
Financial Resource Flows for Population Activities

Report of a case study in China

The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.

Table of Contents

Table of Contents

List of Figures

List of Tables

Preface

1. Demography of China.....	1
2. Methodological issues.....	5
3. National Population Policy and Programmes.....	7
3.1 Family planning programme.....	7
3.2 HIV/AIDS programme.....	13
4. Financial Flows.....	15
4.1 Role of the government of China.....	15
4.2 Role of national NGOs and research institutions.....	20
4.3 Role of the international donor community.....	25
4.4 Role of the private sector.....	29
4.5 Summary.....	29
5. Concluding remarks.....	33

References

Annex

List of Figures

Figure 1. Crude birth rates, death rates and total fertility rates in China, 1949-1999	3
Figure 2. Contraceptive prevalence by method, China, 1997.....	12
Figure 3. CFPA central level income by source, 1997 and 1998 (in %).	23
Figure 4. Final expenditures for population assistance in China, by channel of disbursement, 1989-1998.....	26
Figure 5. China's total expenditures for family planning programmes in selected years (in millions of Yuan and US\$)	31
Figure 6. Per capita expenditures for family planning in selected years (in Yuan and US\$)	32

List of Tables

Table 1. Basic national demographic indicators, China.....	2
Table 2. Government Family Planning budget by level, 1996 – 1998.....	16
Table 3. State Family Planning Commission budget by source, 1996 – 1998	17
Table 4. Chinese population programme budget, 1998	30

Preface

In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS activities;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analysing population data will cost US\$ 17.0 billion in 2000, and increase to US\$ 21.7 billion in 2015. Two-thirds should be paid by the recipient countries, one-third will be paid by the international donor community.

The case study in China was conducted from 17/01/2000 to 02/02/2000, and forms part of the UNFPA/NIDI project that measures global financial resource flows for population activities. For this purpose, questionnaires are sent annually to public and private donor organisations in developed countries, and to government departments and national NGOs in developing countries and countries-in-transition. Collecting all this information from a broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. For better illustrations of the problems, country case studies are being carried out. The case studies complement our knowledge about financial flows for population activities that were obtained through the mail enquiry.

I want to express my sincere thanks to the following people of the China State Family Planning Commission: Ms. Hao Linna (Deputy Director, Department of International Cooperation), Ms. Zhang Yang (Deputy Director, Division of International Organisations, Department of International Cooperation), Ms. Li Rui (translator, Department of International Cooperation), Mr. Jiang Yongxian (Director, Department of Planning, Statistics and Finance), Mr. Wu Jiahua (Chief, Division of Planning, Department of Planning, Statistics and Finance) and Mr. Guo Zhenwei (Department of Planning, Statistics and Finance). It would not have been possible to get an insight in the complex issue of financial flows for population activities in China without the guidance of these people. They were responsible for all logistics, and gave ample time for long discussions.

I also want to express my sincere thanks to Mr. Sven Burmester, UNFPA representative, Mr. Jin Zhicheng, assistant representative, and Ms. Junko Sazaki, deputy representative at the China UNFPA office for their logistical assistance and frank discussions.

Many thanks go to all respondents who shared their time and information with me.

Due to the complexity of China's national resource flows for population activities and the short duration of the study, this report contains significant omissions. It's main purpose lies therefore in providing base line data, which should be updated and improved over the coming years. This can be done through the annual data collection with the UNFPA/NIDI resource flows questionnaires. The author welcomes any comments, corrections or updates.

Marja Exterkate,
June 2000

1. Demography of China

The People's Republic of China was founded on 1 October 1949, and counted at that time roughly 540 million people. The country is divided into 22 provinces, 4 municipalities and 5 autonomous regions, 334 prefectures, 2,143 counties and 640 cities. The People's Republic is a socialist state led by the Communist Party. Since 1978, the planned economy is changing towards an open market economy.

In 1969, the population had grown to 800 million, and today, China is the most populous country in the world; more than one fifth of the world population lives in China. 94 per cent of the population lives in 46 per cent of its land area, mostly in the eastern and south-eastern parts of the country (Riley *et al.*, 1997).

With a Gross National Product of US\$ 860 in 1997, China belongs to the category of middle-income economies.

Table 1 provides some basic national demographic indicators for China for the period 1953 to 1999.

Table 1. Basic national demographic indicators, China

	1953 census	1964 census	1982 census	1990 census	1999*
Population (million)	581.3	694.6	1,004.0	1,130.5	1,259.1 [#]
Natural increase rate [#]	2.30	2.76	1.57	1.44	0.88 [#]
Per cent urban	13.3	18.4	21.1	26.4	30.9 [#]
Crude birth rate	37.0	39.1	22.3	21.1	15.2 [#]
Crude death rate	14.0	11.5	6.6	6.7	6.5 [#]
Total fertility rate	6.0	6.2	2.9	2.3	1.8
Contraceptive prevalence rate					83
Infant mortality rate	107.6**	72.1**	36.4		31
Life expectancy at birth Male			66.4***		69
Female			69.4***		73

Source: Basic data of China's population. Data User Service Series No 1,1994.

* Source: Population Reference Bureau: World Population Data Sheet 1999.

** respectively 1955 and 1965

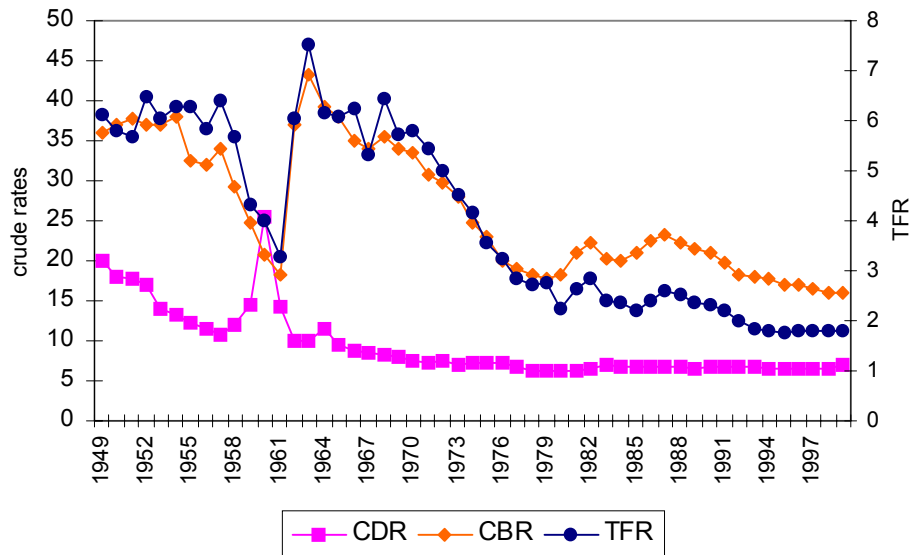
*** 1981

[#] Source: National Statistics Bureau (NSB): China Population Statistics Yearbook, 1999.

