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Quality of Care in China: From Pilot Project to National Program

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Abstract:

China's family planning program ranks as history's most intensive effort to control national population growth. While many 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 of its approach to implementing the family planning program has begun to re-focus the program on client needs, informed choice of contraceptives, and better quality services. Originally inspired by the Cairo ICPD conference, the reform program began as a pilot project among six counties and has now become a blueprint for re-orienting the national family planning program. This article 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 include the importance of local ownership, adapting concepts to make them locally meaningful, careful choice of pilots to ensure success, strategic use of 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 a new generation.

KEYWORDS: scaling up, quality of care, China, family planning, pilot projects

I. Introduction

China's family planning program ranks as history's most intensive effort to control national population growth through deliberate birth control. While some strong advocates for global population control have lauded China's effort to limit births as a fundamental 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, which aimed to encourage one birth per couple with detailed regulations and birth targets has been blamed for motivating coercive measures, especially forced sterilizations and abortions, by local officials trying to enforce them on an unwilling population. A reform of its approach to implementing the family planning program has begun to re-focus the program on individual couples' needs, informed choice of contraceptives, and better quality services. Partly inspired by the ICPD conference held in Cairo in 1994 (United Nations Population Fund, 1996), the reform program began as a pilot project in six counties and has now become a blueprint for re-orienting the national family planning program. The authors of this article were deeply involved in the pilot project and its scaling up.¹ This article reviews the process by which this innovative experiment was scaled up into a national reform effort.

China began a concerted family planning effort in the early 1970's (Tien, HY, 1980). By the end of the 1970s China's national total fertility rate dropped from nearly seven births per woman to 2.7 (Banister, 1987 p.230). Recognizing that demographic momentum would fuel population growth for decades to come, the "One Child Policy" was introduced in 1980 to dramatically slow down the rate of growth.

Policy implementation was based on parity-driven prescriptions of reliable contraceptive use: IUD after the first birth and sterilization after the second birth. There was no counseling about choice of methods and minimal medical follow up (Kaufman et al, 1992). Women were obliged to accept IUDs or sterilization soon after childbirth and those with IUDs, were required to come for regular checkups by ultrasound to confirm that the IUD was in place and they were not pregnant. Couples were required to obtain official permission from local birth planning 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 unwilling couples to do so. From the start, the policy met with popular resistance by rural couples, especially the heavy-handed methods of implementing unwanted abortions and sterilizations. Also, unlike their urban counterparts, rural couples have no pensions or social security other than grown sons who traditionally care for aged parents and who do not marry out into

¹ Zhang Erli was the pilot project's creator and first project director who has retained his role as senior strategist of the program since its inception. Xie Zhenming was a key member of the resource team and has, since 1999, directed the operational office of the Quality of Care pilot project at the CPIRC, Zhang Kaining, Director of China's leading reproductive health NGO, YRHRA, joined the project in 2000 as a Phase 2 technical advisor and manager of the western expansion sub project. Joan Kaufman was the China-based Ford Foundation Reproductive Health Program Officer who began financial support for the effort in 1996 and worked closely with the project team on strategy and planning.

other families, like daughters. Together with the persistence of Confucian traditions of son preference, the prospect of an only daughter was untenable.

At the international level, prior to the 1994 International Conference on Population and Development (ICPD) in Cairo, there was little appreciation for client perspectives and quality of care concerns in China's family planning program (Kaufman et al,1992) or the need to protect voluntarism in couples choice about the number and spacing of children and choice of contraceptive method. By 1994, "Quality of Care" perspectives in international family planning programs (Bruce, 1990) began to be promoted and became a central focus of the shift in paradigms that resulted from ICPD. ICPD, followed the next year by the Fourth World Conference on Women in Beijing in 1995, shifted the focus of family planning programs internationally from population control to women's health and rights (UNFPA,1996).

China's Family Planning Program is managed as a top down process from national to provincial to prefecture to county to township and finally to village. National guidelines and regulations on births, population targets and monitoring and evaluation systems, and standards of care are formulated at the top, at the National Population and Family Planning Commission (name changed from State Family Planning Commission in 2003). Provinces then formulate regulations and, because population control is a key national policy, all levels of government are required to provide adequate funding to local family planning bureaus to carry out the policy. The top down nature of the population policy process contributed to the rapid scaling up of the quality of care pilot program once the decision was made to do so. In the 1980's, family planning and health services were separated and independent family planning clinics were established at county and township levels (Kaufman et al, 1992b p.18-23).

