

Chapter 3

Quality of care in China: from pilot project to national programme

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Summary

China's family planning programme ranks as history's most intensive effort to control national population growth. While some have lauded China's effort to limit births as a fundamental part of its sustainable development goals, the population policy has also generated much international criticism. A long-overdue reform has begun to focus the family planning programme on client needs, informed choice of contraceptives, and better quality services. Partly inspired by the International Conference on Population and Development in 1994, the reform began as a pilot project in six counties and is now a blueprint for reorienting the national family planning programme. This chapter reviews the process by which a small innovative pilot project was scaled up into a national reform effort and the lessons learned about scaling up sensitive but needed innovation in a difficult political environment. These lessons relate to the importance of local ownership, adapting concepts to make them locally meaningful, careful choice of pilot sites to ensure success, mobilizing political networks, cultivating and educating allies in senior leadership positions, strategic use of donor funding and technical assistance, and the willingness to transfer project management to the next generation of leaders.

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Introduction

China's family planning programme ranks as history's strongest effort to curtail national population growth through deliberate birth control. While some advocates for global population control have praised China's effort to limit births as a basic part of its sustainable development goals, the population policy has also generated much criticism from governments and groups concerned about human rights. The one-child policy, introduced in 1980, aimed to encourage one birth per couple with detailed regulations and birth targets.¹ This policy has been blamed for motivating coercive measures, especially forced sterilizations and abortions, enforced by local officials on an unwilling population. From 1995, a reform of the family planning programme began to introduce a focus on individual couples' needs, informed choice of contraceptives, and better quality services. Partly inspired by the International Conference on Population and Development (ICPD), held in Cairo in 1994 (1), the reform began as a pilot project in six counties and is now a model for reorienting the national family planning programme. This chapter reviews the process by which this innovative experiment was scaled up into a national reform effort. The authors were deeply involved in the pilot project and its scaling up.

China began a concerted family planning effort in the early 1970s (2). By the end of the decade, China's national total fertility rate had dropped from nearly seven births per woman to 2.7 (3). As it was recognized that demographic momentum would fuel population growth for decades to come, the one-child policy was introduced to dramatically slow down the rate of growth.

Policy implementation was based on parity-driven prescriptions of reliable contraceptive use: an intrauterine device (IUD) after the first birth and sterilization after the second. Prior to the ICPD, there was little appreciation of clients' perspectives and quality of care. The need to protect voluntarism in couples' choice about the number and spacing of children was considered less important than achieving overall fertility goals. There was no counselling about choice of methods and medical follow-up was minimal (4). Women were obliged to accept the IUD or sterilization soon after childbirth, and those with an IUD were required to obtain regular ultrasound check-ups to confirm that the device was in place and that they were not pregnant. Couples were required to obtain official permission from local birth planning

¹ Birth targets refers to the number of allowed births in a given year that are set at national, provincial, and prefectural levels and are then communicated to county governments to become a basis for cadre evaluation for promotion. Regulations refer to the explicit rules on pregnancies and births, for example on who is allowed to have a second birth.

officials for allowed pregnancies and births, based on detailed regulations. Out-of-plan pregnancies had to be aborted and intense pressure, psychological and sometimes physical, was put on couples unwilling to conform.

From the start, the policy – especially the heavy-handed methods of implementing unwanted abortions and sterilizations – met with popular resistance by rural couples. Unlike their urban counterparts, rural couples have no pensions or social security; they rely on grown sons, who traditionally care for aged parents and do not marry out into other families as daughters do. Together with the persistence of Confucian traditions of son preference, the prospect of an only daughter was untenable.

China's family planning programme is managed as a top-down process, from national level to province, prefecture, county, township and, finally, village. National guidelines, regulations concerning births, population targets, monitoring and evaluation systems and standards of care are formulated at the top, by the National Population and Family Planning Commission (NPFPC) (its name was changed from State Family Planning Commission in 2003). Provinces then enact regulations and, because population control is a key national policy, all levels of government are required to provide adequate funding to local family planning bureaux to carry out the policy. In the 1980s, family planning and health services were separated, and independent family planning clinics were established at county and township levels (5).

