Summary

Since the 1990s, many national population and family planning programmes have been under re-examination and reorientation in light of the Programme of Action adopted at the International Conference on Population and Development in 1994. This is the case in China.

The present case study documents an experiment initiated by the State Family Planning Commission – now the National Population and Family Planning Commission – in 1995 to introduce the quality-of-care approach into China’s family planning programme in a few counties and districts. The introduction of this approach, which focuses on the standardized services and the client’s choices, was to serve as a means of reorienting the programme away from its previous demographically driven track as well as scaling it up nationwide thereafter.

Following the official call of the State Family Planning Commission to reorient the family planning programme in both its guiding ideology and implementation approaches, the experiment was intended to demonstrate, through the pilot projects, how the programme could be reoriented and what a client-centred and quality-focused programme might look like in the context of China. With the field evidence, the experiment also sought to convince the people in charge of the programme at all levels that the full-fledged promotion of the reorientation of the programme nationwide would be feasible.
To achieve sound implementation of the quality-of-care experiment, the latter was carried out in various settings but based on three major objectives: changing to a client-centred ideology, upgrading services through overall retraining, and improving the facilities to achieve the best care that could be provided. The strategy used in implementing the experiment consisted of four mutually supportive components: phase in before phasing out, pilot before scaling up, be flexible and encourage diversity, and learn via experience.

The experience of the pilot project has provided firm evidence that with an approach oriented towards quality of care, not only is the programme able to provide better services to the clients and to protect the clients’ health and rights but the approach is also able to lead to a more effective programme and even better demographic outcomes.

The quality-of-care approach was later adopted in several major international endeavours such as the United Nations Population Fund (UNFPA) Reproductive Health and Family Planning Project and the Japanese Organization for International Cooperation in Family Planning Integrated Project. It also was scaled up under the name of the “Quality-of-Care Advanced Unit” nationwide campaign.

While the State Family Planning Commission experiment was initiated with virtually no external assistance, the need to subject the experiment to international exposure as well as to request support from international collaboration was well acknowledged.

**Information on the Author**

**Prof. Zhenming Xie**, Professor at the China Population and Development Research Centre and Secretary-General of the China Population Association.
Growing more than 2 per cent per annum and the fertility level was around six children per couple. The next two decades witnessed a drop in the population growth rate to less than 1 per cent. Thus China can no longer be regarded as a country with “rapid growth” of its population. In addition, the fertility level has been below the replacement rate since the early 1990s; thus the country can no longer be regarded as having a “high-fertility” population. By the end of the twentieth century, China’s population dynamics had experienced a historic transformation.

Meanwhile, the “reform and opening era” initiated from the late 1970s triggered China’s booming economy and social transformation towards a modern society. As the result of the market-driven economy, people tended to be more attuned to quality-of-life issues, including personal reproductive health care and reproductive rights as well as gender equality. The family planning programme faced an entirely new generation, which had grown up with the exposure to enormous amounts of information and an ever-changing life reality. Internationally, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 exposed China to a whole set of new concepts such as “informed choice”, “reproductive rights and health”, “women’s empowerment” and “gender perspective”.

All these necessitated the reform of the family planning programme according to the changing situation. Therefore, the State Family Planning Commission issued an official call in 1995 for the “two reorientations”, with the intention of initiating the programme reform all over the country. As the first step in the reorientation, several counties and one district were selected in the mid-1990s for an experimental project to explore the programme, changing the focus from demographic targets to quality of care.

**State Family Planning Commission Goal in the Reorientation**

At the beginning of the period of the Ninth Five-Year Plan (1996-2000) in late 1995, the State Family Planning Commission issued an official call for reorientation of the family planning programme from an emphasis on demographic targets towards client-centred approaches and from a narrow focus on contraceptive prevalence towards relevant integration, with reproductive health and women’s empowerment objectives. In early 1998, it reiterated and elaborated its goal in reorienting the programme, specifying that with the successful demonstration of the innovative experiment in a number of pilot counties and districts by the year 2000, the client-centred and quality-focused approach to family planning would be gradually expanded throughout the country and the nationwide reorientation of the programme should be realized by the year 2010.

**Objectives of the Experiment**

While the State Family Planning Commission had explicitly called for the reorientation of the family planning pro-
programme, the overall objective of the experiment was to demonstrate, through the pilot projects, how the programme could be reoriented and what a client-centred and quality-focused programme might look like in the context of China. The experiment also sought to convince the people in charge of the programme at all levels throughout the country of the feasibility of the reorientation process as integral preparation for the full-fledged promotion of the reorientation of the programme after 2000. The specific objectives of the experiment crystallized over the course of the experiment and are threefold: changing the ideology, upgrading management and services, and improving facilities and institutional support.

**Changing the Ideology**

China's programme had been on a demographically driven track for so long that many of the programme managers and service providers had become used to it and found it very difficult to conceptualize, implement or manage the programme in an alternative manner. Some worried that negative demographic consequences would result from a less stringent approach to the programme or that the experiment would meet resistance from the local managers and service providers because it would imply a greater workload and responsibility. Others also worried that they would receive very little appreciation from the clients, who might not be aware of and might even be skeptical about the need for reproductive health care. Therefore, changing the ideology to accept a client-centred approach was the priority goal of the experiment.