These figures are obviously national averages. Figures differ between regions, rural and urban areas and ethnic groups. In table one we can see that death rates declined gradually, and that birth rates and fertility declined dramatically. Contraceptive prevalence nowadays is more than 80 per cent.

In Figure 1 we look more closely to the birth, death and fertility rates.

Figure 1. Crude birth rates, death rates and total fertility rates in China, 1949 – 1999.



Sources: until 1992: Basic data of China's Population, 1994,
 after 1993: National Statistics Bureau (NSB): China Population Statistics
 Yearbook, 1999. TFR for this period is estimated by the dept. of planning,
 statistics and finance of the SFPC.

Between 1949 and 1957 the death rates declined with 47 per cent from 20 to 10.8. Since then it increased dramatically till as high as 25 per 1000 in 1960, due to the famine during the Great Leap Forward. In 1964/65 it returned to its level of 10 – 11 per 1,000, and it declined gradually ever since.

Since 1949 fertility initially decreased slowly. Birth rates dropped suddenly to as low as 18 per 1,000 in 1961, due to the famine during the Great Leap Forward. As soon as food supplies were restored, fertility rose to a maximum in 1963. Total fertility rates declined from 5.8 in 1970 (CBR of 33.4) to 1.8 in 1999 (CBR of 16). The most remarkable decline took place between 1970 and 1979 with a decline of the TFR of 53 per cent.

2. Methodological issues

The specific objectives of the case study in China are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail inquiry;
- to use the findings of the study as benchmarks for studying the quality of data gathered through the mail inquiry in other countries;
- to investigate the roles of government, NGOs, and the international community in the field of population activities;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programmes within the country? And how?

From 17/01/2000 to 02/02/2000 interviews were held with representatives from ministries, international donors, national NGOs and research institutions in Beijing. Annex 1 provides a list of all persons and organisations contacted during the case study. The co-operation of all respondents was very positive.

To optimise the quality of the information, the team followed as much as possible a standard strategy:

- 1998 national financial data were collected through questionnaires.
- questionnaires were controlled and internal and external quality checks were done. If necessary, information was corrected or adapted.
- in-depth oral information was gathered about various activities of the organisation such as: overview of funding, implementation of the ICPD Programme of Action, future plans and activities, et cetera.

The author is confident that the information obtained in this study is of good quality. This does however not mean that the information is complete.

During the case study it became clear that certain aspects of the data collection pose some problems and that there is still further room for improvement in the coming years.

Due to the complexity of China's financial accounting for population activities, we were not able to capture all levels. The following information is missing:

- at central level: questions concerning personnel and other overhead costs caused enormous problems. Some salaries originate directly from different departments from the State Council.
- due to the vertical organisation of the system, many sectors, like e.g. the organised labour sector are responsible for their own population and health programmes, including its funding.
- at provincial and lower levels: although the policy is made at the central level, provinces and other lower administrative levels can adjust it according to their needs and funding for the population program is also highly decentralised. As the provincial (and lower) levels are not accountable to the central level, these data are also not available at the central level. Data need to be collected from the provinces, counties, prefectures, townships and villages directly.

3. National Population Policy and Programmes

3.1 | Family planning programme

Since mid-1950 problems associated with rapid population growth and development began to appear (China Population Association, 1996). The government began to call upon people to practice family planning and promote the use of birth control measures (*ibid.*). In 1953 the government passed the Contraceptives and Induced Abortion Procedures Act, legalising the importation and sale of contraceptives and legalising sterilisation and abortion with certain restrictions (Conly *et al.*, 1992).

The first family planning campaign got underway in 1956 and lasted for about two years (Riley *et al.*, 1997). It was not very successful, having limited impact on some coastal urban populations (*ibid.*), due to a lack of trained health personnel and facilities in rural areas (Conly *et al.*, 1992). At that time the government did not have available adequate supplies of high-quality contraceptives, and policy makers did not rely on sophisticated population principles (Riley *et al.*, 1997).

That campaign ended just as the Great Leap Forward began in 1958, with the push for labour mobilisation and industrial development. Due to the famine in the late 1950s to early 1960s, family planning efforts were disrupted.

The second family planning campaign began in 1962 and lasted until the disruptions of the Cultural Revolution in 1966 (Riley *et al.*, 1997). The government encouraged later marriage, smaller family size and longer intervals between births, and worked to make contraceptives and abortions available (*ibid.*). In 1964, a Family Planning Office was established directly under the

State Council (China Population Today, 1999) and became responsible for the activities. The campaign was focused on urban areas and some urban areas experienced remarkable declines during this period. Rural areas were less equipped for such a campaign and in general, the campaign had little effect there (Riley *et al.*, 1997).

During the Cultural Revolution greater emphasis was placed on health services in the countryside. Through the network of community-based primary health services it was possible to provide contraceptive services to the rural population.

By the late 1960s, China had begun to develop and produce its own contraceptive devices and by 1972 was considered self-sufficient in this area (Riley *et al.*, 1997). It has developed various contraceptive technologies (and is still doing so).

Altogether, the seriousness of the population problem was underestimated and a clear population policy had not been formulated so far (China Population Association, 1996). In the early 1970s, the Government began to realise that rapid population growth had a negative impact on social and economic development and started to initiate a childbirth publicity campaign throughout the country providing free contraceptives and birth control technical services to all people (China Population Association, 1996).

The third family planning campaign began in 1971, when the government incorporated efforts to slow population growth into overall national economic planning for the first time. In 1973, the Family Planning Office was upgraded into a Leading Group, which consisted of members of various ministries (China Population Today, 1999). The campaign continued until the end of the decade and had a far wider impact, both geographically and demographically (Riley, *et al.*, 1997). Called the *Wan, Xi, Shao* (later-longer-fewer) campaign to emphasise its focus on later marriage, longer birth intervals and fewer births, it represented a much stronger effort by the government than any earlier efforts (*ibid.*). By limiting the number of marriage permits issued, the government was also able to significantly increase the average age of marriage, especially in the cities (Conly *et al.*, 1992). During this campaign, rural health services increased in coverage and scope, making available contraceptive and abortion services throughout most of the country (Riley, *et al.*, 1997). Annual targets for births were established at the central and provincial levels, and were the basis of approved births at local levels (*ibid.*). At the start of this campaign, couples were

discouraged from having three children and by the end of it, in the late 1970s, they were encouraged to have only one child (*ibid.*).

By the end of the 1970s, China had already undergone a dramatic decline in fertility (53 per cent between 1970 and 1979). The primary reasons for this decline were the increased availability of modern birth control through the network of rural health services, combined with intensive IEC. Contraceptives were delivered free of charge. Sterilization, IUDs and abortion services were provided through the primary health care system at village, township and county health institutions; oral contraceptives and barrier methods were provided through a community based distribution system (Kaufman *et al.*, 1992). Contraceptive prevalence rates came near to 70 per cent.