Beginnings of reform: 1990–1995

A number of events in the first half of the 1990s contributed to the initiation of a pilot project that led to the national family planning reform. In 1991, a project aimed at introducing new contraceptive technologies to China initiated the introduction of quality improvements in family planning services, especially the concept of informed choice of contraceptive methods (6, 7). Other collaborations during the 1990s, involving the International Planned Parenthood Federation (IPPF), its affiliate the China Family Planning Association, the World Health Organization (WHO) and Chinese family planning research institutes, further developed concepts of counselling, client rights and informed choice. Nevertheless, these efforts remained uncoordinated and isolated, and there was little rethinking at the State Family Planning Commission (SFPC) about reforming the mechanisms of implementing the family planning programme.

From 1994 to 1995, a large contingent of Chinese family planning officials and researchers attended ICPD preparatory meetings in Bali, the ICPD in Cairo, and the Beijing Women's Conference, where concepts

of reproductive rights and ethical perspectives on family planning programmes were discussed and widely endorsed. Following these conferences, a leading Chinese demographer translated and published a book of key documents from the meeting, including the Programme of Action and the seminal article by Judith Bruce (8) on the need for quality-of-care improvements in family planning programmes (9). The book was distributed to senior family planning policy-makers, many of whom had attended the ICPD or had previously been involved in donor-supported projects.

The senior SFPC official responsible for setting and monitoring implementation of population targets² participated in the ICPD and was strongly influenced by the humanism of the Bruce framework. This exposure, together with his own difficult experience in implementing population targets, made him receptive to rethinking the methods of implementing China's family planning programme. After years of trying to correct falsification of family planning data by local officials worried about performance evaluations, and observing changes resulting from the move to a market economy, the Bruce framework provided him with an appealing new approach. He believed that as market reforms advanced, client expectations for good quality services grew, especially in more economically developed areas (10). He felt that the programme had to adjust to this shift and start giving individuals greater choice in their selection of contraceptive methods and begin providing other reproductive health services. Together with like-minded colleagues from the China Population and Information Research Center (CPIRC), he formulated the idea of a pilot project in six counties to introduce quality-of-care improvements in the programme.

The goal of the proposed project was to test whether realigning the programme to people's interests and needs was possible, desirable, and would not result in additional births. All of the project initiators supported the government's population control goals in principle, but they had misgivings about the way the policy had been implemented and felt that serious reform was necessary. Their vision was supported by the Minister of Family Planning, who provided them with an opportunity to try out this radical new approach that could potentially question the underpinnings of a top-down mandated birth control policy. Many years of dialogue between the SFPC and the United Nations Population Fund (UNFPA) on the issue of voluntarism in the family planning programme may have helped to create some of the pressure for change and to influence the Minister's thinking.

² Zhang Erli, the second author of this paper.

In 1995, the Minister made an official call for “two reorientations” of the Chinese family planning programme: to move the programme away from family planning alone and integrate it closely with economic and social development and address population issues in a comprehensive manner; and to shift programme implementation from primary reliance on social constraints, such as coercion and fines, to gradually institutionalizing interest-driven methods, such as individual choice and demand-based services, along with coordinated information, education and communication (IEC), comprehensive services and scientific management (11). The early proposal by the Minister promoted the idea of keeping a tight control on population, but doing so without coercive measures. The two reorientations were to be achieved nationally by 2010, along with other goals of the government’s ninth Five-Year Plan (1996–2001). The Minister saw the pilot project as an opportunity to move the two reorientations forward (12).

The Quality-of-Care Pilot Project, Phase 1: 1995–1999

Initiation in six counties: 1995–1997

The Quality-of-Care Pilot Project was initiated in 1995 as an experiment to test out the new approach called for in the two reorientations. During the early years, project innovators were isolated and relied on the Minister for their political support. Local participation was not mandated by the SFPC. The project initiators stipulated in advance that no central or provincial government funds would be provided to carry out project activities. The intention of this was to demonstrate sustainability and to ensure local commitment. The project leaders selected counties where they had good personal relationships with lower-level managers in the family planning system. Five rural counties and one city in six provinces on China’s eastern seaboard (Jiangsu, Jilin, Liaoning, Shandong, Shanghai and Zhejiang) were chosen to participate. Their social and economic development had rapidly progressed since the beginning of the economic reforms in the late 1970s. Total fertility rates in these counties were under two; thus there was little fear that introducing the new approach would result in a surge of births.

