Quality of Care in Family Planning: Gradual and Comprehensive Reform in China

Zhenming Xie

Abstract:
Since the 1990s, many national population and family planning program 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 a program reform initiated by the State Family Planning Commission of China in 1995 to introduce the quality-of-care approach in a few counties and districts. The introduction of this approach, which focuses on the quality services and the client's choices in family planning/reproductive health at community level, was to serve as a means of reorienting the program away from its previous demographically driven track as well as scaling it up nationwide thereafter.

Given the Chinese fertility policy context, a question has been raised whether China could change its program and improve the quality of service along the lines of the ICPD principles without changes in the fertility policy. This paper seeks to answer this question by discussing how quality of care initiatives have affected the provision of services, and by identifying the driving forces, process and impacts of changes based on the evidence from baseline survey and follow-up survey of pilot projects. The paper also describes how the innovations of quality of care pilot project could be expanded to the nationwide successfully and what the determinants for scaling up are.

Providing quality services and respect reproductive rights require a fundamental cultural change that is not easily accomplished anywhere in the world. However, given its remarkable administrative capacity and organizational strength, with international supports, China may surprise the world by reaching its newly set quality of care and reproductive health goals faster than most outsiders would believe possible.

Introduction

1 Zhenming Xie, Secretary-general of China Population Association, and Senior Researcher of the China Population and Development Research Center, #12 Dahuisi Road, Haidian District, Beijing, 100081, China. Tel: (8610) 62177872, zhmxie@gmail.com. The author would like to express sincere thanks to Professor Ruth Simmons at University of Michigan for her assistance in paper drafting, and to Joan Kaufman, Laura Ghiron and Eve Lee for their comments and suggestions on the revisions.
In 1995 the Minister of the State Family Planning Commission of China (SFPC)\(^2\) issued a declaration calling for the “reorientation” of the family planning program from a narrow focus on family planning towards an integration with social and economic development and from a primary focus on “social constraints”, towards approaches that would also be driven by people’s interest and that would emphasize comprehensive services, scientific management, publicity and education. This statement signaled the beginning of initiatives directed at program reform away from an exclusive focus on the attainment of demographic targets towards attention to client-centered approaches. In order to initiate the process of reform, the SFPC selected a number of rural counties and urban districts with relatively better-off conditions as pilots in which new approaches could be tested. In the beginning of 1995 five rural counties and one urban district were selected to participate in SFPC’s pilot project. In 1997 four more urban districts and one rural county were added. Since these early beginnings, many provincial family planning commissions have initiated their own quality of care pilots and several other initiatives have been put into place in different parts of the country and at different levels of government to advance the objective of providing good quality contraceptive and related reproductive health services. In recent years these changes have assumed such significant proportions that within China they are viewed as a major reform within the nation’s family planning program.

Efforts to improve the quality of care in family planning in China occur within the context of China’s current fertility policy of encouraging one child per couple (the so-called “one child policy”). The policy allows for variations in implementation in different areas, but is usually interpreted as allowing one child per couple in urban areas, two for rural couples especially if the first is a girl, three or more for ethnic minorities. The resulting fertility in the early 1990s is about 1.8 for the country as a whole, and the aggregated policy fertility is 1.47 (Gou et al, 2003). The policy also requires that couples should practice contraception with an emphasis on long-acting or permanent methods, and encourages contraception rather than abortion. A widely practiced rule by the family planning program has been that couples should use the intra-uterine device (IUD) after the first child and sterilization after the second. Population plans formulated at the national, provincial, and local levels set targets consistent with national demographic goals to ensure that couples comply with family planning rules and regulations. The complex birth management systems have been established. Such systems have commonly required couples to obtain written approval from the community family planning office to initiate a pregnancy. In order to get permission to have a child, couples have been required to sign a family planning contract and government leaders, program managers and family planning workers sign a responsibility contract in which they agree to meet the program’s goals.

The Program of Action of International Conference on Population and Development (ICPD) has challenged governments and civil society to implement quality of care, which is described as “comprehensive, good quality reproductive and sexual health services, that foster women’s rights and empowerment, while ensuring that men take responsibility for their own sexual behavior, fertility and the well-being of their partners and children”. Governments which have focused on family planning were advised to ensure the quality of these services in terms of informed contraceptive choice, unbiased information about the range of methods available, respect for people’s health and rights, good interpersonal relations between program staff and clients, follow up, and an appropriate service mix, which catered to wider reproductive health issues than merely those for family planning, e.g. treatment for infertility, prevention and control of disease, pre- and postnatal care, promotion of breastfeeding. ICPD also advises against the use of targets and quotas in the recruitment of clients.

