated from clinical services.

THCs have no decision-making power to increase or decrease their staff and beds; but can only plan how to use the existing health resources. The activities of THCs in Dafang County are stipulated in the three contracts signed, respectively with the CHB, CMCHH and county CDC. They are MCH work contract, anti-epidemic work contract and comprehensive health work contract. At the beginning of each year THC directors attend the annual county health work meeting. During the meeting, the previous year's work will be summarised and evaluated, and the work for next year will be arranged by signing the contracts. A monitoring and evaluation method will also be included in the contract. After the meeting, the THC will

develop its annual work plan based on the contracts. The tasks in these contracts will be distributed to each staff member through the annual work plan. Monitoring and evaluation will be conducted by the CHB twice a year, in the middle and at the end, to check on progress. One THC director said: 'I only plan the following things each year. First is how much money I need to earn this year; second is how to arrange each staff's work; third is what things need to be repaired; fourth is how to finish the MCH and anti-epidemic tasks assigned by the upper level'. The director of Dafang CHB said that basically, THCs only complete works arranged by the upper levels, they do not have the administrative power to plan their work.

In terms of the work arrangements within each THC, there are various approaches. In some THCs, it was the director who arranged everything, while in other THCs, it was a small group formed by the director, accountant, and the person who is responsible for the management of inpatient division to discuss and decide together. The formal way promoted by the CHB is through the centre's management committee, which should be formed by five staff members, namely: the director, the two health workers who are responsible for MCH work and anti-epidemic work respectively, the accountant and the secretary. The approach was being tested in a few big THCs at the time we did the fieldwork. One thing is very clear that, at best, the participation in this process is limited to internal staff with no people outside the health centre involved in the process, not to mention any women's organisations or clients.

3.4 Women's organisation and its work planning in Dafang

3.4.1 The background of the All China Women's Federation

There is no other legitimate formal women's organisation in Dafang County than the All China Women's Federation (ACWF). The ACWF was set up by the Chinese Communist Party (CCP) with the aim of ensuring its control over society and mobilising participation (Howell 1995). The former body of present ACWF is called the All-China Democratic Women's Federation and was established in March 1949. However, it was not until its third congress held in September 1957 that the organisation had its organisational structure spelt out fully and at the same time, changed its name to the All-China Women's Federation (Jacka 1997). The latter congress announced that the Federation would have representative groups at each level of government.

During the Cultural Revolution, the ACWF, along with other mass organisations, was branded revisionist and was disbanded. In 1978, the ACWF was rehabilitated by setting up branches at all levels. In the system of the ACWF, full-time and salaried staff are employed down to the township level, below this level are part-time and either unpaid or poorly remunerated cadres.

ACWF has been sponsored by the state and vertically integrated into its structures, which means that the structure, sources of revenue, and methods of participation of the organisation bear the hallmarks of the party-state. ACWF has served as ‘a link between the party and government and the female masses’ (Zhang 1994) and ‘a transmission belt’ between the party and society (Howell 1996). Like other mass organisations in China, ACWF has been established with the goal of mobilising people for the complement and implementation of the tasks and polices of party-state. In the last two decades, these mass organisations have been more oriented toward economic development; for instance, many local branches of ACWF provide training in agricultural techniques for women in order to help them increase productivity.

The ACWF has the dual tasks of mobilising mass support for CCP policies and defending and furthering the interests of women. Although the rhetoric of both the ACWF and the CCP leadership has shown no conflict between the two tasks, some observers believe there is an uneasy tension and even conflict between the two aims and the ACWF often fails to tackle problems for women that the Communist Party itself does not acknowledge, or regards as unimportant (Jacka 1997; Howell 1996). Before the economic reform started in 1978, under the leadership of CCP, the ACWF had actively devoted itself to the implementation of many policies and laws as well as various campaigns whenever the party-state considered it appropriate for the ACWF to play a role. Examples are the implementation of the 1950 marriage law and the family planning policy started in the late 1970s. A number of factors, such as the economic reforms, and the greater opening up to gender issues, particularly after the Fourth UN Women’s Conference in Beijing, and the enormous socioeconomic changes and much more socially heterogeneous constituencies of women; have put ACWF under pressure to reform. It has striven to gain more autonomy, in particular to try to represent the interests of women more closely. For example, in response to socioeconomic change in rural areas, especially the change of production system with the demise of the communes, the ACWF’s

constitution issued in 1983 stipulates that women in each village should be represented by a grassroots women's representative congress (*Jiceng funu daibiao hui* or *fudaihui* for short), and women's congresses are also to be formed at township, county and provincial levels. Congress at township level is to meet once every two years, county level meets every three years and provincial level meets every five years. However, the reality does not necessarily match with the regulation. In many villages, women's congress consists of one woman who may or may not be a full-time cadre and does most of the education and propaganda for family planning in addition to other women-focused work, and a few women are appointed to represent women from different occupations and residential areas (Jacka 1997).

Despite its efforts, the ACWF can by no means claim to be an independent organisation. It is still subordinate to the party-state and often subsumes the interests of its member under the party's objectives, although the party has loosened its grip over the ACWF since the economic reform. Furthermore, it still adopts a top-down working style and imposes tasks and activities on lower levels of the women's federation.

3.4.2 The work planning of Dafang County ACWF

As a county level branch of the ACWF, the Women's Federation at Dafang County is under the dual leadership of Dafang County Communist Party Committee and the district branch of ACWF. There are five staff members at the County Women's Federation and there is one women cadre at each township as well as a women's congress in each administrative village. However, only the cadres working at county and township level are salaried staff, while cadres at village level are either paid a modest subsidy or no subsidy at all. According to the County Women's Federation, around one-third of the village women cadre have some subsidy, for example, 80 Yuan (around US$10) per year is the subsidy for village women's cadres at Jichang Township.

According to the ACWF's 1983 constitution, the executive committee of the village women's congress is supposed to be formed by a head, a deputy head and an unspecified number of committee members, and one delegate should be elected from every 30 women to form the village women's congress. These delegates should be elected every two years to represent the different residential areas and types of employment of the women in the village.

However, the reality in Dafang is far away from the requirement. There is only one women's cadre in each village and two-thirds of those cadres are without any subsidy. Some village committees can provide a names list of the village women's congress, but many women in these villages do not know who their representatives in the village women's congress are, and they did not participate in any activities organised by the congress, which implies that the village women's congress is just a names list used by the village committee to meet the requirement from the upper levels of the organisation, while in reality it has no function at all.

The activities of Dafang County Women's Federation are decided and arranged from these upper levels. Similar to the health sector, each year the chairperson of the County Women's Federation will attend the meeting organised by the District Women's Federation. During the meeting, the previous year's work will be summarised and evaluated and the following year's work, as well as the monitoring and evaluation methods, will be arranged. After the meeting, the County Women's Federation will assign the tasks it has received from the district to each township and working unit at county level. According to the chairperson of the Dafang Women's Federation, the work in recent years has included a number of campaigns that encourage women to make better contributions in their working units and families. Apart from the tasks arranged by the District Women's Federation, the County Women's Federation is also assigned tasks by the County Party Committee such as poverty alleviation, and the extension of certain agricultural technologies.

Although Dafang County Women's Federation is assigned tasks by both District Women's Federation and Dafang County Party Committee, its work is constrained by lack of funds. Apart from the staff salary, the County Women's Federation obtains just 400 Yuan per staff member/year from the county government to support its activities. In total, there is 2,000 Yuan (around US$244) per year available for the County Women's Federation and this money has also to be used to cover the electricity and telephone bills of the office, stationery and transport costs if they go to villages.

In addition to the severe financial constraints, the role of the Women's Federation is also hindered by its top-down working approach that makes it hardly respond to the needs of rural women. The women's Federation plays little role in local healthcare, although many indicators in the 'two guidelines and one law' are health or health-related ones.

In the same way, the women's cadre at township level is also under the dual leadership of the County Women's Federation and township government. As a staff member of the township government, she has to fulfil whatever tasks are assigned by the township government, such as monitoring and supervising agricultural production; assistance in the implementing of the nine-year compulsory education and family planning policy. It is hard for the cadre to specifically focus on women's work. As mentioned by the deputy chairwoman of County Women's Federation: 'it's impossible for township women's cadre just to conduct women's work, as a grassroots cadre of the government, there are many things waiting for her, she can only find some time gaps to insert women's work.' Compared with women's cadres at county level, there is not even 400 Yuan per year for the cadre to conduct her work.