The main objective of the project was to introduce the six elements of quality of care developed by Bruce (8) into family planning services in the six counties.³ Project leaders supported the counties with training, materials and regular workshops to share experience.

³ The six elements of quality of care are: informed choice, information giving, technical competence, client-provider relations, follow-up and an appropriate constellation of services (8).

In the early years, the project can be described as a context-specific quality-of-care approach, which retained China's population control imperatives but relaxed some of its restrictions, especially in the area of contraceptive choice. The project implemented a more human-centred programme with greater levels of informed choice, counselling and follow-up for side-effects. The counties began to offer couples a choice of five contraceptive methods (IUDs, oral contraceptives, condoms, Norplant[®] implants and sterilization), provided more face-to-face counselling and computer-based information about contraceptive methods, and increased the constellation of services for women, all within the context of strict regulations about the number of allowed births. While all counties followed common guidelines for improving service quality based on the six elements of quality of care (8), there were some differences in emphasis. For example, one county focused on developing youth services, another on improvements in counselling and IEC activities, and another on informed choice.

At the end of 1996, project leaders sought and received funding from the Ford Foundation to begin a process of evaluating the impact of their effort to improve the quality of services. This began with a workshop where the six counties proposed indicators for evaluating their quality-of-care improvements and international participants presented the quality-of-care experience from other countries. After one year of the project, with no observable increase in birth rates, a meeting was held between the Minister and the mayors of the six pilot counties, together with their provincial and county family planning directors in which the mayors and directors endorsed the project and convinced the Minister that the reorientation should continue and expand.

Expansion: 1997-1999

Reassured that the pilot project was not jeopardizing fertility goals, the Minister agreed to expand the project to five new counties at the end of 1997. This modest official expansion involved replication and little change in approach, because the main goal until then had been to achieve support for expansion. However, as the project and the Minister's decision to expand it became known within provinces, many other counties perceived this as a "green light" to visit pilot sites to learn more and to begin some level of similar activities in their own counties, without formal project involvement. They were eager to join an initiative where some of the policy restrictions on parity-specific method requirements were being relaxed.

From 1997 to 1999 a second track of quality-of-care innovations began, characterized by rapid replication of the pilot county experience by neighbouring counties within some of the same provinces (Jiangsu,

Shandong, Zhejiang) and endorsed by the Minister. By 1998, over 200 counties (of about 3000 counties in 31 provinces in the country) were participating informally, using their own resources. These informal county participants were invited to attend project-sponsored training courses on different topics, with occasional participation by international quality-of-care consultants. These second-track counties can be classified as spontaneous expansion, where innovations from the original pilots were adopted with some local adaptations. The number of second-track counties expanded rapidly, especially in the provinces where the pilot counties were located, reaching over 800 by early 2000.

A number of activities helped to consolidate learning and reshape the programme to conform more closely to international concepts of quality of care. Continued Ford Foundation support in 1998, which included international technical assistance, helped project leaders evaluate their efforts to introduce international practices and to develop strategies for training and other activities. Eight senior officials from the SFPC visited India in 1998 to meet government counterparts and researchers to learn about India's experience in lifting demographic targets, moving towards a reproductive health approach and using new indicators to evaluate the programme. Those who participated in the study tour to India became important internal advocates for project expansion within the SFPC. A contact group, comprising the project leaders and core international partners, was formed in 1998 to provide strategic direction for the project. This group played an important role for several years, supporting and informing internal debates about strategy and expansion.

In late 1998, a crisis and an opportunity helped to push the Quality-of-Care Pilot Project closer to centre stage. A leadership transition occurred and the project initiators, with help from external facilitators, succeeded in developing a strategy to ensure continuity and ongoing political support. The Minister was changing, and the project's creator and chief strategist retired from his official SFPC post and was thus obliged to step aside as director. Project management was transferred to the SFPC's new Director General of the Science and Technology Division – an important development for the potential expansion of quality innovations within the national family planning service network and the SFPC. The project's creator recognized the need to have the new director learn about the project who soon recognized its value. Similarly, the Vice-Minister responsible for the programme was cultivated and became an advocate for reform. The new director began consolidation of donor-supported projects to sustain the reform effort and, with her backing and collaboration, the core team set up an opera-

tional office at CPIRC from where they maintained day-to-day management of activities. The project creator continued his involvement as a consultant and volunteer, though without an official role. With great benefit to the project, ownership had passed to powerful new insiders in the government with the ear of the new Minister.