\(^2\) The SFPC’s name changed in 2003 into the National Population and Family Planning Commission–NPFPC – to reflect a wider mandate.
China was an active participant in both the ICPD in 1994 and the Women’s Conference in Beijing in 1995, helping to draft and adopting the respective programmes of action. Participants not only learned from and contributed to international experience, but returned with the intention of living up to international best practices.

Given the Chinese population policy context, a question has been raised whether China could change its family planning program and improve the quality of its services along the lines of the ICPD principles without changes in the fertility policy. Many international missions from governments or civil society have visited China since the inception of the quality of care reform. Foreign visitors are often pleased to observe that many changes have been made in the Chinese family planning program in the past decades, but they are often also express concern about how significant these changes could be, given that the fertility policy has remained unchanged. This paper seeks to answer this question by discussing how quality of care initiatives have affected the provision of services, and by identifying the driving forces, process and impacts of changes.

Quality of Care Reform is Driven by Internal and External Dynamics

China is well known as a developing country with the largest population in the world. In 2010 national census it counted a population of over 1.34 billion (National Bureau of Statistics of China, 2011), which accounts for more than one-fifth of the world’s total population, or the total size of all the developed countries of the world.

In the early 1990s, with the effort in past two decades in family planning program initiated in the early 1970s, China achieved low fertility with a total fertility rate (TFR, that is the number of children per women/couple) at 1.8, well below replacement level (TFR=2.1). Meanwhile China’s yearly population increment is still above ten million in 1990s. The government felt that in order to maintain low fertility it is necessary to keep the current fertility policy in place. Government also recognized that because of the strong administrative measures of the family planning program, the existing fertility rate is unstable and could increase anytime – just like a squeezed spring could rebound at anytime. To stabilize the low fertility level, the Government feels that tensions between the program and the people must be released slowly.

At the same time, China has undergone dramatic changes in term of social and economic development. In the wake of the Cultural Revolution at the end of the 1970s, China adopted an open-door policy and has been determined to move toward a market economy. The economic reform and the development of a market economy have had a tremendous impact on various aspects of society. As lawful individual freedom and responsibility have become increasingly real in various aspects of personal life, and individual initiative has become more respected, people are increasingly aware of personal interests and rights, and are more sensitive about the quality of life, including personal reproductive health and reproductive rights, as well as gender equality. Facing the changed situation, some of officials in the SFPC, as the pioneer of program reform, started to think of the necessity and possibility of changes in China family planning program (Zhang Erli, 2001).

Just then, the Asian-Pacific Population Conferences in Bali in 1992, ICPD in Cairo in 1994, and Women’s Conference in Beijing in 1995, and a series of other international events have drawn attention to some new concepts in population and family planning. Many national population and family planning programs have undergone reexamination and reorientation. Public debate in the international level has exerted a remarkable impact on China’s program. The ICPD exposed China to the concept of reproductive health and reproductive rights, and the World Women’s Conference in Beijing in 1995 exposed even more Chinese directly to the concepts of women’s rights and
interests, as well as women’s empowerment. The pioneers of program reform invited these new perspectives with the international assistance. Chinese and foreign scholars translated and introduced international perspectives such as Bruce’s framework on quality of care and the International Planned Parenthood Federation’s user’s rights to China (Gu, et al, 1996). When a foreign scholar visited one of the pilot counties in Northeast China in 1997, she was surprised to find the Chinese version of Bruce’s six elements of quality of care in family planning posted on the wall of rural center household, where in the past one could see Chairman Mao’s picture or slogans during the Cultural Revolution (1966-1976). Chinese people may not fully understand international concepts when first introduced to them, but they know it is the right direction that should be followed. Resident reproductive health organizations, such as the United Nations Population Fund (UNFPA) or NGOs such as Ford Foundation, also provided a continuing window on the outside world through exchange of experience and international standards.

The new sense of individual freedom and rights that have accompanied economic reform and openness to the world has left people less tolerant of the strict and often harsh implementation of the one-child policy. With the growing resistance and complaints from people of different age and sex groups, China’s Family Planning Program started a process of self-review, analyzing and realizing the problems that have accompanied the strict implementation of the program. The lack of attention to the concerns and needs of clients, families, and particularly women was acknowledged as well as the poor quality of services that were provided. Demands for personal choice and increased reproductive health care were increasingly recognized as legitimate. These were major reasons why the SFPC declared that “the family planning work should shift from following the demographic plan which focuses on controlling population growth towards providing people at reproductive age with comprehensive and quality services” (Zhang Erli, et al, 1999).

Possibility and Feasibility of Changes

Social and economic development not only pushed the family planning program towards change, but also created the conditions for it. As living standards of the Chinese people increased significantly, the cost of children and the opportunity costs of childbearing increased dramatically. People’s needs, interests and preferences have shifted towards a stronger focus on well-being and welfare, thereby reducing the demand for children. Rural people in Anhui province, where rural economic reform began in the early 1980s, summarize this shift with a slogan “having fewer children and planting more trees (Shao Shenghaizi Duo Zaishu)”.