**Upgrading Management and Services**

While the demographically driven approach was in place, the quality of services and the care of clients tended to lose priority in the programme. After the experiment unfolded, many managers and service providers found that they did not have the capacity to provide services according to the goals of the experiment. For example, while the providers were trained to do insertions and removals of intrauterine devices (IUDs), they had not been trained in the advantages and disadvantages of the various IUDs nor were they knowledgeable about the potential side effects of a given IUD. The providers lacked awareness of and skills in pre-operation counselling and post-operation follow-up services and had no professional training in interpersonal communication. Therefore, the Quality-of-Care Pilot Project considered the upgrading of management and services as the main content of the experiment.

**Improving Facilities and Institutional Support**

When the quality of services rather than demographic targets is stressed, the working conditions of the programme with regard to infrastructure and facilities, resource allocation, contraceptive supply and staff recruitment must be reshaped. Greater priority should be given to the observance of aseptic conditions in the clinics and to service-procedure protocols, with more space allocated
for examination and counselling and more attention paid to the privacy and confidentiality of the client. Many of the local service clinics in the pilot areas had been expanded or renovated, and the equipment necessary for quality of care and reproductive health care had been purchased and installed. With the support of the local government, additional resources had been allocated and more qualified and capable staff were recruited throughout the experiment. Thus, improving facilities and institutional support were necessary as the safeguards for a successful experiment.

**Strategies**

To ensure a sound and healthy programme transition in sensitive circumstances, an innovative strategy had to be developed in the experiment among the pilot counties and districts. The strategy had four mutually supportive components:

- **“Phase in, phase out”**. To ensure a smooth transition, the pilot projects adopted a strategy called “phase in, phase out”. This means that throughout the experiment, the priority was to introduce the new and innovative approaches into the programme first and then make them workable within the local programme and acceptable to the local people, including the clients, providers, managers and local leaders. This process takes time. Every effort was made to avoid overzealous attempts to abandon the existing approach and systems prematurely. When the new approach became well established in the programmes and was recognized and welcomed by the local people, then it was time to phase out the old approach;

- **“Pilot first, expand later”**. Introducing a quality-of-care approach in the context of China was an experiment without precedent. To proceed with the experiment in a step-by-step manner, a few pilot areas were first carefully selected as the quality-of-care pioneers or models. The intention was to initiate the experiment in smaller areas with relatively favourable socio-economic conditions and sound performance in their family planning programmes to ensure that the pilot would succeed more easily. With the successful demonstration of the experiment, the approach was introduced to larger areas, following the successful models. The goal of scaling up the strategy had been kept in mind from the very beginning of the project;

- **“Be flexible and encourage diversity”**. The experiment in each pilot area was initiated with what was locally deemed acceptable and doable. Though the State Family Planning Commission set the overall goals for the experiment as stated above, from the very beginning of the experiment, no fixed timetable or specific procedures were dictated from the top. The entire experiment emphasized great respect for local initiatives and encouraged a great deal of
diversity. The experiment among the pilots started with a variety of innovative efforts, such as the adoption of informed choice of contraceptives and development of new information, education and communication materials. Other innovations included the issuance of the newly designed *Reproductive Health Care Handbook*, restructuring of service clinics by placing the contraceptive display desk in the front of the clinic, invention of contraceptive display packages, creation of “quiet-talk” rooms for private counselling and installation of a 24-hour hotline telephone service. All of these local efforts were acknowledged and encouraged so long as they contributed towards a client-centred, quality-focused approach to their family planning programmes;

- “Learn via experience”.

Throughout the course of the experiment and even now, understanding of the concepts of “quality of care”, “programme reorientation” and even “informed choice” have varied considerably among the leaders, managers and providers involved. Rather than debating and attempting to clarify the concepts once and for all, the experiment followed the principle of “practice first”, i.e., letting people learn and begin to understand the concepts of “quality of care” and “reproductive health and rights” not only from books or lectures but also through their own experiences. The experiment suggests that for the local programme managers and service providers, rather than attempting to understand the concepts theoretically, it is most useful to conceive the concepts in concrete terms.

**Implementation of the Pilot Project**

During the period of initiating and implementing the Quality-of-Care Pilot Project (from 1995 to 1999), a number of activities were carried out. These are described in the following sections.

**Pilot Selection**

The main mechanism adopted by the State Family Planning Commission to develop and establish the quality-of-care models was the selection of a few counties and districts as pilots for quality of care. At the beginning of 1995, the Commission selected five rural counties

![Figure 1](image.png)
and one urban district as the first pilots for the experiment (fig. 1). In 1997, five more pilots were added.

**Leadership Development**

In early 1995, the State Family Planning Commission set up the leadership group of the Quality-of-Care Pilot Project at the national level with a vice minister of the Commission as the head and all Directors General from departments of the Commission as the members. The operational office of the Quality-of-Care Pilot Project, under the Planning and Statistics Department of the State Family Planning Commission, was in charge of planning, monitoring and evaluating at the national level. It was facilitated by the adviser group and the resource team from some international or domestic universities or research institutions. The State Family Planning Commission required that, under its leadership, all pilot counties and districts set up their own leadership groups, issue their own official documents and work plans, and conduct initiation activities, such as social mobilization and advocacy.