At the International Symposium on Quality of Care, held in Beijing in November 1999, both the new Minister and the Vice-Minister gave speeches endorsing the reform (13, 14). Following that meeting, the contact group discussed plans for project expansion, based on the findings of the qualitative assessment undertaken the previous year. An influential national advisory board was set up for the project during the symposium. This board included researchers, provincial family planning officials, women's activists and representatives of non-governmental organizations (NGOs) involved in reproductive health research and projects, who provided both validity and increased advocacy for the project.

Evaluation of the initial pilots

Evaluation research involved an assessment of the original six counties using an adaptation of the Strategic Approach to Strengthening Reproductive Health Policies and Programmes (15, 16). An international researcher involved in the development of the Strategic Approach participated in the research. The assessment was carried out in 1998 by an interdisciplinary team of more than 20 Chinese and two international participants, including researchers, project team staff and programme managers. Several members of the Quality-of-Care Pilot Project national advisory board participated in the evaluation. The direct involvement of advisory board members further broadened the base of support for the project and helped to publicize it.

The assessment team interviewed programme managers, service providers, local leaders and community members, with special emphasis on married women of reproductive age. The study showed many positive changes. Stable low fertility was maintained and women enjoyed greater freedom in choosing a contraceptive method and relations between clients and providers had improved, as had those between family planning programme managers and the local population. Women reported that they felt more respected and cared for, and local leaders indicated that tensions were eased in implementing the family planning programme. The full report was published in Chinese in 1999 (16). An in-depth analysis of one of the original pilot counties revealed some changes in the contraceptive method mix accompanying the introduction of informed choice, especially in moving away from sterilizations and towards condoms (17). These method mix changes

are important indications of the move away from government-dictated method use based on parity. A study undertaken among 2000 women in one of the second-track counties showed that, as the quality-of-care index increased over three years, abortions decreased significantly (18).

These studies indicate that even though this first phase of the project only offered a limited version of the international quality-of-care model proposed by Bruce, progress was made in beginning to improve clients' choice of method and in reducing contraceptive failures. The project counties adapted the quality-of-care approach to local realities, including, especially, the requirements of China's population policy that contraception must be used. The main achievement during Phase 1 was improving the method mix, especially by providing alternative choices to sterilization, though there was little change in the pressure to abort out-of-plan births. Many pilot counties reported that abortion numbers decreased as contraceptive choice and follow-up increased, which was attributed to fewer contraceptive failures (19). More importantly, the project began to introduce concepts of client orientation in services, and the focus shifted from top-down implementation to more client-need driven and more user-friendly services.

The Quality-of-Care Pilot Project, Phase 2: 2000-2004

The second phase of the project included geographical expansion and functional diversification and the beginning of institutionalization within the SFPC. Responding to the growing interest in the approach from an increasing number of counties, the project was expanded from 11 to 19 counties. Activities were diversified to include new services and approaches as well as management changes. Four new subprojects were initiated, including: further development of informed choice within the Chinese context; improvement of the family planning management information system to incorporate indicators and approaches to measure quality of services; further work on incorporating prevention, treatment and diagnosis of reproductive tract infections (RTIs) into routine family planning services; and expansion of the project to the less developed western regions of the country. The subproject on improvement of the family planning management information system produced new indicators on quality of care that were disseminated for national use in 2002. The project leadership selected influential national universities and research institutions to lead and manage the work, distributing ownership to powerful allies and away from exclusive SFPC control. Respected national and international experts were brought in as consultants, thereby further broadening the

base of support for the project among academics and related institutions already working on reproductive health.