Recent demographic research shows that the number of desired children of Chinese people has been reduced. This change is in large measure the result of the family planning program and social economical development (Zheng, 2004). A survey conducted by SFPC in 2001 found the average number of desired children of married women at reproductive age was about 1.78, which is close to the current policy fertility level. However, results also showed continuing regional variation (Table 1), which implied that the lower fertility desire was correlated with relatively higher social and economic development. It suggests that giving people the freedom to choose the contraceptive method by them does not threaten the attainment of demographic goals in low fertility regions but might do so in the Mid-west China where average fertility desires continue to be higher. Implementing informed choice in these regions might therefore be considered more difficult.

Table 1. Average Number of Desired Children of Married Women at Reproductive Age by Provinces in China, 2001
<table>
<thead>
<tr>
<th>Provinces/Municipalities/Autonomous Regions</th>
<th>Average Number of Desired Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East China</strong></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Beijing, Tianjin, Shanghai</td>
<td>-</td>
</tr>
<tr>
<td>Liaoning, Jiangsu</td>
<td>Inner Mongolia,</td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Zhejiang, Shandong</td>
<td>Shannxi</td>
</tr>
<tr>
<td>Hebei</td>
<td>Gansu, Ningxia</td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Fujian</td>
<td>Qinghai</td>
</tr>
<tr>
<td>Hainan</td>
<td>Guizhou, Yunnan, Xinjiang</td>
</tr>
<tr>
<td>Guangdong</td>
<td>Guangxi</td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Tibet</td>
</tr>
<tr>
<td><strong>Mid China</strong></td>
<td></td>
</tr>
<tr>
<td>Heilongjiang</td>
<td>-</td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>West China</strong></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>1.3</td>
</tr>
<tr>
<td>-</td>
<td>1.4</td>
</tr>
<tr>
<td>-</td>
<td>1.5</td>
</tr>
<tr>
<td>-</td>
<td>1.6</td>
</tr>
<tr>
<td>-</td>
<td>1.7</td>
</tr>
<tr>
<td>-</td>
<td>1.8</td>
</tr>
<tr>
<td>-</td>
<td>1.9</td>
</tr>
<tr>
<td>-</td>
<td>2.0</td>
</tr>
<tr>
<td>-</td>
<td>2.1</td>
</tr>
<tr>
<td>-</td>
<td>2.3</td>
</tr>
<tr>
<td>-</td>
<td>2.4</td>
</tr>
<tr>
<td>-</td>
<td>2.5</td>
</tr>
</tbody>
</table>

**The disaggregated policy TFR levels in early 1990s by regions:**

1.385 1.472 1.560 (or 1.728*)

Note: The disaggregated policy TFR levels in west region would be 1.728, if takes Sichuan and Chongqing out.

Recourse: National survey on family planning and reproductive health conducted by SFPC in 2001. The disaggregated policy TFR levels by regions estimated by Zhigang Guo (Gou et al., 2003).

Given these variations in fertility preferences it was decided to select the first group of quality of care (QoC) pilot project counties from among six provinces (Jilin, Shanghai, Liaoning, Jiangsu, Zhejiang and Shandong) in eastern China because when people have low fertility desires they are not likely to be in conflict with the requirements of the family planning program. When some of pilot counties organized a mass campaign to launch the quality of care pilot project, community people seemed eager to see the family planning program provide more information and services that they really wanted. A knowledge, attitude and practice (KAP) survey conducted by SFPC in pilot counties in 1995 (Xie, et al, 1995) showed that most users would like to use long-term effect and reversible methods, but did not like the way the program persuaded them to adopt methods, and that they lacked information.

The same 1995 survey showed that some of program staff and officials were eager to participate in the QoC pilot project, but that there was also potential for anxiety because they were afraid they would be evaluated by the old evaluation system (which emphasizes demographic indicators) while being asked to introduce quality of care. When the pilots started in 1995, the SFPC pilot selection team was quite moved by the responses of some county leaders. The county governor of Yandu County said to the team, “We cannot practice family planning using a harsh manner which already damaged the relationship between cadres and the masses. We need to change. If we cannot be selected as the pilot, we will do it by ourselves. If we are selected we will follow you.” Similarly in Deqing County, a county leader said, “This is the second time for family planning to be carved out”. It means that in the early 1970s China family planning program started but focused on birth control, the new approach started and shifted to quality of care and reproductive health. These two counties were allowed to participate in the quality of care experiment mainly due to the leaders’ understandings and commitments.