**Partnership Development**

International organizations and funding agencies as well as international and national expertise became involved in the Quality-of-Care Pilot Project with financial and technical support, especially in training, supervision, monitoring and assessment. These included the Population Council, the International Council on Management of Population Programmes (ICOMP) and the University of Michigan. More than 20 scholars or experts from universities or institutes in China were involved in the Quality-of-Care Pilot Project from the beginning. Some of them were assigned as members of the advisory group; others participated as resource persons.

**Capacity-building**

To implement the Pilot Project, several activities for capacity-building were conducted as follows, with facilitation from some international agencies and domestic institutions:

- Training-of-trainers (TOT) training workshops were organized by international and domestic experts to train national and provincial managers and service providers. Cascade training sessions were conducted in each pilot county and district.
- Family-planning service stations at the county and township levels were rebuilt or improved in most pilot counties and districts, following the client-centred approach, to make them a “user’s home”.
- Several study tours and training activities for directors of pilots were also organized by the Quality-of-Care Pilot Project Operational Office in Thailand in October 1996 and in the United States in July 1999.
- Training of high-level officials was undertaken in the United States for Directors General in the State Family Planning Commission and provincial family planning commissions (1998-2002), organized by the State Family Planning...
Commission in cooperation with the Public Media Center in the United States.

**Supportive Communications**

With respect to supportive communications, several activities were well organized as follows:

- several seminars and symposiums in pilot areas, such as an international seminar on the evaluation of the Quality-of-Care Pilot Project held in Yandu County in May 1997 and an international symposium on the quality-of-care approach in Beijing in November 1999;
- a dialogue between China and India on population and family planning in April 1998;
- exchange activities among pilot-project counties and districts, organized by the Quality-of-Care Operational Office of the State Family Planning Commission for exchanging experiences; some models selected from pilot areas to be visited and followed; and
- sharing of experiences of several international cooperation projects in China following the quality-of-care approach since 1998; the experiences from the international cooperation projects also enriched the contents of quality-of-care approaches in China.

During the experimental period (1995-1999), many formal or informal supervisory and monitoring visits were made by international and domestic experts, the Quality-of-Care Operational Office, the State Family Planning Commission officials and international agencies, such as the Beijing offices of UNFPA and the Ford Foundation.

**Results and Achievements of the Pilot Project**

After three years, a follow-up survey and an assessment of the pilots were conducted. Significant changes resulting from an effort to achieve the two reorientations were observed at all pilot sites from different perspectives. For example, positive feedback from local people showed that the clients welcomed the Quality-of-Care Pilot Project, as did the service providers and managers working at the grass-roots level. The long-term impact of the quality-of-care initiatives could also be observed from national surveys years later.

**Achievements**

The changes in the contraceptive method mix were the result of the promotion of informed choice. Meanwhile, more information on family planning and reproductive health was provided to people, with the information and education approaches improved. In addition, the clients received more high-quality clinic services, counselling and follow-up services, with services upgraded and facilities improved. Finally, changes in administra-
tive and management practices had been brought about as well.

**Informed Choice and Changes in the Contraceptive Method Mix**

Informed choice is the key component for client-centred service. For many years, IUDs had been highly recommended by providers of family planning services for spacing, and sterilization for limiting the number of children born. After the introduction of informed choice, more clients received counselling before choosing the contraceptive method, more diverse contraceptive methods were made available, and more clients took the decision by themselves.

The percentage of survey respondents who reported that the current contraceptive used was required or recommended by family planning workers rather than chosen by clients on their own dropped from 38.7 per cent before the quality-of-care experiment to 17.8 per cent after quality-of-care implementation. More female users consulted with service providers or had discussions with their husbands before they chose a method to use. Furthermore, women’s knowledge about the contraception that they used was greatly improved, such as the type of IUD, its function and its possible side effects.

In addition, the contraception method mix changed to a more diversified pattern, dominated not merely by the IUD and sterilization, implying a more individualized selection of methods. For example, in Deqing, one of the pilot counties, the contraception method mix of 14,339 couples with informed choice was as follows: IUD, 44.8 per cent; sterilization, 12.2 per cent; condom, 31.2 per cent; hormonal methods, 10.5 per cent; and others, 1.3 per cent.

**Improved Information and Education Approaches**

A large amount of funding and human capital was input on information, education and communication approaches. Major changes were made to readjust the focus of the content of information and education in line with the needs of local people and to change the forms of information and education.

The family planning workers used to distribute family planning regulations and information, education and communication materials in general to families. The materials were not taken seriously by local people since they were often not easy to read and were not of interest to the people. After the quality-of-care experiment, more specific information, education and communication materials were developed with pictures and words to correspond to different needs of people at different life stages, such as contraceptive informed choice, premartial education, breast feeding, infant nursing and prevention of reproductive tract infections. The knowledge was also spread via mass media, such as broadcasting, television and wall newspaper. Nongan County, for example, developed a portable information, education and communication package with contraceptive samples and a user's handbook for
family planning workers to communicate with clients face to face (fig. 2).