Of the four subprojects, the western expansion was critical for demonstrating the potential to scale up the project nationally. Unlike the coastal counties, where social and economic development was advanced and total fertility rates were below two, fertility desires were higher in the poorer western regions. If the reform could be implemented in these counties without extra resources and without raising fertility, then senior leadership would endorse its expansion on a larger scale.

In February 2000, the western subproject was initiated in six counties, all committed to undertaking the reforms without extra funding. These counties faced more economic difficulty and more limited personnel capacity than the pilot counties in the east. Recognizing this, the project team permitted them to begin by adding services that were relatively easy to implement and/or met immediate needs, such as RTI check-ups or other women's health improvements including infertility treatments. As in the eastern pilots in Phase 1, the western pilots were allowed to move gradually to a pattern of greater informed choice. Self-designed project activities gave the counties a strong sense of ownership.

The Quality-of-Care Pilot Project as a model for national reform

By the end of 2000, the momentum of reform was evident and ownership of the effort by SFPC's senior leaders was clear. This momentum was enhanced by another major initiative promoting quality of care: the UNFPA 32-county reproductive health improvement project. The UNFPA effort was nationally designed and standardized with extensive donor input. It sought to improve reproductive health in rural counties that were more diverse, and in some cases poorer, than those involved in the Quality-of-Care Pilot Project. The project provided opportunities for training, the development of new counselling and IEC materials and technical assistance on evaluation and monitoring. It supported a re-thinking of programme goals, methods and evaluation criteria and promoted a wider reproductive health agenda.

Consensus at the top levels of leadership was reflected in a series of official documents enshrining the concept of informed choice of contraceptives and emphasizing the necessity of protecting the rights of citizens and safeguarding them from coercion in the implementation of the family planning programme. Donor inputs were increasingly being coordinated by the SFPC to support its national reform effort, rather than handled as separate programmes within different parts of the Commission. This institutionalization ties together a number of

similar efforts that began around the same time as the Quality-of-Care Pilot Project. Several donor-initiated projects promoted many of the same ICPD themes: reproductive health and rights, informed choice, better quality services and client orientation. These other projects, involving UNFPA, the IPPF and several United States NGOs, were originally developed and carried out in isolation from the Quality-of-Care Pilot Project, but have now begun to come together. The project provided an acceptable local model for consolidating these various post-ICPD donor programmes that had not previously been seen as workable in the China context.

In the second half of the 1990s, several departments in the SFPC had also introduced reform-oriented initiatives, such as formulating a new population law, an IEC campaign emphasizing gender equity in family life, improving the female child survival environment, and distributing new technical guidelines. By 2000 the SFPC began to bring these initiatives together with the Quality-of-Care Pilot Project. The SFPC began to refer to the more than 800 second-track counties as “the SFPC quality counties” or the “provincial pilots”, thereby officially beginning to claim ownership of the experiment. In an important meeting in northern China in 2000, the new Minister held a television conference with all the directors of provincial family planning commissions, in which he endorsed the quality-of-care approach.

In December 2000, a “white paper” issued by the central government, entitled *China’s population and development in the 21st century*, endorsed the changes, albeit within a continued emphasis on population control (20). This important document used the language of the two reorientations and explicitly stated that quality services should be provided (Article 14) and that citizens’ legal rights should be protected in the implementation of the family planning programme. This document was followed in early 2001 by new regulations for technical service management in family planning for all family planning workers and government officials, promoting quality services and informed choice of methods. In mid-2001, a draft Population Law was submitted to the National People’s Congress with provisions for criminal prosecution of cadres who use coercion to implement family planning and reiterating the language on informed choice (21). The Law was passed and became effective in December 2002.

In 2001, some of China’s leading women’s activists were involved in an activity intended to help family planning staff to see the programme through women’s eyes and to increase gender sensitivity in programme implementation. Training used participatory methodologies and approaches developed by the IPPF/Western Hemisphere Region, in collaboration with the Latin American and Caribbean Women’s Health

Network (22). For the first time, Chinese women activists from the All China Women's Federation, university-based women's studies centres and women's NGOs were willing to engage with the family planning programme, after years of silent opposition to rights abuses within it.