Another reason why China’s shift towards quality of care was feasible is the strong administrative capacity of the family planning program consisting of a vast network of service stations, outreach staff and a strong management infrastructure. This capacity has been used to enforce population control but it can also be utilized for promoting
quality of care once program managers and service providers have been trained in the new concepts and philosophy. Especially, with the international assistances of new concepts introduced and technique supported, the capacity in quality service delivery and management has been significantly improved. The Chinese Population Award granted UNFPA and Ford Foundation in 2001 mainly due to their contributions in recent changes in family planning program in China, and expressed the belief that international support is one of factors affecting China’s program reform.

Nonetheless, changing China’s large and complex bureaucratic family planning program from a demographic to a quality of care approach is a daunting task and not something that could be accomplished quickly. It required intensive effort and a process of learning. For this reason the SFPC adopted a gradual, step-by-step approach to implement the reform and created the six-county quality of care pilot project. In doing so the project followed the same pattern that the former senior Chinese leader Deng Xiaoping used when he set up special market economy zones at the initial stages of economic reform, because they provided a model and lessons from which others could learn.

**Commitment from Governments at County, Prefecture and Provincial levels**

*County level commitment:* Three key features characterized the introduction of quality of care at the county level of the SFPC pilot project: flexibility, voluntary participation and the absence of external financial support.

Each county was left free to determine with which specific changes it wished to initiate the process and was not asked to implement a predetermined set of steps. Such flexibility and the emphasis on local determination and creativity alleviated fears among county officials and ensured a strong sense of ownership and satisfaction with the process. The result was sustainable quality innovations that were doable in local contexts, and that could be expanded to other areas. This open-ended approach has sometimes been criticized for its lack of precision. However the value of flexibility was demonstrated by the creative results that it produced in the pilot areas. As will be discussed below, it also became apparent that, as experience with the quality of care initiative expanded and more and more counties joined in this expansion, it became essential to establish indicators for measuring progress.

The voluntary nature of participation was consistently emphasized because it was felt that the motivation to participate was essential for success. County officials, who did not want to join the project, were not obliged to do so and if they chose to drop out during the implementation of the project, they could do so as well. This has in fact happened in two counties. The reasons of withdraw are mainly due to lack of enough courage facing the risk and challenge of adopting innovations, or some of difficulties in financial and personnel inputs. County leaders experienced the opportunity to be part of the SFPC’s pilot project as being part of a social reform experiment and felt like pioneers, but there was also some worry about what they might lose if they participated.

Finally, counties were told from the very outset that they would not receive any external financial support to implement quality of care innovations. They had to mobilize local resources to implement the changes and could not count on either external donor support or financial assistance from the central office. This was considered essential in order to ensure sustainability and to communicate the principle that “child always feed by others would not be strong enough to be independent”, because quality of care was to become a regular program orientation intended to become institutionalized within local resource constraints. However, some external support either from the central government or from an external donor was provided for technical training, workshops and exchange visits both from county to county and also to visit foreign programs. These were vital mechanism for communicating the general
principles of quality of care, for learning from the international experience, and for stimulating the creative process of moving counties forward during a period of uncertainty and experimentation.

Prefecture and provincial level commitment: Successful implementation of the quality of care initiative would not have been possible without support from higher levels of administration at the prefecture and provincial levels. Most of these levels of government provided good support to the pilot counties. However, initially when the SFPC introduced the two reorientations, leaders at these levels of government did not have much understanding of what these reorientations implied and as a result they were not particularly active. Leaders needed training to understand what quality of care is, to generate commitment to introduce new criteria for evaluating the counties and to abandon the old ones and above all, that it was allowed to “loosen the rope around the counties and untie them”. Training was conducted by the quality of care project but also in connection with other initiatives in China, supported by other donors. A good example is the Advanced Leadership Program (ALP), with support of Ford Foundation, the Public Media Center (PMC), and other international donors. About 100 high officials from the state and provincial family planning commissions participated in training workshops in the United States to discuss and share ideas with international resource persons. A critical tool used in these trainings was to encourage leaders to empathize with clients and, looking at the program from the perspective of clients, to understand their needs and to be able to see what changes needed to be made to serve people better. The training of prefecture and provincial level leaders created the understanding and support without which counties would not have been able to continue to make change and to expand initiatives to other areas.

Significant Changes in SFPC’s Pilot Counties: Concepts Shifted, Services Upgraded, and Clients Benefited

To evaluate the introduction of quality in the six pilot counties a follow-up survey of family planning staff and clients as well as a predominantly qualitative assessment were conducted in 1998 with support from the Ford Foundation. The in-depth assessment was conducted by an interdisciplinary team of professionals consisting of researchers (both Chinese and international), program managers and service providers. The team sought to answer the following three strategic questions: 1) has there been any change? 2) what are the reactions of local people? 3) are these changes sustainable and expandable to other regions? The team had opportunity to visit remote rural areas as well as more urban sites, often making unannounced home visits to local people or talking informally with them by the roadside, or making unannounced visits to clinic sites. At other times the team made announced visits to clinics or talked to groups of clients assembled by local family planning staff.