In 1979, the Government announced a major shift in official policy: the promotion of a one-child family norm (Conly *et al.*, 1992). As initially implemented, all couples were to be limited to just one birth and couples were expected to apply for official approval before conceiving a child. In addition, a system of rewards for compliance and punishments for non-compliance was put into place. These differed by locality, but included preference in education, health care, housing and job assignments for those who had only one child. Those bearing an out-of-quota child might lose access to education or be fined (Riley *et al.*, 1997).

Due to the economic reform in China (since 1978), this one-child policy changed from strict, centrally enforced policy implementation in the late 1970s and early 1980s to more decentralized policy implementation and local family planning regulations since the mid 1980s (Yang, 1994). From the early 1980s, some provincial family planning regulations appeared in China (Yang, 1994).

New service institutions -family planning service stations- were set up (Kaufman *et al.*, 1992).

The one-child policy has been highly successful in the cities and urban towns, both because urban people are more amenable to having only one child than are rural people and because government control is more effective in urban areas. Rural people have resisted the one-child policy and China's government launched a two-child policy or a "one and a half child policy" for the rural areas of most provinces in 1984. The latter policy imposes a one-child limit on those

couples with a firstborn son, but allows a second birth to those couples with a first born daughter (Banister *et al.*, 1994).

These moderating trends have continued. In ethnic-population areas, women generally can have two or three children. For ethnic minorities with a small population there is no restriction.

The Chinese government aims at a fertility rate at replacement level, and a natural annual growth rate below 1.25 per cent in the 1990 – 2000 period. It targets to limit the total population to 1.3 billion by 2000, and below 1.4 billion in 2010. As can be seen in table one, the aim for the 1990-2000 period seems to be reached already.

In accordance with the Programme of Action of the ICPD in 1994 and the Declaration and the Platform for Action of the Fourth World conference on Women in Beijing, the Chinese government has formulated action plans and programmes in line with China's national conditions (China Population Association, 1996). All these are reflected in "An outline for the family planning work in China" (1995 – 2000) and Programme for the Development of Chinese Women (1995 – 2000) (China Population Association, 1996).

These conferences have certainly influenced the Chinese population policy: the family planning programme is slowly changing. The State Family Planning Commission launched an "Improving quality of care in family planning services in China" programme in June 1995 in five rural counties and one urban district. These selected areas serve as a pilot for reorienting the family planning programme towards client centred services. In 1997, five more areas were added: four urban districts and one rural county. Since 1997 the Ford Foundation is also involved in the programme. The concepts of Cairo (quality of care approach and integration of activities) are put into practice. The programme focuses on:

- Informed choice: extensive information on several temporary contraceptive methods;
- Training of service providers: develop one curriculum (include prevention and treatment of RTIs and STDs) and change the criteria for the family planning workers;
- Advocacy for programme managers and IEC for the public;
- Improvement of service facilities, especially training equipment;
- Focus on MCH and prenatal care, including home-visits.

The results so far have been encouraging: management and services are improving, more attention is paid to quality of care. A spin off effect is that currently more than 300 counties or districts are in one way or another trying to adopt some of the quality of care measures.

In addition to this programme, there is more room for new views: two pilot projects are running since October 1998 in two urban districts (one near Beijing and one near Shanghai) by the State Family Planning Commission, with assistance of UNFPA: adolescent reproductive health and social marketing.

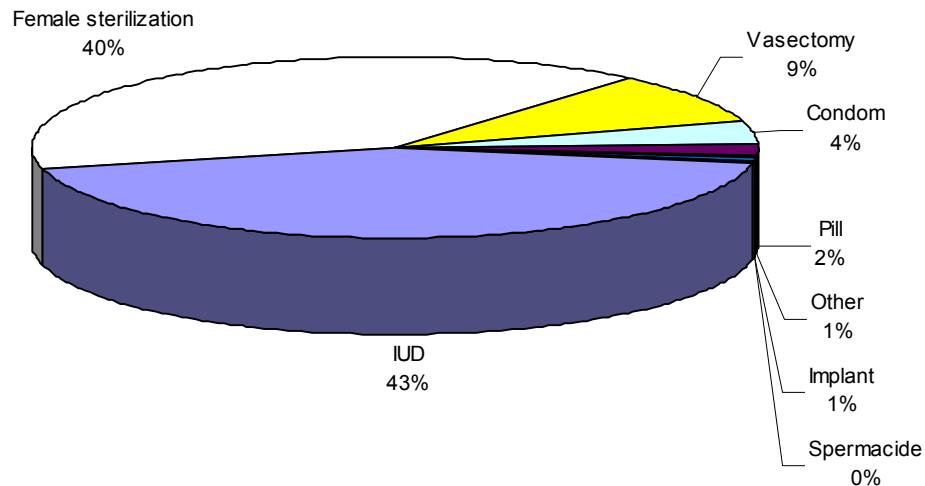
The project targets three different groups:

- seasonal migrants,
- adolescents (through the China Family Planning Association),
- higher educated people, who can afford and are willing to pay for better quality.

Contraceptive method mix.

The contraceptive prevalence rate increased from 71 per cent in 1982 to a high 83 per cent nowadays. Figure 2 makes clear that in 1997 two methods dominate: the IUD with 43.4 per cent and female sterilisation with 40 per cent. The dominance of these two methods has been so historically. This can be explained by major influence of the national guideline of “first child: IUD, and second child: sterilisation” on providers in practicing family planning in the early 1980s (Yang, 1994).

Figure 2. Contraceptive prevalence by method, China, 1997.



Source: State Family Planning Commission

Management of the Family Planning programme.

In 1981, the Family Planning Leading Group of the State Council, the central co-ordinating authority for family planning was given Ministry status and renamed the State Family Planning Commission, falling directly under the State Council (Conly *et al.*, 1992).

The State Family Planning Commission is supplemented by (but has no direct authority over) provincial and local level family planning commissions, affiliated training, research and information centres, and Ministry of Health facilities which provide clinical birth control services (*ibid.*).

The State Family Planning Commission (SFPC) formulates family planning policies, strategies and programmes, and provides information and contraceptive services. The Commission proposes changes in national population policy, provides partial financial support to provincial and local family planning institutions, and finances and co-ordinates production of contraceptives (Conly, *et al.*, 1992). But responsibility for programme implementation rests with the provincial family planning commissions, which are under the provincial People's Congress rather than the central Family Planning Commission. Provincial and local authorities finance most staff and operating costs and share

the capital costs of constructing new facilities with the central government (*ibid.*).