The SFPC launched a new effort in 2002 to establish 100 "quality advanced counties", representing every province (two to three counties per province), from which to model province-wide expansions. These counties were selected from those involved in the Quality-of-Care Pilot Project, from UNFPA's project counties and from the second-track quality pilots. The 33 criteria and standards to evaluate quality services in these counties are based on indicators developed in the second phase of the Quality-of-Care Pilot Project.

A further expansion of the project was developed during 2003 and was launched in early 2004. This expansion includes diversification through new subprojects and geographical expansion to new sites. Diversification is responding to newly identified challenges, such as HIV/AIDS training and services for rural migrants living in urban areas, in line with new pro-poor government welfare policies and with the growing HIV/AIDS epidemic. The NPFPC is increasingly coordinating all donor funding and technical assistance to support its national reform effort. At an important project training workshop in early 2004, new evaluation standards developed by the project were presented, including six indicators used to measure "the people's satisfaction rate".

Lessons learned about scaling up

The Chinese Quality-of-Care Pilot Project experience and its success to date in scaling up offers important lessons about how to move controversial innovations to a national stage in a sensitive political environment. Many of these lessons provide additional support for insights derived from other scaling-up literature.

1. Foster government ownership

The Quality-of-Care Pilot Project was devised and initiated from within the SFPC and was not donor-driven. In China, a major mechanism of institutional change is the use of pilot demonstration projects. Model areas are often held up for national replication, and testing ideas is always considered more relevant than wholesale application of ideas from abroad. The still limited role of NGOs in mobilizing change and the central role of powerful officials, constrained by Communist Party mandates that discourage true experimentation from going forward, make the China context somewhat different from other regions. A major challenge for scaling up in China is to build innovation from within

the government, which remains the main actor in service delivery and policy formulation. NGOs can play a role in demonstrating innovative approaches, but without government ownership and endorsement they are unlikely to lead to national reform.

When the momentum of reform and SFPC's senior leaders' endorsement were evident by the end of 2000, the effort moved rapidly to deliberate scaling up and institutionalization, with a clear focus on organizational change (23). The political support and increasing ownership by SFPC's senior leaders helped to move the pilot project to the second phase, from a replicated demonstration project to an expanded and functionally diversified project, and shortly thereafter toward institutionalization within the national family planning programme.

2. Choose pilots carefully to ensure success and local ownership

Although the project leaders utilized a long tradition in China of model counties to garner support for the reforms, they altered their approach in several significant ways. They provided no additional funding so as to demonstrate sustainability and to attract local enthusiasts, who would willingly navigate the potential difficulties of the new approach. Participating counties volunteered knowing that they would receive no additional funds to carry out project activities. Counties were carefully chosen to reassure senior leaders that there would not be any adverse fertility outcomes of the reform. Starting small, and choosing their original project sites strategically to ensure success, allowed project leaders to make a case for expansion. They carefully built a movement for change from the bottom up, by allowing other interested counties to participate freely in training and workshops and encouraging them to visit pilot sites.

The Chinese scaling-up experience shares common features with other international projects, especially ones undertaken by governments rather than NGOs. Initial scaling up involved replication as a way to expand the pilot experiences to other counties. Staged replication as conceptualized by Wazir & Van Oudenhoven (24) involves a process of pilot testing, followed by carefully evaluated implementation in different sites and then expansion more broadly. Demand from below and careful pilot testing and replication, though locally adapted and owned, was a central feature of the China experience.

3. Cultivate powerful allies and be willing to transfer project management to new leaders

A number of strategies were used by the project team to consolidate gains in Phase 1 and encourage further expansion. Attracting the attention of the senior SFPC leadership expanded the base of support. These efforts to foster ownership of the project by a widening circle of

leaders who assumed positions of power under the new Minister built an internal constituency for reform. The willingness of the project creator to step aside and transfer the strategic management of the project to a more appropriate location ensured its integration into the technical work of the SFPC. The creation of an operational office outside the SFPC guaranteed that the work moved forward during these transitions.

4. *Use research and technical assistance to define expansion needs*

Research during Phase 1 was used to generate evidence on project achievements and to guide the reform effort. The project management team then used the research findings to orchestrate the development of four new subprojects, in order to develop the systems and mechanisms for integration of quality of care into the day-to-day operations of the national family planning programme. International technical assistance and funding contributed to the credibility and visibility of the research effort and findings. Research and technical assistance have continued to guide the evolution of the Quality-of-Care Pilot Project during its second phase.

5. *Adapt concepts to make them locally meaningful*

The Quality-of-Care Pilot Project was based on adoption of a new international paradigm agreed to at the ICPD, which spoke to recognized problems in the China context. The quality-of-care concepts were adapted considerably to fit national realities, and then even more to fit local needs and opportunities. Adaptation was especially needed to fit the constrained environment for free and informed choice and the restrictions on couples' ability to make decisions regarding the number of children and the spacing of births. Such adaptation made it possible for the paradigm shift to occur within a political setting that is resistant to change.

The project leaders were all innovative public sector bureaucratic actors who used their positions of leadership and opportunities for internal advocacy to drive the reform. Their clear messages were relevant to the local areas, especially because of the credibility of the messengers. They used personal contacts to advance the quality-of-care agenda and strategically mobilized technical assistance and donor funding both to gain legitimacy and to increase internal visibility. In other words, the project innovators applied many of the strategies that the literature suggests are important in effective scaling up: they recognized policy windows and cultivated ownership for the experiment among their leaders, recognized and encouraged demand for the reforms from lower levels, and carried out the reforms using phased implementation, adaptation and learning (23, Chapter 1).

Conclusion

Quality-of-care reform in China is still a work in progress. Although significant improvements have been achieved, many challenges remain. As the reform effort expands, there is a continuing need for further clarification and application of international concepts in the China context. Although the concept of informed choice of contraceptive methods has moved far beyond its initial limited interpretation in the early 1990s, it is still not truly implemented as intended by the ICPD, that is, as a programme that prioritizes reproductive rights over population goals and guarantees full voluntarism in the timing and numbers of births. Women in the pilot counties are still not permitted to decline contraceptive use or to choose freely the number and spacing of their children. Although they have more choice in selecting their contraceptive methods and more freedom to change them, they are still urged to abort out-of-plan births. The family planning programme still has a long way to go in terms of adopting a gender perspective in its design and implementation.

Many mechanisms still remain to ensure that contraceptives are being used and to discourage out-of-plan births. There are numerous financial and administrative burdens on couples to ensure that they comply with population goals, such as registering for permission to become pregnant and give birth. Incremental gains are being made, however, through the quality-of-care reform to push back some policy restrictions on birth spacing and the requirement to register for the first birth. Overall, the reform is changing the interface between the family planning programme and the population and instilling an appreciation among local managers and service providers for user perspectives and for client rights to good quality services, information and reasonable policies. Introducing the concept of informed choice through a bottom-up process of change is building pressure for greater voluntarism in the family planning programme and is helping to support reformers at the national level who seek to back away from target-driven, coercive and restrictive aspects of population planning (17). However, the programme requires systematic external evaluation to document real changes in informed choice and contraceptive method mix, so as to respond to the concerns of sceptics and critics.

That the Quality-of-Care Pilot Project is home-grown is probably the major reason for its success in taking the reform as far as it has come. In the sensitive area of China's family planning programme, no experiment or reform effort imposed by external actors could garner the political support necessary to go forward. The project team educated and cultivated senior leaders and broadened their base of support with the SFPC and the provincial-level governments and family planning

commissions, capitalizing on other programmes under way to support their agenda and vision for change. Subprojects were strategically distributed to be led by influential national organizations. Despite uncertainties about commitment and understanding of the project by a new generation of SFPC leaders, the project creators recognized the need to transfer ownership of the experiment to a new group of power brokers who could take the project to the national stage. Recognizing the value of the project, the new director used her influence and considerable insights to scale it up as the centrepiece of a national reform effort. In fact, her recognition in 1999 that the project would not succeed unless integrated with the other work of the SFPC gave the project its most crucial advocate within the government and set the stage for the major scaling up that ensued. She actively pushed for coordination of the project with other donor-supported reform efforts at the same time as spearheading the incorporation of these reforms into the national programme. The vision stemmed from a group of internal reformers with a humanistic perspective and immediate practical problems to solve. They used a window of opportunity to begin a long-overdue reform to one of the world's most controversial programmes.

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