Even though this assessment was conducted at a very early stage in the implementation of SFPC’s pilot project, assessment results showed considerable impact: informed choice was beginning to be practiced, family planning services were expanded to include related aspects of reproductive health; more information was provided to clients, and follow-up visits were increased. Overall services had become more user-friendly and the relationship between clients and program staff was much improved. The most significant among these changes relates to informed choice of contraception. People in the pilots refer to informed choice as “the core of quality of care”, similar to the Chinese saying that “by pulling the hair the whole body will move” (Qian Yifa Er Dong Quansheng). It implies that once an informed choice has been introduced, more changes will be possible thereafter.

At the policy level, introduction of informed choice required 1) changes in the concepts and philosophy of leaders at all levels, 2) reforms in the process and methodology of management and evaluation, and 3) abolishing the strict regulations that couples should use IUD after the first birth, and sterilization after the second birth. The assessment
found that change had not always been an easy process. Some local government leaders or family planning program managers worried that "if we remove restrictions, people might not choose long-term effective methods, so extra births or abortions might result". When they subsequently learned that this was not necessarily the case and that instead low level of fertility were maintained and fewer induced abortions occurred, their tensions lessened, and they were ready to eliminate more of the administrative constraints surrounding informed choice. In some of pilot counties, the financial deposits, which clients in the past had to make if they wanted to choose their own methods were discontinued and refunded, and instead of using long-term effective methods as indicator of family planning performance, new evaluation criteria were introduced which measure client initiative and satisfaction. As confidence with the introduction of informed choice increased, leaders at all levels in pilots felt more at ease to give more freedom to clients in childbirth and contraceptive use. Some pilot counties tried to remove the birth target for towns/townships, and change the Birth Permission Certificate into a Service Certificate.\(^3\) (For detail discussion of these findings please see: Zhang Erli, et al., 1999; Gu, 1999; Simmons et al., 2000, and reports or articles related the QoC pilot project\(^4\)).

**At the service level,** the range of services provided was expanded beyond contraception to include counseling, check-ups and treatment or referral for reproductive tract infections. While the target-driven approach was in place the quality of services and the care of clients tended to lose priority in the program. As the pilot progressed, many managers and service providers found they did not have the competence to provide services at the level required by the new quality of care goals. For example, because prior to the introduction of informed choice clients were not considered capable of making an informed choice about what contraceptive is best for them, providers were only trained to do insertions and removals of IUD, but they were not trained to counsel clients on the characteristics and side effects of IUDs. The providers lacked a concept of and skills for pre-operation counseling and post-operation follow-up, as well as the professional training for interpersonal communication. The pilot thus required an overall re-training of the FP staff, including both managers and providers and the development of new service protocols and standards.

Comparison of the findings of the follow-up survey in 1998 with the KAP baseline survey of 1995 shows that the number of respondents who were using the contraceptive method required by the family planning program were only slightly reduced. This is explained by the fact that most respondents were not new users but had adopted a long-term method prior to the beginning of the pilot project. However the number of women who reported selecting a method recommended by a FP worker or service provider reduced significantly, and the proportion of women who said they chose the method themselves or with their husbands increased (see Table 2).

<table>
<thead>
<tr>
<th>Table 2. Comparison of Two Surveys on Method Choice in Six Pilots, in 1995 and 1998</th>
</tr>
</thead>
</table>

\(^3\) Before the pilot, married couple wants to have a birth must to apply for a “Birth Permission Certificate”. Any birth without permission would be accounted as an out-of-plan birth. After the pilot, the first child of a married couple would not need to apply the permission for access to services the “Service Certificate” assigned to childbearing women.

\(^4\) Some reports and articles about the pilot project are collected in the “QoC Exchanges”, a newsletter edited by the QoC operation office. Since 1999, more than 30 volumes edited and distributed to all pilot counties/districts and affiliated provinces and prefectures. All these volumes can be downloaded from the website http://www.fpqoc.org.cn
The KAP Survey in 1995 | % | Follow up Survey in 1998 | %
--- | --- | --- | ---
The selected method was: | | The selected method was: | |
Required by FP program | 37.7 | Required by FP program | 33.5 |
Required by local convention | 3.7 | Required by husband/family member | 0.6 |
Recommend by FP worker | 22.6 | Recommend by FP worker | 15.9 |
Recommended by others | 2.5 | Recommend by others | 0.3 |
Considered suitable by me | 32.5 | Decided with husband | 27.1 |
Other/ No answer | 1.1 | Other | 0.7 |
Total | 100.0 | Total | 100.0 |
Number of respondents | 3524 | Number of respondents | 3469 |

Recourse: Zhang Erli et al., 1999.