II. Beginnings of Reform: 1990-1995

A number of events in the early to mid 1990s contributed to the initiation of a pilot project that led to the national family planning reform program. A project which began in 1991 aimed at introducing new contraceptive technologies to China initiated the first effort to introduce quality improvements to China's family planning services, especially the concept of informed choice of contraceptives (Tu Ping et al, 1997). Other collaborations during the 1990's, between IPPF and China Family Planning Association (CFPA) and WHO and Family Planning Research Institutes further developed concepts of counseling, client rights, and informed choice of contraceptives. Nevertheless, these efforts remained uncoordinated and isolated and there was little re-thinking at the State Family Planning Commission about reforming the mechanisms of implementing the family planning program.

In 1994-95, a large contingent of Chinese family planning officials and researchers attended ICPD preparatory meetings in Bali, Indonesia, the ICPD in Cairo and the Beijing Women's Conference where new concepts of reproductive rights and ethical perspectives on family planning programs were discussed and agreed upon. Following the ICPD conference, a leading Chinese demographer translated and published key

documents from the meeting, including the Platform for Action and the seminal article by Judith Bruce (Bruce, 1989) on the need for quality of care improvements in family planning programs (Gu, 1996). This book was distributed to senior family planning policy makers, many of whom had attended the ICPD themselves or had previously been involved in donor supported projects.

A senior official from the China State Family Planning Commission (SFPC)(one of the authors of this paper), the official responsible for setting and monitoring implementation of population targets, participated in 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 re-thinking the methods of China's own family planning program implementation. After years of trying to correct falsification of family planning data by local officials worried about performance evaluations and influenced by changes resulting from the move to a market economy in China, the Bruce framework provided an appealing new approach. He believed that as market reforms advanced, client expectations for good quality services were growing, especially in more economically developed areas (Zhang, 2001). The family planning program had to also shift to a mechanism where individuals had greater choice about their selection of contraceptives and could demand and receive other reproductive health services they needed. He formulated the idea of a pilot project in six counties to introduce quality of care improvements in China's family planning program. The goal of the project was to demonstrate that re-aligning the family planning program to people's real interests and needs was possible and desirable and would not result in additional births.

The project initiators also included like-minded colleagues from the China Population and Information Research Center, CPIRC. All of them 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 reforms were necessary. The goal of the project was to demonstrate that re-aligning the family planning program to people's real interests and needs was possible and desirable and would not result in additional births.

Their vision was supported by China's then Minister of Family Planning who soon provided them with an opportunity to try out this radical new approach, which could potentially question the underpinnings of a top down mandated birth control policy. Many years of engagement and dialogue between the China State Family Planning Commission and the UN Population Fund on the issues of voluntarism in the family planning program may have helped to create some of the pressure for change that led to the Minister's own thinking.

In the year leading up to ICPD, the Minister had made an official call for "two re-orientations" of the Chinese family planning program: 1) to move the program away from "family planning alone" to "closely integrating it with economic and social development and addressing population issues in a comprehensive manner" and 2) "from implementing the program primarily relying on social constraints [nb: coercion and fines]

to gradually institutionalizing a mechanism to integrate ‘interest driven’ (nb: individual choice and demand driven] along with coordinated IEC, comprehensive services and scientific management. 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”, which emerged from this concept, were to be achieved nationally by 2010 along with other goals of the government’s ninth five year plan for 1996-2001. The Minister saw the quality project as an opportunity to move forward the two reorientations on the ground (Gu, 2000).

III. The Quality Project Phase 1, 1995-1999

Initiation in Six Counties: 1995-1997

The Quality project was initiated in 1995 as an experiment to test out the new approach called for in the “two re-orientations”. For the first years of the project, the innovators relied on the Minister for their political support.

Local participation in the Quality Project was not mandated from the SFPC. The project group stipulated in advance that no central or provincial government funds would be provided to carry out project activities. The intention of this was two fold: to demonstrate sustainability and to ensure local commitment. The counties selected by the project group to participate in the project were ones where the project group had good personal relationships with lower level managers in the family planning system. Six rural counties and cities in six provinces on China’s eastern seaboard (Jilin, Shanghai, Liaoning, Jiangsu, Zhejiang and Shandong) were chosen to participate, places where social and economic development had rapidly progressed since the beginning of economic reforms in the late 1970’s. These were counties with low TFR’s (under 2) so 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 (Bruce, 1989) into China’s family planning program service approach.(1) The project group supported the county teams with training and materials and regular meetings to share experience.

In these early years of the project (1995-1997), the effort can be described as the invention of a context specific quality of care approach whereby the project leaders retained China’s population control imperatives but began to move to the program towards a more “human-centered” implementation with greater levels of informed choice, counseling, and follow up for side effects. The counties began to offer couples a choice of five contraceptives (IUDs, oral contraceptive pills, condoms, Norplant implants, and sterilization), increased face-to- face and computer assisted counseling about contraceptive methods to support a couple’s choice, and increased the constellation of needed services for women, all within the context of strict regulations about the number of allowed births, which were not changed.

While all counties followed common guidelines for improving service quality there were some differences in project emphases in the six pilot counties. Regular meetings ensured that experiences and approaches were shared among the counties.

Project leaders sought and received external support from the Ford Foundation at the end of 1996 to obtain technical assistance in evaluating the impact of quality improvements in the pilot counties. But even before they developed new indicators, after one year of the project, with no observable increase in birth rates, the mayors of the six pilot counties together with their provincial and county family planning directors endorsed the pilot project at a meeting with the Minister and convinced her that the re-orientation 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. The modest official expansion involved replication and little change in project approach since the main goal of the project team up to then had been to achieve support for expansion. However, as the pilot project and the Minister's decision to expand it became known within provinces, many counties perceived this as a "green light" and visited project sites to learn more and began some level of similar activities in their own counties, without formal project involvement. They were eager to join a project where some of the policy restrictions were being relaxed.

So, from 1997-1999 a second track of the project began, characterized by rapid replication of the pilot county experience by neighboring counties within some of the same provinces (Jiangsu, Zhejiang, and Shandong). The Minister endorsed this second track. By 1998, over 200 counties (out of a total 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 scaling up areas where the same types of new activities 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 begin to re-shape the program to conform more closely to international concepts of quality of care. A series of projects supported by Ford Foundation beginning in late 1996 helped the project team evaluate their efforts to introduce international practices, and to strategize needed training and activities going forward. Eight senior officials from the State Family Planning Commission visited India in 1998 to meet with Indian government officials and researchers to learn about India's experience in lifting demographic targets and moving to a reproductive health approach and the new indicators being introduced to evaluate program efforts. Those who participated in the study tour to India became important internal advocates for project expansion within the State Family Planning Commission.

A “contact group” was formed in 1998 to provide strategic direction to the project, comprised of the project team and core international partners. This group played an important role for several years in supporting and informing internal debates about strategy and expansion.

In late 1998 a crisis and opportunity helped push the Quality Project closer to “center stage”. A leadership transition occurred and the resource team, with help from external facilitators, developed and achieved a strategy to insure continuity and continuing political support. The Minister was changing and the project’s creator and chief strategist also retired from his official SFPC post and thus was forced to step aside as the Quality Project director. Project management was transferred to the new Director General of the Science and Technology Division of SFPC, an important development for potentially expanding the work within the national family planning service network and within the SFPC. The project’s creator recognized the need to involve the new SFPC leadership in the project and to have the new project director to learn about the project and recognize its value, which she soon did. The new director soon began consolidation of donor-supported projects to support the reform effort. Likewise, the responsible Vice Minister was cultivated and became an advocate for the reform program. With support and collaboration from the new project director, the core project team set up an operational office at China Population Information and Research Center where they maintained day-to-day management of project activities. The project creator continued his involvement as a consultant and volunteer outside an official role, and passed ownership of the project to powerful new insiders in government with the ear of the new Minister.

At the November 1999 International Symposium on Quality of Care in Beijing both the Minister and Vice Minister gave speeches endorsing the reforms (Zhang, 2000; Population Council, 1999). Following that meeting, the “contact group” met and formulated 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 International symposium on Quality of Care. This board included researchers, provincial family planning officials, women’s activists, and NGO representatives involved in reproductive health research and projects and provided both validity and increased advocacy for the project.

Evaluation of the Initial Pilots

The project team requested and received donor support for international technical assistance for research to identify needed new activities for the project and the goals for further expansion. This research involved a situational analysis of the original six counties (an adaptation of the strategic approach to contraceptive introduction) (Simmons et al, 1997, Zhang et al , 1999). An international researcher involved in the development of the strategic approach participated in the research which was carried out by a team made up of more than twenty Chinese researchers, project team staff. Several members of the Quality 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 interviewed program managers, providers, and married reproductive age women (clients). Results were compared with a pre project survey undertaken in 1995. The study showed many positive changes: along with stable low fertility, there was more freedom by women to select contraceptives, there were better relations between clients and providers, and between family planning program managers and the local population, women reporting greater respect and feeling of being cared for, local leaders reporting relief that tensions were eased in implementing the family planning program. The full report was published in Chinese in 2000 (Zhang et al, 2000). An in depth analysis of one of the original pilot counties revealed substantial changes in method mix accompanying the introduction of informed choice, especially away from sterilizations and towards condoms (Gu et al, 2002). 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 (Li, 1999).

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 client choice of method and in reducing 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 one was in improving the method mix, especially by providing alternative choices to sterilization, although there was little change in the pressure to abort out of plan births. Many pilots however reported that abortion numbers decreased as contraceptive choice and follow-up increased, attributed to less contraceptive failure (Gu, 2000). More importantly, participation in the project began to introduce concepts of client orientation in services and shifted the focus of the program from top down implementation to more client need driven and more “user friendly” services.

IV. The Quality Project Phase 2, 2000 -2003

The second phase of the project involved both functional and geographic expansion of the project and the beginning of institutionalization within the SFPC. The functional expansion of the Quality of Care project involved inclusion of new needed services and approaches (RTIs), management changes (MIS system) and approaches (expanding informed choice). The project was expanded to 19 counties and four new sub-projects were initiated, including: 1) further development of informed choice in the Chinese context, 2) improvement of the family planning management information system to incorporate indicators and approaches to measuring quality services and informed choice, 3) incorporation of prevention, treatment and diagnosis of reproductive tract infections into routine family planning services, and 4) and expansion of the project to the less developed western regions of the country. 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, and brought in

respected national and international experts as consultants with national level team leaders and project consultants, thus broadening further the base of support for the project among academics and related institutions already working on reproductive health. The project capitalized on and responded to the growing interest in the project approach from increasing numbers of local counties.

Of the four sub-projects in the second phase, the “western expansion” was critical for demonstrating the potential to scale up the project nationally. Unlike the coastal counties where social and economic development had already reduced TFRs to below two, fertility desires are higher in the poorer western regions. If the reforms could be implemented in these counties without extra resources and without raising fertility, then senior leadership would endorse its expansion.

The sub project was initiated in six new counties in February 2000, all committed to undertaking the reforms without extra funding. The six pilot counties faced more economic difficulty and more limited personnel capacity than the pilots in the East. Recognising this, the project group permitted them to begin the work with adding services that were easier and met more immediate needs, like RTI checkups or other women’s health improvements. 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 stronger feeling of ownership of the initiatives.

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

By the end of 2000, the momentum of reform was evident and SFPC’s senior leaders’ ownership of the reform effort was clear. Consensus at the top levels of SFPC 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 from coercion in the implementation of the family planning program. Donor inputs were increasing being coordinated by SFPC to support its own national reform effort rather than handled as separate programs within different parts of the Commission.

In the mid to late 1990’s other departments in the SFPC had also initiated “reform” oriented projects and initiatives such as formulating a new population law, setting up a modern system of marriage and family, improving the female child survival environment, distributing new technical guidelines. By 2000 the SFPC has begun to bring these initiatives together with the Quality Project, the only one focused directly on changing service delivery practices. The SFPC had begun to refer to the 800+ “second track” counties instituting quality reforms in association with the Quality Project as “the SFPC Quality Counties” and the “Provincial Pilots”. 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 and endorsed the Quality of Care approach.

In December 2000, an document was issued by the central government entitled “China’s Population and Development in the 21st Century” endorsing the changes, albeit within a continued emphasis on population control (State Council of China, 2000). This “white

paper” used the language of the “two re-orientations” and explicitly stated that quality services should be provided (article 14) and that citizen’s legal rights should be protected in the implementation of the family planning program. This was followed in early 2001 by the issuance by SFPC of new regulations on technical service management in family planning to all family planning workers and government officials promoting quality services and informed choice. In the summer of 2001 a draft Population Law was submitted to 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 (Winckler, 2002).

SFPC launched a new effort in 2002 to establish 100 “quality advanced counties” in every province(2-3 per province) from which to model province wide expansions. These counties were selected from previous pilots involved in the Quality Project, UNFPA’s projects, or the “second track” quality pilots. Thirty three criteria and standards for evaluating quality services in these counties are based on indicators developed in the second phase of the Quality Project.

A new activity begun in 2001, has formed the basis for a new subproject. This effort utilized participatory methods to help see the program from women’s eyes and began training to increase gender sensitivity in program implementation. Some of China’s leading women’s activists were involved in this effort using methodologies and approaches developed by the IPPF/WHR in collaboration with Latin American and Caribbean Women’s Health Network (IPPF/WHR, 2000). This effort represented the first time Chinese women activists from the All China Women’s Federation and from University based Women’s Studies Centers and Women’s NGOs were willing to engage with the family planning program, after years of silent opposition to the rights abuses within it.

A further expansion of the Quality Project was developed during 2003 and was launched in early 2004. This expansion also includes diversification to new sub projects and geographic expansion to new sites. New functional 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 HIV/AIDS. The NPFPC is increasingly coordinating 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 introduced, including the six indicators used to measure “the people’s satisfaction rate”.

The institutionalization of the Quality of Care project ties together a number of similar efforts begun around the same time as the Quality 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 the UNFPA, the International Planned Parenthood Federation and several U.S. NGOs were originally developed and carried out in isolation from the Quality of Care Pilot Project, but have now begun to come together.

V. Lessons learned about scaling up

1. Fostering government ownership

In China, a major mechanism of institutional change is through the pilot demonstration project process. “Model” areas are often held up for national replication and the testing of ideas in the Chinese context is always considered more relevant than wholesale application of ideas from abroad. The still limited role of NGOs in mobilizing change in China and the central role of powerful officials, constrained by Communist Party mandates, to allow true experimentation to go forward make the China context somewhat different from others described in this volume. A major challenge for scaling up in China is to build innovation from within 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 within the government system, they are unlikely to lead to national reform.

2. Choose pilots carefully to ensure success

Chinese scaling up experience nevertheless shares common features with other international projects, especially ones undertaken by governments rather than NGOs. Staged replication as conceptualized by Wazir and Oudenhoven (1998) 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, although locally adapted and owned, was a central feature of the China experience.

The Quality Project was devised and initiated from within China’s State Family Planning Commission and was not donor driven. Participating county project sites voluntarily participated knowing that they would receive no additional funds to carry out project activities. Counties were carefully chosen to re-assure senior leaders that there would not be any adverse fertility outcomes of the reforms. Initial scaling up involved “replication” as a way to expand the pilot experiences to other counties. The project was predicated on no increase in organizational capacity or funding of the program.

3. Cultivating Powerful Allies and Willingness 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. This included raising attention to the project among senior leadership at the SFPC to expand the base of support. Research during Phase 1 was used to generate evidence on project achievements and to guide the reform effort; efforts to foster “ownership” of the project by a widening circle of SFPC leaders who assumed positions of power under the new Minister; a willingness by the project director to step aside and transfer the strategic management of the project to a more appropriate location within SFPC that would insure its integration into all the technical work of the SFPC (the project director understood that he needed to transfer ownership of the project to powerful insiders within the SFPC); the creation of an operational office outside the SFPC to insure that the work moved forward during these transitions; and then orchestrating the development of four new sub-projects to develop the systems and

mechanisms for integration of quality of care into the day to day operations of the national family planning program.

4.Strategic Use of Technical Assistance and Research to Define Expansion Needs

In the second phase of the scaling up, the effort was oriented towards “functional scaling up or diversification” based on an assessment of needed activities and efforts to transform organizational management of the reform effort to insure success. By the end of 2000, the momentum of reform was evident and SFPC’s senior leaders’ endorsement of the reform effort was clear. At this point the effort moved rapidly to “deliberate scaling up” and “institutionalization” with a clear focus on “organizational change” (Simmons, et al, 2002). 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 towards institutionalization within the national family planning program.

5.Adapt Concepts to Make them Locally Meaningful

The China pilot project was based on adoption of a new international paradigm, agreed to at ICPD that spoke to recognized problems in the China context. The paradigm was adapted considerably to fit national realities and then even more to fit local needs and opportunities, so that a paradigm shift could occur slowly within a political context that is resistant to change. Innovative public sector bureaucratic actors (the resource team) used their positions of leadership and opportunity for internal advocacy to drive the reforms. Their clear messages were relevant to the local areas, especially because of the credibility of the “messengers”. They used personal contacts and adapted family planning quality of care concepts to local realities and strategically utilized technical assistance and donor funding to both gain legitimacy and increase internal visibility. These innovators from within the public sector bureaucracy (the resource team) 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”.

VI. Analysis and Conclusions

The Chinese “Quality of Care” 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. This was done at least in part by adapting an international agenda to context specific requirements, in particular the constrained environment for real informed choice and full voluntarism by couples regarding numbers of births. But the Quality of Care reforms in China are still a “work in progress” and while significant improvements have been achieved in the implementation of the family planning program, 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. While the concept of informed choice of contraceptives has moved far beyond its initial limited interpretation in the early 1990’s, it is still not truly implemented as intended by the ICPD Platform for action: prioritizing reproductive rights over population goals and guaranteeing full voluntarism in the timing and numbers of births. Women in the pilot counties are still not able to

choose NOT to use contraception or to freely choose the number and spacing of their children. They do however, have more choice in selecting their own contraceptive methods, more freedom to change methods, but are still urged to abort out of plan births. The family planning program still has a long way to go in terms of gender sensitivity and perspectives in its design and implementation. .

Many mechanisms still remain to insure that contraceptives are being used and to discourage out of plan births. There are numerous administrative burdens on couples to insure that they comply with population goals, such as registering for permission to get pregnant and give birth. But incremental gains are being made through the Quality of Care reforms to push back some policy restrictions on birth spacing and the need to register for the first birth. Overall, the reforms begun by the Quality Project are changing the interface of the family planning program with the population and creating a program that is inculcating among local managers and service providers an appreciation for user perspectives and client rights to good quality services, information and reasonable policies. The concept of “informed choice” is pushing the boundaries of “voluntarism” in the family planning program from the bottom up and helping to support reformers at the national level seeking to back away from target driven, coercive and restrictive aspects of population planning (Gu et al, 2002). However, at this point the program requires systematic external evaluation to document real changes in informed choice and contraceptive method mix to external skeptics and critics

That the project was “home-grown” is probably the major reason for its success in taking the reforms as far as they have come. In the sensitive arena of China’s family planning program no experiment or reform effort imposed by external international actors could garner the political support necessary to go forward. The project leaders utilized a long tradition in China of “model counties” to garner support for the reforms. But they altered their approach in several significant ways: they provided no additional funding so as to demonstrate sustainability and attracted local enthusiasts for the changes who would willingly navigate the potential difficulties of the new approach and its impacts. They started small and choose their original project sites carefully so as to ensure success so they could 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. They educated and cultivated senior leaders and broadened their base of support with the SFPC and the provincial level Family Planning Commissions and governments, capitalizing on other programs underway to support their agenda and vision for change. Sub projects were strategically distributed to influential national organizations to lead. And despite uncertainties about commitment and understanding of the project by a new generation of leaders at SFPC, they recognized the need to transfer ownership of the experiment to this new group of power brokers who could take the project to the national stage. The new project director quickly recognized the value of the work and used her influence and considerable insights to scale up the project as the centerpiece 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 government and set the stage for the major scaling up that ensued. She actively pushed coordination of the

Quality of Care experiment with other donor supported reform efforts at the same time as spearheading the incorporation of these reforms into routine work of the SFPC nationally.

But the vision began from a group of internal reformers with a humanist vision and immediate practical problems to solve. They used a window of opportunity to create a long overdue reform to one of the world's most controversial programs.

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Footnotes:

1. The six elements of quality of care proposed by Bruce, 1989 include: counseling
and informed choice of contraceptives, technical quality of service providers,
contraceptive follow up, improving client-provider interactions, better
constellation of services....

2. Targets refers to the numerical targets on allowed numbers of births in a given
Year that are set at national, provincial, and prefectural levels and then
communicated to county governments and become a basis for cadre evaluation for
promotion. Regulations refers to the explicit rules on who is allowed to have
second births, spacing. The regulations on births remained in the pilot counties as
they do still.