**Figure 2** | Home visit by family planning workers with a portable information, education and communication package in Nong’an County.

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**Improved Quality of Services, Especially Counselling and Follow-up Services**

With the reconstruction or renovation of service sites in counties, townships and villages of the pilots (fig. 3), a client-friendly environment was created, including some educational materials and a video display in the waiting room and a touch-screen information counselling system in the reception area.

With the standardization of the informed-choice procedures, the quality of services was emphasized, especially counselling and follow-up services (see table for more details), which had not received adequate attention in the past. There were more varieties of different contraceptive methods available with improved validity, which gave people more choices for either spacing or limitation.

**Figure 3** | Equipped operation room in a township family-planning service station in Yandu County.

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**Extended Scope of Service in Reproductive Health Care**

With the promotion of the quality-of-care experiment, the service provided at pilot sites greatly expanded to include a wide range of family planning services and related reproductive health care, such as diagnosis and treatment of reproductive tract infections. Many of the pilots launched the life-cycle service in reproductive health care for people in different age and sex groups, for instance sex education and contraception for adolescents and health care for women in menopause. The check-up for and treatment and prevention of gynecological diseases were considered as important components of the “universal access to primary reproductive health care” campaign at each pilot site. The 1998 follow-up survey found that about 90 per cent of women had a gynecological check-up, a much higher proportion than the national average (about 61-65 per cent).
Counselling and follow-up services received before and after 1995, as reported by women at pilot sites.

<table>
<thead>
<tr>
<th>Service Provided before or after the Operation</th>
<th>Family Planning Operation</th>
<th>Service Received (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>before 1995</td>
</tr>
<tr>
<td>Introducing advantages and disadvantages of contraceptives</td>
<td>Female sterilization</td>
<td>61.1</td>
</tr>
<tr>
<td></td>
<td>IUD insertion</td>
<td>66.6</td>
</tr>
<tr>
<td>Explaining the procedure of the family planning operation</td>
<td>Female sterilization</td>
<td>50.5</td>
</tr>
<tr>
<td></td>
<td>IUD insertion</td>
<td>56.9</td>
</tr>
<tr>
<td></td>
<td>Abortion</td>
<td>50.5</td>
</tr>
<tr>
<td>Introducing possible risks and their treatments</td>
<td>Female sterilization</td>
<td>79.8</td>
</tr>
<tr>
<td></td>
<td>IUD insertion</td>
<td>81.0</td>
</tr>
<tr>
<td></td>
<td>Abortion</td>
<td>67.9</td>
</tr>
<tr>
<td>Making a follow-up appointment</td>
<td>Female sterilization</td>
<td>65.0</td>
</tr>
<tr>
<td></td>
<td>IUD insertion</td>
<td>71.2</td>
</tr>
<tr>
<td></td>
<td>Abortion</td>
<td>50.5</td>
</tr>
</tbody>
</table>

Source: Zhang, Gu and Xie (eds.), 1999.

Changed Administrative and Management Practices

The reorientation of the way of thinking was considered as the key point in each pilot site, meetings, training workshops and various discussions at different levels. After years of efforts, the ideology changed and it brought changes in administrative and management practices, such as the changing of “Birth Certificate” to “Reproductive Health Service Record Handbook” (this change was followed nationwide later), which recorded the date and type of contraceptive use and shift, pregnancy, maternal check-up and child-birth as well as other service records.

A computerized information system was set up at all the pilot sites to keep a record of information about child-bearing and contraceptive use, which serves as information for both management (for regular statistics) and service provision (as a source of service need and follow-up visits).

All pilot sites explored the possibility of new ways of evaluating, such as a change or modification of evaluation indicators and a change in methods of evaluation, especially adding information on client satisfaction to the evaluation content. Although the period of the pilot experiment was not long enough to test the new indicators or to complete a list of recommended evaluation indicators, the practice created a foundation for evaluation reform of the system in the near future.
MAIN OUTCOMES OR DIRECT IMPACT OBSERVED

The outcomes of the quality-of-care project were analysed from the perspective of the clients and the service system. Some are direct and immediate outcomes while others have long-term impact.

From the Clients’ Perspective

The feedback from local people about the Pilot Project was very positive and supportive. People enjoyed the improved services, especially with much more interpersonal communication while the services were being provided. More people felt respected and cared for in the new approach. The providers listened to the clients and tried to provide better and suitable contraceptives as well as to meet the reproductive health needs of the clients. The managers were concerned about the reaction of the people in terms of quality of care and their satisfaction with the services. All these actions sent clear messages to clients that they were no longer patients to be watched but rather that they, as masters of family planning, were respected and cared for.

Counselling, informed choice, knowledge-focused information, education and communication, and follow-up visits, all of these measures adopted in the experiment made clients, particularly women, more knowledgeable about contraceptive use. In return for this, women as beneficiaries of the project more actively participated in informed choice. Thus fewer unnecessary contraceptive failures and fewer abortions were the direct results of increasing the user's responsibilities in family planning. According to annual statistics in a pilot county, the cases of unintended pregnancy in the first nine months of 1998 represented a 57 per cent reduction from the same period in 1995.