At the individual level, the target group of the family planning program expanded from women of reproductive age to all women, men and adolescents. More information on FP/RH empowered clients with more consciousness, knowledge and ability to make active choices about family planning and reproductive health.

Most of the people interviewed by the assessment team spoke favorably of the changes. They regarded the Information, Education and Communication (IEC) materials as "beneficial to physical health and income-generating". A college graduate in Luwan District of Shanghai conceded that even though she attended college, she knew little about contraception, so the promotional materials were very helpful to her. One township family planning manager described informed choice as a "good way to control population growth and serve the people." A family planning worker reported that the women he visited were friendlier to him because they knew he was trying to help them. Many people expressed their satisfactions with the program changes, started to enjoy and declare their rights and needs in family planning and reproductive health.

Deqing County is one of the Chinese state’s six pilot counties which introduced informed choice in one village at the beginning of pilot in 1995, then gradually spread to the whole county in 2 or 3 years. Information about the successful experiences of informed choice in state’s pilot was exchanged with the state’s non-pilots in SFPC-held training workshops and activities. The knowledge and process of informed choice has been spread, but the nature of informed choice, such as client’s rights, may not be fully understood at that time. After almost nine years practice, a sample survey of 1000 women was conducted in 2003 in Deqing to measure the outcomes of the introduction of quality of care (Deqing FPC, 2003). The results showed that 98 percent of respondents approved of informed choice, and that 98 percent felt they had the ability to choose the appropriate contraceptive method. 77 percent of respondents regarded the freedom to choose their contraceptive method as their individual rights. The remainder considered it a favor from the family planning program or a reward for adhering to the fertility policy. This indicates that the process of informed choice should continue to emphasize people’s right to make their own decisions.

Expanding the Quality of Care Project to New Counties and New Regions across China

Expansion to new areas occurred quickly. After only two years of operation, the project was expanded from six to eleven counties in 1997, based on the favorable reports from pilot counties and provincial leaders about the
experience of implementing the QoC project. The Minister of SFPC was happy to hear that the quality of care is the way of benefiting both local people and the family planning worker. The argument for years about program implementation should be both good and strict finally got the answer. Expansion to new counties was requested by the Minister, facilitated by provincial leaders and other non-pilot county leaders who wished to join the project, and supported by the FORD foundation since 1998 with technique assistances and seeding grants.

The QoC experiences expansion was timely backed up by the introduction of UNFPA 4th cycle of assistance in 1998. Because SFPC’s pilot project is small and has allowed great flexibility in implementation, counties have accumulated a variety of experience in how to advance quality of care, thereby providing lessons which can be built upon and augmented by other projects. For example, the experience of SFPC pilot counties showed that some of them were able to use to remove targets at township levels, or how to implement informed choice. With UNFPA assistance, SFPC not only expanded this experience to 32 counties in 22 provinces, including several in Western Provinces, but also took the lifting of targets and quotas to county level, eliminating birth permits for first birth, and added strong monitoring and impact evaluation mechanisms. This was crucial in order to document the experience, and thereby build the foundation for future scaling up.

Another effort of introducing international concepts to China is the Integrated Project (IP), which operates in a total of 42 counties in all provinces and is funded by the Japanese Organization for International Cooperation in Family Planning (JOICFP), which was begun in the mid 1980s, had demonstrated success in parasite control, in maternal and child health and in motivating of people’s participation in the family planning program. At the beginning of the 6th cycle of project funding in 1998 national leadership asked that the QoC approach in family planning be integrated into the new project cycle and invited leaders from SFPC’s quality of care pilot project to provide guidance in this process. The IP Project in turn taught SFPC’s pilot counties the valuable lesson that projects which address women’s needs and increase health care consciousness – in this case the provision of parasite control for children – are well received by people. This example suggested that the family planning program should also find ways of providing assistance to people in their daily life and not only focus on fertility control.

Expansion to new counties also took place outside of the framework of SFPC’s pilot project. Some counties/districts, which were not selected to join the SFPC’s pilot project, started their own pilot based on the same framework paper developed by the pilot program which articulates goals, objectives and main activities (Zhang Erli, 1999). Thus, by 1999 a total of more than 300 pilots were active and by the year 2000 the number had expanded to 827. Several training workshops were held in Shanghai and Hangzhou to provide county leaders with the necessary information to initiate the quality of care process. County leaders who attended these workshops were organized by the provincial family planning commission and had to obtain permission from the leaders of SFPC’s pilot project and pay for their attendance with county resources. Workshops were combined with field visits to the SFPC’s pilot counties to share experiences. Many of the new pilot leaders visited all the first pilot counties, and also some of provincial pilots.