Each province has some autonomy in determining the size of its own input into the family planning programme, each locality also has enough autonomy to decide what proportion of its family planning funds to allocate to various projects (Banister *et al.*, 1994). The family planning policy can therefore differ between provinces and lower levels.

So the Chinese family planning programme is highly decentralised and set up like a pyramid (Banister *et al.*, 1994). At the top of the pyramid is the State Family Planning Commission, and at the bottom are the peasant small groups, neighbourhood small groups, and the workshop or section teams (*ibid.*).

Before the 1980s, family planning services were delivered through the Ministry of Health's structure. With the creation of the State Family Planning Commission in 1981, family planning committees were set up at different levels. In addition, clinical Family Planning Service Stations were established at the county and township levels. Due to the establishment of this new institutional structure, the role of the health institutions in providing fully reimbursed family planning services has diminished (Kaufman, 1998).

3.2 | HIV/AIDS programme¹

The first HIV/AIDS case was reported in 1985. Until 1988 only a few foreign people or overseas Chinese were infected with HIV. Between 1989 and 1993, HIV infection became more epidemic in the South-Western part of Yunnan province. The majority of these people were drug users. Since 1994, HIV is spreading beyond Yunnan province. All 31 provinces, municipalities and autonomous regions have reported HIV/AIDS.

In 1999, 15,088 HIV positive cases were officially reported, but experts estimate a number of 400,000 people that are infected with HIV/AIDS. Roughly 70 per cent is transmitted through the sharing of contaminated needles among drug users, another 10 to 20 per cent is sexually transmitted. Although the HIV/AIDS prevalence is still relatively low and concentrated in particular areas and populations, a potential danger is the rapid increasing prevalence of STDs. The reported number of STDs is increasing between 30 per cent to 40 per cent

¹ Most of this paragraph is based on information found at <http://www.unchina.org/un aids>

annually. It is however expected that this increase is much higher.

Since 1987, a national programme on HIV/AIDS prevention and control is in existence. The Ministry of Health, Department of Disease Control is in charge of AIDS prevention and control, ensuring the safety of blood products and HIV/AIDS education. In 1990 the Ministry of Health adopted a first medium-term plan for the prevention and control of AIDS. This plan was divided into a national plan and 13 plans for selected provinces.

In 1994, the Chinese government signed the Paris Declaration at the World AIDS Summit. The central government has a high political commitment towards the prevention of HIV/AIDS: policies, laws and regulations in the HIV/AIDS fields are regularly adjusted and updated.

The first plan was succeeded by a second for the period 1995 to 2000. This second plan guided multisectoral AIDS activities in the country.

In 1998, a Mid- and Long- Term Plan for HIV/AIDS Prevention and Control was approved by the State Council. The plan sets out strategies for prevention and control until the year 2010. Governments at all levels need to integrate HIV/AIDS prevention and control into their local social economic development plans. Targets are to control the rapid increase in HIV/AIDS infected persons, diminish the growth of new HIV cases with 50 per cent by 2002 and stabilise the growth by the year 2020. However, at the lower levels, HIV/AIDS has to compete with many other social priorities, and is not always seen as a priority area.

4. Financial Flows

The family planning programme is nearly self-sufficient, less than 0.5 per cent originates from international assistance. The same is true for the other aspects of the population spectrum: reproductive health, HIV/AIDS, and basic research.

4.1 | Role of the government of China

The financial system in China is highly complex. Local levels operate independently from the central level. With 31 provinces, 2,143 counties, and many more lower levels, the decentralised financial flows are enormous. All provinces get their health budgets from their own provincial governments. These budgets are planned and decided upon by the 31 provincial authorities. National authorities are not necessarily aware of the health expenditures by the provincial level. The same goes for the lower levels, like districts and counties. Provinces only fund activities at the provincial level, districts only activities at district level, etc.

At the central level, it's not much easier: departments at the ministries (e.g. the MCH department at the Ministry of Health) are technical departments, which are in charge of policy making, evaluation and monitoring, and research. Salaries and other overhead costs come from different departments directly at the State Council. The State Council is the executive body of the Chinese government and ranks above the ministries, state commissions and ministry-level corporations and companies. Data for the central level can probably be compiled at the Ministry of Finance. In order to get data from the local governments, information need to be gathered at the local levels.

Many departments play a role in the population programme. The major ones are the State Family Planning Commission for the family planning programme and reproductive health, the MCH department at the Ministry of Health for mother and child health including reproductive health, and finally the Disease Control Department under the Ministry of Health for the STD, HIV/AIDS control

programme. The Ministry of Health and the State Family Planning Commission are vertical structures under the State Council.

State Family Planning Commission

Family planning is one of the priorities of the Chinese government. The State Family Planning Commission is responsible for the family planning policy. Government funding for the family planning programme originates from five different levels:

- Central government
- Provincial government, autonomous regions and municipalities
- Prefecture level
- County level
- Township level

In Table 2 we find the government budget for family planning, distinguished by these different levels. We see in the table below that the county and township levels play the major role in government funding: roughly 80 per cent of the budget originates from these levels. It is interesting to see that the share of this level decreases slightly, whereas the other levels increased.

Table 2. Government Family Planning budget by level, 1996 – 1998.

	in billions of Yuan:			in millions of US\$:					
	1996	1997	1998	1996	1997	1998	1996	1997	1998
Central	0.4	0.5	0.6	48	60	72	5%	6%	7%
Provincial	0.5	0.6	0.7	60	72	85	6%	7%	8%
Prefecture	0.5	0.6	0.7	60	72	85	6%	7%	8%
County and Township	6.3	6.9	7.0	758	832	846	82%	80%	78%
Total	7.7	8.6	9.0	926	1,037	1,087	100%	100%	100%

All levels contribute in regular and operational expenses. In some special cases the central level funds certain items at lower levels:

- Exceptionally the central level gives subsidies (for training) to the lower levels in poor areas or in areas with minorities.
- The central level funds contraceptives (98 per cent of contraceptives are free of charge for the user).
- Mobile family planning service stations: 2/3 of these mobile stations are financed by the central level; 1/3 by the local government.

In addition to the government budget, other public sources of financing family planning activities are existent. Roughly speaking one can say that the national family planning budget consists of three parts:

1. Government investments at the five different levels (table above).
2. Operating income: income of family planning service stations conducting IEC and training for family planning and technical services.
3. Taxes from peasants at the township or village level to the township government: from all these taxes, a certain percentage (max five per cent) needs to be used for family planning services.