4. Discussion

4.1 The current status of health planning at county and township level

It is evident that the Chinese government does commit to promote equality between men and women and to improve women's status, including health status. National polices and laws aimed at achieving these goals have been constantly issued, and the party-state has also made efforts to implement these polices and laws. However, the progress made in reality of poor rural China does not match the expectation well.

In order for the intended goals to be met, these national policies need to be implemented by local governments at various levels. In addition, given the broad territory and the heterogeneity of socioeconomic development level in different parts of China, these national polices are necessary but may not be sufficient to ensure the fulfilment of these goals. Local governments should be allowed space to plan and arrange their work according to local needs. However, the evidence from Dafang County clearly shows that county and township governments as well as health institutions and women's federations in poor rural China have very limited space to do so. This is due first to the top-down planning and implementing approach that was shaped by the traditional governance style of the party-state and was working effectively in the era of planned economy but is encountering problems in a more market based economy. However, this approach is still practised in the health sector and

Women's federation, as well as other systems. The top-down planning processes of the health department and women's federation in Dafang County are shown in Figures 1 and 2. There are extremely limited financial resources available for county and township governments in poor rural China to plan and carry out their work. The top-down planning and implementing approach has been reinforced since the adoption of the target-oriented responsibility management system by the Chinese government in the late 1980s and early 1990s. It is widely practised in all government administration in order to ensure the implementation of polices and targets handed down from the upper levels (Fang 2006). The fulfilment of the targets listed in the contracts of the target-oriented responsibility management system is also closely linked to the cadre evaluation system and thus the remuneration and promotion of cadres, and these form powerful political and economic incentives for local cadres to fulfil those targets (Edin 2000; Whiting 2000).

Figure 1 The inputs and outputs of healthcare planning in Dafang County

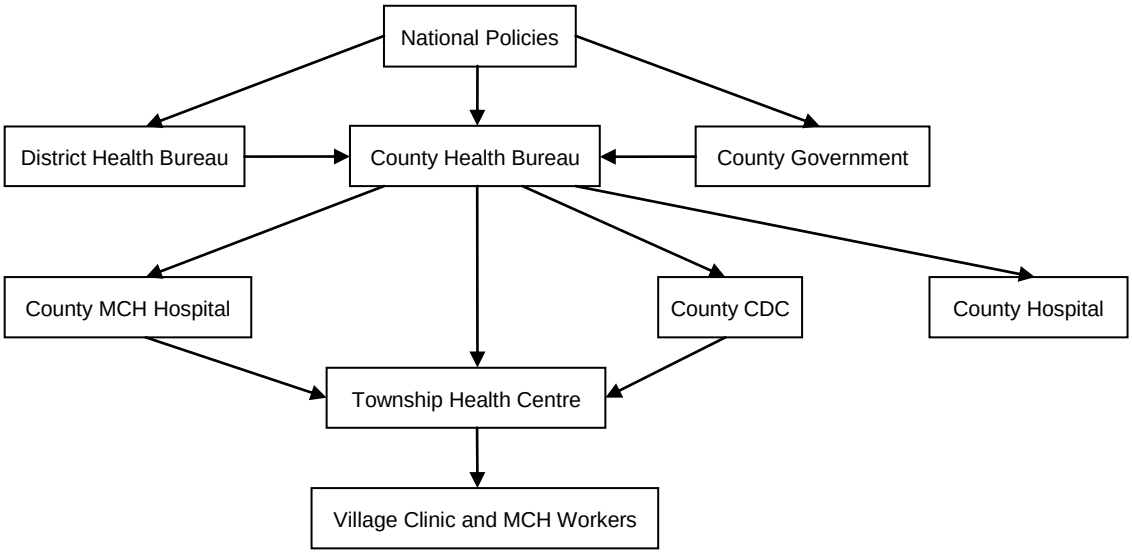
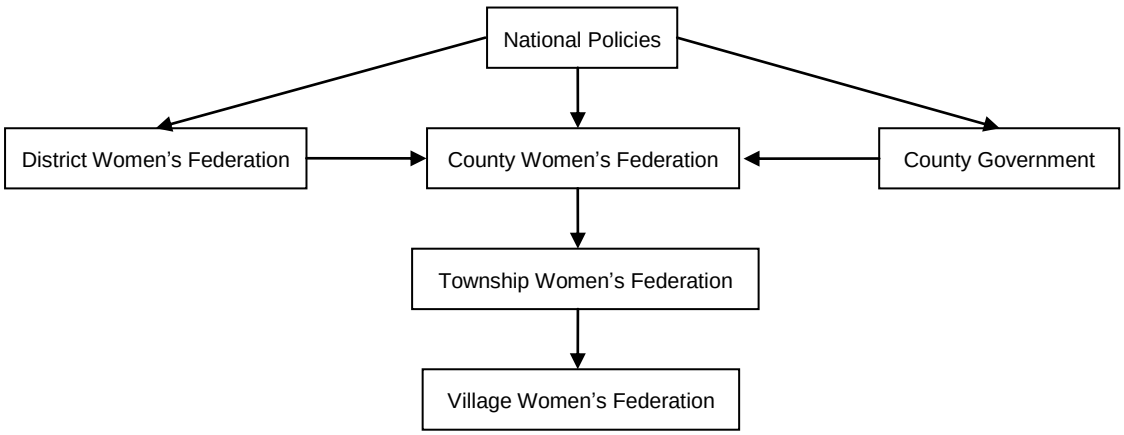


Figure 2 The inputs and outputs of Women Federation planning in Dafang County



However, while county and township governments, health institutions and women's federations as well as other departments in poor rural China have very limited financial resources, fulfilling these top-down targets has posed a challenge to them, because of the 'unfunded mandates' (Bernstein and Lu 2003). Local governments in poor rural China struggle hard using whatever resources they can find to fulfil these targets. Many exploit the opportunity provided by the market-oriented reform, which is allowed or even encouraged, implicitly or explicitly, in order to compensate for the extremely insufficient funds. As this paper has shown, the CHB sought funds through issuing licences to private clinics and drug stores to fulfil these targets and maintain its operation, while health service institutions generate income through their clinical services. Even the Women's Federation is allowed to raise funds to support its activities (Howell 1996). Entrepreneurial spirit is widespread among government departments and health institutions that desperately need funds to maintain their function and fulfil various targets. Consequently, these governments and institutions have even less resources to respond to local needs and they are more likely not interested in providing services that have less or no economic gain such as health education and other preventive care. In addition to that, there is no formal channel or institutional arrangement to bring local health needs, particularly women's needs into the decision-making process, which further exacerbates the non-responsiveness of health institutions to women's needs.

In this paper, we have argued that a new approach is definitely needed in order to better implement these policies and to improve gender equity in health in poor rural China. The latter is not yet explicitly on the government agenda, although it may be partially covered by the slogan 'equality between men and women'. However, what are the options in terms of the new approaches and what are the possibilities for the new approaches in the context of poor rural China?

4.2 Options and opportunities for change

There is little practical experience to draw on from the existing literature in terms of improving gender equity in health in resource-poor settings, although plenty of work has been done at the conceptual and theoretical level (see Sen *et al.* 2004). However, experience can be drawn upon and lessons can be learnt from the arenas of public health practice and development studies. Community participation was promoted and employed by WHO as a strategy to achieve the goal: health for all by the year 2000 (WHO 1992). Although the international health experience shows that there is no quick way for achieving this goal, community participation is still considered as an important approach for reaching health objectives and goals (Cornwall *et al.* 2000), and participation in matters that affect people's life itself is considered as the right of citizens (Gaventa *et al.* 2002). Thus, participation itself should be treated as a goal rather than merely a means to achieve goals. In the arena of development studies, decentralisation and participation have also been promoted as effective approaches for better economic and social development and these approaches have been widely practised in many developing countries in the last few decades (Turner and Hulme 1997; Shah 1998). Although the outcomes of these development practices may not be as satisfactory as intended, decentralisation and participation are still widely believed to be effective approaches for development. Decentralisation and participation can bring governments and public service institutions closer to community and people, thus the government and public service institutions may be more responsive to the needs of people (Turner and Hulme 1997; Shah 1998). In the 1990s, the agenda and discourse of good governance, has become the dominating developmental mode, in which accountability is a central component (World Bank 1992; Hyden and Bratton 1992;

Paul 1994; Polidano and Hulme 1997). The new paradigm of good governance has been linked with the approaches of decentralisation and participation, and it is widely perceived that participation will increase accountability, and thus lead to good governance as well as better development outcomes. In the public service field, clients' voices are considered as an effective means to elicit more responsiveness from the providers (Paul 1991, 1994).

In the light of these international experiences, it could be argued that women's participation in local health service planning, implementation, monitoring and evaluation may enhance the responsiveness of health services to their needs, and improve gender equity in health service utilisation. However, is this feasible and acceptable in poor rural China? What are the possibilities and opportunities for change? The financial situation facing local governments in poor rural China may not change within the short term unless there are greater fiscal transfers from the central government to poor local governments. The top-down planning approach and the entrepreneurial behaviour adopted by county and township level governments to deal with unfunded mandates are embedded in complex institutional arrangements that have evolved in the transition period in China. This approach has been powerfully shaped and may not be easy to change through any short-term intervention.

This study also notes that the Women's Federation is the only legitimate women's organisation in Dafang County but it cannot be claimed as an organisation that acts on behalf of the interests of women, particularly poor women, given its nature and the manner of its cadres' appointments. The Women's Federation in Dafang is not involved in the health planning process, although it has the mandate for promoting women's health. However, the Women's Federation has the potential to improve its representation to women. In fact, if the version of women's congress at village, township and county level as spelt out by the ACWF's constitution in 1983 was to materialise in rural China, it would greatly enhance its representation of women. Evidence from other studies also shows that the Women's Federation has now gained more space to work for women's interests (Howell 1995), and there are some newly created local women's organisations in rural China, although they are all under the supervision of Women's Federation and not really involved in healthcare (Zhang 1994). These changes do provide opportunities for women's organisations to develop and to work on healthcare and be involved in local health planning.

Another way in which voices can be manifested is by taking advantage of the healthcare marketisation happening in China. Although there are many negative impacts brought about by the marketisation of healthcare, it is undeniable that a healthcare market has gradually taken shape in China and the market provides opportunities for clients to complain or leave if they are not satisfied with the services they have received, which generates pressure on providers to be more responsive. A study conducted in Dafang described examples of this (Fang 2006).

This study indicates that there is a need for change and there are opportunities for interventions to make change, despite the constraints determined by the structural arrangements. However, the key is how to design interventions that are politically acceptable and technically workable for change.

5 Moving forward

Given the current situation of the women's organisation in Dafang County, new mechanisms and structures may be created by using existing legitimate organisations in order to bring women's voices into the health planning process. Alternatively, efforts could also be made to work with the Women's Federation and to transform it into a real representative organisation of local women, and to create mechanisms for the Women's Federation to be involved in local health planning. Both approaches have opportunities and challenges ahead. As is well demonstrated by a number of studies, women's physical participation does not guarantee that they can have their say and their voice will be heard and taken into account (Agarwal 2001; Cornwall 2003).

The planned interventions of the GHEN China case study in Luoping and Zhenning Counties are to create a new gender and governance group at township level as a vehicle to bring women's voice into the local health planning process (see Kaufman *et al.* forthcoming). The group consists of women's representatives elected by village women, the deputy governor of the township who is responsible for health work, director of township health centre, cadre of township Women's Federation and the director or provider of township family planning service station. Training on gender and health will be provided to local government cadres and health service providers to inform them about international conventions on health rights and gender

equity and to teach them how to analyse health issues from a gender perspective. Training on international and Chinese health-related legislations and laws as well as practical accountability skills will be provided to women's representatives to build their capacity and to empower them. The group will be provided with an incentive fund that they can plan and use to support the services identified by women themselves.

Improving gender equality in health in poor rural China is likely to take a long time using the approach of women's participation in local health planning. Nevertheless, no matter whatever approach is to be taken, it needs to be tested on the ground. This is the main task of the China case study on gender and health equity.

References

Agarwal, Bina (2001) 'Participatory Exclusions, Community Forestry, and Gender: an Analysis for South Asia and a Conceptual Framework', *World Development* 29.10: 1623–48

Bernstein, Thomas P. and Lu, Xiaobo (2003) *Taxation Without Representation in Contemporary Rural China*, Cambridge University Press

Cai, Renhua (2000) 'Comments on Some Issues of China Rural Health Development', a paper presented at the Conference on China Rural Health Reform and Development, CHEI and IDS, Beijing, China, 7–9 November

Chen, L. (1994) 'Fighting Against Absolute Poverty', *Xinhua Monthly* 600: 86–7

Chen, X. (2000) 'Consideration on the Development of Western Rural Healthcare in China', *Chinese Health Resources* 3.6: 243–45

Cornwall, Andrea (2003) 'Whose Voices? Whose Choices? Reflections on Gender and Participatory Development', *World Development* 31.8: 1325–42

Cornwall, Andrea; Lucas, Henry and Pasteur, Kath (2000) 'Accountability Through Participation-developing Workable Partnership Models in the Health Sector', *IDS Bulletin* 31.1: 1–11

Edin, Marie (2000) *Market Forces and Communist Power-Local Political Institutions and Economic Development in China*, Uppsala

Fang, Jing (2006) 'Tailoring a Western Coat for a Chinese Body: Understanding the Accountability of a Health System in Transition', unpublished DPhil Thesis, IDS, University of Sussex

Fang, Jing (2004) 'Health Sector Reform and Reproductive Health Services in Poor Rural China', *Health Policy and Planning* 19: 40–9

Fang, Jing, Kaufman, Joan and Zhang Kaining (1997) *A Study of Women's Needs for and Utilization of Basic Reproductive Health Services in Rural China, Research Report of Financing, Provision and Utilization of Reproductive Health Services in Rural China*, Cambridge MA: Abt Associates: 71–7

Gaventa, J.; Shankland, A. and Howard, J. (2002) 'Introduction: Exploring Citizenship, Participation and Accountability', *IDS Bulletin* 33.2

George, Asha; Iyer, Aditi and Sen, Gita (2005) *Gendered Health Systems Biased Against Maternal Survival: Preliminary Findings from Koppal, Karnataka and India*, IDS Working Paper 253, Brighton: IDS

He, Yeying; Zhang, Junqing; Han Haiwang, *et al.* (2000) 'An Investigation of Reproductive Health Services Status in Yusher County of Shanxi Province', *Chinese Primary Healthcare* 14.9: 44–7

Howell, Jude (1996) 'The Struggle for Survival: Prospects for the Women's Federation in Post-Mao China', *World Development* 24.1: 129–43

Howell, Jude (1995) 'Prospects for NGOs in China', *Development in Practice* 5.1: 5–15

Huang, X. (2001) 'The Structure and Effect of China's Fiscal Capital Regional Distribution', *The Study of Finance and Economics* 27.3: 12–19

Hyden, G. and Bratton, M. (1992) *Governance and Politics in Africa*, Boulder: Lynne Rienner

Jacka, Tamara (1997) *Women's Work in Rural China – Change and Continuity in an Era of Reform*, Cambridge University Press

Jones, Derek; Li, Cheng and Owen, Ann (2003) 'Growth and Regional Inequality in China During the Reform Era', *China Economic Review* 14.2: 186–200

Kaufman, Joan and Fang, Jing (2002) 'Privatisation of Health Services and the Reproductive Health of Rural Chinese Women', *Reproductive Health Matters* 10.20: 108–16

Li, Changming (2002) 'China Rural Health in Economic Transition', PowerPoint presented at the China Health Development Forum, Department of Primary Care and Maternal/Child Care, MoH, China, Beijing, April

Li, Changping (2003) *I Tell Populace the Truth*, Huhehaote City: Yanfang Publishing House

Li, Shuzhuo and Zhu Chuzhu (2001) *Research and Practice on Gender Differences in Child Survival in China*, Beijing: China Population Press

Liu, Yuanli *et al.* (1999) 'Equity in Health and Healthcare: the Chinese Experience', *Social Science and Medicine* 49.10: 1349–56

Ma, Baojin; Zou, Liping and Huang Xiaohong (2000) 'A Quantitative Survey on Improving Reproductive Health Services in Song County of Henan Province', *Chinese Primary Healthcare* 14.9: 38–41

Park, Albert; Scott, Rozelle; Christine Wong, and Changqing, Ren (1996) 'Distributional Consequences of Reforming Local Public Finance in China', *The China Quarterly* 147: 751–78

Paul, Samuel (1994) *Does Voice Matter? For Public Accountability, Yes*, Policy Research Working Paper 1388, Finance and Private Sector Development Division, Policy Research Department, Washington, DC: World Bank

Paul, Samuel (1991) *Accountability in Public Service: Exit, Voice and Capture*, Policy Research and External Affairs Working Paper WPS 614, Washington DC: World Bank

Polidano, C. and Hulme, D. (1997) 'No Magical Wands: Accountability and Governance in Developing Countries', *Regional Development Dialogue* 18.2: 1–15

Sen, Gita; George, Asha and Osltin, Piroska (2004) *Engendering International Health: The Challenge of Equity*, Cambridge, MA: MIT Press

Shah, A. (1998) *Balance, Accountability, and Responsiveness – Lessons about Decentralization*, Policy Working Paper 2021, the World Bank Operations Evaluation Department Country and Regional Department Country and Regional Evaluation Division, Washington, DC: World Bank

Turner, M. and Hulme, D. (1997) 'Administrative Reform: the Continuing Search for Performance Improvement', in M. Turner and D. Hulme (eds), *Governance Administration and Development-Making the State Work*, Basingstoke: Macmillan Press, Ch. 5

United Nations (1995) 'Platform for Action', The United Nations Fourth World Conference on Women, Beijing, 4–15 September 1995

Wang, D. (2005) 'Gender Inequality in Health and Poverty', paper presented on the Thematic Forum on Women and Poverty in Beijing Plus 10 Conference, Beijing 2005

Wang, Rong (2002) *Political Dimensions of County Government Budgeting in China: A Case Study*, IDS Working Paper 166, Social Policy Programme, Brighton: IDS

Wei, Huilan and Hui, Dongxu (2001) 'Reproductive Health Awareness Education: An Important Variable for Women's Poverty Alleviation in Poor Areas', *Collection of Women's Studies* 6: 12–20

Wei, Yehua Dennis (2002) 'Multiscale and Multimechanisms of Regional Inequality in China: Implications for Regional Policy', *Journal of Contemporary China* 11.30: 109–24

Whiting, Susan H. (2000) *Power and Wealth in Rural China – the Political Economy of Institutional Change*, Cambridge University Press

World Bank (1992) *Governance and Development*, Washington DC: World Bank

World Health Organization (1992) Basic Documents, 39th ed. Geneva: WHO

Xiang, Huacheng (2001) 'A Review of the Ten Years' Finance and Tax Reform of Our Country', *The Study of Finance and Economics* 27.6: 3–7

Yan Diying; Liu Maowei; Yang Yan and Jin Qiaoyan (2000) 'A Survey of the Current Statues of Reproductive Health Education and the Needs of People in the Poor Rural Areas', *Chinese Primary Health Care* 14.9: 14–16

Yan Jiasheng , Shan Yanli , Liu Jiazhi *et al.* (2000) An Investigation of the Current Status of Reproductive Health Service in Dafang County, Guizhou Province, *Chinese Primary Health Care* 14.9: 41–3

Zhang, Junzuo (1994) 'Development in a Chinese Reality: Rural Women's Organisations in China', *Journal of Communist Studies and Transition Politics* 10.4: 71–92

Zhang Xiaohe (1999) 'The Increasing Income Inequity in China and Its Causes', *China Report* 35.2: 163–77

Zhao, Simon Xiaobin and Gu, Chaolin (1995) 'A Policy Review on Spatial Strategy of Regional Development in China 1953–92', *China Report* 31:385–410