SFPC’s pilot project was initiated in the relatively developed regions of eastern China. This was justified on the grounds that low fertility preferences in these regions would facilitate the reorientation of the family planning program towards quality of care and provide an opportunity to learn how the reorientation could be accomplished. It was felt that in the middle and western part of China, where fertility preferences continue to be higher, and where development has not progressed as fast, introduction of quality of care would be more difficult. The experiences of 32 counties in UNFPA 4th cycle, most of them located in the Mid-west China showed that quality services and client-centered approaches welcome by west people and should be introduced in different ways. In order to generate
the west model and document their experiences, a total of 6 counties were chosen in 2000 from Yunnan, Sichuan, Hubei, Qinghai and Gansu and encouraged to start at whatever level they felt was feasible. For example, a leader of Yandu, one of the first group of pilots, who visited one of these new pilots in western China encouraged service station staff to begin by improving the physical appearance of the waiting room, by protecting the privacy of clients, by making the waiting rooms more attractive, cleaning up garbage outside of the station, making the entrance to the station more accessible, and more generally by convincing staff that the service station should be organized around the needs of clients rather than the needs of staff.

Starting with easy tasks did not mean that the more difficult elements of quality of care were not addressed. For example one of pilot counties in the west which did not initially choose to implement informed choice which allows users to select their contraceptive method from among both long-acting and short term reversible methods, was encouraged to do so later on. The county project manager proposed three patterns whereby clients could choose a method. Villages or townships could from among the three following choices: 1) participating in informed choice freely without any limitation; 2) signing a contract that a pregnancy resulting from contraceptive failure would not be carried to term; and 3) depositing money which would become part of the social compensation fee in case an un-allowed pregnancy would be carried to term. About one third of the villages in this county started the experiment in the first year of the pilot. Only one village took the “deposit pattern”, and the majority selected the “contract pattern”. Other villages allowed more freedom and did not ask clients to sign anything, but it was reiterated that contraceptive choice was only allowable within the constraints of the fertility policy. In other words, most villages do not like the strictest option, but are afraid of the freest one.

**Institutionalizing quality of care at the national level**

Beginning with the year 2000 several major initiatives were introduced by the central government which signified that quality of care was beginning to be institutionalized at the national level: 1) the Population and Family Planning Decision announced by China Center Government in 2000, the Population and Family Planning Law and other related documents issued in 2001; 2) integration of a quality of care focus in family planning into externally funded projects to further promote QoC approaches; 3) the Comprehensive Reform in Family Planning started in 2000; and 4) the National Campaign of QoC advanced County Promotion initiated in 2002.

The joint party and state decision of 2000 authorized a significant change in program emphasizing the need to introduce client-centered services not only for women but also for men and adolescents. In this document quality of care is mentioned several times and it is emphasized that coercion is unacceptable. The 2001 population and family planning law are even stronger than the 2000 decision. It lists eight rights including the right to have information, to choose a contraceptive method and to access reproductive care services. In using the language of informed choice, quality of care and reproductive rights, these two documents for the first time articulate the new directions in family planning and reproductive health. This signifies a major change from the initial years of the pilot project, where the language of quality of care was voiced by only a small group of program pioneers.

Another way of institutionalizing the quality of care movement is to integrate quality of care innovations into the external funded projects, and to facilitate QoC promotion in larger areas. For example, the UNFPA 5th Country
Project (CP5, 2003-2005) decided to implement the project of reproductive health and family planning service in 30 counties/districts of 30 provinces in China. The SFPC proposed all project counties should be selected from the counties experienced in quality of care practice, and could be the model for promoting quality of care approach in reproductive health and family planning. As the documented quality of care innovations integrated from different projects recent years, the proposal of CP5 suggested some of activities as the priority, such as human rights protection, contraceptive informed choice promotion, standard service adaptation, and management and evaluation reformation. The project also suggested some of reproductive health and family planning activities appropriate to local needs, including prevention to RTI/HIV/ADIS, adolescence sexual and reproductive health (SRH) education and service, gender perspective and man involvement etc (China and UNFPA, 2003). The CP5 project initiated in April of 2003, then some provinces, such as Zhejiang, Jiangsu and Beijing, selected some counties to follow the project’s pattern to promote quality of care in their provinces. Scaling up the integrated quality of care innovations are a great opportunity to make QoC institutionalization, but also are a great challenge. A group of more than forty Chinese experts or scholars organized by the SFPC as the resource team working with the international consultants, further progress toward consolidated QoC approach, such as revising training curricular at the national training institutions, documenting with survey data and pilot experiences, developing AIDS prevention approach taken the comparative advantage in family planning system, revising the monitoring and evaluation system to ensure approaches are more widely applied.