If all this is added, we come to the following numbers:

Table 3. State Family Planning Commission budget by source, 1996 – 1998

	in billions of Yuan:			in millions of US\$:			1996	1997	1998
	1996	1997	1998	1996	1997	1998			
Government, all levels	7.7	8.6	9.0	926	1,037	1,087	81%	77%	72%
Operating income	0.3	0.4	1.3	36	48	157	3%	4%	10%
Taxes at township level	1.5	2.1	2.2	180	253	266	16%	19%	18%
Total	9.5	11.1	12.5	1,143	1,339	1,510	100%	100%	100%

This budget also includes:

- the central level of the China Family Planning Association (NOT the provincial and lower levels);
- the China Population Information and Research Centre;
- the National Research Institute for Family Planning;
- all funding at the provincial and lower levels.

As can be seen in the table above, the government share was 72 per cent of the total budget in 1998, but it had declined from as high as 81 per cent in 1996. Instead, the “operating income” has increased dramatically, perhaps indicating the shift towards more self-generated income.

The budget is spent on the following seven items:

- Medical operations
- Contraceptives
- Training for family planning workers
- Family planning IEC activities
- Salaries for full time workers at grassroots levels
- One-child incentive programmes
- Other

Unfortunately, no data could be retrieved on expenses by category.

Ministry of Health

Funding for health services by the Ministry of Health has changed dramatically: prior to 1976 the country was organised into a commune system (Kaufman, 1998). Rural health services were collectively financed in these communes through the Co-operative Medical Services (CMS) system (*ibid.*). Preventive MCH services were free-of-charge. Since the dismantling of the commune system in the beginning of the 1980s, the rural co-operative medical system declined. The financing gap that resulted at the lower levels was filled mainly by private out-of-pocket spending (World Bank, 1997). Central, provincial and county government levels still contribute to the public health, but at township and village level the sector is mostly financed through fees-for-services.

Two departments in the Ministry are of particular interest to us:

- Department of Grassroots Health Service and Maternal and Child Health. In 1993, only 3 per cent (or 0.3 billion Yuan) of the government health budget was allocated for MCH (World Bank, 1997, based on table 2.1). Of the total MCH budget in 1993 (3.1 billion Yuan), 26 per cent originated from rural fees-for-services (*ibid.*).

In 2000, the Government launched a special programme to reduce maternal mortality and neonatal tetanus especially in underdeveloped, remote areas and in areas with minorities in 12 provinces in the Northern, Eastern and Southern part of China. A total of 378 counties are included in the programme. The central ministry allocated 200 million Yuan (US\$ 24 million) for two years to the programme. This amount is earmarked for activities at the central level only, and excludes salaries.

- Department of Disease Control for HIV/AIDS control.

Annually, the Central Ministry contributes earmarked funds for HIV/AIDS activities at the central level of 15 million Yuan (US\$ 2 million). This amount is allocated for programme activities of the department of disease control at the MoH at the central level only, and excludes salaries and other overhead costs. These figures and funding for local levels could not be retrieved during the period of this study.

Between 1980 and 1996, 22 provinces invested more than 47 million Yuan in AIDS prevention and control (www.unchina.org/un aids).

National Bureau of Statistics

Every 10 years a national population census is conducted. In between, in every fifth year, a 1 per cent sample, and every year a 1 pro-mill sample. The Bureau is currently preparing the fifth census, which will be held at 1 November 2000.

For the preparation of the national census and the printing of the first tables, the central government contributes 500 million Yuan (US\$ 60 million), the local governments 2 billion Yuan (US\$ 242 million). 80 per cent of the census costs are paid by the local governments. The total amount serves a period of roughly four years, which means on average 625 million Yuan annually.

For the other sample surveys, the central government contributes 2 million a year; the local governments less: for every 5 Yuan from the central, the local level contributes 4, which comes to roughly 1.6 million Yuan. Furthermore, in these sample surveys, the central levels funds all training materials, survey papers, etc.

All these figures are without salaries. The administrative system for the census is an ad-hoc committee from different departments: the National Bureau of Statistics, State Family Planning Commission, IEC departments, cultural departments. The salaries are paid by these different departments. The same holds for the field workers (6 million people in total).

In addition to the census, the National Bureau of Statistics conducts some smaller studies in collaboration with donors, e.g.:

- With UNICEF: monitoring maternal and child health; at provincial level.
- With UNFPA: women's empowerment through improving reproductive health and development of micro-enterprise (see p. 26 ?). The National Bureau of Statistics is in charge of monitoring the implementation.
- With the EU: preparation of a labour force survey, which will be held in 2001.

In addition to the SFPC, the MoH and the National Bureau of Statistics, other departments or sectors also play an important role in financing the “population” budget. Unfortunately no figures could be obtained during this study. Nevertheless they are mentioned here, as their role is expected to be considerable and they should be taken into account in follow-up studies.

Ministry of Finance

The Ministry of Finance has its share in the population budget by:

- Directly financing those family planning NGOs which do not fall under the SFPC.
- Expenditures for basic construction of family planning facilities.

Ministry of Science and Technology

The Ministry of Science and Technology directly finances those population research institutions, which do not fall under the State Family Planning Commission.

Organized Labour Sector

The labour sector (state and collective industrial enterprises, military) has their own family planning and health programmes. Unfortunately, data could not be obtained during this study.

4.2 | Role of national NGOs and research institutions

The term NGO is somewhat misleading in the Chinese context, as the national NGOs receive part of their income directly from the Ministry of Finance. China has many population research institutions; most of their income originates from the Ministry of Science and Technology.

Only the key organisations are mentioned here.

China Family Planning Association (CFPA)

The CFPA was founded in 1980 by the government, in order to channel the sources and expertise from international organisations. In 1983 the association became an affiliate of the IPPF. Until 1986 the organisation gradually evolved and started to serve the unmet needs of the people at the provincial and lower levels. From 1986 onwards, they established local offices at grassroots levels to assist the State Family Planning Commission with implementing its population policy, and focuses on educating the public. The Association focuses on those groups that are not captured by the government: unmarried youth, poverty areas and the “floating population” (seasonal migrants).

After the ICPD, the CFPA revised its constitution, which was approved at the end of 1995. It now includes objectives such as promotion of gender equality, quality of care and elimination of unsafe abortion.

Next to the headoffice in Beijing, the CFPA has 31 provincial associations, 389 at prefecture level, 3,026 at county level, another 55,906 associations at township and 966,555 at village level. The associations at the central, provincial, prefecture and county level are registered as national NGOs, the associations at township and village level are not registered and serve as extensions of the county level. So the network consists of one million associations at all levels with a total of approximately 83 million members and plays a very important role in family planning, reproductive health, community development and poverty alleviation. Its main objectives are:

- to complement the government in implementing state family planning policies, laws, regulations and programmes;
- protect the legal rights of all adults and adolescents in family planning and reproductive health and to promote equality between the sexes;
- to advocate and satisfy the unmet need for family planning and reproductive health information and services.

The CFPA is not so much involved in services as such, but more in education and counselling activities in their centres. Their strategic plan for the period 1996 – 2000 covers five major programme areas:

- Reproductive health: develop IEC material and educate adolescents;
- Women development: income generating activities (raising livestock, planting);
- Democratic participation and supervision: monitor the government policy;

- Public affairs: strengthen the international Co-operation, and education programmes in China;
- Institutional development.

Future activities may involve:

- Adolescent Reproductive Health (started already with a pilot project in 2 districts, funded by UNFPA),
- Social marketing of condoms (started already with a pilot project in 2 districts, funded by UNFPA),
- STD, HIV/AIDS prevention.

Financial flows:

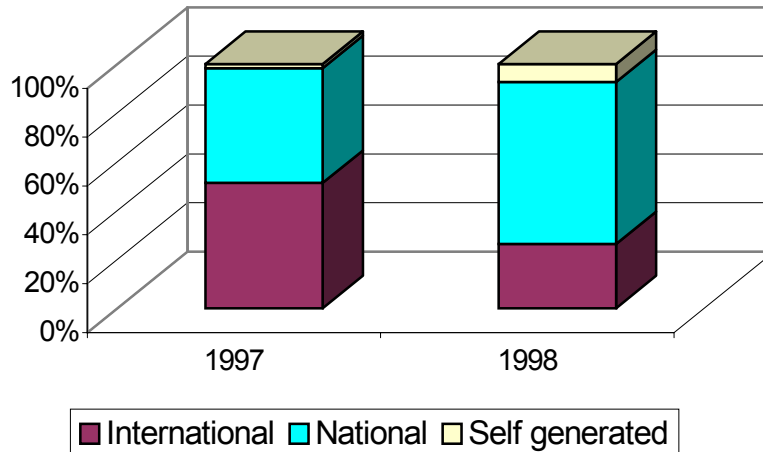
Financial data represent financial flows from the central, provincial, prefecture and county level. Data on the township and village level are hard to capture; the other levels report on an annual basis to the headoffice.

The central level includes:

- support activities implemented at central level to the local level (training, workshops, etc)
- pilot projects (e.g. adolescent RH incl. quality of care and social marketing) in several areas at lower level: the central level provides direct financial and technical support to the provincial level.

In 1998 the income for the central level CFPA of roughly US\$ 3 million was more than 50 per cent higher than it was in 1997. US\$ 2.8 million was spent in 1998, against US\$ 1.3 million in 1997. It is clear from Figure 3 that the increase in income was due to national sources and self generated sources. The share of international funding in the central level income decreased dramatically from 51 per cent to 26 per cent.

Figure 3. CFPA central level income by source, 1997 and 1998 (in %).



In the previous years most funds originated from IPPF. Three years ago, IPPF started cutting the budget with 6 per cent a year. For 1999 and 2000, the budget has even been cut with 50 per cent.

Financial support from the government was increasing (from 300,000 Yuan annually for general support to currently more than 4 million Yuan (US\$ 500,000) a year). These funds are disbursed by the Ministry of Finance through the SFPC.

The future funding of the government is unsure since the government reform of 1998. NGOs are more and more expected to generate their own funds, or apply on a project basis (instead of general support). The CFPA started in some areas with requesting fees-for-services and income generating projects.

The lower levels of the CFPA receive most of their income from the local governments and activities. Although exact data are missing, the CFPA estimates that central level funding is only 4 per cent of the total finances of the CFPA. This means that the lower levels of the CFPA receive about 962 million Yuan (US\$ 116 million) annually from the local governments.

China Population Information and Research Centre (CPIRC)

The China Population Information and Research Centre was established in 1980 with assistance of UNFPA, with the main objective to collect data, conduct research and disseminate information on population and family planning. The centre is affiliated with the State Family Planning Commission.

With its applied research, it tries to build a bridge between government agencies and academic institutions.

The centre has four major divisions:

1. Population Information Service Division: library, information technology and data-users services.
2. Population Research Division: fertility surveys, quality of care, women status, sex ratio, ageing, floating people.
3. Publication Division: four regular publications (Population and Family Planning, Chinese Family Planning Yearbook, Population Abstracts (all three in Chinese) and China Population Today (English)); data sheets and translations of existing materials.
4. International Co-operation and Exchange: the China Population Information Network (POPIN) is a member of the international POPIN, and has 40 members in China, all population research centres.

Most of their income originates from the Ministry of Science and Technology, through the State Family Planning Commission.

Financial data are included with the SFPC figures.

National Research Institute for Family Planning (NRIFP)

The National Research Institute for Family Planning was founded in 1979 with UNFPA funds, with the objective to conduct research on contraceptive technology and human reproduction. The institute is affiliated with the Ministry of Science and Technology and the State Family Planning Commission. In 1991, the institute was designated as the WHO collaboration centre for research in reproductive health.

Currently, a total of 224 people are working at the institute in four different branches:

- Research branch: develop new methods; evaluate existing methods; develop methods for diagnoses of birth defects
- RH service centre
- RH training centre
- Information centre: journals for FP experts (in Chinese with English abstracts)

Funding for the institute increased from 10 million Yuan in 1995 to 18 million Yuan in 1999 (incl. personnel costs), and roughly 50 per cent is spent on research. Sources of income nowadays are:

- the Ministry of Science and Technology through the State Family Planning Commission (70 per cent of income)
- self generated income (28 per cent)
- international funding (2 per cent): WHO, Rockefeller, pharmaceutical companies.

Peking University, Institute of Population Research (IPRPU)

The Institute of Population Research at Peking University is an interdisciplinary centre in population and development research and training. It was established in 1979 as a department in the Economic Faculty and gradually became an independent department. In 1991, it was designated as a WHO collaborative centre for research and reproductive health and population science. Currently the institute has 22 faculty members and about 30 graduate students from various developing countries including China.

Major training and research areas are population and economy, population projections, reproductive health and Asian studies.

Most of the funding originates from international sources: UNFPA since the 1980s and, in addition since 1992, the WHO as well (science research Reproductive Health).

Money flows from the international donor through the Peking University to the Population Institute. Domestic sources are very limited.

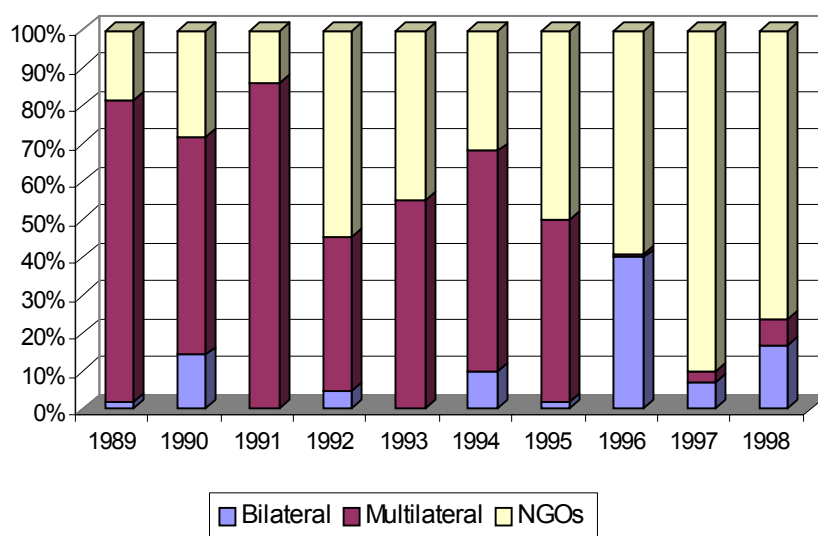
The IPRPU conducts collaborative studies with the China Population Information and Research Centre.

4.3 | Role of the international donor community

In terms of money, donor assistance has never played an important role in China. Until 1995 it has been fluctuating around US\$ 10 million annually (with a range of US\$ 7 million and US\$ 14 million). In 1996/97 funding decreased to US\$ 4 million. This was mainly due to the suspension of funds flowing through multilateral organisations (UNFPA). Preliminary figures for 1998 show an increase to US\$ 6.7 million.

Figure 4 gives an overview of international aid by channel.

Figure 4 Final expenditures for population assistance in China, by channel of disbursement, 1989 – 1998



Source: UNFPA Global Population Assistance Report 1997, UNFPA/NIDI database. 1998 figures are preliminary

Although the donors' financial input is negligible, their very important role lies in pioneering, pilot and advocacy activities. The majority of foreign aid was and is allocated to projects relating to the production of contraceptives, advocacy, training, IEC and research projects.

Only a few donors assist the Chinese family planning programme, the major ones being UNFPA and the Ford Foundation.

Quite a number of other donors are involved in the STD, HIV/AIDS prevention area: UNAIDS, UNDP, WHO (HIV/AIDS and STD control), UNESCO (education materials for schools), UNICEF, World Bank (safe blood transmission), EU (education and training), AusAid (condom promotion) and DFID (condom promotion). Concerning HIV/AIDS activities undertaken and sponsored by external donors since the beginning of the 1990s, it is recommended to check the excellent website of UNAIDS in China (www.unchina.org/unaid).

There appears to be no systematic reporting on foreign assistance. The UN system works through the Ministry of Foreign Trade and Economic Co-operation (MOFTEC), the other donors directly with the concerned central, provincial or lower level counterpart. Although donors do co-ordinate their activities, they decide themselves where they work and which are their priorities (except for the family planning where the SFPC decides). This results in an uneven distribution of donor inputs.

Some attention will be given here to the work of UNFPA and the Ford Foundation in the area of family planning and reproductive health.

UNFPA

UNFPA has provided assistance in China since 1979. Between 1980 and 1994 UNFPA funded local production of contraceptives for approximately US\$ 28 million. The main objectives of UNFPA assistance were to introduce safer and more effective modern contraceptives (UNFPA, 1996).

In addition, the first two country programmes (1981 to 1984 and 1985 to 1989) focused on women empowerment and capacity building. Both programmes amounted to US\$ 50 million each (UNFPA, 1997). The third country programme (1990 – 1995) provided US\$ 57 million and focused on capacity building and on innovative interventions (*ibid.*).

UNFPA is currently implementing its 4th country programme (1997 – 2000; US\$ 20 million). The programme focuses on reproductive health, and consists of several projects, of which the most important are:

- Reproductive Health/Family Planning (RH/FP) Project (US\$ 14 million; implemented in 32 counties in 22 provinces), through the SFPC (70 per cent) and the MoH (30 per cent).

The objective of the project is to establish a client-oriented reproductive health approach, which provides a wide range of quality health services, e.g. maternal health care; treatment of reproductive tract infections and sexually transmitted infections and family planning services. The Chinese Government has lifted acceptor targets and birth quotas in these areas.

Two pilot projects are being carried out in two urban districts: social marketing (with the SFPC) and adolescent reproductive health (with the CFPA).

- Women's Empowerment through Improving Reproductive Health and Development of Micro-Enterprise (US\$ 5 million; implemented in 15 poor counties in 13 provinces).
In each county, one or two townships are selected. A total of roughly 15,000 rural women are given a micro credit of 2000 Yuan. This project aims at contributing to the improvement of women's economic status and gender equality, the increased utilisation of RH/FP services and the provision of information to promote responsible reproductive behaviour.

Ford Foundation

The Ford Foundation opened its office in Beijing in 1988, but had collaborated with China already long before then: the focus was to strengthen academic and professional competence. Currently the emphasis is on four main areas:

- Rural poverty and resources,
- Reproductive health,
- Economic reform and its social consequences,
- Laws, rights and governance.

The China reproductive health programme supports governmental agencies, research institutes, training centres and NGOs.

The reproductive health area follows three strategies:

- Support for social science research: research relating to reform of population policy, links between economic transformation and RH, to under-recognized reproductive health problems, like STDs, RTIs, HIV/AIDS, prostitution, domestic violence and female suicides.
- Assistance for community-based initiatives.
- Promotion of discussions on the ethical and legal contexts in which sexual and reproductive health programmes are carried out.

Ethical issues in reproductive health are funded by the Foundation through supporting the Chinese Academy of Social Sciences, which hosted seminars on ethical issues in sexual and reproductive health, AIDS prevention and family planning. The foundation also supports the Yunnan Reproductive Health Research Association, which was founded in 1994. The association promotes the integration of reproductive health with women's empowerment, poverty alleviation and community development through research and applied projects.

Since 1992, they fund the Women's Reproductive Health and Development Programme in Yunnan province. The project focuses on improving reproductive health through a participatory approach: empower local women to take part in shaping their own health care.

Since 1997, the Foundation is assisting the SFPC with the Quality of Care project.

Expenditures for reproductive health in China increased from US\$ 750,000 in 1992 to US\$ 2.85 million in 1999.

4.4 | Role of the private sector

The private sector does not (yet) play a big role in the Chinese family planning programme. More than 98 per cent of contraceptives are provided by the public sector. Some pilot programmes are currently being conducted with social marketing of condoms.

A different picture emerges from the health sector at the local levels: since the beginning of the 1980s, the health system has adopted health financing mechanisms such as fees-for-services and drugs to supplement income for rural doctors (Kaufman, 1998). More research needs to take place on how many reproductive health services are funded by the private sector.

4.5 | Summary

When we summarise what we have so far, an estimate of total expenditures in the population programme in 1998 can be given. In the table below, columns 1, 2 and 3, we see that the Chinese government contributes 14.2 billion Yuan (US\$ 1.7 billion). Since not all data were available during the period of the case study, it can be assumed that this estimate is far too low. These figures only include information from:

- the SFPC at all levels (including salaries),
- the CFPA lower levels (central level is included with the SFPC budget),
- the MCH and HIV/AIDS programmes at the MoH at central level only (excluding salaries and other overhead).
- annual estimates from the National Bureau of Statistics, central and local level (excluding salaries and other overhead).

From the government share of the SFPC budget, we saw in paragraph 4.1, table four, that only 7 per cent originated from the central level, which leaves 93 per cent from the lower levels. As a matter of exercise, we assume that the MCH and HIV/AIDS programmes at the central level (115 million Yuan) also represent only 7 per cent of the total, with 93 per cent contribution of local levels. If we recalculate the first two columns in the table, we finally get a government contribution of 15.7 billion Yuan (almost US\$ 2 billion) (columns 4,5,6).

Table 4. Chinese population programme budget, 1998

	Yuan ('000)	US\$ ('000)		Recalculated*		
				Yuan ('000)	US\$ ('000)	
	(1)	(2)	(3)	(4)	(5)	(6)
SFPC	12,500,000	1,509,844	87.6%	12,500,000	1,509,844	79.2%
MoH/MCH national level	100,000	12,079	0.7%	1,428,600	172,557	9.0%
MoH/HIV/AIDS national level	15,000	1,812	0.1%	214,000	25,849	1.4%
National Bureau of Statistics	628,600	75,927	4.4%	628,600	75,927	4.0%
CFPA lower levels	962,925	116,309	6.8%	962,925	116,309	6.1%
International assistance		6,693	0.4%		6,693	0.4%
	14,206,525	1,722,664	100%	15,734,125	1,907,179	100%

* assuming that the figures in column (1) for the MOH only represent seven per cent of the total programme expenditures

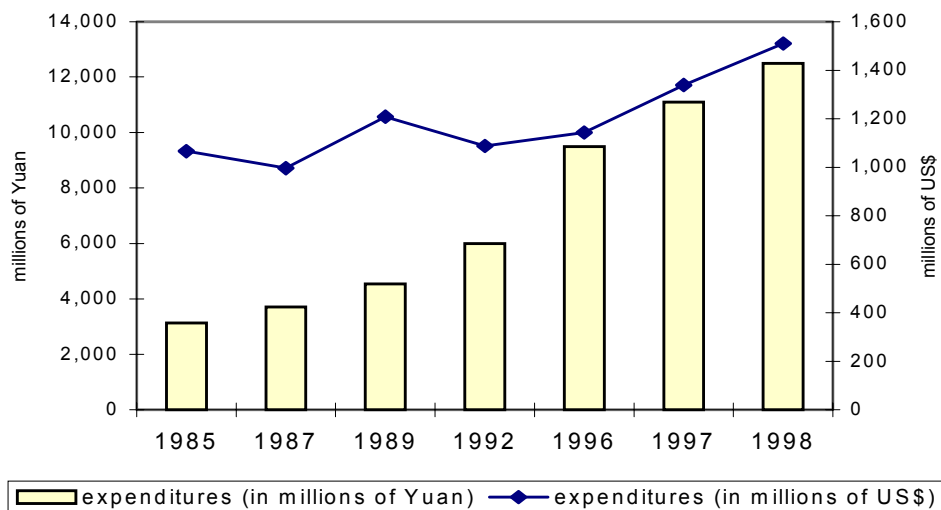
But we are still missing salary costs (except for the SFPC). Therefore, even the estimated US\$ 2 million will be too low. But nevertheless, even with this very conservative estimate, it is clear that 99.6 per cent of the total population budget in China originates from domestic sources. It is also clear, that most originates from the family planning budget, although one has to be careful here, as the SFPC figure includes salaries and the other sources of funding exclude salary costs.

This dominance of the family planning budget is also seen in other studies. For example, in a study conducted in two rural counties in Yunnan province by Kaufman (1997), she shows that current (county) government budgets for

family planning are two to ten times as high as that for MCH and the annual increase for family planning has been consistently higher during the period 1990–1995 (p. 267)

Figure 5 gives China's total expenditures for family planning programmes in selected years. It is clear that the family planning expenditures have been increasing annually.

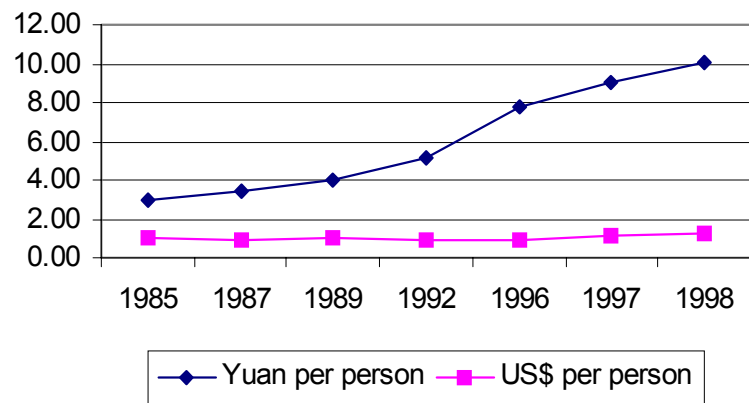
Figure 5. China's total expenditures for family planning programmes in selected years (in millions of Yuan and US\$)



Sources: 1985, 1987, 1989: Banister et al, 1994; 1992: Conly et al, 1992; 1996, 1997, 1998: this study.

When these figures are corrected for the population in China (Figure 6), we find that per capita expenditures increased from 2 to 10 Yuan, which however has been quite stable at a level around 1 US\$ per capita over all those years.

Figure 6. Per capita expenditures for family planning in selected years (in Yuan and US\$)



5. Concluding remarks

Although the data are far from complete, it became clear that China's population programme is almost self-reliant. Donors represent less than 0.5% of the total population budget.

China's family planning programme can be regarded as successful when one looks at achieving of demographic objectives. The challenge faced is to evolve the traditional family planning towards an integrated and client-oriented reproductive health approach, integrating contraceptive services with reproductive health. A start has already been made with some pilot projects reflecting the principles of the Cairo (1994) and Beijing (1995) conferences, and the World AIDS Summit (Paris, 1994).

The increasing prevalence of STDs forms a potential danger for HIV/AIDS. More needs to be done in this area, since only four per cent of contraceptive users are using a condom.

SFPC and MoH co-ordination.

Although data are not complete, it seems that much more is invested in the family planning programme than in the MCH programme. While family planning remains without any doubt, an important issue, reproductive health in general and STD and RTI prevention and treatment in particular, gain their importance, especially since the Cairo agenda. Most of these items fall under the health sector. The two existing systems function next to each other with many overlapping activities and not much co-ordination. Streamlining of the activities under these different ministries forms another challenge for the future.

Studies concerning expenditures for population expenditures in China need to focus much more on decentralised levels.

More research needs to take place on how much reproductive health services are funded by the private sector.

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