Impact on the Service System

The service facilities and personnel involved in service provision were greatly improved to meet the requirements of the quality-of-care approach in the pilots. There were prominent changes in the age structure and service knowledge of the local service providers. The technical capacities of the technical personnel in service stations were strengthened through enhanced training and recruiting. For example, during the three years of the Pilot Project, the number of professional technicians increased from 7 to 12 in the service stations at the county level in Deqing County while Yandu County recruited 60 university or polytechnic school graduates into the family planning service team. Intensive on-the-job training was carried out to emphasize standardized service procedures, to learn new technology, to improve technical skills and to improve skills in interpersonal communication.

All pilot sites input/allocated resources to improve the service environment at the county, township and village levels to ensure that each service station had standardized service rooms for different functions. Strict regulations and standards were developed and implemented for all types of technical services, especially emphasizing counselling during the
whole process of any family planning operation and follow-up visits (as shown in the table).

**Assessment and Evaluation of the Pilots**

Through carefully designed impact assessments with mixed research methodologies, it was determined that changes at the pilot sites were significant, and the experiments were successful regarding the goal of achieving the two reorientations in different aspects (management and decision-making) and the principle of “quality of care”. The assessment team suggested that the pilot experiences were expandable and sustainable.

**Methodology**

Immediately after the Quality-of-Care Pilot Project was initiated in six pilot counties and districts in 1995, a baseline survey of knowledge, attitudes and practices was conducted regarding the six pilots to interview the sampled clients, programme managers and service providers. The main purpose of the baseline survey was to assess the needs of local people. The survey was also designed to provide a base to measure the effectiveness of the Quality-of-Care Pilot Project. Three years later, follow-up surveys and the rapid assessment survey were designed and carried out.

The follow-up surveys in the six pilot areas in mid-1998 employed two kinds of questionnaires: one for clients and the other for services providers and managers. Valuable quantitative data were collected for comparative analysis with the baseline survey of 1995.

The rapid assessments in the six pilot areas were conducted in October-November of 1998 by an interdisciplinary team consisting of Chinese and international specialists in sociology, management, demography, women's studies, public health, etc. The methodologies adopted in the field included focus-group discussion, in-depth interviews with clients, home visits and other qualitative methods. The qualitative data and information were also collected for in-depth analyses as a complement to the quantitative data obtained from follow-up surveys. A general report and six sub-reports (one for each pilot county and district) were drafted and published by the Quality-of-Care Operational Office in 1999 (Zhang, Gu and Xie (eds.), 1999).

**Major Findings and Impact**

The follow-up survey and the rapid assessment in 1998 indicated that most clients were satisfied with the family planning performance: 85.8 per cent of respondents overall in the follow-up survey in 1998 expressed their satisfaction with family planning although with a wide variation among the pilots, ranging from 75.6 per cent to 95.6 per cent. Furthermore, 76.9 per cent of respondents in the survey indicated that they always or often participated in family planning activities in their community.
Local people mentioned some indirect impacts of the Pilot Project, and some of the impacts were not expected at the initial stage. These indirect impacts would have a long-term influence on the family planning programme both locally and nationally.

**Improved Awareness of Reproductive Rights and Benefits**

The key message delivered by the quality-of-care approach and emphasized by the Pilot Project initiatives was to respect people’s reproductive rights. For example, the new information, education and communication approaches focused not only on the knowledge of reproductive health care but also on the reproductive rights and benefits. Both programme managers and clients clearly understood that the family planning had to be carried out in a lawful manner, and people had the right to enjoy the benefits defined by the Government. In some of the pilot counties and districts, a system was set up whereby the client would be compensated if the programme failed to provide the service promised or in a timely manner.

Female clients felt that their reproductive rights were more respected after the introduction of informed choice. A comparison of the findings from the follow-up survey in 1998 with the knowledge, attitudes and practices baseline survey in 1995 showed that the number of women who reported that a contraceptive method used was suggested by family planning workers or others fell significantly. Nearly 50 per cent of female respondents in 1998 reported that either they or their husbands made the decision on the choice of the method of contraception. This practice of free choice would affect more people in the longer term. The 2006 National Population and Family Planning Survey found out that among 24,176 female respondents using contraceptive methods, 76 per cent reported that the decision was made by themselves or by the couple, and the percentage was even higher among women ages 20 to 29 (83 per cent).

**Improved Relationship between Clients and Service Providers**

Service providers also felt the effect of the change on their work, which became easier even though their workload increased owing to more pre- and post-operation services, and door-to-door visits. They felt very good that their services had met the clients’ needs, and some of their clients became their friends. In the family-planning service stations, more efforts were made to improve the relationship with clients, such as putting more colourful and decorated signs and greetings in the stations, setting up more private counselling rooms, using polite and soft words, and providing patient explanations for a trusting relationship between the service providers and the clients. The de-hospitalized and client-friendly appearance and atmosphere attracted more clients to the service stations. In villages or communities, family planning workers or doctors became the most welcomed persons for counselling on
health issues, daily life and even home businesses.

A county doctor said that in the past when she had visited villages, people had kept a distance from her (because her job was mainly to delivery contraception). After the services had expanded to include gynecological check-ups and counselling, local people were looking forward to her visit and were anxious to know her schedule for the village because she provided more services that local people needed. Some women called her affectionately “elder sister” or “aunt” instead of “doctor”. The improvement in the relationship encouraged service providers and family planning workers to build a more trusting relationship between service providers and clients and to make great efforts to operate the programme more efficiently.

**Improved Image of the Family Planning Programme**

The quality-of-care experiment in the long run changed the image of the family planning programme from an approach driven purely by demographic targets to a more comprehensive and human-centred one. Under the target-driven approach, the programme was seen as a tool to achieve the targets or a demographic outcome rather than the goal of caring for people. The experiment reoriented the focus of the programme to people’s well-being and reproductive health care, thus greatly improving the image of the programme among the clients in particular and in society in general.

**Stable Low Fertility Rate**

After the new approach was introduced, couples’ needs for family planning and reproductive health were better met, and therefore there were fewer unintended pregnancies. The low fertility rate became even more stabilized in all the pilot counties at a level much lower than the replacement level (total fertility rate = 2.1). Statistics showed that the crude birth rates before (1994) and after (1997) the quality-of-care approach in each county and district were stable at a low level. The fact that there was stable low fertility in the regions eased the concern about the negative impact of quality-of-care approaches and provided supporting evidence for the scaling up of the project later.

**Experiences and Lessons Learned from Pilots**

The successful experiment of the quality-of-care project not only sets the model for programme reform but also provides the experiences and lessons for anyone who is interested in the model.

**Government Commitment to Quality-of-care Approaches**

In China, the government commitment at four levels – State, province, prefecture and county – is the key to the success of the quality-of-care pilots.
The State Family Planning Commission has been in charge of the population and family planning programme at the national level, initiatives of the Quality-of-Care Pilot Project, and the promotion of scaling up nationwide. Its roles were to:

- develop national project strategies and implementation and scaling-up plans;
- create a supportive policy environment for quality-of-care innovation; and
- mobilize the financial and technical resources from international and domestic agencies.

The host provinces and prefectures of the pilot sites involved in the whole process of the Quality-of-Care Pilot Project played the role of linkage and bridge between the State Family Planning Commission and pilot counties and districts. The county/district is the basic administrative unit of social structure in China. Governments and family planning commissions at the county/district level made their own choice and decision to participate in this Pilot Project. They were encouraged to mobilize local resources to implement the innovation.

**Framework of the Quality-of-Care Working Mechanism**

The three systems – the decision-maker/leadership system, the service system and the management system – backed up the client-centred interactions of the quality-of-care approaches and comprised the framework of the quality-of-care working mechanism.

The theoretical framework of the quality-of-care working mechanism includes four groups of people involved in the quality-of-care project: leaders/decision makers, service providers, managers and clients. There is a logical connection among these four groups. The main activity of the leaders/decision makers is to focus on the inputs, which guarantees the regular running of the service system and the management system. The main activity of service providers and managers is to focus on implementing quality of care. The aim is to have clients participating in the family planning/reproductive health activities to maintain the clients’ own rights and their level of reproductive health. The relationships among these four groups of people are presented in figure 4.

The three elements in the framework of the quality-of-care approach – target people (clients), service system and management system – have an interactive relationship to carry out client-centred interactions. From the experiences of the pilots, none of the three elements can be absent. With the upgrading of the service system, clients receive higher-quality family planning and reproductive health services. With the reform of the management system, which was to remove the quota of sterilization for service providers’ evaluation, clients were free to choose the methods that they preferred. The participation of target people/clients is the dynamic for changing or reforming the
**Figure 4** | Working mechanism of the quality-of-care approach in China.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision-maker/Leadership System:</strong></td>
<td><strong>Service System:</strong></td>
<td><strong>Client-centred Interactions:</strong></td>
</tr>
<tr>
<td>• Political commitment</td>
<td>• Concept change</td>
<td>• Informed choice</td>
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<td>• Policy support</td>
<td>• Capacity-building</td>
<td>• Information, education and communication activities</td>
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<td>• Financial/personnel support</td>
<td>• Protocol of services</td>
<td>• Quality services</td>
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<td>• Coordination</td>
<td>• Facility improvement</td>
<td>• Rights protection</td>
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<td>• Interpersonal relationship built</td>
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<td></td>
<td>• Administrative reform</td>
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<tr>
<td><strong>Management System:</strong></td>
<td><strong>Service System:</strong></td>
<td><strong>Client-centred Interactions:</strong></td>
</tr>
<tr>
<td>• Decision-making with needs assessment</td>
<td>• Concept change</td>
<td>• Informed choice</td>
</tr>
<tr>
<td>• Planning implemented with protocols</td>
<td>• Capacity-building</td>
<td>• Information, education and communication activities</td>
</tr>
<tr>
<td>• Evaluation reform</td>
<td>• Protocol of services</td>
<td>• Quality services</td>
</tr>
<tr>
<td>• Information system</td>
<td>• Facility improvement</td>
<td>• Rights protection</td>
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**External Support for Pilots**

The success of quality-of-care approaches in pilot counties did not rely on a large amount of external financial input. Although the socio-economic development of China in the last decade made it possible to have financial resources in place, pilot counties were told from the very beginning that they would not receive any external financial support either from the central government or international donors. They had to mobilize local resources to implement the changes and could not count on any external financial assistance. This was considered essential in order to ensure sustainability because quality of care was to become a regular programme orientation, which was intended to become institutionalized within local resource constraints. It proved to be strategic and ensured the subsequent project expansion to Western China where the socio-economic situation was underdeveloped. However, to keep innovation moving in the correct direction, technical support such as training workshops and domestic and international visits were important. They were supported by the central government and external donors.

**Replicability and Scalability**

With the successful demonstration of pilots in smaller areas, the State Family Planning Commission immediately proposed a scaling-up strategy to push the quality-of-care approach forward to the whole country.

**Prerequisites for Replication**

Before the experiences of the Quality-of-Care Pilot Project are replicated by
potential users, some elements of the scaling-up procedure, such as the innovations, the environment and the resource team, should be in place.

**Acceptable Innovations**

The experiences of the quality-of-care pilots have been systematically summarized and well documented as innovations, including the national guidebook, a series of publications on the pilot experiences, and an advocacy package containing the main aspects of the quality-of-care approach. Some training curriculums and teaching materials have also been developed. These documents, some with English translations, are available and can easily be adapted by different user organizations.

The innovations of the quality-of-care project are also in line with the “CORRECT” attributes that enhance the potential for scaling up as proposed by the World Health Organization (WHO) and ExpandNet (Simmons, Fajans and Ghiron (eds.), 2007):

- **Credible** in that the innovations are based on sound evidence and/or advocated by respected persons or institutions;
- **Observable** to ensure that potential users can see the results in practice;
- **Relevant** for addressing persistent or sharply felt problems;
- **Relative advantage** over existing practices so that potential users are convinced that the costs of implementation are counteracted by the benefits;
- **Easy to install and understand** rather than complex and complicated;
- **Compatible with** the potential users’ established values, norms and facilities; fit well into the practices of the national programme; and
- **Testable** without committing the potential user to complete adoption when results have not yet been seen.

**Favourable Environment**

In China, governments at all levels involve the population and the family planning programme in the national or local socio-economic development plan. This means that the main leaders of government must take responsibility for dealing with population and family planning issues. Since 2000, several national laws and regulations have been issued. For example, the Law on Population and Family Planning and the Regulation on Family Planning Technical Service and Management issued in 2001 emphasize the client’s rights such as contraceptive informed choice and quality of service. In 2002, the National Population and Family Planning Commission proposed quality-of-care approaches as the innovations of population and family planning reformation and required the governments at all levels to adopt the quality-of-care approaches. Then several official documents and policies were issued for scaling up, which created a favourable policy.
environment for expanding quality-of-care innovations to the whole country.

**Support of a Resource Team**

The Quality-of-Care Pilot Project had a resource team that included both international and domestic experts with different academic backgrounds and practical experience in the field of family planning and reproductive health. The resource team was involved in the process of project design, supervision, monitoring and evaluation. Having a good relationship with national and local government officials, it facilitated the pilots and the scaling-up process with high-level advocacy and supervision. The names and designations of the experts can be found in the “Contacts” section of this case study.

**REPLICATION AND SCALING UP**

The process of replicating the quality-of-care experiences in other areas in China could be divided into two periods: spontaneous duplication (1998-2000), and scaling up vertically and horizontally (2000-2010).

In the first period, with the positive results from the quality-of-care pilots found in the follow-up evaluation and assessment, some provincial family planning commissions were encouraged to follow State Family Planning Commission pilots and to implement their own experiments. Meanwhile, some international cooperation projects, such as the UNFPA Reproductive Health and Family Planning Project and the Japanese Organization for International Cooperation in Family Planning Integrated Project, decided to replicate the innovations of the quality-of-care pilots. With the experiences of quality-of-care pilots spontaneously duplicated, the number of counties and districts adopting quality-of-care approaches in China increased to 200 in 1998, 300 in 1999 and more than 800 by 2000.

In the second period, the State Family Planning Commission officially announced the expansion of the innovation of the quality-of-care pilots to the whole country. In order to spread the quality-of-care approach as well as to scale it up systematically, it adopted a top-down strategy and model demonstration to initiate a national campaign on the Quality-of-Care Advanced Unit in 2002 (the name has the same meaning as Quality-of-Care Pioneer or Model given to quality-of-care pilot counties/districts selected in the mid-1990s). The State Family Planning Commission set the unified criteria and indicators for the Quality-of-Care Advanced Unit and requested provincial family planning commissions to select the provincial models first and recommend them to the national Commission. Since 2003, the National Population and Family Planning Commission (formerly the State Family Planning Commission, which was renamed in 2003) has organized several evaluation teams each year, comprising experts and officials, to evaluate the candidates for national Quality-of-Care Advanced Unit proposed by provincial commissions. Up to 2009, about 2,021 counties and districts had been evaluated and awarded recognition as the national (918) or provincial (1,103) Quality-of-Care Advanced Units, accounting for 70
per cent of the counties and districts in China. This campaign will not end until the quality-of-care innovations have spread to the entire country.

**Experiences and Lessons Learned from Scaling Up**

The experiences and lessons learned from scaling up could be adapted and applied by other regions or countries, especially those still not achieving a great deal in the area of family planning and reproductive health care. Several issues that arose from the scaling-up process are listed below for further discussion:

- **Advantage vs. disadvantage of a top-down strategy**
  The national campaign of the Quality-of-Care Advanced Unit was initiated by the National Population and Family Planning Commission with a top-down strategy. Being awarded the designation of national Quality-of-Care Advanced Unit means a great honour for county leaders and their superiors and some local officials will spare no effort to win such an honour. However, the disadvantage of this top-down strategy is that it might excessively push local governments at provincial, prefecture and county levels to chase the award instead of following the innovation.

- **Centralization vs. decentralization**
  In a country with a vast territory such as China, the role of local governments such as those at the provincial level must be brought into full play in scaling up. The National Population and Family Planning Commission requested provincial family planning commissions to select the provincial models first and recommend them to the national Commission. With decentralization in China, the local governments have more power to take decisions based on their socio-economic affairs including population and family planning. Therefore, some provinces overstated their privileges and refused to follow the national standard for recommending advanced units, which may produce an adverse effect on scaling up.

- **Unified standard vs. flexible adaptation**
  To control the quality of the scaling up, a unified evaluation module with 33 indicators and a methodology was developed by the National Population and Family Planning Commission and followed by all provinces. With rapid changes in the socio-economic situation in recent years, the concepts and content of quality-of-care approaches have been extended and improved. For example, integrating gender perspectives and considering ageing issues, family planning and reproductive health services should be provided not only to women of reproductive age but also to the family members including the husband, the elderly and youths as well as to migrants. Quality of
care is an open-ended approach. The standard of quality of care must be modified according to social changes. Meanwhile, owing to the regional differences, adaptation to the standards of quality of care should always be encouraged.

- **Ownership vs. sharing of resources**
  The National Population and Family Planning Commission had initiated and has the ownership of the quality-of-care project. This does not mean that the project is an isolated, static project. In the past few decades, China conducted some international cooperation projects and many domestic projects. Although these projects had their own executive agencies, the Commission adopted the integration approach and established a coordination mechanism for sharing resources and experiences with one another.

**Future Plan**

**Challenges**

Although the overall goal of reorientation of the family planning programme has been realized in most regions in China, the scaling up of the quality-of-care approaches is still ongoing.

- Currently, about 30 per cent of counties in China have yet to reach the standards of quality of care. Most of these counties are located in the western regions with poor economic conditions. Considering that people in poor regions are in urgent need of better-quality family planning and reproductive health services, more supportive policies and inputs need to be put forward by governments at all levels.

- Some counties have been evaluated and named as a "Quality-of-Care Advanced Unit", but with the changing situation, there is in fact a gap between their work and the quality-of-care approaches. This is shown in two areas: lack of capacity to meet the increasing needs of clients, and lack of gender sensitivity and inadequate male participation.

**Policy Objectives**

The State Council of China has emphasized family planning as a programme for the people’s well-being. It was pointed out in the 2010 Report on the Work of the Government that China “will do a good job in population and family planning work. We will continue to maintain a low birthrate. We will provide good family planning services for the floating population. We will provide regular gynecological examinations and subsidize hospital childbirths for rural women. We will strengthen intervention in birth defects, carry out a pilot program of free pre-pregnancy checkups, and provide quality health services for infants, pre-school children, and prenatal and nursing women… We will intensify strategic research on coping with an aging population and move more quickly to create a sound system of old-age services so that people can live a happy life in their old age.”
The National Population and Family Planning Commission has realized that further promotion of the quality-of-care approaches should be integrated with comprehensive reform of the family planning programme, socio-economic development, the anti-poverty strategy and the Millennium Development Goals (MDGs).

**Action Plan**

In 2009, the National Population and Family Planning Commission announced that the “Quality-of-Care Advanced Unit” national campaign would be “upgraded and sped up”. It requested that the public service and management in family planning and reproductive health be equalized in urban and in rural China and that the quality-of-care standards should reach everywhere in the country. A nationwide public service system, which meets the needs of family planning and reproductive health, should be established by 2015.

Specific goals of the action plan include:

- establishing the whole-population information system and increasing accessibility of clients to quality service with information technology; and
- speeding up the reform of the Target Responsibility Management System in the family planning programme in China, establishing an assessment and evaluation system for population and family planning in the new era, and promoting the “Quality-of-Care Advanced Unit” national campaign.

The overall goal of promoting the quality-of-care approaches consists of family planning programme reform, pays greater attention to people’s needs and requirements, respects their rights to access necessary information and high-quality services, and helps people to enjoy happier and more decent lives.

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