The comprehensive reform, instituted by the SFPC in 2001 in 16 pilot prefectures, contributes towards the institutionalization of quality of care in major ways. This multi-sectors initiative dealing with social welfare and village self-management creates new flexibility in the evaluation system. Prior to the comprehensive reform a pilot county within a prefecture would be allowed to move ahead with a variety of quality of care innovations and with the understanding that the conventional evaluation system with its emphasis on target fulfillment would not be utilized. However upon the conclusion of the experiment, they would be expected to revert back to the old system. Remaining counties within the prefecture, on the other hand, felt that the pilot was often moving ahead too rapidly and that they were not allowed to follow. As part of this reform all counties within a prefecture are allowed to initiate quality of care innovations with the understanding that they will not be penalized by the evaluation system.

In July of 2002, the SFPC initiated a national campaign, named as the Quality of Care Advanced County Promotion. It constitutes a new stage in the process of institutionalizing the scaling up of the quality of care movement in China. As part of the new central government’s drive to promote policies which are human centered, have development priority but balanced it with social change, the minister of SFPC decided to use quality of care in family planning as a demonstration of this new emphasis on human centered approaches. Indicators measuring people’s satisfaction, whether their needs were assessed, whether informed choice was implemented, birth targets and quotas were removed, male participation, improved sex ratio at birth and whether services required by law were provided etc were identified through an extensive consultative process. These indicators were utilized at the end of 2003 by 11 teams consisting of key leaders of the quality of care movement in China to select the advanced counties through a process of intensive field visits. The selected counties were congratulated by the Minister of NPFPC (the SFPC changed its name as National Family Planning Commission-NPFPC in 2003) in a televised conference in December of 2003 where he referred them as the pioneers of the family planning reform and the engine that will lead population and family planning program to a new age. Giving such national visibility to the quality of care reform in China demonstrates that what ten years ago began as a relatively small initiative in six counties, is now considered by the NPFPC and by the central government more generally as a movement that will continue to grow. By the year of 2009, among 2860 county level units in China, about 2021 counties were named as the QoC Advanced (County) Unit, takes
above 70% of total. Now the national campaign of QoC advanced county promotion is still continued.

**Conclusion and Discussion**

ICPD coincided with a period of remarkable change and openness in China towards global ideas and currents. Previous tendencies towards black and white contrasts between socialism and capitalism and between China and the rest of the world were abandoned and the leadership began to articulate views of China as part of global society. China was no longer seen as a train running on its own tracks unconnected to those of the rest of the world. These changes more than anything else have provided the prerequisite for making the transition to quality of care in China possible.

In this new era of openness towards outside ideas and influences, ICPD provided a major stimulus in the reorientation of the family planning program from exclusive attention to demographic objectives towards a human-centered focus on quality of care, reproductive health and even reproductive rights. Pioneers among the family planning leadership realized that it was time for a fundamental program reform in which health and human development would assume a central place. Given the deeply rooted and single-minded commitment to population control within the Chinese bureaucracy, such reform would have to begin with a major reorientation in philosophy and program culture and require a process of change that could not be accomplished overnight.

This is the background against which the initiation of state’s pilot project should be seen. It had to start slowly and encourage learning so as to gradually build the experience and evidence-base from which the entire national leadership could be convinced that the quality of care reform would succeed without threatening China’s commitment to its demographic objectives.

Although there is no doubt that real change has occurred in the program, and that the quality of care reform is an irreversible process and will continue to grow, the reform has only just begun and will take many years to complete. Even in the various pilot or advanced counties the transition to a client centered reproductive health approach is not as thoroughly rooted and widespread as it should be. Many challenges remain, e.g. improving counseling skills, human rights approaches, and access of some groups which are still underserved. Standards have to be further developed and reflected in legislation with more of the "softer" aspects, e.g. gender perspective etc. In some parts of the country, the transition has not even begun. In the less developed and poorer regions of China the quality of care reform meets its biggest challenge because people’s fertility preferences exceed what is allowed under policy rules and the resources to implement quality of care and provide a broader range of reproductive health services are scarce. Even if China’s population policy was to be altered, or more resources would be made available to these poorer regions, the quality of care transition would still require major effort and continued attention. Implementing quality of care and respect for reproductive rights and choice require a fundamental cultural change that is not easily accomplished anywhere in the world. However, given its remarkable administrative capacity and organizational strength, with international supports, China may surprise the world by reaching its newly set quality of care and reproductive health goals faster than most outsiders would believe possible.
References:


