Japan-China Technical Cooperation Project on Family Healthcare
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Guidance for Family Healthcare Services

Drafted by the Experts Group of the Japan-China Technical Cooperation Project on Family Healthcare

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Introduction

Following the implementation of the Japan-China Technical Cooperation Project on Capacity Building for Enhancing Reproductive Health and Family healthcare services in China's Central and Western Regions (2006-2009), with the cooperation of China's former National Health and Family Planning Commission and the Japan International Cooperation Agency, the Japan-China Technical Cooperation Project on Further Enhancing Family healthcare services and Promoting Healthcare Education in Such Areas as the Prevention of Communicable Diseases (January 2011-January 2016) was initiated as the Second Cycle Project of Japan-China Cooperation on Family Healthcare.

The second cycle project put a premium on the standardization of family healthcare and drafted the Guidance for Family healthcare services, Handbook of Family healthcare services and Collection of Case Studies of Family healthcare services. We expect the present book to garner extensive readership and application.

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Chapter 1 Concepts and Principles of Family Healthcare Services

Section 1 Background to the Promotion of Family Healthcare Services

According to the Decisions of the Central Committee of the Communist Party of China and the State Council Concerning the Comprehensive Enhancement of Work on Population and Family Planning and the Overall Solution of Population Issues (hereinafter referred to as the "Decisions") adopted in 2006, "a new chapter has been ushered in for the work (of the Chinese government) on population and family planning characterized by priority placed on stabilizing the low fertility level, resolving population issues in a coordinated manner and promoting all-round social development. In the face of the new situation and task, not only should we follow the basic experience that proved to be effective over the years but efforts must be made to emancipate the mind, seek truth from facts, keep pace with the times, investigate new circumstances, solve new problems, and continuously enrich and develop the approach, scope and means of resolving population issues with Chinese characteristics. We must comprehensively implement the scientific concept of development, give priority to investment in all-round social development, stabilize the low fertility level, improve the quality of the population and demographic structure, guide the rational distribution of population and ensure demographic security." It is particularly mentioned in Article 4 (``Vigorously improving the quality of the new-borns") of the Decisions that "efforts must be made to improve the quality of new-borns, ... implement the program for the promotion of family planning and reproductive health, ... and vigorously popularize scientific knowledge for the upbringing of infants and babies. The advantages of communication networks should be used to promote awareness and education, technical services, information consulting, contraceptive dispensing and personnel training for both healthy and sub-healthy groups. We should also implement the New Countryside and New Family Project and Reproductive Care Initiative to deliver services in the areas of family planning, reproductive health and family healthcare."

During the 11th Five-Year Plan period [WHEN??], guided by the strategy of coordinated development, the former population and family planning department made great efforts to broaden the scope of public services, make public services available to more people, and improve the effectiveness of public services. In this area, international cooperation and particularly the Japan-China Cooperation Project on Capacity Building for Enhancing Reproductive Health and Family Healthcare in China's Central and Western Regions represents a positive effort of exploration and facilitation, which was elaborated in the Final Evaluation Report of the 11th Five-Year Plan for Population Development. The development and transition of family healthcare and relevant public services were expanded in the Guiding Opinions of the National Population and Family Planning Commission on Further Deepening the Comprehensive Reform and Innovation of Institutional Mechanisms (June 2009), the Guiding Opinions of the National Population and Family Planning Commission (NHFPC) on Expediting the Reform of Administrative Mechanisms for County- and Township-level Population and Family Planning Service Institutions (August 2009), the Guiding Opinions of the National Population and Family Planning Commission (NHFPC) on Implementing the Enhancing Grassroots Capabilities and Improving Quality Project (December 2009) and the Mid-and Long-Term Skills Development Plan for Population and Family Planning (2010-2020) promulgated during the 11th Five-Year Plan period.

Chapter 36 of the Outline of the 12th Five-Year Plan for China's National Economic and Social Development comprehensively elaborated on the implications of "properly conducting the work on population," re-emphasizing the importance of "controlling the population, improving population quality, optimizing the demographic structure, and promoting the long-term and

balanced development of the population." The Outline specifically called for "enhancing family development capabilities, continuing to expedite the development of population and family planning services and expanding their scope, ensuring the priority development of children, proactively responding to the problem of the ageing population and developing a system of services for the elderly based on homecare and supported by communities and institutions, broadening the areas of services for the elderly, extending related services from basic daily care to medical health, rehabilitation medicine, psychological counseling, legal services and emergency aid, as well as requirements for public healthcare services." The 12th Five-Year Plan for National Population Development and the 12th Five-Year Plan for the Development of National Population and Family Planning Undertakings clearly elaborated on family healthcare. The 12th Five-Year Plan for the Development of Health Undertakings also called for "re-focusing healthcare development from the treatment of diseases to the promotion of health and from the priority of services for individuals to the priority of services for families and social groups." In mentioning the promotion of medical reform and health services, the Government Work Report of 2014 also highlighted the importance of "caring for the physical and mental health of the people and family happiness."

In 2013, as part of the reform and functional transformation of the State Council institutions, the National Health and Family Planning Commission (NHFPC) was organized to consolidate the responsibilities of the former Ministry of Health and the administrative and service functions of the former National Population and Family Planning Commission. This great change and the strategy to ensure "health for everyone" and "universal healthcare coverage" created a more positive, constructive and supportive environment for further promoting the advantages of policy and technical resources, enhancing the linkage and coordination of prevention, healthcare and medical treatment, and promoting family healthcare services. Meanwhile, the newly organized NHFPC established the Department of Family Development, and identified the specific functional departments responsible for the implementation of strategies related to family development in the 12th Five-Year Plan for National Population Development, the Draft 12th Five-Year Plan for the Development of National Population and Family Planning Undertakings, and the 12th Five-Year Plan for the Development of Healthcare Undertakings, giving rise to greater potential for development of family healthcare based on the strategy of "health for everyone" from the two major dimensions of healthcare service and family development. In August 2013 the Department of International Cooperation of the NHFPC and the China Office of the Japan International Cooperation Agency (JICA) signed the minutes of a mid-term appraisal meeting, which affirmed their cooperation, with relevant departments and bureaus contributing to policy improvement. At the project joint coordination committee meeting held in February 2014, the Department of International Cooperation of the NHFPC and the China Office of the Japan International Cooperation Agency (JICA) signed the minutes of the meeting, which reaffirmed their cooperation and specifically identified their priorities with the Department of Family Development. In April 2014 the Symposium on Family Development and Family Healthcare was held and reached a consensus that "family healthcare is an important element of family development; the health of the family and its members is an important reflection of family development capabilities; and the promotion of family healthcare is an important aspect of the work of family development." In May of the same year, the NHFPC launched the "New Family Plan -- Capacity Building for Family Development," which was implemented at 72 locations across China, identifying the four key components of family healthcare, scientific parenting, old-age care and family culture. The project carried out level I and level II training and supporting activities in light of urban and rural characteristics in different project sites, and achieved extensive progress and significant results. In July 2015 the National New Family Plan and Family Healthcare Project Experience Workshop were initiated, and many provinces, autonomous regions and municipalities expanded the scope of implementation of the "New

Family Plan - Capacity Building for Family Development." In addition, the first batch of pilot programs for family planning and home-based old-age care, scientific parenting, adolescent health development and the integration of medical resources and old-age care resources were been carried out successively. After four years of implementation, the campaign to create happy families has further highlighted the promotion of family health.

Section 2 Progress of Family Healthcare Services

The former population and family planning department made proactive and successful explorations in the area of family healthcare, and accumulated abundant experience. The implementation of international cooperation projects played a forward-looking, piloting, explorative and demonstrative role. The China/UNFPA Reproductive Health and Family Planning Project, and particularly its fifth and sixth cycles, at the concept and operation level, proactively advocated and practiced people-oriented and rights-based high-quality services of reproductive health/family planning, and promoted standardized services and informed choice; the seventh cycle of the project also took the expansion and transition of public services and family-centered health promotion as important objectives and elements.

The Japan-China Cooperation Project on Capacity Building for Enhancing Reproductive Health and Family healthcare services in China's Central and Western Regions (The First Cycle Project of Japan-China Cooperation on Family Healthcare, the same below) implemented from 2006 to 2009 identified the "3×3" framework for health education, counseling and examination for children, adolescents, women and the middle-aged and elderly population. It carried out the capacity building of family healthcare services for 20 provincial-level personnel from central and western China and at project sites in eight provinces (municipalities) -- Shanxi, Jiangxi, Henan, Hunan, Hainan, Chongqing, Yunnan and Gansu -- and offered family healthcare services at eight project sites and 21 promotion locations. Normative documents such as training textbooks and guidance pamphlets developed in the course of project implementation played a positive role in project rollout on a larger scale. The former population and family planning commissions of such provinces (municipalities) as Jiangxi, Henan, Hainan and Chongqing systematically and completely promoted the service model of family healthcare throughout their jurisdictions. As commented in the Final Evaluation Report of the 11th Five-Year Plan for National Population Development, "the pilot programs of the international cooperation project for reproductive health and family healthcare carried out in eight provinces and municipalities in central and western China represented an effective exploration for the transition of public services concerning population and family planning in the new era."

The Japan-China Cooperation Project on Enhancing Family healthcare services and Promoting their Role in Health Education for the Prevention of Communicable Diseases (the Second Cycle Project of Japan-China Cooperation on Family Healthcare, the same below) was implemented at 12 project sites in Hebei, Anhui, Henan and Hubei provinces and Chongqing Municipality. With greater importance attached to system promotion, institutional innovation and policy improvement on the basis of standardized family healthcare services, Henan and Hubei, as well as certain project sites, incorporated family healthcare into their local "12th Five-Year Plans." For instance, family healthcare was identified by Hubei as an element in building a "healthy Hubei," and Chongqing enacted a document stipulating that family healthcare services are one of the four basic service functions of service institutions. The Capacity Building Project for Quality Services and Integrated Sexual and Reproductive Health counseling, International Cooperation Project for Integrated HIV/AIDS Prevention and Reproductive Health Services, Sino-Australia Cooperation Project on the Reproductive Health Rights of Women in Central and Western China, Sino-German Floating Population and Gender Project, Social Work Project and

Japan-China Integrated Poverty Alleviation Project for Guizhou Province carried out during the same period of time explored the expansion and transition of public service and family-centered health promotion from different perspectives and levels.

Synchronous with project development, various efforts on family development, family health and family healthcare continued to make headway. The Guiding Opinions of the National Population and Family Planning Commission on Further Deepening the Comprehensive Reform and Innovation of Institutional Mechanisms (2009), the Guiding Opinions of the National Population and Family Planning Commission on Expediting the Reform of the Administrative Mechanisms of County and Township–level Population and Family Planning Service Institutions (2009) and the Opinions of the National Population and Family Planning Commission on the Comprehensive and In-Depth Implementation of the New Countryside and New Family Initiative (2011), successively promulgated, all explicitly call for "continuously broadening the scope of services according to the needs of the general public and proactively promoting reproductive health and family healthcare services," and stipulated that "the county-level population and family planning service guidance center is the center for family planning, reproductive health and family healthcare services in the local jurisdiction and assumes the functions of public services concerning population and family planning in the local jurisdiction, including technical and family healthcare services," and that efforts must be made to "carry out family healthcare services, including health education, health examination and health counseling." National free pre-pregnancy health examination is a major project with the two major dimensions of health services and family development, and represents the service model of health examination, health education and health counseling. Focused on five aspects -- civilization, health, prenatal care, prosperity and contribution -- the "National Campaign for Creating Happy Families" features the three activities of "public awareness, health promotion and development for prosperity." Relevant initiatives concerning family development carried out in various provinces all highlighted the elements of family healthcare and family health. Family healthcare services were proactively promoted; for instance, Jiangsu improved its "generational service" system, transforming service institutions into family planning/reproductive health/family healthcare services centers, and launched the "Healthy Family Promotion Plan." The "Family Health Promotion Plan" of Liaoning Province, which draws upon the "Healthy Family Plan" of Dalian City, offers all-round family planning, reproductive health and family healthcare services for both the healthy and sub-healthy populations. By implementing its "pro-people project," Hebei offers free health service for women supported by its family planning service system developed over the years and covering tens of millions of people. Qinghai Province implemented the "Healthy and Happy Family Initiative" for individual families based on needs of the general public and with the theme of health and well-being. Shanghai provides family planning guidance in diverse and individualized forms. Tianjin and Ningbo municipalities carefully planned "population and family public services centers," highlighting health services for families and all groups of people focusing on reproductive health.

After the establishment of the National Health and Family Planning Commission (NHFPC), the Second Cycle Project of Japan-China Cooperation on Family Healthcare proactively communicated and coordinated with relevant departments and bureaus. In August 2013 the Bureau of Disease Prevention and Control, Department of Primary Health, Department of Maternal and Child Health, Department of Community Family Planning, Department of Family Development and Department of Communications of the NHFPC dispatched personnel to attend a mid-term project appraisal meeting and made positive comments on project progress and their intention of participating in project activities. In September 2013 a delegation to Japan consisting of personnel from the above-mentioned departments and bureaus proposed suggestions in the project investigation summary to "create an integrated intervention project for healthy families"

and "establish a team of national family health practitioners." The Department of Family Development has identified family healthcare as an important element of family development, and carried out proactive exchanges and cooperation with the project at national and local levels to learn about and promote relevant practices and experiences. The "New Family Plan -- Capacity Building for Family Development" launched on World Family Day in May 2014 included family healthcare as one of its four themes (The other three were "family culture," "old-age care" and "scientific parenting") shares objectives, concepts and themes with the Japan-China Cooperation Project on Family Healthcare. Both the Chinese and Japanese experts from the Japan-China Cooperation Project on Family Healthcare participated in the deliberations on designing the framework of the New Family Plan. The New Family Plan has carried out exchange and cooperation with the Japan-China Cooperation Project on Family Healthcare in various ways, including training and workshops, sharing experiences and results, and expert participation. The Department of Family Development drafted the Guidance for Scientific Parenting, Healthy Development of Adolescents, and Home-based Healthcare and Nursing Care for the Elderly for key target groups. Family healthcare textbooks under the "New Family Plan - Capacity Building for Family Development" cover the following topics: family healthcare and healthy life, protection from chronic non-communicable diseases in family healthcare, reproductive health and family healthcare, as well as the environment for family healthcare and family health. Supporting activities include: health education for rational diet and prevention of three major chronic non-communicable diseases (high blood pressure, diabetes and dyslipidemia) for persons responsible for family health and leading family members, health education and counseling concerning sexual and reproductive health for adolescents, education in personal hygiene (such as brushing the teeth, taking showers and avoiding spitting) for those responsible for family health and family members, special lectures and training in cardiopulmonary resuscitation and other first-aid as well as in disaster evacuation, including smoke, fire and earthquake evacuation. Since the end of 2014 the New Family Plan has organized inspections on the implementation of these programs in various provinces, and local project offices have expressed confidence in the implementation of family healthcare, attaching great importance and making efforts to expedite them.

The 2015 National New Family Plan and Family Healthcare Project Experience Sharing Workshop were held in Baotou City, in the Inner Mongolia autonomous Region. Deputy Director of the NHFPC Wang Pei'an attended the meeting, and delegates from the project offices of the New Family Plan and Japan-China Cooperation Project on Family Healthcare made speeches at the meeting, and exchanged ideas with one another. Wang Pei'an noted in his speech that "over the past year of the implementation of the New Family Plan, with the proactive efforts of various localities, the great importance attached by the Party commissions and governments at various levels, and the support and coordination of relevant departments, various forms of training and service activities have been carried out in a creative manner, and the New Family Plan has gained a fine reputation at pilot localities as well as among the general public." He added, ``With a family-centered and preventative approach based on people's needs, the Japan-China Cooperation Project on Family Healthcare has carried out a series of health services for vulnerable groups in families within the "3×3" framework, focusing on capacity building, grassroots participation, and supervision and evaluation, achieved fruitful results at the project sites, and accumulated experience for the work on family development in concepts, scope and work methodologies." Wang also remarked that "family healthcare needs to focus on all family members and pay more attention to life-cycle health." After this, the implementation of the New Family Plan entered a new stage, with some provinces expanding the scope of pilot programs and carrying out thematic training in such areas as family planning, home-based old-age care, scientific parenting and healthy development of adolescents.

Section 3 Definition and Framework of Family Healthcare

The Second Cycle Project of Japan-China Cooperation on Family Healthcare conducted careful and repeated deliberation on the applied studies of relevant matters of the Project and the definition of family healthcare services. The results were as follows: "family healthcare is family-centered healthcare services to promote the health of families and their members through such methods as health education, examination and counseling." In comparison with the definition of family healthcare services followed during the first-cycle project implementation of the Japan-China Cooperation Project on Family Healthcare, i.e. "Services are for families and their members, with the primary objectives of prevention and health protection, by means of dissemination, advocacy, education and counseling supplemented with screening, simple treatment and healthcare/rehabilitation guidance," the new definition highlights a "family-centered approach and interactive support among family members," giving prominence to such methods of family healthcare services as health education, examination and counseling, as well as the ultimate goal of "enhancing the health of families and their members."

The "3×3" framework initially identified children, adolescents, women and the middle-aged and elderly as target groups, emphasizing the service methods of health education, examination and counseling. In the Second Cycle Project of Japan-China Cooperation on Family Healthcare, women as a target group were expanded to the population of reproductive age, i.e. children, adolescents, population of reproductive age and the middle-aged and elderly as target groups, and in light of the reality of project progress and service provision, first conducted the deliberation and summary of family healthcare services models and schemes for adolescents and the middle-aged and elderly.

Health education, examination and counseling reflect the importance of putting a premium on preventive healthcare and health promotion, and comprise an interrelated and integrated service process. They can be combined and designed in light of actual conditions in the course of practice.

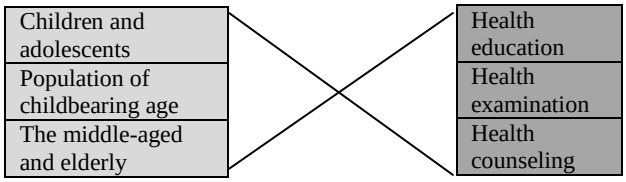


Figure 1-1 "3×3" service pattern

Section 4 Principles of Family Healthcare Services and Management

I. Emphasizing the characteristics of families as the basic unit of family healthcare

Health and family life influence each other. Family healthcare services focus on families and their members with the purpose of maintaining and improving their health.

Chinese culture has always valued family pedigree and interests. Yet with the diversification of life-styles and values brought about by rapid economic development and social transformation, "families" have become the basic units of social development.

Hence, the applied studies of the Project from 2012 to 2013 conducted another round of

deliberation and elaboration of the definition of family healthcare, which pointed out that "family healthcare services are family-centered to promote the health of families and their members through health education, examination and counseling."

In providing family healthcare services, the characteristics of families as the basic units of family healthcare must be fully understood:

1. The fundamental and the critical nature of families in social life

Family is the basic cell constituting human society. Human being forms family, lives under the same roof and raises children who later form new family in their adulthood. In this sense, family has the function to maintain and safeguard the likelihood of family members. Family has the function to maintain the life of family members and engage in production and labor, to raise children, and to ensure that family members support and care for each other when they become sick or too old to fend for themselves. It is due to these family functions that human being is able to survive and thrive through generations and our society continues to exist.

2. Interdependence of family members

A family is a complex, interdependent and organic social unit. In a family, members including couples, parents and children, siblings and grandchildren support and assist each other, and the status of family members not only affects individuals, it also involves the family as a whole. Family healthcare services should be planned and carried out in light of this characteristic.

3. Change and succession of family roles and relationships

Families become transformed with the passage of time, and so do family roles and relationships. For instance, men and women of reproductive age who are married will experience multiple changes of family roles and family relationships as their children are born, grow up and become independent. Such a transition is accompanied by biological inheritance, cultural succession and behavioral influence. With regard to health, behavioral influence is highly noticeable, and includes such aspects as diet, hygiene, daily life, sports and recreation.

4. Diversity of family healthcare needs as determined by family characteristics

Family characteristics are fully embodied in healthcare as well. As noted by Liu Xiaoxian in the journal *Social Medicine*, "Health services should address all the major problems of the full family life cycle." Therefore, in conducting family healthcare services, attention should be paid not only to the status quo of families and family roles and relations, but to such matters in the past as well in order to foretell potential variations, and respond in an integrated and prompt manner.

The social and economic environment in which families are situated, such as the natural, labor, living, dietary, information, educational and cultural environment, will influence the health of families and individuals. Constant changes of social environment in which families are situated also influence families in major ways, and particularly in their health situation. Such transformations vary across different regions of habitat, economic forms and composition of family members. Thus, the health problems of families are diverse and complex, and people expect that targeted family healthcare services to be provided according to the different demands of each and every family.

5. The family is the entry point and focus for family healthcare services

Services provided by medical institutions play a certain role in family healthcare, yet, observed from the overall process, most family healthcare services occur at the main venue of families and either professionals provide those healthcare services or family members care for each other. Highlighting the family as the entry point and focus, and giving prominence to the family role and family relationships will make family healthcare services more sustainable.

II. Focus on health education, health and health as major methods of family healthcare services

1. Giving priority to preventive healthcare and highlighting primary prevention

"Priority on prevention" is a principle of health services and the objective of family healthcare as well. The recipients of family healthcare services can be classified into such groups as healthy, sub-healthy and ill populations. For the first two types of service recipients, preventive health is the major method of health services, while for service recipients who need to seek medical treatment, preventive healthcare is also necessary. Family healthcare services for healthy and sub-healthy populations as recipients should always attach importance to preventive healthcare.

Preventive healthcare can be classified into primary, secondary and tertiary prevention. Primary prevention is also known as causal prophylaxis, which refers to measures taken against the causes of disease before disease actually occurs. It represents a fundamental measure for the prevention, control and elimination of diseases. Secondary prevention refers to measures taken to curb or mitigate the occurrence of diseases during the latent period, i.e. early discovery, early diagnosis and early treatment. Tertiary prevention or clinical prevention refers to measures taken to mitigate the harm from diseases during the clinical period. Tertiary prevention can avoid disabilities and promote functional recovery, improve the quality of life, extend longevity and reduce mortality. Tertiary prevention includes symptomatic treatment and rehabilitation treatment.

Family healthcare services should focus on the areas of primary prevention such as health promotion and preventive healthcare that can best reflect and take advantage of the characteristics, functions and advantages of family healthcare services. Meanwhile, health examination with the primary objective of identifying hazardous factors should be included in primary prevention activities. Hazardous factor identification, post-discovery tracing and abatement of hazardous factors, among other types of intervention in secondary prevention, are extremely important. Relevant departments should contribute to secondary prevention by fully using their advantage of being close to community residents and having rapid access to information and public communication and education. Diagnosis of diseases in secondary prevention and rehabilitation treatment in tertiary prevention all need to be based on the latest medical technology, and require continuous medical monitoring.

2. Adhering to an integrated family healthcare services model encompassing health education, counseling and examination

Major forms of family healthcare services are as follows:

(1) Health education. Health education is an important opportunity for learning. Apart from guiding the health behavior of individuals and society through the dissemination of knowledge and information, health education also aims to inspire the motivations, skills and self-confidence of families and individuals to stay healthy and fit.

Health education as part of family healthcare services cannot be confined to the communication of knowledge to individuals; it should also be coordinated with health awareness and actions by families, paying attention to the form and method of education. In mass health education activities, not only should health lectures and open-air activities be held but they should be integrated with group activities.

(2) Health counseling. After a health examination, it is extremely important to communicate with the recipients the results of the examination and provide them with relevant health counseling and guidance. Health counseling should be offered not only to the recipients of health services themselves but with consideration taken of the family as a whole, in order to explore and improve the method of health counseling while paying attention to continuous counseling on specific matters. The scope of family healthcare services should be determined according to the areas and target groups that currently can be covered, and then they should be continue to be covered and enhanced.

(3) Health examination. Rather than simply to provide diagnosis of diseases, the primary objective of health examination is to learn about specific health conditions and identify any suspicious signals in order to promote timely further diagnosis. Health examination is both an effective means and a major opportunity for the promotion of family healthcare services. It is also crucial for the verification of the effectiveness of family healthcare services.

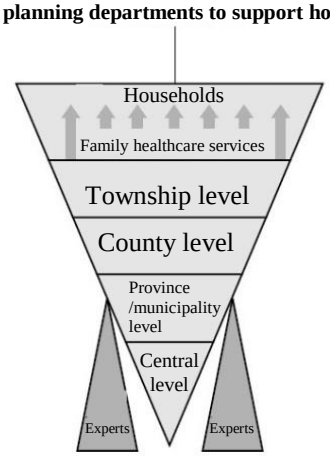
Meanwhile, the design of health examinations should be forward-looking, integrated and sustained. A referral system should be created and improved prior to the conduct of health examinations.

III. Paying attention to service recipients

Family healthcare services cannot be implemented through a top-down approach but must be carried out on the basis of voluntary reception by the target groups. Therefore, family healthcare services should be offered on the basis of understanding the awareness and the needs of target groups, i.e. families and their members. Otherwise, the acceptability of such services would be restricted.

Given the diversity of families and regions, prefectural (city, district)-level family healthcare services departments should learn the needs of local residents in order to reflect the principle of being “people-oriented.” Service providers should identify the appropriate plan, scope and method of services, and make clear the service plan that has been drafted in order to gain more understanding and support from the recipients.

Model of family healthcare services offered by health and family planning departments to support households



IV. Paying attention to the PDCA cycle[①]

In order to effectively provide family healthcare services, it is essential to formulate a plan for such services. On the basis of taking stock of the current situations and problems, the plan should identify the objectives of family healthcare services, prioritization of service activities, evaluation indicators and objectives of activities, and the scope, objectives and annual activity plan of specific service activities.

V. Paying attention to summarizing and extensively applying the family healthcare services model to develop typical cases and promote institutionalization

Right from the time of its implementation, the Project has identified the objectives of policy promotion and institutional innovation for population and family healthcare services, and the directions of policy promotion have been reaffirmed by the mid-term appraisal conducted in 2013. Following this principle, the Project carried out applied studies to encourage local project offices to attach importance to case development, and study and summarize the model of family healthcare services for the middle-aged and elderly and adolescents through repeated deliberations. In conscientiously offering family healthcare services, local project offices should take stock of, improve and promote the service model, develop typical cases, and expedite further institutional developments of family healthcare services through multiple methods such as coordination and integration under the overall situation of family development and health services.

VI. Stressing the role of the project backbone, and emphasizing resource integration and optimization

In offering family health services, the relevant departments -- especially the former population and family planning departments -- should pay attention to the advantages of the project backbone. These advantages are mainly as follows: (1) strategic and policy advantages for addressing demographic issues in a coordinated manner; (2) the network advantage of being close to families in urban communities and rural villages with close ties to the families and their members; (3) certain advantages arising from long-term service to healthy people, avoiding the disease- and hospital-oriented approach; (4) advantages of coordination and experience developed through the implementation and expansion of international cooperation. The Japan-China Cooperation Project on Family Healthcare has entered its second cycle, while relevant international projects such as the seventh cycle of UNFPA are also committed to making relevant explorations. These international cooperation projects serve to promote and coordinate the exploration, summarization, sharing, consolidation and promotion of relevant experiences.

Nevertheless, the provision of family healthcare services also confronts certain challenges, mainly as follows: (1) Capacity, which not only includes service capacity but the capacity of policy development and promotion, formulation of plan and design of scheme as well; (2) Management. The previous model of management was rather crude, i.e. adept at mobilizing organizations but inept at refined operations; and (3) Absence of a ready and fixed model of family healthcare services.

Given the integration of administrative functions for health and family planning, the project implementation should further put a premium on the optimization and integration of resources. Currently, a series of activities have already been launched at the national level: The “Family

[①] PDCA: P - Plan, D - Do, C - Check, A - Act, with specific implications explained in Chapter 3.

Development and Family Healthcare" symposium was held jointly with the NHFPC Department of Family Development, and local project offices took part in the ``New Family Plan" training, while the local project offices of the "New Family Plan" also took part in the Japan-China Cooperation Project on Family Healthcare training; experts from the Department of Family Development and the Department of Communications of the NHFPC have been invited to deliver training courses and lectures for the national-level project; relevant public communication materials and products for the Project have been made in collaboration with the Bureau of Disease Control of the NHFPC, National Oral Health Foundation (NOHF), Department of Communications of the NHFPC and China Center for Health Education. Moreover, communication was carried out with the Department of Primary Health, Department of Maternal and Child Health and Department of Community Family Planning of the NHFPC. With the implementation of institutional reform at various levels, project sites have also been proactively exploring the integration of resources, i.e. integrating the Project with basic public health services and the "New Family Plan."

VII. Stressing capacity building

Since the implementation of family healthcare services, a team with professional medical background has already been developed. After institutional consolidation, the former health system will also participate in service provision, which will vigorously promote service capacity.

Capacity building is the premise and assurance for family healthcare services, and has been identified by the project as an important activity. Multiple methods, including self-organized training, project overall training and retraining, site guidance and exchange, supervision and evaluation, and regular training workshops will be adopted to promote capacity improvement. Among them, training serves as the most important means of capacity building. Therefore, in the project cycle, attention will be paid to the institutional development of training to ensure that it is carried out in a targeted, planned, regular, standard and efficient manner.

Capacity building in the Project is not confined to the technical service capability of family healthcare per se, but includes such elements as service management and organization capability, service awareness and advocacy capacity. Across the project cycle of five years, capacity building efforts have primarily focused on 12 project sites at the current stage, and capacity-building activities will be carried out in all promotion regions in the future in a step-by-step manner.

Chapter 2 Standards for Family Healthcare Services

Family healthcare services are family-centered service with the emphasis on prevention. In terms of the recipients, family healthcare services are offered to all family members. In terms of the scope, family healthcare services cover the full life-cycle health services for family members in diverse forms. Family healthcare services offered by the present health and family planning service system cannot suit all needs, and selectivity based on such factors as service capabilities and people's needs is required. This chapter will give specific explanations in such areas as the recipients, scope and method of family healthcare services conducted in project cycles.

Recipients of family healthcare services include children/adolescents, people of reproductive age (including men), as well as the middle-aged and elderly, and the forms of service include health education, counseling and examination. Service in these three forms is targeted at each and every type of recipients, i.e. the "3×3" service model indicated in Figure 1.

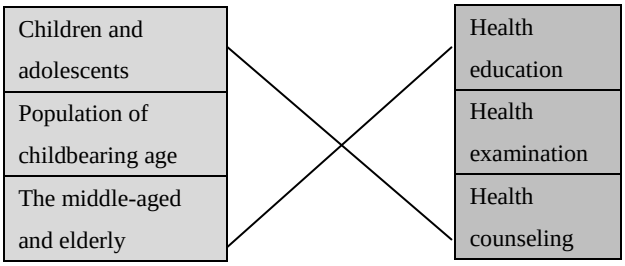


Figure 2-1 "3×3" service model

Section 1 Recipients of Service

Recipients of family healthcare services primarily include three groups of people, i.e. children/adolescents, people of reproductive age and the middle-aged and elderly. As shown by the applied studies of the family healthcare project, women of reproductive age are important recipients, and the critical group for the family planning work of health and family planning commissions, which are well positioned to take the initiative to conduct health promotion among women of reproductive age. Thus, it is suggested that women of reproductive age be taken as the key group for family healthcare services and the entry point for the provision of healthcare services for all family members.

1. Children and adolescents

Recipients of services for children and adolescents are those aged up to 18 years, including fetuses. "Child" in the United Nations Convention on the Rights of the Child refers to any one aged below 18. From the perspective of project services provision, this Guidance classifies the concept of "child" into children (aged 0 ~12) and adolescents (aged 13 ~18). According to the characteristics of child growth and development and primary tasks at different growth stages, the above definition is further divided into seven stages -- fetus , newborn infant, infant, baby, preschool, school and puberty periods.

- Fetus period: according to standards for pregnancy and natal care, this period can be divided into the early stage of pregnancy (first 12 weeks of pregnancy), middle stage of pregnancy (from 13 to 27 weeks of pregnancy and late stage of pregnancy (from 28 weeks of pregnancy to the delivery of the fetus).

- Newborn infant period: from the delivery of the fetus to 28 days after birth.
- Infant period: from birth to one year of age.
- Baby period: from one year to three years of age.
- Preschool period: from three to six years of age.
- School period: the period from school enrolment (about six years of age) to twelve years of age, which is equivalent to the age section for primary school.
- Puberty: refers to the period when fertility is initially acquired, characterized by the maturity of the reproductive organs and the development of secondary sex characteristics. It is a transitional period for children to gradually develop into adults and a critical period for the rapid growth and development of the human body. It is equivalent to juveniles in the junior middle school and high school stages.

With family miniaturization, it is increasingly rare for children/adolescents to be exposed to the ageing and death of the middle-aged and elderly people in their own families or in their communities at large and thus they have fewer opportunities to be exposed to the health problems of the elderly and take part in caring for them. Therefore, for adolescents, as well as imparting knowledge about their own health, it is also necessary to impart to them relevant knowledge about family health for them to be able to provide health support to their families later in their adulthood.

2. Population of reproductive age

Reproductive age starts from the ability of pregnancy to the disability of pregnancy, i.e. the duration of reproductive abilities, and usually refers to the period from 15 to 49 years of age in demographics. The population of reproductive age in this Guidance refers to men and women aged 19 to 44 regardless of their marital status.

The reproductive age is characterized by the following critical periods of healthcare:

- Premarital period: refers to a certain period of time before and after marriage.
- Preconception period: refers to seven months before and after pregnancy.
- Perinatal period: refers to the period from the 28th week of conception to one week after delivery.
- Lactation period: refers to the period when a postpartum mother feeds her baby with her own milk, which is usually about one year.
- Birth interval period: a long period when birth control is needed.
- Climacteric period: the period when the testicle/ovary function of a man/woman declines.

For women of reproductive age, the gestation period is extremely important. According to data from the Sixth National Population Census, the total fertility rate in China is 1.18, and 62.2% of newborn babies are the first child while 31.3% are the second child. Most Chinese women only have one or two gestation periods. Therefore, the long birth interval deserves special attention.

Men of child-producing age also need to take part in the selection of contraception and birth control methods in order to reduce the incidence of unexpected pregnancy. Meanwhile, men of child-producing age also need to pay attention to reproductive problems such as common difficulties of intercourse and the prevention of prostate-related diseases.

Furthermore, both men and women of this age group also need to pay attention to such health problems as climacteric health and the development of a healthy lifestyle.

3. Middle-aged and elderly population

The middle-aged and elderly population as targets of family healthcare services refers to those above 45 years of age, and may also be divided into the middle-aged (from 45 to 65 years of age) and the elderly (above 65 years of age, of whom those above 80 years of age are the "oldest seniors"). Health problems for this age group are primarily lifestyle diseases, and with the advancement of age the incidence of chronic diseases also increases. From the perspective of the growing incidence and burden of diseases, service personnel should fully consider how to delay the onset of chronic diseases and prolong healthy lives.

Section 2 Scope of Services

The scope of family healthcare services is determined by consideration of the healthcare priorities for the three types of service target groups and the current (maximum) service capacity of the health and family planning services system, as elaborated in Table 2-1, Table 2-2, Table 2-3 and Table 2- 4 ("√" means optional service). Various localities may determine the specific scope of services according to the needs of local people and service capacity.

Table 2 -1 Catalogue of healthcare services for children (aged 0 ~ 12)

Service description		Health education	Health counseling	Health examination
Primary catalogue	Secondary catalogue			
Guidance on the daily care of infants and babies aged 0 to 3	Warmth tor newborn infants, and oral, umbilical cord and skin care	√	√	√
	Bathing and touching	√	√	√
	Infant and baby health management	√	√	√
Guidance on feeding and nutrition	Breastfeeding within 6 months	√	√	√
	Supplementary food after 6 months	√	√	√
	Baby nutrition and diet	√	√	√
Prevention and protection of accidental injury	Clogging of child respiratory tract			
	Injury	√	√	
	Intoxication	√	√	
	Drowning	√	√	
	Empyrosis	√	√	
	Animal scratch and bite injury	√	√	
	Electric injury	√	√	
	Child road traffic injury	√	√	
	Prevention of sexual assault	√	√	
Prevention and protection of common diseases	Common diseases of newborn infants	√	√	
	Early discovery and family intervention in case of birth defects	√	√	
	Common communicable diseases of infants and babies	√	√	
	Nutritional disorder diseases and growth and development deviations of infants and babies	√	√	√
	Common diseases of eyes, ears and mouth	√	√	√
	Prevention and control of	√	√	

	hand-mouth-foot diseases			
Development of abilities and behaviors	Living habits	√	√	
	Study habits			

Note: "√" indicates that the service methods of corresponding items have been adopted by certain project sites during the project cycle.

Table 2-2 Catalogue of health services for adolescents (aged 13 to 18)

Service description		Health education	Health counseling	Health examination
Primary catalogue	Secondary catalogue			
Physiological guidance at puberty	Structure and functions of the reproductive organs	√	√	
	Sexual development at puberty	√	√	
Psychological guidance at puberty	Psychological development at puberty	√	√	
	Sexual confusion of adolescents	√	√	
Health guidance at puberty	Urogenital system health	√	√	
	Menstrual health	√	√	
	Breast care	√	√	
	Nocturnal emission	√	√	
Unintended pregnancy and treatment	Gestational physiology	√	√	
	Principles and common methods of contraception	√	√	
	Artificial abortion and avoidance of repeated abortion	√	√	
Prevention and protection of reproductive system diseases	Venereal diseases (VD)/HIV AIDS	√	√	
	Reproductive tract infection	√	√	
	Safe sex	√	√	
	Menstruation-related diseases	√	√	
	Maldevelopment of reproductive organs	√	√	
Health behavior	Addictive behavior	√	√	
	Development of good habits	√	√	√
	Accidental injury prevention and protection	√	√	
	Frustration education	√	√	
Nutrition guidance	Characteristics of pubertal nutrition requirements	√		
	Guidance for common malnutrition and diet	√	√	√
	Weight control	√	√	√

Table 2-3 Catalogue of health services for population of reproductive age (aged 19 to 44)

Service description		Health education	Health counseling	Health examination
Primary catalogue	Secondary catalogue			
Contraception and treatment of unintended pregnancy	Reproductive physiology	√	√	
	Contraception service (emphasizing informed choice)	√	√	√
	Diagnosis, treatment and post-abortion service of unintended pregnancy	√	√	√
Prevention and protection of reproductive system diseases	Reproductive tract infection and venereal diseases (VD)/HIV AIDS	√	√	√
	Infertility	√	√	
	Genital system tumor	√	√	√
	Sexual dysfunction	√	√	
	Other common gynecological diseases	√	√	
Prepregnancy and pregnancy health	Periconceptional and gestational physiology	√	√	
	Prenatal and postnatal guidance	√	√	√
	Prenatal health	√	√	√
	Guidance for home care after hospitalized delivery	√	√	
Prevention of lifestyle diseases	Prevention and treatment of chronic diseases such as hypertension and diabetes	√	√	√
	Neoplastic diseases of the non-reproductive system	√		
	Guidance on postnatal care	√	√	
	Guidance on postnatal contraception and birth control	√	√	
	Prevention of puerperal diseases	√	√	√
Nutritional health	Basic nutrition knowledge	√	√	
	Nutrition and diet during different periods	√	√	
	Nutrition and relevant diseases	√	√	
Sexual care	Sexual health	√	√	
	Safe and harmonious sexual life	√	√	
	Guidance for intercourse during special physiological periods	√	√	

Guidance for Family healthcare services

Interpersonal communication and psychological health	Interpersonal relationship and communication skills	√	√	
	Psychological health	√	√	

Figure 2-4 Catalogue of health services for the middle-aged and elderly (above 45 years of age)

Service description		Health education	Health counseling	Health examination
Primary catalogue	Secondary catalogue			
Reproductive health service	Guidance for safe and appropriate contraception methods	√	√	√
	Guidance for sexual life	√	√	
	Climacteric health	√	√	
	Climacteric syndrome	√	√	√
Prevention and protection of common diseases	Common gynecological diseases	√	√	√
	Male reproductive system diseases	√	√	
	Venereal diseases (VD) and HIV/AIDS	√	√	
	Chronic diseases such as hypertension and diabetes	√	√	√
	Prevention and treatment of cognitive impairment	√	√	
	Neoplastic diseases	√	√	
Promotion of healthy lifestyle	Sports	√	√	
	Teeth and visual protection	√	√	√
	Alcohol and tobacco control	√	√	
	Social activities	√	√	
	Psychological health	√	√	
Nutrition and dietary guidance	Nutritional guidance	√	√	
	Dietary guidance	√	√	
	Dietary and nutritional guidance for common diseases	√	√	
Healthcare for disabled elders	Home nursing	√	√	
	Rehabilitation nursing	√	√	

I. Children and adolescents

In providing child healthcare services, attention should be paid to the characteristics of child growth and development, and the services should be targeted more at parents lacking parenting experience rather than at the children themselves.

Currently, the health and family planning departments carry out regular health examinations

for children/adolescents. Maternal healthcare work standards have prescribed pregnancy examination, prenatal screening of birth defects and prenatal diagnosis, neonatal visits and health examination within 42 days after delivery. Health examinations for children have been prescribed in the National Child Healthcare Work Standards, etc. Hence, it is suggested that, depending on the status of resources possessed by various institutions, efforts should be made to coordinate with competent authorities/agencies of education, youth league committees, women's federations, schools and agencies, focusing on health education and health counseling.

Regarding adolescent healthcare services, given that most adolescents are of school age and under the management of schools, coordination with educational departments is essential. Hence, project implementation should focus on health education and counseling for them. The scope and methods for healthcare for this age group should follow the principle of promoting the self-development of adolescents and pay full attention to their swift transition to reproductive age. On the other hand, adolescents who have dropped out of school cannot be neglected, as they face more problems and greater health risks. Therefore, the health and family planning departments should take the initiative to offer individualized services for them.

In Appendix 6 of this Guidance, we have attached the Plan for Provision of Family healthcare services for Adolescents, which is based on the summary made in the mid- and late stages of implementation of this Project, and offers a reference plan for the future provision of family healthcare services for adolescents.

II. Population of reproductive age

The Project should provide integrated family healthcare services for the population of reproductive age. Such services should not only include health education, counseling and examination related to reproductive health currently being implemented in various project counties but consider selectively providing them with health information related to children and the middle-aged and elderly according to the specific family situations. In the course of providing health services for the population of reproductive age, full attention should also be paid to men's health.

III. The middle-aged and elderly population

Healthcare services for the middle-aged and elderly population not only focus on the existing problems of the recipients of services but give priority to preventive activities such as the maintenance of health conditions and health improvement. Once the recipients need medical treatment or aid, referral must be conducted in a timely manner with consideration of coordination with relevant departments such as departments of civil affairs and human resources, and social security. For middle-aged recipients, the priorities of family healthcare are to conduct regular health examinations, maintain a healthy way of life, prevent frequently-occurring diseases and ensure climacteric health; for elderly recipients, the priorities of family healthcare are the prevention and treatment of chronic diseases, home care for disabled elders and terminal care.

In Appendix 5 of this Guidance we have attached the Plan for the Provision of Family healthcare services for the Middle-aged and Elderly, which is based on the summary made in the mid-and late stages of the implementation of this Project and offers a reference plan for the

further provision of family healthcare services for the middle-aged and elderly.

Section 3 Methods of Service

Methods of family healthcare services primarily include health education, counseling and examination, supplemented by clinical treatment. Integrated healthcare services encompassing health examination, education and counseling may invite public participation, increase the comprehensive understanding of the public on the significance of health examinations and make the health guidance or lectures offered after health examinations better understood and received by the general public.

I. Health education

1. Objective

Health education for families conducted in the course of provision of family healthcare services is important for the maintenance and promotion of family health. The core objective of health education is to promote positive behavioral changes in the recipients and their families.

The aforementioned “positive behavioral changes” refers to the acquisition of necessary knowledge and abilities to make assessments and develop the capacity to proactively respond to health problems .Specifically, one should avoid health problems as much as possible (prevention of diseases) and be able to immediately handle health problems once they occur (early discovery/early treatment of diseases), resolve health problems (treatment) and return to social activities once health problems are resolved (rehabilitation). In order to build a healthy way of life, promote a healthy social environment and achieve the transformation of the recipients and their families, the following aspects of educational assistance may be offered:

(1) Ensure that the recipients of services acquire correct knowledge and correct understanding (acquiring and mastering knowledge).

(2) Stimulate their willingness to develop healthy habits (change of attitude).

(3) Get them to practice and develop healthy habits in daily life (change and maintenance of behavior).

The final objective is to enable the recipients of services to know about their health conditions and the ways to keep healthy through self-management in order to maintain and promote health.

2. Methods

Health education in family healthcare can take various forms, including being spread by TV, radio, newspapers and the Internet, as well as bulletins, billboards, leaflets and lectures at the venues of health examinations. It should be noted that in the production of health education materials, plagiarism is prohibited due to copyright concerns.

Implementation of health education will increase the health awareness of households and stimulate their healthcare demands. On the one hand, health education is normally the precursor to conducting family healthcare services such as counseling and examination. On the other hand, it is also very important to conduct health education for those who have been found to be at risk

through health examination. As indicated by the implementation of the previous cycle of family healthcare, integrating health education with counseling and basic examination may promote public participation, make people better informed of the significance of such examinations, and increase their understanding and acceptance of guidance and advice offered after health examinations.

Japan attaches great importance to health education in providing health services, and some of its practical experience can be incorporated in the Project. For instance:

(1) Cooperation with stakeholders. (i) Educational materials are developed jointly with local students. Health education was supported by local high school cartoon clubs, which drew comic strips calling upon families with children to carry out anti-smoking activities. Volunteers and relevant personnel perform at kindergartens to appeal parents to quit smoking. (ii) Participation of volunteers. In the education on good dietary habits, for instance, volunteers demonstrated their cooking of low-salt miso soup. At the site of health examination, volunteers for the improvement of dietary habits cooked miso soup with appropriate amount of salt for the recipients of health examination, and ask them to taste and compare with their daily diet to promote healthy diet throughout the whole community.

(2) Eye-catching. (i) Make cartoon images. According to the cartoons provided by famous local cartoonists, cartoon apparels can be made and dressed at major public communication activities, together with promotional items and brochures. (ii) Puppet performance. Personnel and students of medicine provide collective counseling and guidance through such activities as puppet performance. In showing children how to brush teeth, with songs and puppets drawing the attention of children, provide parent-child guidance.

(3) Personal experience. (i) Simulated pregnancy experience. At the site of health education, participants are asked to wear coats with sandbags tied to their abdomen to personally experience the feeling and movements of pregnant women in the middle and late stages of pregnancy and learn relevant methods to take care of pregnant women. (ii) Simulated experience of the elderly. At the site of health education, participants are asked to wear the apparels to experience as an elderly person and feel the inconveniences as movement functions declines after one becomes aged by wearing glasses that narrow one's view, earplugs that block sound and protective gears and sandbags that restrict the movements of hands and feet, and learn relevant methods to take care of the elderly. (iii) Human fat model. By observing and touching a model that mimics the feel, color and weight of human fat, participants will deepen their understanding on the health problems brought about by excessive fat.

It needs to be noted that effective results will not be achieved if lectures are conducted regardless of the response of the participants at the site or simply playing audiovisual teaching materials such as videos as a one-way form of communication. Such method should be avoided or combined with other methods.

II. Health counseling

1. Objective

Health counseling aims to train advice-seekers to, when faced with health problems to be addressed, be able to identify problems, deepen their understanding on those problems and proactively respond to those problems and take actions.

The objective and process of health counseling and health education share quite a lot of similarities but the biggest difference with health education is that health counseling service is offered to those who take the initiative to seek advice. Therefore, how to make counseling service well known to potential advice seekers and create a friendly environment of counseling will significantly influence the utilization and effectiveness of counseling.

2. Methods

In addition to enabling people to receive advice at the service institutions or through other channels as hotline telephone and e-mail, we should dispatch more service personnel to villages and households to offer advice and guidance at their doors. Health counseling can play a vital role in providing detailed and careful guidance and support on a one-on-one basis according to the specific situations of individuals and families. Health and family planning departments should be aware of this in order to continuously train personnel and expand counseling service for children, adolescents, the middle-aged and elderly.

There are many techniques and methods for conducting counseling service (such as counseling, analytical and guidance technique; educational and coaching method; guidance method and improvement of self-efficacy; self-efficacy technique, assistance technique for collective activity, etc.). Service personnel practicing health counseling should skillfully master these techniques and methods and use flexibly according to the conditions of those who seek advice.

On the other hand, experts are not the only ones to provide counseling services. Having received certain training and education, volunteers may also engage in counseling activities. While expert support is necessary, having someone with the same trouble and experience to share their own story is easier to stimulate resonance compared with mere intellectual support and may achieve desirable result in certain circumstances. The practice of peer counseling is often used in Japan, e.g. puberty peer education and counseling and activities for relatives of patient.

III. Change to healthy habit and delivery of intervention

The key to promoting the effective delivery of health counseling and education is to adopt targeted interventions in light of the actuality of service recipient. For instance, the process of behavior change for an individual usually needs to go through the following five stages (Figure 2-2). Prior to progressing to a new stage, the current position of the individual must be understood first before appropriate interventions are selected.

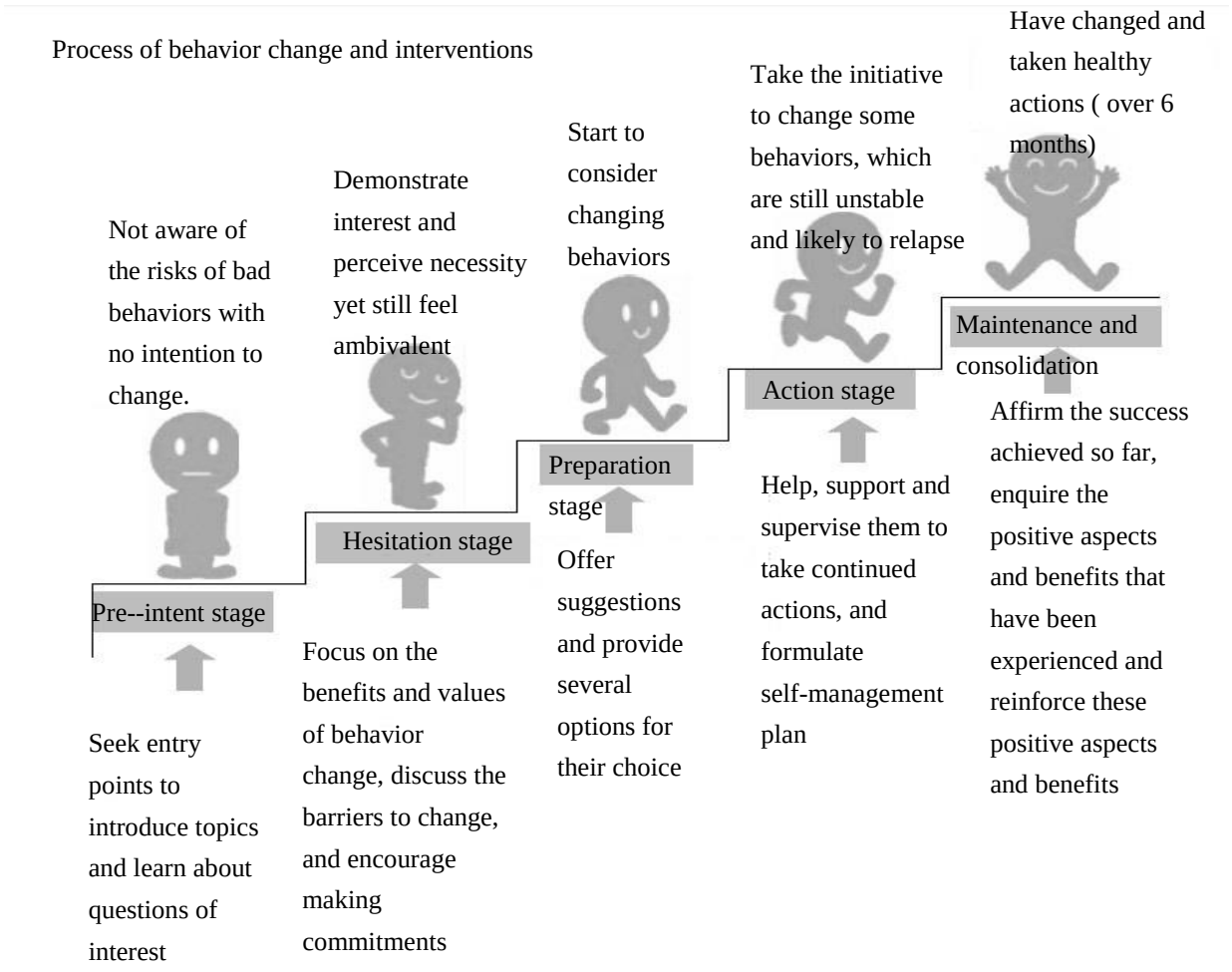


Figure 2-2 Process of behavior change and interventions[①]

IV. Health examination

1. Objective

Health examination may not only discover disease on an early date for timely counseling, treatment or referral so as to reduce the harmfulness of disease, but may increase the health awareness and popularize health knowledge among the general public, and provide the basis for targeted health education in the future, which serves the objective to promote the development of healthy habit, create a healthy environment and improve the level of health.

2. Classification

According to the organization of health examination, health examination can be classified into self-selected health examination and organized health examination. Self-selected health examination refers to the health examination for which expenses are paid by an individual based

① Reference: theoretical model for the transformation of behavioral stages by Prochaska J.O.

on his/her own choice. The scope of examination, selection of the medical institution and method of examination are all determined based on the choice. Another type is organized health examination, which refers to the examination stipulated by law or subsidized by the government and systematically carried out with the costs totally or partially covered by the government. Organized health examination should sufficiently consider input-output, selection of target groups, selection of examination methods and post-examination guidance and also requires careful planning. The health examination mentioned in the following sections of this Guidance mainly refers to organized health examination.

According to the objective, health examination can be roughly classified into the following two types: the first type is health examination for evaluating health status (healthy, sub-healthy, unhealthy), e.g. health examination upon school enrolment, health examination before employment and regular examination for pregnant women. The second type is health examination for the early discovery of certain diseases, e.g. examination for the screening of cervical cancer and breast cancer. This type of health examination usually presents high requirements on technology and equipment.

There are two types of service venue for health examination. The first is the provision of service at service station or health examination institution. The second is outreach service, e.g. delivery of service to countryside (including door-to-door service), delivery of service to school, agency and enterprise.

Health examination in outreach service can be carried out in conjunction with technical service and follow-up visit such as family planning and women and children's healthcare in village and household. For health examination with relatively high technical and equipment requirements such as cervical cancer and breast cancer examination, sample may be collected by grassroots service personnel during the delivery of service to village and household or by organizing local residents to assemble and receive examinations at the county health station or central service office.

3. Design and implementation of health examination

In designing the content of health examination, attention should be paid to learn about the health problems, demands of households and the status and contents of health examinations implemented by the health and family planning departments and relevant departments, as well as the current medical service level of local health and family planning institutions. Health examination is a medical practice that must comply with the technical standards of regulatory department or relevant industry association and if the current capabilities of service personnel are not up to the requirements, prior training is necessary.

4. Feedback of health examination results and follow-up service

Health examination is a good opportunity for the identification of diseases or the risk factors of diseases, and the best opportunities for mitigating problems (including re-examination and treatment) cannot be missed. In order to provide feedback and follow-up service, each and every institution that conducts health examination should draft regulations concerning follow-up service (please refer to Section 4 "Procedure of service"). E.g.:

- Time for the feedback of examination results (within xx days after examination).

- Methods for the feedback of examination results (methods of feedback may vary when the results are normal or abnormal and specifically include personal collection, mail delivery or oral explanation through telephone, etc.)

- Treatment and follow-up service such as referral.

- Method for the management of examination results.

- Statistical analysis and use of examination results.

Section 4 Procedure of Service

I. Procedure of health examination service

From the perspective of management, the service procedure for health examination sequentially includes planning, implementation, feedback of results and post-implementation summary.

1. Development of health examination plan

(1) Clarify objective. The first task is to make sure that each and every staff taking part in the implementation of health examination clearly understands the objective of this health examination. In general circumstances, health examination is implemented according to the law or the instruction/notice of a superior institution, while some health examinations are carried out upon the discretion of an institution itself in light of local conditions. Whichever the circumstance, the objective of the health examination must be clearly stated. Only when the objective of examination is made clear will it be possible to define the target groups of examination, methods of examination and key targets of post-examination follow-up visit. E.g.:

- Health examination for pregnant women: focuses on learning about the development status of fetus and the health status of pregnant women.

- Health examination of infants and babies: focuses on learning about the development status and daily habits of babies, early discovery of diseases and the parenting behavior of parents.

- Examination of reproductive system cancer: early discovery of cervical cancer, breast cancer and ovarian cancer.

- Health examination of the middle-aged and elderly: early identification of risks for chronic non-communicable diseases (referred to as “lifestyle diseases in Japan”).

(2) Selection of target group for health examination. In order to achieve the objective of examination, it is necessary to define the most appropriate target group for health examination. Definition of target population should follow the business rules of relevant departments and bureaus of the NHFPC and guidance requirements recommended by relevant industry association, as well as practical work experience. First of all, the age and gender of target group for health examination should be determined. While it is important to respect the wish of the recipient, it is more important to identify target group in a scientific and effective manner to highlight the results.

Take the examination of osteoporosis for instance, the incidence of osteoporosis varies greatly between men and women. Therefore, women and especially those around menopause should be defined as priority target group of examination.

Apart from the objective and method of health examination, the final determination of target group for health examination should also take into account the personnel, technical competence, facility and equipment and budget, etc. of implementing agency.

(3) Selection of health examination method. Necessary and minimal methods and items should be selected to achieve the objective of health examination. In health examination, some items may cause adverse reactions and false positive results and thus selection should be made on the basis of sufficient understanding of examination items in light of the objective of examination, status of recipient of examination, as well as the personnel, facility and equipment of service institution. For instance, recipients of health examination prefer to more items in blood examination, yet if more examination items are included, there will be more people asking for explanations over the results of examination, which will take longer time. Therefore, the minimum scope of health examination should be adopted.

In addition to the diagnosis and examination by physicians, it is also important to assess the health status and daily habits of residents. When necessary, questionnaire should be designed to learn about the basic status, daily habits and past medical history of the recipient of examination, so as to provide further counseling and health education.

(4) Consider the appropriate number of people included in collective health examination. In conducting health examination, attention should be paid to avoiding the chaotic situation where too many people are included as to exceed the receiving capacity of service institution. An overcrowded venue of examination will make both the examinees and personnel anxious, making examination inaccurate and some examinees drop out from the process of examination. Therefore, the number of people to be examined in one day or half a day should be defined in advance according to the types of health examination.

Meanwhile, in conducting health examination, an implementing team should be set up according to the expected number of people to receive health examination and the duration of examination, and the number of personnel necessary for each department should be defined according to the work process of health examination. When the workload of front desk and enquiry personnel reduces in the first part, they should assist in guidance in the second part where the workload increases. Such collaboration will ensure the smooth conduct of work. Roles and functions of personnel should be arranged in different ways according to the scope of examination. If the number of people to be examined exceeds designed number, there must be a plan to increase personnel.

(5) Determination of schedule. In most cases, health examination cannot be accomplished at one go and normally, are carried out at one venue (e.g.: health examination of infants and babies), while some examinations are carried out at different venues (e.g. health examination for the lifestyle diseases of the middle-aged and elderly). Institutions of examination service should design and offer flexible time options for the convenience of examination recipients. If target group refuse to accept examination, the effectiveness will be reduced by half. Therefore, a schedule of health examination convenient for the participation of residents should be determined. In drafting the schedule, priority consideration should not be given to the work arrangements of

service institutions. Rather, sufficient consideration should be given to the pace of life among local residents. For instance, if health examination is conducted in the countryside, farming season should be avoided in designing the schedule. Items of examination requiring fasting cannot be conducted after noon break. In addition, for the health examination conducted in the same region, when the number of examinees exceeds the receiving capacity of a standard team, a plan should be formulated to conduct multiple rounds of examination at the same venue.

(6) Notify residents. Public participation is vital. Prior to examination, it is important to notify local residents of the time, venue and scope of examination, etc. Such notification may take the following forms: notification to individual, notification by the village committee, or notification directly by the organization or service institution to which the examinees are affiliated. It is preferable to provide examinees with a hardcopy notification to read the time, items and instructions of examination.

2. Conduct of health examination

(1) Make a name list beforehand. It is preferable to draft a list of examinees in advance, including such information as their name, gender, date of birth, age, address and telephone, which will facilitate the work of front desk reception and enable it to maintain order. In this manner, site personnel will also be able to make reasonable adjustments in a timely manner to avoid chaos. Meanwhile, another benefit of making the name list of examinees is that the status of those who did not receive examination may also be found out soon after the end of examination.

(2) Front desk reception. For those receiving health examinations, their names should be verified according to the name list of examinees made in advance. For those not in the list but still wishing to receive examination, they can be additionally included in the list if they are classified as target group. If they are not classified as intended recipients, the intentions of the health examination should be, in principle, explained to them and their participation will not be accepted.

(3) Enquiry work. Enquiry should be conducted according to the enquiry form or survey form made in advance to learn about the health status, daily habits, health knowledge and health behaviors of examinees. When it is difficult for the examinees themselves (parents complete the forms for infants and babies) to complete these forms, the personnel responsible for enquiry may ask for information and write on their behalf.

(4) Examination work. Items of examination for which results can be obtained on the same day should be conducted prior to the consultation with physicians, e.g. height, body weight, blood pressure, cardiograph, type-B ultrasonic scanning, bone mineral density, etc. Various items should be conducted according to the standards formulated by relevant departments and bureaus of the NHFPC and relevant associations.

(5) Physician’s consultation. According to the health examination form and the results of examination and enquiry received on the same day, appropriate explanations should be made to the examinees. When external physicians are assigned to conduct diagnosis and examination, explanatory materials such as the intentions, participants and assessment benchmark of health examination should be dispensed to the physicians for conducting examination and guidance.

(6) Health guidance and counseling. After checking the examination results and learning about the problems of examinees, the physician may use relevant materials to provide appropriate health guidance and answer questions raised by examinees. For questions that cannot be answered, the physician should clearly ask for the contact information and inform the examinees to reply to the questions later.

(7) Layout of environment. In order to facilitate the conduct of health examination, it is important to avoid long waiting queues of examinees in front of certain clinical departments (e.g.: enquiry or examination, inspection, etc.). Reasonable arrangements should be made in advance according to specific conditions of the consulting rooms/examination processes where the number of examinees is high. On the site of examination, an overall flow chart drawn in a way clearly understandable to examinees should be put up at a clearly visible place. Reasonable zoning should be made to the site of health examination, personnel should be assigned to keep order, and the number of examinees for each slot of time should be defined. In addition, waiting time can be used effectively to offer health education, which can make examinees less anxious. It is preferable to create a separate waiting area for examinees, which is inappropriate to be the same area of enquiry. Meanwhile, in areas such as enquiry and examination where privacy needs to be protected, consideration should be given to environmental requirements by putting up isolation wall and curtain, etc.

3. Post-examination work

(1) Post-examination wrap-up meeting. If possible, a wrap-up meeting for the personnel should be held after the completion of health examination to communicate the work of the day, feedbacks by personnel, problems encountered, examinees that require special attention (such as those with high blood pressure yet receiving no treatment), schedule for follow-up activities and assignment of responsible persons.

If the wrap-up meeting cannot be held on the same day, the persons in charge of various activities should be required to make notes to be submitted at the wrap-up meeting to be held later.

(2) Report and notification of the results of examinees. Providing feedbacks of specific results to all examinees involves excessive workload, and thus differentiated treatment should be adopted according to the risk level of examinees.

If the results of examination are normal, the results should be sealed and delivered by the post office or liaison personnel at various locations. If there are low risks, information of relevant diseases and improvement of daily habits should be provided with the results. For risks above medium level, relevant information should be prepared for proper follow-up visits and follow-up intervention if necessary and possible.

(3) Work for those who did not receive examination. The name list of examinees made in advance should be checked to verify who did not participate and where possible, learn about the reasons for their absence and their current status, etc. Whether the examinees who did not receive examinations have received diagnosis at medical institutions and whether they are likely to have health-related problems should be confirmed. If necessary, they should be persuaded to receive health examination.

(4) Analysis of health examination results for groups. After the processing of individual cases, the results should be summarized to make status and problems of examinees clear. If necessary, examinees and the scope of examination or the overall scope of activities should be revisited and discussed. If conditions permit, examinees can be classified according to the results of health examination into such groups as healthy population, high-risk group (for a certain disease) and affected group, etc. Differentiated follow-up health management and follow-up intervention should be implemented according to classification.

II. Service procedure for health education

Health education is conducted either for specific recipients on the basis of health examination results or for an indefinite majority group in light of overall examination results and local health problems. For health education conducted according to health examination, the results of examination should be firstly analyzed to classify recipients into high-risk group and non-high-risk group who still need health guidance. The objective and scope of health education should be discussed in light of the conditions of target groups and the specific methods for improvement should be clarified. Notifications should be issued respectively to individual recipients to inform the time, objective and description of an activity. Health education should be carried out for specific target groups, and follow-up tracing is also very important. For instance, whether they can improve their dietary habits and do more physical exercises in a planned manner according to guidance and the effectiveness of their actions. Improvements can be facilitated if they are confirmed with target groups through follow-up tracing. Evaluation must be carried out after the completion of activity and ensure the results of evaluation are used as reference in following activities. Please refer to the first part of Section 3 “Methods of service” of Chapter 2.

III. Service procedure for health counseling

In principle, health counseling should be carried out separately based on personal intent. Service providers should offer correct information according to various questions raised by service recipients. The content of counseling must be properly recorded for future analysis and utilization. Analysis helps understand different problems facing boys and girls at puberty and can be specifically applied in health education. Please refer to the second part of Section 3 “Methods of service” of Chapter 2.

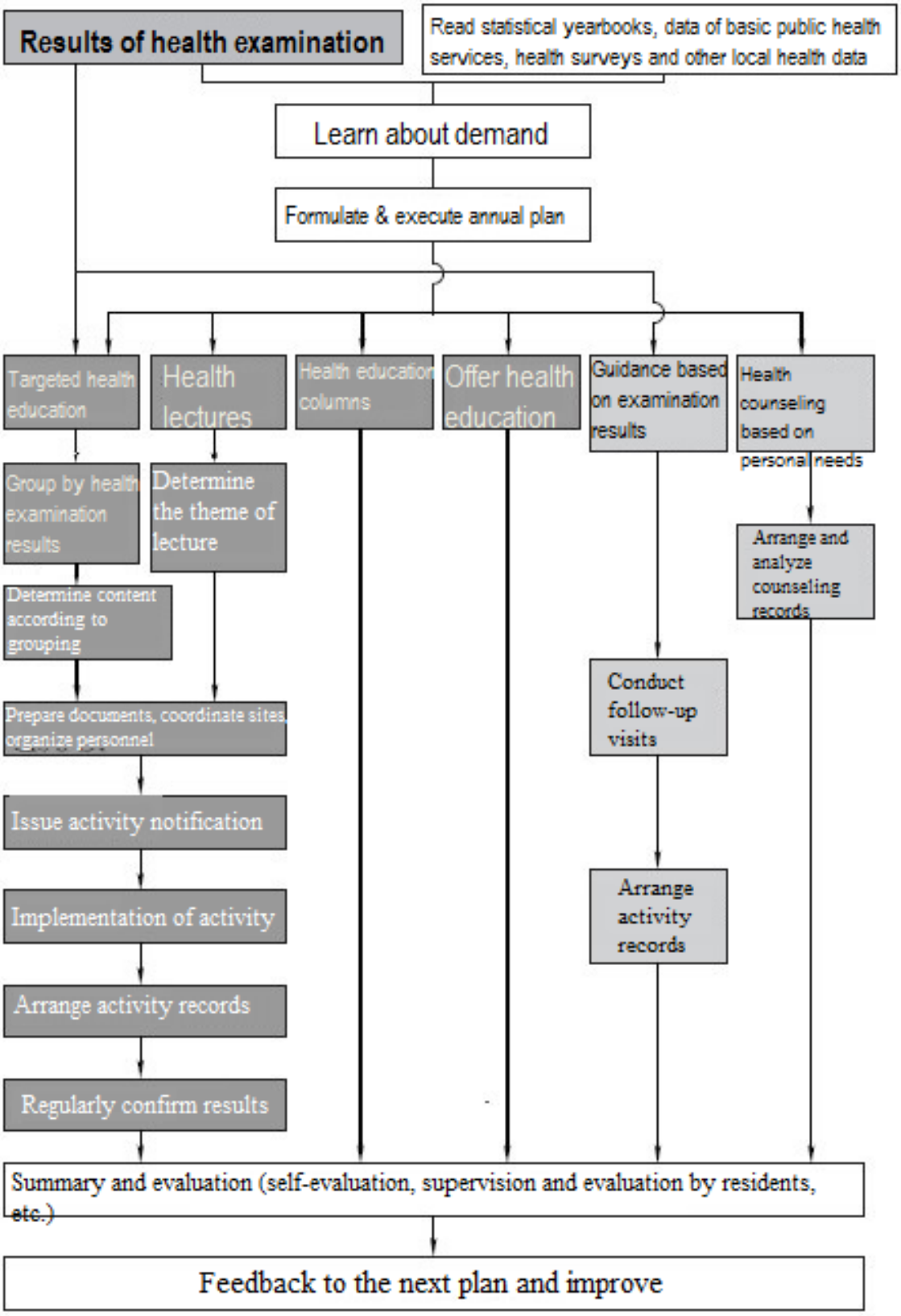


Figure 2-3 Integrated service procedure for health education, counseling and examination

Section 5 Record-keeping and Management of Services

In order to provide more effective services, an "Annual Activity Plan" should be formulated for various types of service recipients (see Appendix 1), according to which a specific implementation plan should be drafted prior to the execution of activities. Please refer to Chapter

3 for the description of this part of the content. This section focuses on record-keeping for services. According to the content of the services, the record keeping can be divided into the activity plan and record sheet of the family healthcare service (Table 2-5). The record sheet should include health education record (Table 2-6), counseling service record (Table 2-7) and health examination service record (Table 2-8).

Table 2-5 Activity plan and record sheet of family healthcare service at county/city/district level

Activity:

Plan section	
Date of activity	Location/scope of activity
Target population	Size of target population
Organizer	Co-organizer
Person in charge	Form of activity
Objectives of activity	
Design of activity (state the scope of activity, participants, organizational process, venue, and equipment requirements)	
Budget of activity	
Activity record section 1. Status of activity implementation 2. Whether the activity is carried out as planned (please state the reason/s if any changes) 3. Activity implementation effect analysis / service data summary and analysis (health examination) 4. Typical cases identified in the activity (if applicable) 5. Problems existing in the activity and ideas for future improvement 6. Please attach archive materials hereunder, as follows: □ Written material □ Photos □ Printed material □ Audio and video materials □ Attendance sheet □ Others	

Person-in-charge (signature): Completed by:

Date of completion:

Table 2-6 Record sheet of health education activity

Date of Activity	Location of Activity
Form of activity	
Theme of activity	
Organizer	
Type of health education recipients	Number of health education recipients
Type and quantity of health education materials distributed	
Description of activity	
Overall comments on the activity	
Please attach archive materials hereunder, as follows: □ Written materials □ Photos □ Printed materials □ Audio and video materials □ Attendance sheet □ Others	

Completed by: Person-in-charge (signature):

Date of completion:

Table 2-7 Record of counseling service

No.	Date	Gender	Age*	Telephone number*	Content of counseling	Response	Service staff signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							

Note: *This information will only be recorded if service recipients are willing to provide it.

Table 2-8 Health examination record

Name Date of health examination: No.□□ -□□□□□

Description	Items of examination			
Symptom	1 Asymptomatic□ 2 Headache□ 3 Dizziness□ 4 Palpitations□ 5 Chest distress □ 6 Chest pain□ 7 Chronic cough□ 8 Expectoration□ 9 Dyspnea□ 10 Polydipsia□ 11 Diuresis□ 12 Weight loss□ 13 Weakness□ 14 Swelling of joints□ 15 Blurring of vision□ 16 Numbness of hands and /or feet □ 17 Urgent urination□ 18 Dysuria□ 19 Constipation□ 20 Diarrhea□ 21 Nausea and vomiting□ 22 Dim eyesight□ 23 Tinnitus□ 24 Breast-distending pain□ 25 Others_____			
General status	Respiratory rate	Times/min	Pulse rate	Times/min
	Blood pressure	/ mmHg		
	Height	cm	Weight	kg
	Waist	cm	Body mass index (BMI)	
	Hip	cm	Waist-to-hip ratio	
	Dietary habits	1 Balanced meat and vegetables 2 Mainly meat 3 Mainly vegetables 4 Salty 5 Oily 6 Sugary □		

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	Smoking data	Smoking status	1 Never 2 Quit 3
		Daily amount of smoking	___cigarettes on average
	Alcohol consumption data	Alcohol consumption frequency	1 Never 2 Occasionally 3 Often 4 Daily
		Occasions of inebriation during the past one year	1 Yes, inebriated ____ times 2 None____□

Continued

Description	Items of examination		
Liver Function	Oral cavity	Mouth and lips 1 Ruddy 2 Pale 3 Dry 4 Chapped 5 Herpes Dentition 1 Normal 2 Missing teeth + 3 Dental caries + 4 Dentures + Throat 1 No hyperemia 2 Hyperemia 3 Hyperplasia of lymph follicle	
	Vision	Left eye_____ Right eye_____ (corrected distance visual acuity): Left eye_____ Right eye_____)	
	Hearing	1 Clear 2 Dull or absent	
Physical examination	Skin	1 Normal 2 Flushed 3 Pale 4 Cyanosis 5 Yellowish 6 Pigmentation 7 Others_____	
	Sclera	1 Normal 2 Yellow sclera 3 Hyperemia 4 Other_____	
	Lymph gland	1 Non-palpable 2 Clavicle 3 Armpit 4 Other_____	
	Lungs	Barrel chest: 1 No_____ 2 Yes_____	
		Breathing sound：1 Normal 2 Abnormal_____	
		Rale：1 No 2 Rhonchi 3 Moist rale 4 Other_____	
	Heart	Heart rate：_____ times/min Cardiac rhythm: 1 Regular 2 Irregular 3 Absolute arrhythmia Noise: 1 No 2 Yes_____	
	Abdomen	Pressing pain: 1 No 2 Yes____ Abdominal mass: 1 No 2 Yes____ Hepatomegaly: 1 No 2 Yes____ Splenomegaly: 1 No 2 Yes____ Shifting dullness: 1 No 2 Yes____	
	Edema of lower extremity	1 No 2 Unilateral 3 Bilateral asymmetry 4 Bilateral symmetry □	
	Breast	1 Nothing abnormal detected (NAD) □ 2 Mastectomy□ 3 Abnormal lactation□ 4 Breast mass□ 5 Others_____	
	Gynecology	Vulva	1 Nothing abnormal detected (NAD) 2 Abnormal_____ □
		Vagina	1 Nothing abnormal detected (NAD) 2 Abnormal_____ □
		Cervix	1 Nothing abnormal detected (NAD) 2 Abnormal_____ □
		Uterus	1 Nothing abnormal detected (NAD) 2 Abnormal_____ □
		Adnexa	1 Nothing abnormal detected (NAD) 2 Abnormal_____ □

Continued

Description	Items of examination	
Auxiliary examination	Fasting blood glucose (FBG)	_____mmol/L or _____mg/dL
	Blood routine	Hemoglobin_____g/L Leukocyte_____/L Thrombocyte /L
	Urine routine	Urine protein_____Urinary sugar_____Urine ketone Urine occult blood_____
	Microalbuminuria	_____mg/dL
	Fecal occult blood test	1 Negative 2 Positive □
	Liver function	Serum glutamic pyruvic transaminase (SGPT)_____U/L Serum glutamic-oxaloacetic transaminase (SGOT) U/L Albumin_____G/L Total bilirubin μmoL/L Conjugated bilirubin_____μmoL/L
	Renal function	Serum creatinine_____μmoL/L Blood urea nitrogen_____mmoL/L Serum potassium level_____mmoL/L Serum natrium level_____mmoL/L
	Blood fat	Total cholesterol_____mmoL/L Triglycerides mmoL/L LDL-C_____mmoL/L HDL-C_____mmoL/L
	Electrocardiogram	1 Normal 2 Abnormal □
	Type-B ultrasonic scanning	1 Normal 2 Abnormal □
	Cervical smears	1 Normal 2 Abnormal □
Health assessment	1 Nothing abnormal detected □ 2 Abnormal Abnormal 1_____ Abnormal 2_____ Abnormal 3_____ Abnormal 4_____	
Health guide		Control of hazardous factors 1 Quit smoking□ 2 Healthy drinking□ 3 Diet□ 4 Exercise□ 5 Lose weight (target_____) □ 6 Recommended vaccination/s_____□ 7 Other_____□

Note:The contents of the tables may be modified appropriately according to the examination items that have been determined. After the completion of each major item of examination, the person in charge of the examination is advised to affix his or her private seal.

In the process of each service delivery, service personnel should enter the record using the appropriate forms. If a service record is entered on a computer, a hard-copy version should be printed out for the record as well. Township service stations should, within the first 10 days of

each quarter, submit the service information of the previous quarter to the relevant division of the county health and family-planning commission that oversees the project. The personnel of that division are responsible for recording guidance, summary and management of information.

Service records should be used as information sources in the course of supervision and evaluation. Registered information will be fully utilized to identify potential problems that may exist in the services, and to guide and evaluate the services. Project sites should also use service record information to learn the demands of service recipients and formulate service plans accordingly.

If the conditions of project sites permit, it is advisable to input the family health service records that have been provided into a computer (direct or subsequent input), so as to archive records electronically. The benefits of electronic records are as follows: (1)To create electronic archives of family healthcare for follow-up services and dynamic comparison of the results of service recipients' occasions of examination, which promotes health management; (2)To identify major public health problems (hazards and high-risk factors) in a timely fashion, in order to take relevant and prompt countermeasures ; and (3)To provide a basis for the scientific management of family healthcare services.

Electronic records not only provide full information about each service occasion, they also facilitate summary and analysis, providing the most important information for understanding service quality and effectiveness.

Chapter 3 Management and Appraisal of Family Healthcare Services

Management and appraisal of family healthcare services mainly include the formulation of family healthcare services plan, implementation of service activities and supervision and appraisal of service activities, etc. Prior to the implementation of family healthcare services, a science-based and feasible service plan needs to be formulated in the first place and secondly, the roles and responsibilities of government and service institutions at various levels should be properly assigned. In addition, the process of service implementation should be brought under whole-process supervision and regular evaluation. The content of this chapter can be applied to the management and appraisal of family healthcare services or the design, implementation and evaluation of specific activities.

Section 1 PDCA Cycle Management of Family Healthcare Services

In order to facilitate the successful implementation of family healthcare services, we recommend the widely applied PDCA cycle management approach, which consists of the following four management stages. The first stage is the formulation of service plan based on previous experience and future forecast (planning stage - Plan); the second stage is the provision of relevant service activities according to the service plan (implementation stage - Do); the third stage is the validation of whether service activities are executed in accordance with the plan (evaluation stage - Check); the final stage is the adjustment of service activities that are implemented not in accordance with the plan (improvement stage - Act). Through the sequential implementation of the above-mentioned four stages and the linkage between the final stage Act and the next cycle of Plan, a spiral cycle can be formed to achieve the objective of constant improvement of work practice and quality. The initial alphabets of the four management stages are linked to form the acronym of the PDCA cycle.

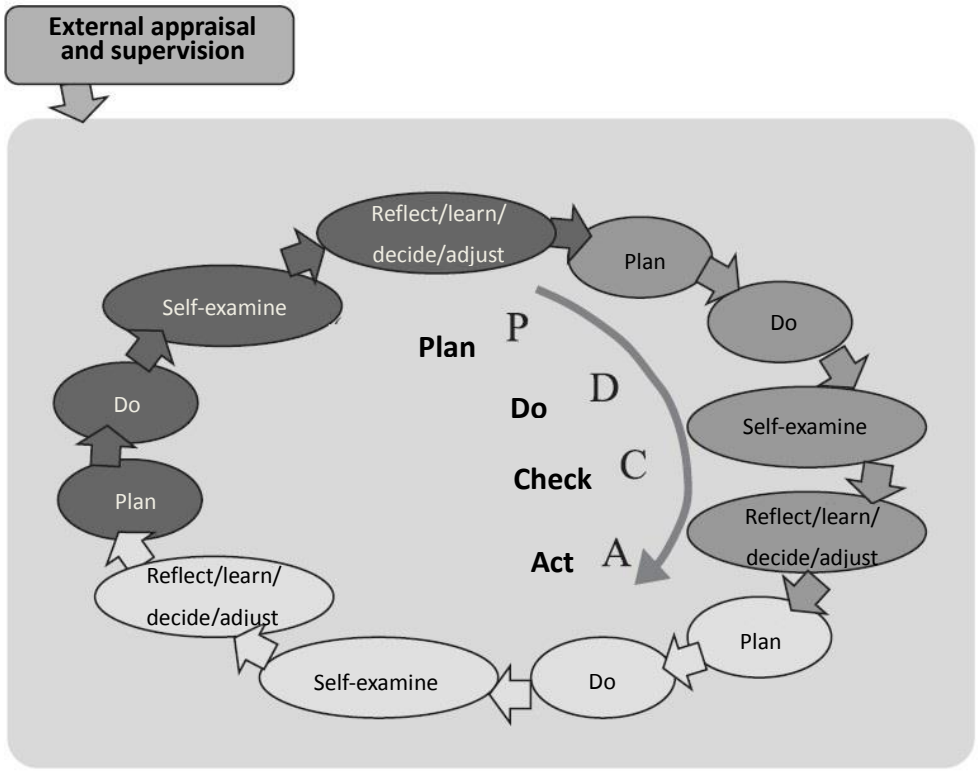

Figure 3-1 Process of the PDCA cycle management

Management of family healthcare services aims to achieve the improvement of service quality through the utilization of the PDCA cycle management method. Specifically:

I. Plan stage

The Japan-China Cooperation Project on Family healthcare services involves a five-year cycle service implementation plan, annual service plan and service plan for each item of service activity. Please refer to Appendix 1 for specific content and format. Although each type of plan varies in terms of its duration and depth, it is required to create service objectives and design relevant service activities on the basis of demand analysis, analysis of the provision status of relevant services and analysis of service capabilities, etc. For instance, in the annual service plan of family healthcare project, the required "analysis of the problems and benefits of the previous year - direction of activities for this year - annual objectives and indicators - summary of annual activities" follow such an approach. The objectives and indicators in the annual plan provide specific basis for examining the quality and effectiveness of the completion of annual activities, for which Appendix 3 of this Guidance can be referred to.

II. Do stage

In this stage, each service activity should be executed in accordance of the service plan. In order to facilitate follow-up check of the PDCA cycle and provide the basis of check, the family healthcare project requires that an activity should be recorded after its completion, which includes the following: the status of activity implementation, whether the plan has been complied with (reasons should be explained if any changes), analysis of the effectiveness of activity/service data summary and analysis, as well as typical cases in the activities. Some project personnel consider that it is too complicated to record project activities during implementation process and thus made records in a perfunctorily manner at times. However, project records are the trails of projects after the completion of project activities and provide not only the basis for project inspection activities but meaningful original information for annual wrap-up, project audit, future project design and project activities of other regions as well.

III. Check stage

Family healthcare project can be evaluated in the following two ways: i.e. external appraisal / supervision and self-examination / appraisal. Supervision of project service activities should be conducted at different levels including national, provincial and prefectural or municipal levels. Please refer to Appendix 2 for national level supervision form and after the completion of supervision at various levels, it is necessary to formulate a supervision report and provide feedback of supervision conclusions and suggestions to the supervision offices. Self-examination / appraisal should be conducted after the completion of each item of service activity and at the end of each year. After the completion of project service activities, it is required that the problems of service activities be analyzed together with the project team to discuss the strategies and methods for future improvement. The content of inspection of project service activities is required to be recorded in the last item "Problems in the Activity and Vision for Future Improvement" of the "Project Activity Plan and Record Sheet". At the end of each year, the family healthcare project will host an "annual wrap-up and planning meeting" and each project county is required to formulate and submit annual report to report the completion status of objectives according to the

annual service plan, and take stock of the problems and successful experiences. This is also a regular project evaluation activity.

IV. Act stage

For the problems discovered during external appraisal/supervision and self-examination / appraisal, some of them require immediate action to rectify, while others may allow gradual change in the future or the next year. Some problems may also necessitate the adjustment of service plan itself. In the process of family healthcare project implementation, through constant review (reflection), learning, and (understanding) summary in the process of external evaluation/supervision and self-inspection/evaluation, good practices and experiences will be standardized and the process of project service activities will be adjusted or improved in a timely manner. These activities are considered as part of the Act stage.

Section 2 Formulation of Family Healthcare Services Plan

According to the theory of PDCA cycle management, the management of family health services starts from the formulation of plan, which is a process of science-based decision-making. There is a set of scientific methods and procedures to follow in addressing such questions as what basis should be followed in formulating the plan, how to formulate the plan, which elements should be included in the plan and how to evaluate the implementation status of the plan. First, the following factors must be taken into account as the basis in formulating the family healthcare services plan: (1) demand of target population: in regions where family healthcare services are provided, demand of target population should be investigated through baseline survey, while attention should also be given to learning about the demand of target population in the process of service delivery. (2) Requirements of competent authorities: requirements of competent authorities mainly include the directives of the relevant departments and bureaus of the NHFPC, *the Guidance for Family healthcare services* (this book), as well as *Family healthcare services Handbook*, etc. (3) Analysis of the current situation: includes the analysis of the health status of local residents, analysis of the service capabilities of various types of service institutions, as well as analysis of service provision, etc. Specific elements of family healthcare services should be prioritized based on the analysis of current situation.

There are many methods to formulate a family healthcare services plan and this section will introduce the logical framework method.

I. Basic knowledge about the logical framework method

1. Concept of the logical framework method

Logical framework concept is an instrument used for project design, planning and evaluation often used by international organizations in the design of development projects, formulation of project plan and project review and appraisal. The logical framework method is a science-based method of thinking and reveals the vertical logical relationship among various hierarchies of objectives including the overall goal of the project or work, project objectives, outputs (achievements), activities and inputs. Meanwhile, it also reveals the horizontal logical relationship among the description of various hierarchies of objectives, measurement indicators, means of measurement and risk assumptions. These logical relationships can be expressed in the logical framework matrix (see Table 3-1).

Table 3-1 Logical framework matrix (project design matrix, PDM)

Hierarchies of objectives and their description	Measurement indicators	Measurement methods	Risks and assumptions
Overall goal (macro-level goal)			
Project objectives (direct objectives)			
Outputs (results)			
Activities			
Input assurance			

2. Vertical logical relationship

The vertical column of the logical framework matrix (see Table 3-1) usually divides project objectives into the following five hierarchies.

(1) Overall goal (macro-level goal), which refers to the goal at the highest hierarchy and is the overall goal of a country, region, sector or investment organization (usually in the form of projects). Identification of goal and selection of indicators at this hierarchy are usually the responsibilities of the national government, industry sectors or project investment organizations (project investors). Overall goal is long-term, macro-level and comprehensive in nature and may not be accomplished during project cycle or through project activities alone. Nevertheless, project activities contribute to the achievement of overall goal by a certain degree. Overall goal of family healthcare projects at the national level is as follows: to enhance systematic healthcare and prevention activities of project provinces through the implementation of family healthcare services.

(2) Project objectives (direct objectives). Direct objectives of a project are the direct effects and influences of the project. Hence, project objectives are also referred to as the "effects" or "purposes." For projects of healthcare services, "effects" usually refer to the attitudes, knowledge and behavioral changes of management personnel, service personnel or service recipients, or the changes in the capacity and competence of service institutions. "Effects" are intended to support the achievement of the overall goal and objectives at this hierarchy are determined by the department that formulates the plan or the executing agency of project. The direct objective of family healthcare project at the national level is: to create a family healthcare services model consistent with local needs in pilot regions.

(3) Outputs (achievements), which refer to the direct outputs or achievements after project inputs and activities. After the implementation of project activities, certain "achievements" or "outputs" will be made. If health education lectures for the middle-aged and elderly are carried out under a family healthcare project, the "output" will be an increase in the number of the middle-aged and elderly who have received health education. "Outputs" serve "project objectives, and when "outputs" accumulate to a certain extent, "project objectives" will be accomplished.

"Outputs (achievements)" of family healthcare projects at the national level include the following four, i.e.: improved family healthcare services standards (philosophies, concepts, contents and standards, etc.); enhanced operation and management of family healthcare plan in pilot regions; enhanced execution capabilities including managerial and technical capabilities of family healthcare services institutions and personnel; and improved awareness of household participation for family healthcare services and health awareness.

(4) Activities, which refer to activities that need to be carried out in order to achieve project objectives and expected outputs. In a family healthcare project, "activities" are carried out with the central objective to improve health, e.g. health education lectures for the middle-aged and elderly and health counseling clinics opened to promote their health awareness, health examination activities for the middle-aged and elderly carried out for the early discovery and treatment of diseases, etc. Project regions should design a series of activities based on the "outputs (achievements)" of a project.

(5) Input assurance, which refers to the input of such resources as the funding, human resources, time and equipment that have been invested during the process of project implementation and should also include political or policy assurance measures. These inputs assure the successful implementation of project activities. For instance, in a family healthcare project, it includes the equipment, funds and service personnel, etc. that have been involved for the provision of free health examinations; acquisition of institutional qualification license for the lawful conduct of health examination services by the service institution, etc.

It needs to be emphasized that a causal relationship exists among the elements in the vertical column of the logical framework matrix, i.e. the overall goal, project objectives, outputs, activities and inputs, as shown by Figure 3-1. Only with the implementation of "input assurance" measures will the "activities" be carried out smoothly; only with the implementation of appropriate "activities" will the expected "outputs" be achieved; only with the achievement of the "outputs" will the desired "effects" be accomplished; only with the accomplishment of desired "effects" will the "overall goal" be finally achieved.

The Japan-China Cooperation Project on Family Health Service always follows the logical framework method for the operation of project management. Please refer to Appendix 1-1.

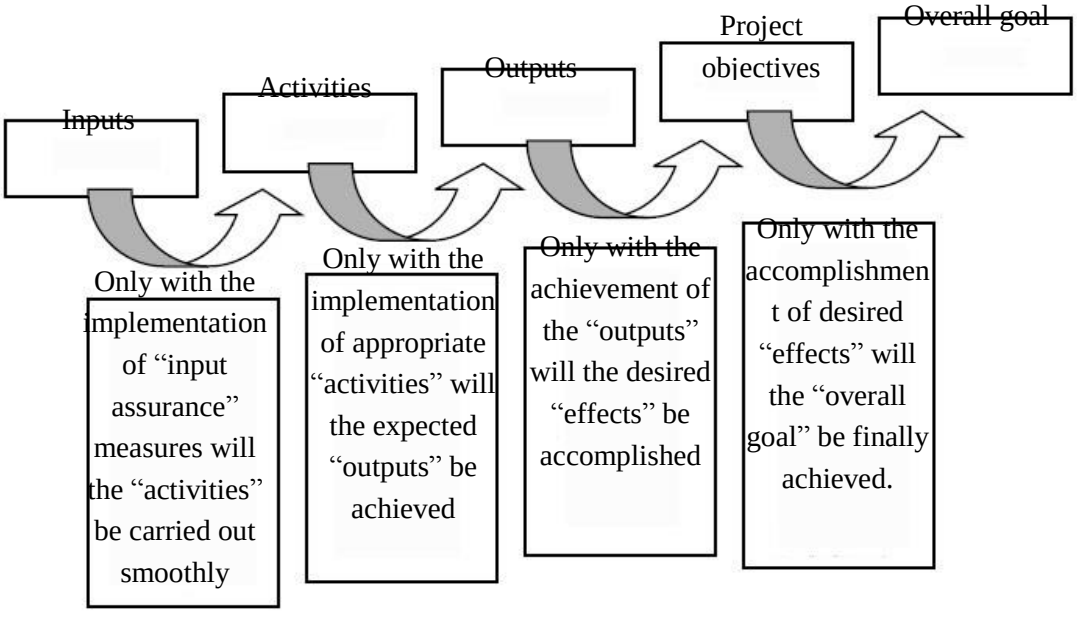

Figure 3-2 Causality of the vertical logical relationship

In the practice, "project objectives" are sometimes combined with "outputs (achievements)" into one item, so that only four hierarchies are left in the logical framework matrix, i.e. overall goal, project objectives, activities and inputs. Sometimes, "activities" and "inputs" are combined into one item, so that the logical framework matrix only contains four hierarchies including the overall goal, project objectives, outputs (achievements) and inputs. There are some logical framework matrixes that only contain three hierarchies: objectives, outputs (achievements) and inputs. The number of hierarchies is related to the size of projects or the complexity of work. For small projects, the outputs (achievements), activities and inputs are relatively simple and may contain fewer hierarchies, while large projects contain more hierarchies, which is favorable to decomposing inputs and activities into appropriate department and personnel for the latter to earnestly take responsibilities.

3. Horizontal logical relationship

In the logical framework matrix, the logical relationship also exists at the horizontal direction of each hierarchy of objectives (see Table 3-1), which consists of the hierarchy and description of objective, measurement indicator, measurement method (source of data), and risk and assumption.

(1) Hierarchy and content of objective, i.e. the specific content of various hierarchies of objectives should be clearly described. Take for instance the overall goal of "carrying out the project of reproductive health and family healthcare services", the overall goal can be "improved level of reproductive health and family healthcare among households" or "improved level and capabilities of health and family planning service institutions in carrying out the project of reproductive health and family healthcare services." Under the overall goal, project objectives (effects), outputs (achievements), activities and input assurance should be elaborated in a step-by-step manner. For different stages of work, various hierarchies of objectives may have different focuses and the prioritization of objectives may vary as well, yet the objectives and goals must be clear.

(2) Measurement indicator, which refers to the indicators for measuring various hierarchies of objectives. For instance, the incidence of high blood pressure or diabetes among rural middle-aged and elderly population can be used to measure the health level of the middle-aged and elderly; the incidence of common gynecological diseases can be used to measure the reproductive health level of woman; the satisfaction ratio of the general public for the reproductive health and family healthcare services provided by the health and family planning service institutions can be used to measure the performance and capabilities of service institutions, etc. For some items, the level of their achievement cannot be reflected by one measurement indicator alone. For instance, improved level of family health services for reproductive health among the general public should be evaluated using multiple indicators in an integrated manner.

For each indicator, a "target value" and "timeline" usually need to be identified. Actual value refers to the actually achieved level that has been measured through appraisal and examination upon the completion of project at a certain point of time, and if "actual value" is below "target value", the implication is that the project has fallen short of expected objectives and the lower the actual value, the greater gap there is towards the objectives. Timeline refers to the time for the

measurement of target value or the deadline for the achievement of target value and is usually "upon project completion" but sometimes may also refer to a certain point of time in a project, e.g. "the first year of project."

(3) Measurement method, which is also referred to as the source of data. They include both the method for calculating various indicators (such as equations) and the methods for data collection required in the calculation of indicators. Data collection methods include quantitative survey and qualitative survey. Sources of data should include existing literature information whenever possible. Quantitative data may derive from questionnaires, record of project activities and statistical statements, etc. In recent years, health promotion projects have also introduced many methods of qualitative survey to acquire necessary data and information, such as the inspection of service rules, observation of service venues, interviews with service recipients, as well as interviews with technical service personnel, etc.

(4) Risk and assumption, which many refers to the external conditions beyond the control of project managers and executors. These risks and assumptions may affect the progress and achievements of projects (work) to some extent, which must be taken into account in project design (or the formulation of work plan). Usually, an explorative new project is riskier and involves more external conditions, while it is less risky to popularize experiences that have proven to work well. For instance, the "3×3" approach of family healthcare services is an explorative effort, which involves the following policy risks: whether government policy supports health and family planning service institutions to offer family healthcare services? Qualification or competence risk: whether the institutions that used to be engaged in family planning services have the qualification and capabilities to offer family healthcare services? Financial risk: whether the government guarantees that funds will be available for the implementation of family health promotion activities? Due to regional differences, consideration should be given to whether the experiences of other localities can be applied locally and what are the risks and conditions required. These questions deserve special attention.

Implementation of a family healthcare services project usually requires the joint participation of various departments such as health, family planning, education, civil affairs, women's federation, the youth league and family planning associations, as well as community organizations. Therefore, responsible departments or persons should be identified for various hierarchies of objectives and relevant activities and necessary inputs, and timelines for the completion of tasks should be defined as well. A relatively detailed logical framework matrix (please refer to Appendix 1-2: Format for the Formulation of PDM plan (five-year plan) and Appendix 1-3: Format of Annual Activity Plan) is favorable to the step-by-step implementation and evaluation of services by different sectors.

II. Formulation of logical framework matrix

The logical framework method can be applied to formulate either the project plan for the entire cycle work or project annual plan. Project plan is realized through the formulation of logical framework matrix, which is actually a process for the decision-making of project activities using the scientific approach based on logical framework for the analysis of the causal relationship among various factors related to project work.

1. Logical analysis of the hierarchies of objectives

In formulating a project plan, the first step is to identify the "objectives" to be achieved by the project within project cycle or within the year, and in particular, under the premise of identification of "overall goal", the "project objectives (direct objectives)" to be achieved should be identified in light of local conditions, public demand and self-capabilities; the second step is to consider which "outputs (achievements)" must be resulted in order to accomplish these "project objectives" (direct objectives); the third step is to consider which "activities" must be carried out in order to achieve the expected "outputs (achievements)"; the fourth step is to identify which "inputs" are necessary assurance for the implementation of these "activities." Based on such considerations and the causal relationship among them, these elements can be written into various hierarchies of project objectives in the logical framework matrix, including "overall goal" (macro-level goal), "project objectives" (direct objectives), "outputs (achievements)", "activities" and "inputs", etc. Lastly, logical analysis for these objectives of various hierarchies is conducted repetitively. Project activities are usually rather specific. They can be necessitated by the project itself, required by the general public or referenced from other project regions. Whichever the case, feasibility analysis of the activities must be conducted based on self-capabilities; consideration must be given to which "inputs" are required as assurance in conducting these activities, which include not only human, financial and material includes but the attention of government leaders and policy support as well; analysis should be made to investigate whether relevant "outputs" can be obtained through the implementation of these "activities"; deliberate which expected "project objectives" can be achieved on the basis of these "outputs", while the "project objectives" may provide support to the achievement of "overall goal."

The following paragraphs take the example of project plan for "healthcare services for the middle-aged and elderly" in a county for specific analysis of how to formulate a project plan through the logical analysis of various hierarchies of objectives.

Step 1: identify the "overall goal" of project. Given the problems of inadequate services and poor level of healthcare in this county regarding "healthcare for the middle-aged and elderly population", this county has established the "overall goal" (macro-level goal) of "healthcare services for the middle-aged and elderly" to be "improved status of healthcare services and enhanced level of healthcare for the middle-aged and elderly throughout the county."

Step 2: identify the "project objectives" (direct objectives) of the project. Based on analysis, it has been found that the biggest problem of the healthcare of local middle-aged and elderly population is the "lack of access to high-quality healthcare services for the middle-aged and elderly people." Therefore, this county has identified the "project objectives" (direct objectives) to be "improved health behaviors among the middle-aged and elderly population in XX county within a five-year cycle of project."

Step 3: identify the "outputs" (achievements) of project. Based on the consideration of factors that "promote the health behaviors of the middle-aged and elderly population", this county has identified the following "outputs" (achievements) of project: output 1, to improve the healthcare service capabilities of health and family planning service institutions in the jurisdiction for the middle-aged and elderly population; output 2, to popularize the knowledge about the prevention and treatment of chronic diseases of the middle-aged and elderly population, to promote healthy lifestyles and to enhance health awareness.

Step 4: identify project "activities" that need to be carried out, i.e. to analyze which activities need to be carried out in order to achieve the aforementioned "outputs." The county has identified the following activities that need to be carried out to achieve "output 1": (1) to hold technical service capacity training; (2) to implement supervision and inspection; (3) to conduct self-examination and appraisal. The following activities should be carried out to achieve "output 2":(1) to carry out "caring for the middle-aged and elderly and delivering health knowledge to the countryside" series of activities; (2) to carry out health examinations for the middle-aged and elderly; (3) to enhance the management of chronic diseases; (4) to hold lectures on the prevention and treatment of chronic diseases and knowledge about healthy lifestyles for the middle-aged and elderly; (5) to popularize "health exercises for the middle-aged and elderly."

Step 5: identify the "inputs" necessary for the project. In order to carry out the aforementioned activities, the following inputs must be secured: inputs of personnel, institutions, facilities, equipment and funding as well as leadership responsibilities, relevant supporting policies and the creation of a departmental coordination mechanism. Major project inputs identified by the project county include: (1) supporting medical devices and training apparatus; (2) dedicated project management personnel; (3) provision of office venues and improvement of office venue functions; (4) project funding for gratuitous services and project operation and management funds; (5) costs of printing various publicity items and materials; (6) funds for training and exchange activities, etc.

After the identification of specific elements for various hierarchies of the above objectives, a box chart (Figure 3-3) can be used to firstly include all the elements for various hierarchies of the objectives. Then, the chart can be checked repetitively for 2 or 3 times from the left to the right and from the right to the left to analyze whether their logical relationship is appropriate and to check whether major omissions exist. After repetitive checks and revisions, the chart can be rotated 90 degrees in the anticlockwise direction, i.e. the horizontal chart will be turned into vertical chart and the sequence from the top to bottom of chart will be "objectives, outputs, activities and inputs." These elements in the chart are then migrated to the "objectives, outputs, activities and inputs" in the logical framework matrix, thus completing the formulation of various hierarchies of objectives and their contents in the logical framework matrix.

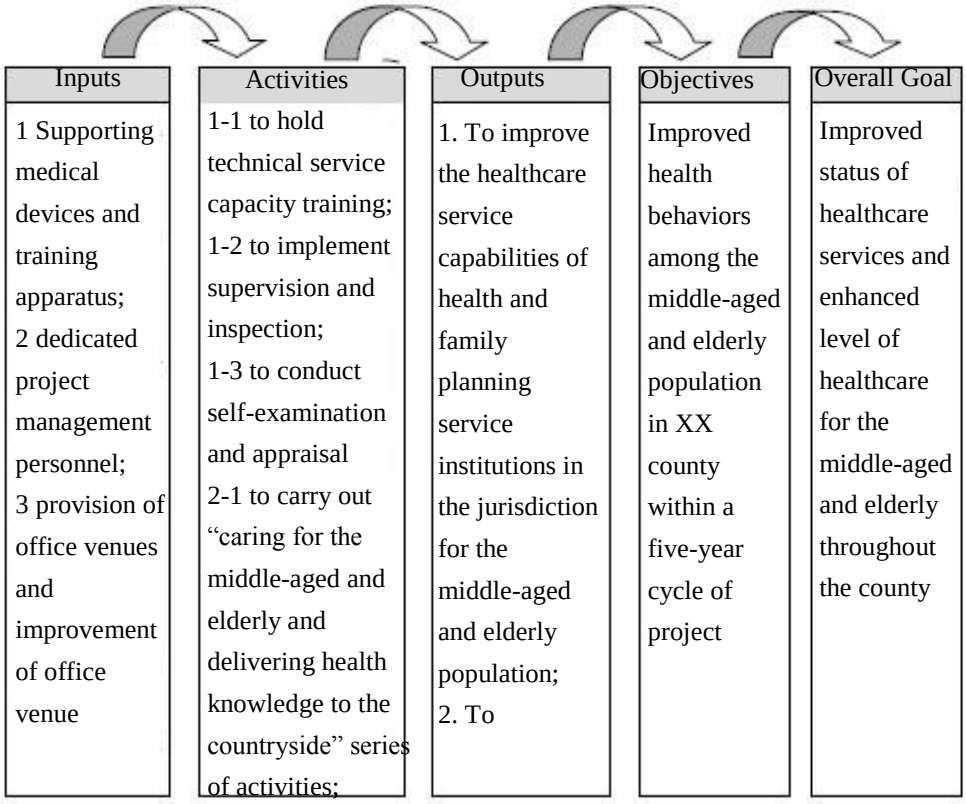

Figure 3-3 Example of the vertical logical relationship (objectives) of health care Project for the middle-aged and elderly in a county

2. Identification of measurement indicators for specific elements of hierarchies of objectives

After the identification of specific elements of hierarchies of objectives, measurement indicators should be determined for each specific element. Measurement indicators are intended to measure whether and how much the specific elements of corresponding hierarchies of objectives have been realized. Take the above-mentioned county for instance, there are five hierarchies of objectives with specific elements and each specific element corresponds to a certain measurement indicators. For some elements, one measurement indicator will be enough, while others require multiple measurement indicators. All these indicators constitute the system of indicators of the project. Under the system of indicators, there is one element at the hierarchy of "overall goal", which correspond to two indicators, i.e.: indicator 1 "incidence of chronic diseases among the middle-aged and elderly population of the county should be controlled below 20%" and indicator 2 "more than 60% of the middle-aged and elderly of the county should receive health examinations"; one element at the hierarchy of "project objectives" (direct objectives), which also corresponds to a measurement indicator "the participation rate of healthcare for the middle-aged and elderly in the intervened group of middle-aged and elderly population should reach 70% on a cumulative basis"; two elements at the hierarchy of "outputs" (achievements), for which 5 indicators have been determined; eight elements at the hierarchy of "activities", for which eight measurement indicators have been identified; six elements at the hierarchy of input assurance, for which seven measurement indicators have been determined. Measurement indicators can be either

quantitative or qualitative indicators but should all be measurable indicators. Even for qualitative indicators, the method of evaluation using these indicators for corresponding elements should be elaborated. For instance, the criteria of "very good, good, average, poor and very poor, etc." can be created to evaluate relevant elements. Take the qualitative indicator "to create such coordination mechanisms as referral system and information interconnection", the scores of five levels including "very good, good, average, poor and very poor" can be assigned.

An indicator value should be determined for each indicator. In order to make this value realistic and both consistent with the requirements of objectives and achievable after some efforts, first, the actual level prior to the project implementation should be assessed accurately, which requires a baseline survey to be carried out to learn about the actual conditions and determine the indicator values on such a basis. In order to facilitate final appraisal and assessment, the respective weights of all indicators can be determined separately. If the total score is 100 points, then the 100 points can be decomposed to various indicators based on the level of their importance and the level of difficulty for achieving these indicators. In this manner, not only should there be an indicator value for each indicator, but the full score for the completion of this indicator value can be determined as well. The composite weight of indicators is normally not addressed in the logical framework. The reason is that such indicators are targeted at the objectives at different hierarchies with different timelines and different responsible persons.

3. Identification of the measurement method of indicators

After the identification of relevant measurement indicators for specific elements of each hierarchy of objectives, the method for acquisition of data necessary for each indicator should be calculated or measured as well. The following measurement methods are common to project evaluation and assessment: consulting literature such as yearbooks, service/activity record, policy literature, etc. and qualitative interviews such as listening to reports and conducting personal interviews, interviews at the end of an activity, door-to-door interviews to households, group interviews, etc., as well as site observations such as the inventory of equipment/facilities and observations of service process, etc., together with quantitative surveys including questionnaires and project statistical tables.

The following principles should be followed in determining the measurement method: simple, easily obtainable, accurate and reliable. Where possible, project existing information should be used and existing data should be acquired. Relevant data and information may also be acquired from other departments.

After the formulation of the logical framework matrix, it is necessary to summarize project activities and arrange them to be conducted in appropriate timeslots. Please refer to Appendix 1 for the format of activity plan for a year developed according to the project logical framework matrix. Prior to the execution of each activity, the implementing plan for each project activity should be designed in accordance with "annual activity plan."

Section 3 Organization and Implementation of Family Healthcare Services

In order to organize and implement family healthcare services, various levels of government and health and family planning departments and their service institutions should carefully fulfill their responsibilities and tasks. In the context of institutional reform, the role of township health

and family planning service institutions should be brought into full play for them to serve as the mainstay in conducting family healthcare services and improving family health.

I. Village (neighborhood) level

Village (neighborhood) level health and family planning networks have the advantage of being close to the general public, which should be brought into play in carefully organizing and implementing family healthcare services activities.

1. Tasks of village (neighborhood) cadres

The primary tasks of village (neighborhood) cadres (mainly referring to village (neighborhood) Party secretaries and directors) include the following:

(1) To provide necessary support of human resources for carrying out family healthcare services by assigning directors of women's affairs or cadres of family planning, village doctors, heads of villager groups, family planning information officers, etc.;

(2) To provide venues for conducting family healthcare services (including venues for the provision of health counseling, health examinations and health lectures, etc.);

(3) Assist in organizing and notifying service recipients while the service institutions provide services.

2. Tasks of village (neighborhood) level family planning cadres, village (neighborhood) doctors and information officers

Under the guidance of township (neighborhood) family planning office and health and family planning service institutions, the village (neighborhood) level family planning cadres, village (neighborhood) doctors and information officers should perform the following activities of the family healthcare services:

(1) Report the service needs of villagers (neighborhood residents).

(2) Distribute health education materials.

(3) Regularly change the content of health education display windows.

(4) Organize villagers (neighborhood residents) to participate in health examination activities.

(5) Provide simple counseling services.

(6) Provide follow-up services to the family under special attention.

II. Township (subdistrict) level

In the context of consolidation between health and family planning systems and service institutions, family healthcare services should focus more on the transitional role of townships

(subdistricts) at the middle level and give play to their advantage of being close to households.

1. Roles and responsibilities of township (subdistrict**) leaders**

Under the guidance of county (prefectural and district) people's government, township (subdistrict) leaders should assume the following roles and responsibilities in the family healthcare services:

(1) Supervise villages and neighborhoods in completing the required family healthcare services activities.

(2) Ensuring the human, material and financial resources and service venues required to be provided by townships (subdistricts) in conducting family healthcare services.

2. Roles and responsibilities of township health and family planning service institutions

(1) Investigate and analyze the health needs and problems of local residents.

(2) Develop the annual plan of family healthcare services and the system for the management of service institutions.

(3) Hold health education lectures.

(4) Carry out health counseling activities.

(5) Organize health examinations for villagers (neighborhood residents).

(6) Report the results of health examinations to villagers (neighborhood residents) and offer health guidance.

(7) Regularly conduct supervision and appraisal of family healthcare services activities at village (neighborhood) level.

(8) Be responsible for the coordination of division of work and cooperation among family planning cadres and service personnel at village (neighborhood) level.

III. County (prefectural or district) level

Counties (cities or districts) are the major executing entities of family healthcare services and assume important roles and responsibilities in coordinating and dispatching resources, formulating service implementation plans, and take in charge of organizing and implementing family health services. They are vital to the success of family healthcare services.

1. Roles and responsibilities of county (prefectural or district) leaders

(1) Formulate the plan for conducting and promoting family healthcare services locally and provide policy assurance.

(2) Secure the human, material and financial resources that need to be provided at the county level for family healthcare services.

(3) Coordinate various government departments in providing family healthcare services

through collaboration.

2. Roles and responsibilities of county (prefectural or district) health and family planning commissions and service institutions

(1) Investigate, analyze and summarize the health needs and problems of local residents.

(2) Formulate county (prefectural or district) family healthcare services plan and annual service plan.

(3) Formulate local family healthcare services standards under the guidance of national standards.

(4) Develop health education materials.

(5) Carry out training and retraining of family healthcare services skills for township (subdistrict) service personnel.

(6) Conduct supervision and appraisal of township (subdistrict) family healthcare project activities on a regular basis.

(7) Jointly conduct comprehensive family healthcare project activities together with relevant government departments.

(8) Be responsible for the coordination of the division of work and cooperation among township health and family planning service institutions.

IV. Provincial (municipal and prefectural) level

Leaders at various levels should develop an in-depth understanding of the significance and effects of conducting family healthcare services. They should bear in mind the overall direction of family healthcare services. Focus on the institutional development of family healthcare services, secure human and financial resources, and develop policies for local implementation of family healthcare services.

The roles and responsibilities of provincial (municipal or prefectural) health and family planning commissions and service institutions mainly include:

1. Formulate the promotion plan of the family healthcare services at provincial (municipal or prefectural) level.

2. Oversee the implementation of family healthcare services throughout the province (city or prefecture).

3. Provide the support of human, material and financial resources in regions where family healthcare services are provided.

4. Organize the development of health education materials.

5. Organize the skills training and further education of family healthcare services personnel.

6. Conduct survey, guidance and appraisal of the implementation of family healthcare services in various regions at least twice a year.

7. Be responsible to organize provincial experts group and give play to their role of guidance in the family healthcare services.

V. National level

During the implementation of the Japan-China Cooperation Project on Family healthcare services, the Department of International Cooperation of the National Health and Family Planning Commission (NHFPC) took charge of the macro-level management of the family healthcare services program on half of the NHFPC, and relevant departments and bureaus of the NHFPC (such as the Department of Family Development) paid great attention and provided vigorous support to the project. The Japan-China project experts group played an important role of guidance and facilitation. For the future implementation of the family healthcare services, it is suggested that the NHFPC give priority attention to the following:

1. Advocate the concept and methodology of the family healthcare services at the national level and promote the exchanges and cooperation among various relevant departments and bureaus;

2. Continue to cooperate with international organizations including the JICA to promote the popularization of the family healthcare services on a wider scale;

3. Improve the catalogue of family healthcare services, management guidance and service handbook, and guide the family healthcare activities in various regions;

4. Incorporate family healthcare services into the “healthy China” and family development plan, and promote the application of the results of family healthcare services;

5. Organize survey, supervision and appraisal activities for the implementation of family healthcare services in various regions;

6. Continue to give play to the guiding role of the national experts group for the family healthcare project.

Section 4 Supervision, Self-inspection and Evaluation of Family Healthcare Services

After the formulation of family healthcare services plan using the logical framework methods, family healthcare services will enter into the stage of implementation. In this stage, continuous attention should be paid to such questions as the effectiveness, efficiency and appropriateness of activities. For instance, whether service activities have been carried out smoothly? What are the problems? How to conduct the services in a better way? Whether some minor adjustments need to be made to the service plan? In order to answer these questions, it is necessary to conduct the supervision, self-inspection and evaluation of the process of service implementation. Therefore, in order to achieve results for family healthcare activities, supervision, self-examination and appraisal during the implementation stage of service activities are vital.

I. Supervision

1. Definition of supervision

Supervision refers to the management activity to inspect, urge and guide the implementation process of family healthcare services on a regular and sustained basis to learn about the status of service progress.

2. Roles of supervision

Supervision serves the following roles: (1) learn about whether the progress of family healthcare services is smooth and what problems exist through the inspection of the status of service implementation; (2) urge the implementation of service plan and promote the implementation of various activities according to the plan; (3) analyze the causes of problems existing in the process of service implementation and guide the work of project sites; (4) learn about the implementation status of service plan and consider whether it is necessary to adjust service objectives and activities.

3. Scope of supervision

The scope of supervision for family healthcare services mainly covers family healthcare services activities and also encompasses the management of service inputs and activities. In family healthcare services, the scope of supervision includes: (1) supervision and assessment of service management; (2) supervision and assessment of service capacity building; (3) supervision and assessment of services, etc.

4. Methods of supervision

Methods of supervision include quantitative survey and qualitative survey methods. Quantitative survey methods mainly include statistical statements of service activities, questionnaire surveys, financial ledgers of services, etc.; qualitative survey methods include literature enquiry, site observation, meeting and individual interviews, etc. Meetings and interviews can be held respectively for service management personnel, service personnel and service recipients.

5. Steps of supervision

Supervision should follow the principle of “openness, justice and fairness”. Steps of supervision include: (1) establishment of supervision working group (experts group); (2) formulation of supervision work plan; (3) supervision of service sites; (4) drafting of supervision report; (5) feedback of supervision results to project sites, etc.

6. Tools of supervision

In order to enhance the supervision of family healthcare services, the Japan-China experts group of the Project developed the Evaluation Form for Site Supervision of Family healthcare services (see Appendix 2), which consists of three forms and one site assessment report. It can be used for the supervision of daily service activities or the evaluation of service effects.

The first form is “Management Supervision and Assessment Form”, which is used for the supervision and appraisal of the status of service management. The following elements of supervision are involved: institutional progress of family healthcare services, service management activities, supervision and guidance of services, service funds and management, service equipment management, etc.

The second form is “Service Capacity Building Supervision and Assessment Form” which is mainly used for supervising the participation of various project regions in the national-level trainings and the implementation of retraining activities after back to project sites. The following elements of supervision are involved: participation in national-level trainings, organization of retraining, status of capacity building, etc.

The third form is “Service Supervision and Assessment Form”, which is mainly for the supervision of service facilities and staffing, the scope and effectiveness of services. The following elements of supervision are involved: service environment and facilities, service capabilities, provision of service and service effectiveness, etc.

Supervision and assessment many take the following methods: service information enquiry, site supervision, interviews and questionnaires. Supervision and assessment team will complete the scoring of three forms according to the status of site assessment and calculate overall score. Each form has 100 points and the three forms have a total score of 300 points; in calculating the overall score, the weight of Table 1 is 35%; the weight of Table 2 is 20%; and the weight of Table 3 is 45%. Overall score of 60 is borderline; 70 is pass; 80 is good; and above 90 is excellent.

After the end of each site supervision and assessment activity, the Report of Family healthcare services Site Assessment (refer to Appendix 2) should be drafted to describe the execution of service activities, summarize achievements, experiences and highlights, take stock of the problems and difficulties existing in the services, and propose opinions and suggestions on the next stage of work. After the completion of supervision and evaluation activities, the results should be reported to various project regions together with specific and practical guiding opinions on the work of project.

II. Self-inspection

Self-inspection is an evaluation conducted on one’s own initiative for a relatively short cycle, which helps identify and resolve problems encountered in the service process on an early date and facilitate the rollout of services in a more effective and efficient manner.

1. Definition of self-inspection

The implementation of a project cannot be accomplished by individuals alone and requires the joint efforts of the project as a whole. No matter who is specifically in charge, the service plan formulated for the project as well as the objectives, activities and expected results must be accomplished under consistent understanding. Therefore, it is all the more important for the persons in charge of service planning and implementation to carry out self-inspection and to communicate the background, intentions (objectives) and processes of the service clearly and unmistakably to each and every service personnel. What may achieve the above is self-inspection. In addition, through a relatively short cycle such as quarterly, biannual or annual appraisal, activities that failed to bring about expected results can be rectified or adjusted in a timely

manner.

2. Effects of self-inspection

Self-inspection serves the following effects:

(1) Confirmation of achievement: to confirm the status of service progress through self-inspection of service activities carried out at project site, which helps assess whether daily service activities can be successively carried out.

(2) Necessity for the adjustment of follow-up activities: to learn about the progress of achievements and results that have been made and to adjust future plan on such a basis, so as to continuously improve the quality and effectiveness of activities.

(3) Justifications for the performance of departmental duties: project implementation is one of the tasks of administrative authorities, which should explain the scope and results of project implementation to the general public. Meanwhile, employers and superior authorities should also demonstrate that their work is intended to contribute to the benefits of the general public, while self-inspection provides the science-based justifications for assuming such responsibilities.

3. Scope of self-inspection

The scope of self-inspection is to confirm the status and results of project activities carried out in accordance with the five-year plan (PDM) and annual plan. Confirmation should be made mainly based on the following three perspectives:

(1) Validation of actual results: "what objectives have been achieved through the implementation of project activities" and "is the status of completion good?"

(2) Validation of implementation process: "what happened during the completion process" and "what are the impacts of the incident that occurred?"

(3) Validation of causal relationship: "whether the completion of objectives is indeed caused by project implementation?"

Based on the above perspectives, the family healthcare project developed the format of evaluation form (refer to Appendix 1-4: Format of Annual Activity Report) for the self-inspection of the following elements: (1) annual objectives and completion of achievements; (2) implementation status of annual activities; (3) problems that exist and their reasons as well as mitigation measures; (4) relatively successful annual activities and analysis of key factors of success; (5) vision for policy improvement; (6) current status of completion in comparison with the initial version of five-year plan; ⑦ identification of the direction of each activity based on the analysis of this year's problems and success factors. Design of the evaluation form ensures that the current status of self-inspection can be monitored and that actual results and implementation process of the analysis can be validated. In addition, the five-year plan and annual plan are designed on the basis of the logical framework as the basic structure, so that the causal relationship of activities→results→objectives can be validated through the pro forma structure. Meanwhile, the evaluation form is formatted in a way that allows the self-inspection results

arrived at through the above-mentioned validation to be fed into the annual plan of the next year. That is to say, as long as self-inspection is conducted according to this format, the PDCA cycle can be utilized to achieve project management.

4. Methods of self-inspection

At the end of each year, the family healthcare project should validate the completion of activities and results of the year following a fixed format in line of the aforementioned "scope of self-inspection". The self-inspection should be conducted at least once a year or may also be carried out on a biannual or quarterly basis.

5. Steps of self-inspection

Specific steps of self-inspection include the following: (1) collect quantitative data of the performance of relevant activities through the collection of family healthcare services records and questionnaires according to the indicators prescribed in the five-year plan and annual plan; (2) hold a meeting or seminar with relevant project personnel to validate project implementation process and the causal relationship between activities and results and summarize them as qualitative data; (3) validate the progress of the five-year plan project and report the results of self-inspection, adjust the five-year plan, and formulate the annual plan of the next year that reflect the results of evaluation.

III. External appraisal

External appraisal is different from project supervision in the following ways: project supervision is an activity that is carried out on a regular and sustained basis in the process of project implementation and mainly aims to figure out whether the project is progressing smoothly; the status of completion of each project activity, risks encountered, analysis of whether follow-up activities can be carried out smoothly and which adjustments are required, whereas project appraisal is the inspection and acceptance of the results of project performance or outcomes of a certain stage, which mainly aims to learn about whether the project is successfully completed according to the plan and whether project objectives have been achieved. External appraisal includes the appraisal directly carried out by superior-level agencies or project experts (sometimes conducted simultaneously with supervision) and third-party appraisal implemented by external agencies.

1. Appraisal by superior-level agencies or project experts

Appraisal by superior-level agencies is a form of comprehensive assessment and appraisal conducted by superior-level health and family planning departments for the implementation status of family healthcare project in the project region. The superior-level competent authorities put together an appraisal team consisted of the leaders of competent authorities and primary responsible persons of departments and relevant experts. Sometimes, the superior-level authorities will authorize project expert team to take charge of the appraisal task on their behalf, which result in the appraisal by expert team. The appraisal is conducted using supervision sample form (in combination with supervision) or the system of evaluation indicators for regular (such as annual) supervision and evaluation of project activities to record problems that exist; after the completion of the appraisal activities, appraisal results will be reported to localities and suggestions for improvement will be made. Specific improvement plan and measures should be jointly discussed

with local project management service personnel, responsible persons should be identified, and the implementation of various measures should be put under supervision.

2. Third-party appraisal

Third-party appraisal is a comprehensive appraisal conducted by professionals outside the health and family planning department for the implementation status of local family healthcare project. Such a form of appraisal can avoid the interpersonal conflicts within the industry, so that the process and conclusions of appraisal are fairly objective and justified. In conducting third-party appraisal, the external agencies and personnel may not be very familiar with the specific content of activities, appraisal criteria and the scope of appraisal. Therefore, various information, data and materials about the project must be provided in order to ensure the accuracy and authenticity of appraisal.

IV. Service appraisal with household participation

In conducting appraisal activities, household opinions and science-based discussions should be involved. Thus, a project appraisal committee consisted of household representatives and experts should be created. The committee should hold meetings to summarize the opinions that reflect the needs of households and the directions of future project development base on the actual performance of project, status of implementation, self-inspection and external appraisal. County (prefectural and district) project offices should draft the scheme for formulating healthcare plan of the next phase while taking consideration of the opinions of the project appraisal committee, self-inspection and external appraisal, etc. And determine the next year's scheme of the annual plan after the approval and recognition of the county (prefectural and district) project steering committee,.

Meetings of project appraisal committee with household participation should preferably conduct appraisal according to the classification of service recipients. In this case, however, the appraisal meeting need to be held for several rounds, which appear to be complicated. Therefore, it may also be considered to combine the appraisal meeting with the participation of various recipients or a joint appraisal committee can be formed to conduct overall appraisal for the family healthcare project as a whole.

V. Application of appraisal results in the annual plan of the next year

Reflecting the appraisal results into the formulation of the service plan for the next year aims to further improve the family healthcare services level of service institutions in the next year, so that the results of appraisal will not only be used to simply mark the end of administrative internal project appraisal. Therefore, apart from self-inspection conducted each quarter, it is recommended that an external appraisal and appraisal committee meeting with the participation of household representatives to be held prior to the formulation of the plan for the next year, i.e. summer or around autumn.

In addition to including such elements as the revision of service plan into the healthcare service plan, the provincial or municipal-level project office should also provide guidance to its project region (city or district) when appropriate base on the result of self-inspection and

supervision. Meanwhile, the guidelines and measures for the implementation of family healthcare services in the province or city as a whole should be discussed and based on the comments and opinions of external experts and household representatives, a report should be submitted to the provincial and municipal project steering committee for its approval.

Based on the reports of project provinces or cities as well as the results of supervision on project regions (cities or districts) and expert opinions, the NHFPC will further revise and improve this Guidance, explore the environment that should be created for the rollout of family healthcare services on a nationwide scale, and strive to manage and improve such an environment.

Chapter 4 Assurance Mechanism for Family Healthcare Service

Section 1 Quality Management Mechanism for Family Healthcare Service

Quality management for family healthcare service refers to the management measures taken to further improve the quality of service during the process of delivering family healthcare service.

I. Quality management of health education activities

As mentioned in Section 4 of Chapter 1, health education is not only the transmission of knowledge and information and its ultimate goal is to create and maintain the knowledge, attitudes and behaviors conducive to health, i.e. the motivation, technique and self-confidence required for the improvement of health.

The basic framework for the Japan-China Cooperation Project on Family Healthcare is the 3×3 framework encompassing health education, examination and counseling for children, adolescents, population of reproductive age and the middle-aged and elderly. Thus, the target groups of health education are classified by age, gender and place of residence. Among the three methods of family healthcare service, health education is the most extensively and frequently employed method. Health education normally takes the following two forms: first, comprehensive health education conducted at the site of family healthcare service, usually in the form of lecture; second, daily health education, which is often carried out through various types of public media. Whichever the method, the principle that health education should transform or create the knowledge, attitudes and behaviors of target families and individuals must always be followed, and the quality control of health education activities should be considered proceeding from this principle as well.

The preceding chapters of this Guidance have described the procedure of family healthcare service. It is suggested that the quality control of health education activities be considered in light of these procedures.

Designing the plan for health education activity is the first step of quality control, in which the first task is to identify the target group for a health education activity. According to the actual project implementation to date, the target groups for family health services are primarily healthy or sub-healthy populations identified by age, gender and place of residence. After the identification of target group, the theme of health education activity should be determined. For quality control, it is normally recommended that only one theme should be selected for a health education lecture and that in conducting health education using public media, a theme should be highlighted as well. The third factor of quality control at this step is the forms of health education activities, which should be utilized in different situations to highlight their respective advantages. Different scopes and methods of health education should be selected according to different types of target groups.

The second step of quality control for health education activity is the preparation of instructors, courseware and health education materials. In this area, relatively abundant experience has already been gathered in project activities carried out to date and some specific practices may continue to be attempted and followed to gain more experience, e.g., pre-test, trial lecture, use of

pictures, texts and plain language, use of local dialect, etc.

Implementation of health education activity is the third step in quality control. No matter in the form of lecture or other forms, an appropriate environment should be in place to ensure the quality of health education activity.

The fourth step of quality control is the appraisal of the effect of health education activity. In fact, the design of activity plan in the first step should include the appraisal process. In the health education activities carried out to date, great attention has already been paid to quality control of process indicators such as the number of activities carried out, the number of people taking part in activities, the quality of health education materials distributed, etc. Attempt has also been made to use questionnaires for the appraisal of the effects.

Certain special surveys may be required to measure the transformation of the knowledge, attitudes and behaviors of target groups through the execution of health education activities, e.g. regular follow-up survey after project implementation. Comparatively speaking, this appraisal method can better reflect the transformation of knowledge, attitudes and behaviors, etc. of target groups. Improvement and adjustment of health education activity based on appraisal result is the most effective form of quality control.

Health education can be understood under the perspective of healthcare service for the middle-aged and elderly in Japan: the plan of health education should be designed according to the result of health examination, so different methods of health education will be adopted with different results: the first method is to provide health information only; the second is to conduct face-to-face health guidance (to inspire the health awareness of target group); the third method is to provide continuous health guidance for a duration of 3 to 6 months. If those with obesity and thus particularly need to lose weight and do exercises are identified as the specific target groups of health education, it will be very difficult to change their behaviors through one particular activity of health education, and continuous individual health education program should be planned and carried out once every three months for a duration of one year (including health education and health counseling). In a nutshell, the scopes of health educations should be catered to different types of target groups.

II. Quality management of health examination

Priorities for the quality management of health examinations include the selection of health examination items (scope) based on project objectives, accuracy management of health examinations, feedback and tracing of health examination results, etc.

First of all, although health examination may reveal the basic facts about bodily functions, screen diseases and help assess the severity of diseases, the items (scope) of health examination should be limited to the minimum scope necessary to achieve project objective. Despite the benefits, more items and broader scope of health examination will also bring about many problems, e.g. rising cost, more personnel required, and increasing workload of feedback to examinees. Moreover, the greatest concern is the psychological and economic burdens that may be brought to examinees by the potential occurrence of false positive results of examinations. Hence, the project offices of project regions should determine the items of health examinations according to this Guidance and Service Handbook.

The following paragraphs present a list of government-related health examination items by age groups in Japan for reference only. The scope of health examinations of the pilot regions should be determined according to the guidelines of relevant Chinese associations and regional conditions.

(1) Unmarried men and women of reproductive age: in Japan, there is no similar practice of premarital and prepregnancy examination system that has been followed in China.

(2) Pregnancy: gynaecological examination, measurement (height, weight, waist, fundus height of uterus, blood pressure), uroscopy (glucose, protein), blood examination (blood type, haemocyte, blood glucose, hepatitis examination, HIV examination, syphilis, rubella, HTLV-1 antibody examination, genital chlamydial infections, group-B hemolytic streptococcus), ultrasonic inspection, and cervical cancer cell examination.

(3) Newborn infants, babies and children: outpatient examination, measurement (height, weight, head circumference, chest circumference), mass screening of newborn infants (phenylketonuria, maple syrup urine disease (MSUD), homocystinuria, galactosemia, congenital thyroid hypofunction, adrenal cortex hyperplasia), hearing test for newborns (AABR test), dental examination.

(4) Children and adolescents: outpatient examination, measurement (height, weight, sitting height, vision and hearing), uroscopy (protein, glucose), electrocardiograph and parasite inspection.

(5) The middle-aged and elderly: outpatient examination, measurement (height, weight, abdomen circumference, blood pressure), uroscopy (urine, protein), blood examination (neutral fat, high density lipoprotein cholesterol, low density lipoprotein cholesterin, liver function (AST, ALT, -GT), fasting blood glucose or HBA1C, electrocardiograph (optional), blood count (optional), cancer examination (stomach, lung, large intestine, uterus, breast).

Then, the accuracy management of health examination can generally be divided into the accuracy management of diagnosis and examination method and the unification of assessment criteria for health examination.

For the accuracy management of physician’s diagnosis, it is necessary to take relevant measures such as the formulation of the standard handbook of diagnosis procedure and the execution of training for its application, so as to avoid different diagnostic results among physicians. Accuracy management of examination method includes internal accuracy management and external accuracy management. Internal accuracy management is carried out within service institution and conducted through the formulation of standard procedure handbook and the validation of regular measured value of standard sample delivered for examination. External accuracy management aims to verify one’s own examination accuracy through comparison with other health examination institutions, i.e. some health examination institutions or administrative institutions take the lead in conducting the testing of standard samples delivered for examination and comparing examination results. While it is important to conduct internal accuracy management for the implementation of daily services within health examination institutions, it is also important to carry out external accuracy management among various health examination

institutions. If external accuracy management is insufficient, even for the same sample delivered for examination, the results obtained by health examination institutions may vary as well. Thus, even with the same assessment criteria, different diagnostic results are still likely to be obtained, which have significant negative effects on examinees.

Internal accuracy management of physician's diagnosis and health examination institutions can be conducted by various service centers and service stations as service implementing agencies under the assistance of project offices in project regions. If necessary, support may be extended by the relevant departments of provincial and municipal family healthcare projects.

The unification of assessment criteria for health examinations should be, in principle, based on the guidelines formulated by relevant departments and bureaus of the National Health and Family Planning Commission (NHFPC) and various national-level associations. These criteria should be selected by the NHFPC and cascaded by the relevant departments of family healthcare projects at provincial and municipal levels to grassroots service institutions.

The third task is to communicate with examinees on results of health examination and such feedback may be graphically presented in order to make it clear and understandable. In Japan, visually striking weather forecast symbols are used in communicating the results of examination. The feedback should be made in considerations of service recipients and efforts should be made to make the results easy to understand. After the feedback of health examination results, it is necessary to trace the actions that are taken by the examinees after receiving such examination results. If the examinees are required to receive precision examinations or seek treatment yet they have ignored such a requirement and do not receive any precision examinations or treatment, health examination will be useless. Hence, equal importance should be given to health examination and follow-up activity.

Moreover, attention should also be paid to the factors affecting the result of health examination. For instance, due to lack of attention to or misunderstanding of certain key process of health examination, various omissions could be made and thus prevent the achievement of health examination objective. Importance should be attached to the timing of some items of examination. For instance, if the timing of blood sampling is too late, the impact of physiological endocrine hormones can cause distortions in the fasting blood glucose. Arbitrary alteration of examination items, e.g. some examinees skipped digital rectal examination because they felt troublesome or bashful to do it and thus could miss the best opportunity for the early diagnosis and treatment of rectal diseases such as rectal cancer. While some examinees carefully completed the health examination, they overlooked the results of examination. They did not receive examination results or carefully read and respond, making the health examination meaningless. It is very important in the management of health examination to pay attention to the details, urge examinees to complete all examination items and take the examination results seriously.

Based on the above views, appraisal of health examination is not only an appraisal of the number of examinees, number of patients and the discovery rate of diseases. More importantly, the appraisal should focus on the attendance rate of precision examination and the effects of health examination results on the examinees.

For output indicators, in addition to the number of outpatient attendances, the ratio of outpatient attendance, the number of examinees found with diseases and the ratio of disease discovery, consideration may also be given to such indicators as the time of result notification, the

ratio of attendance requiring precision examination, and the ratio of attendance requiring treatment, etc. As for indicators of final effects, mid-and long-term indicators may include such indicators as smoking ratio, drinking ratio and blood pressure measurement frequency that reflect the change of behaviors.

III. Quality management of health counseling

The difficulty of quality management for health counseling is how to make the service scope of health counseling for relevant departments responsible for family healthcare projects and the service scope expected by residents seeking health counseling coincide. Furthermore, family members also include persons in different stages of full life-cycle from newborn infants to the elderly. Given the health status of people in different age groups, individualized health counseling should be provided to them, which is also an important factor in the quality management of health counseling.

Health consulting varies in terms of the scope and depth of service. Some counseling is targeted at simple health questions, which can be addressed simply by providing relevant information. Other health counseling activities, e.g. for the weight control of those with obesity, apart from providing information, health guidance for the combined change of understanding and behaviors should be offered. For women with unintended pregnancy, health guidance (including psychological counseling) should be offered to care for their physical and psychological health. Health counseling is a process of two-way communication between service providers and recipients and should help service recipients to express their questions or concerns and enable them to make informed choice. In this process, service personnel must be qualified and capable. Health counseling provided by unqualified personnel is more harmful than beneficial.

First of all, it is necessary to carry out a comprehensive appraisal of personnel competence, the implementation status of training for capacity improvement and the scope and competence of health counseling required in the future. Over the course of project implementation, the service personnel of various project sites have made some progress in interpersonal communication and counseling skills, so that in addition to health counseling and reproductive health for women of reproductive age as the primary target group for the former family planning service institutions, they may also be able to offer counseling for the reproductive health problems and bad lifestyles of children, adolescents, the middle-aged and elderly populations. Nevertheless, further improvement is still required to enhance counseling skills and the abilities to change the behaviors of service recipients through counseling.

For instance, if a service institution had been engaged in the service area of family planning for people of reproductive age, it may provide integrated health counseling for people of reproductive age including physical and psychological care. If the service institution lacks the service experience for the middle-aged and elderly (such as care for the elderly population with ageing, dementia, etc.), it would be difficult for it to immediately offer health counseling for the middle-aged and elderly. In this case, therefore, it should focus on health counseling mainly by providing information before taking steps to conduct training to enhance the counseling capability of service personnel. Under the new situation of institutional consolidation, it is also very important to integrate and utilize the resources of the former maternal and child healthcare centers

and enhance the all-round counseling capability of service personnel.

Hence, the first step of quality management for health consulting is to evaluate the scope and competence of health counseling currently offered by relevant departments of family healthcare projects in project regions (including service centers and service stations) and on this basis, identify the appropriate recipients and scope of health counseling based on project objectives and existing capabilities. For counseling service that cannot be offered due to currently inadequate capability, instead of simply putting them aside, cooperation with appropriate counseling institutions should be pursued to extend counseling services to these institutions. In this case, attention should be paid to avoid the dilemma where service recipients are left unattended by both sides. In providing the counseling, attention should be also paid to the classified counseling according to the health status of individuals. For healthy populations, guidance should be given to promote healthy lifestyles, maintain healthy bedtime, suggest rational diet and nutrition, encourage appropriate physical exercises, help adjust unhealthy emotions and alleviate psychological pressures, avoid contact with health hazards and refrain from salty and sugary food. For sub-healthy populations, counseling should be offered to guide them to pay attention to high-risk factors, exclude the factors to promote health recovery. For instance, for sub-healthy populations resulted from insomnia, guidance should be offered to adhere to regular bedtime, avoid staying up, adjust mentality and reduce their psychological pressures, and if necessary, they may be referred to medical institutions for the auxiliary treatment of medicines. For populations with diseases, they should be guided to seek appropriate medical diagnosis and treatment or recommended to be referred to medical institutions of superior levels for treatment.

As for the appraisal of health counseling, different perspectives of appraisal will necessitate different methods. For health counseling for individuals or families, if the result of counseling service is undesirable, the problem could be either with the service level of counseling or the wrong choice of service content. It may also be due to various other reasons such as the refusal of service recipients to cooperate. Thus, in offering the service, each and every case should be carefully deliberated in order to identify the “reason why the questions have been resolved or left unresolved, why the service cannot be offered and whether other options exist”, etc. Constant research and accumulation are required (which is also a process of self-appraisal).

Such research and accumulation for different situations made the quality management of health counseling projects possible. The following may be considered to be adopted as the appraisal indicators and inputs of health counseling service: complete facilities (e.g.: setup of counseling room), number and qualifications of counseling personnel, etc. Output indicators may include: number of counseling attendances (new counseling and continuous counseling). The aforementioned indicators may not reflect the study result of each and every case that is accumulated, yet it is important to summarize the result of each case as indicators of final effect. Effect indicators may include the persistency rate, completion rate, improvement rate, etc. Appraisal of counseling service is not carried out immediately after the end of counseling service but conducted after a certain period of time according to the status of service recipients and their families, taking into account such indicators as the resolve rate and persistency rate, etc. However, appraisal on those who have received health counseling services as recipients may cause the negligence of relevant information of those who have not received those services. Therefore, it is difficult for such appraisal to be totally accurate. In the desirable situation, appraisal should be conducted for populations including recipients and non-recipients of counseling services at regular intervals to assess their awareness, needs and expectations. Appraisal should be implemented by

the health and family planning departments of project regions. Appraisal requires a certain degree of the accumulation of results, which means that the adjustment of project objectives based on appraisal results should also take into account of the long duration of accumulation.

Section 2 Training Mechanism for Family Healthcare Service

I. Training of family healthcare project

Training of family healthcare project is a systematic training activity carried out with a view to improving the knowledge, skills, attitudes, competence and performance of service and management personnel according to the objective and requirement of family healthcare service. The primary objective of training is to enhance the following capabilities of family healthcare service and management personnel at national, provincial and municipal as well as county and township levels: policy advocacy and coordination, formulation of overall planning for family healthcare service and specific service plan, family healthcare service/project management, training organization capability, and technical capability for family healthcare service.

II. Training management and training procedure of family healthcare project

Training of family healthcare project takes the following three forms: first, project training carried out at the national level; second, retraining conducted at each project site after the implementation of national-level training; third, training activity organized and carried out by individual project site based on needs.

Due to limited training funds and human resources, it is unlikely for training at the national level to cover all personnel of project regions. Therefore, the method of training - retraining is generally adopted, i.e. after the completion of training, trainees will return to project sites to act as trainers and train the rest project personnel to magnify the results of training. Project regions will also dispatch personnel with strong learning, language expression and organizational capabilities to take part in national-level training and ensure that certain stability and continuity of trainees can be maintained. Personnel participating in the national-level training should carefully participate, fully communicate with other trainees and trainers and master the knowledge of training.

In order to implement the training more effectively, it is necessary to enhance management over various aspects including demand survey, formulation of training plan, implementation of training, and evaluation of training result. Such a method of management is applicable to not only national-level training but retraining and other types of training as well.

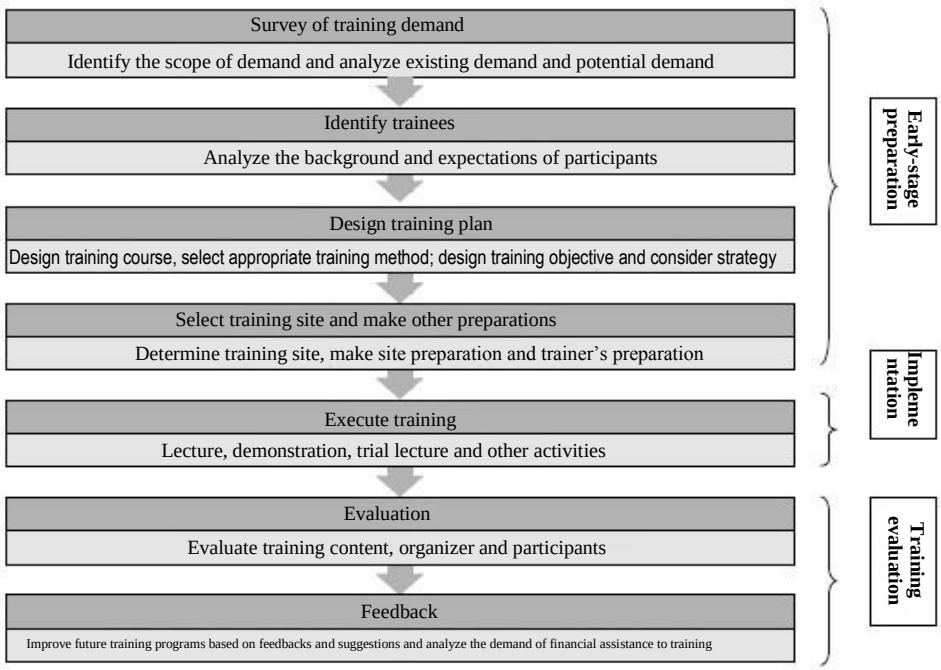

Figure 5-1 Procedure of training activity①

III. Effective training method

An effective training method should include the following components:

1. Survey of training demand

In order to learn about the needs of training activities, it is necessary to conduct a survey on training recipients through such means as questionnaires and face-to-face interviews. It is important to identify the problems that are confronted, inadequacies and demands of trainings and fully listen to the opinions and intents of the target audience of training. Organizers of training should assess the necessity of conducting training activities from the following aspects.

(1) Whether problems arising from the lack of knowledge and skills exist.

(2) Whether the dilemmas facing the target audience of training in their daily work need to be resolved through training.

(3) Whether new knowledge or new technologies have emerged in this area and require professional personnel to learn and acquire through training.

Through such a process of discussion, the knowledge and technologies that need to be involved in training activities can be identified to achieve better results.

2. Objective and target of training

It is very important to make the specific objective and target of training understood by the trainees. The objective cannot be too general and target cannot be too high and should be designed in a

① Refer to the training handbook of the JICA China Vaccine Project

reasonable manner according to training agenda. Training will be more effective if trainees already have an awareness of the problems and objectives upon taking part in the training.

3. Training method

Training can be conducted in various forms and methods including lecture, discussion, demonstration, role play, practice (guidance or apprentice), audiovisual content, and case study, etc. These methods have different features and advantages and should be selected in a rational manner according to the objectives and contents of training, characteristics of trainees and resources (human, material and financial resources). A common form of training is lecture, which is a simple and economical method that may cover a great number of trainees. However, one-way teaching may restrict communication and inevitably hamper the effect of training (see Figure 5-2). Therefore, the combination of various methods should be used in organizing training activities to ensure effectiveness.

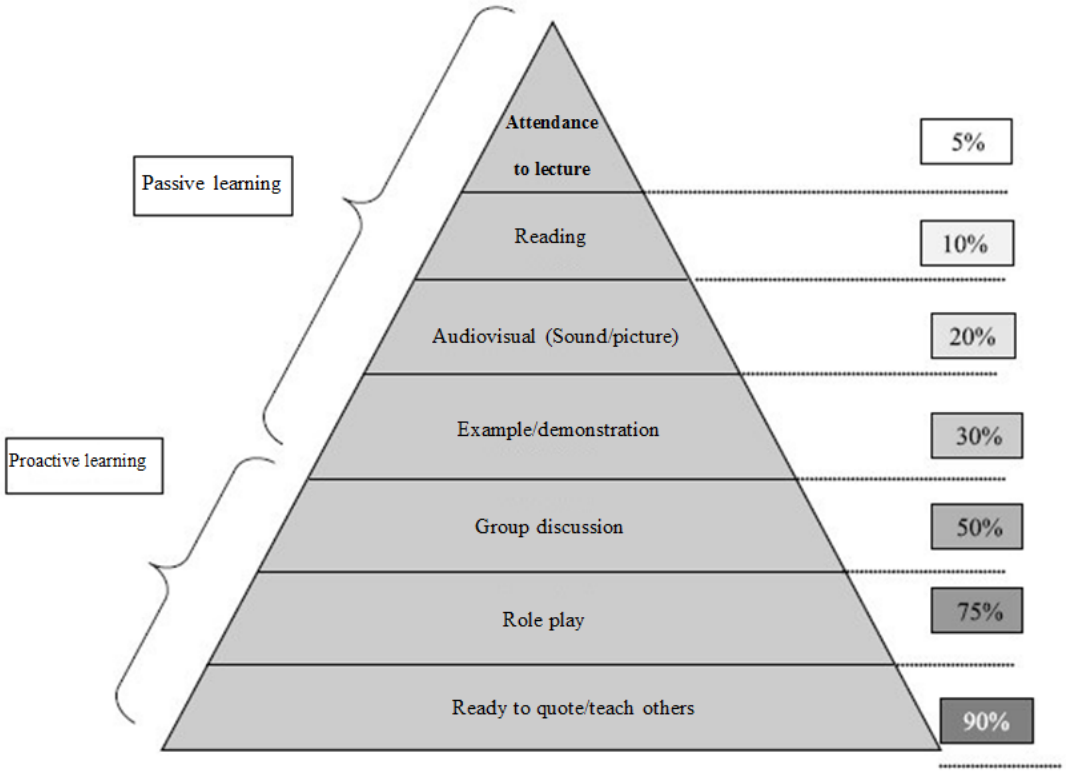

Figure 5-2 Learning pyramid[①]

"How much can be remembered two weeks after learning of various forms?"

In the project, combining training with discussion is a common and effective method. As can be seen from the learning pyramid, group discussion is also an effective method. The reasonable size of a group should be 6 to 8 members since the atmosphere may not be lively if participants are too few while it would be difficult to reach agreement and keep order if the group is too large. In addition, if consideration is given to different backgrounds and positions in the selection of

① Referenced from the National Training Laboratories, Maine of the United States.

team members, discussions will be less biased and will reach better results. Before a discussion starts, the members of a group should be respectively assigned chair group discussion, make discussion records and publish the results of group discussion. In addition, all group members should be aware that each and every participant has the right of equal communication and regardless of their views, and other members cannot be prevented from expressing their views or criticized for doing so. The atmosphere of free discussion should be respected.

4. Content of training

The content of training should be determined primarily according to the demand and with sufficient consideration of what problems will be resolved through the training and how much it can be resolved. Where necessary, the demand can be learned about through early stage questionnaires and consultations. The content of training should be organized in a systematic and logical manner.

In the process of project implementation, the first step is the formulation of training plan, followed by the implementation of training on family healthcare service for different target groups (children and adolescents, population of reproductive age, the middle-aged and elderly) and with different methods of family healthcare service (health education, health examination and health counseling) in accordance with the 3×3 framework. In the late stage of the project implementation, emphasis will be given to the enhancement of training and service capability and the continuous development capacity of family healthcare service.

5. Selection of trainers

Careful selection of trainers is also an important factor determining the success of training. In the same field, many trainers may qualify as candidates and their selection may follow the following consideration.

First, they should be able to proactively communicate, learn about and understand training objectives and demands. Second, trainers should be familiar with the actual situation and have sufficient practical experience. Third, they should have training experience. It is necessary for them "to impart profound knowledge in a simple and easy-to-understand manner". Fourth, in addition to the lectures, the training may also include other forms such as role play to assist understanding and memory and provide trainees with the opportunity to make discoveries.

6. Training evaluation

In order to validate the effects of training, the understanding level of trainees and the change of their behaviors so as to carry out more effective training activities in the future, it is important to carry out comprehensive evaluation after a training activity. Evaluation may be conducted for the following elements.

Item of evaluation	**Description**
Training management	Are the training objectives appropriate and have they been achieved? Whether the setup of training venue, equipment and materials meet the practical needs of training?
Content of	Is the timetable reasonable?

training	Is the theme of training clear? Is the level of difficulty appropriate?
Trainer	Is the delivery of lecture attractive to the audience? Whether the relevant contents have been accurately and effectively imparted within the prescribed time? How is the control of timing and unexpected problems? Have the trainees been fully guided to think and discuss?
Trainee	Have the trainees listened to the lecture carefully and proactively taken part in the discussions? Have their knowledge, skills, attitudes and behaviors been changed?

There are many evaluation methods, including supervision, questionnaire, post-training quiz, role play, site inspection, interview and submission of report. Appropriate methods should be selected according to actual conditions.

Evaluation includes short-term and long-term evaluation. Short-term evaluation refers to the evaluation conducted after the training over the content of training and reception of knowledge to learn about the changes of behaviors and attitudes and improvement of knowledge and skills. On the other side, long-term evaluation will be conducted 6 to 12 months after the completion of training with the purpose to learn about whether the objectives of training activities are consistent with the results of training, whether the relevant knowledge and skills have been fully imparted to the local personnel, whether the training is helpful to the project implementation, how is the appropriateness of the training, whether other training demands exist, etc. The results of training evaluation will be reflected in the future training courses.

7. Training completion ceremony

Sometimes, a completion ceremony will be held at the end of training and a certificate for the completion of training will be presented to the trainee. Although such certificate which do not recognized by any third party may not serve as a certificate of qualification. But it may effectively help to increase the enthusiasm of the trainee. If innovative ideas can be brought to the training completion ceremony, such as asking trainees to say a few words about their training experience and comment, trainees will be left with a deeper impression about the training and will have higher expectations to the future training activities.

V. Training and retraining requirement of the Japan-China Cooperation Project on family healthcare

1. Include independent training and the retraining after national-level training into the project annual plan.

2. After each national-level training, retraining should be carried out within one month.

3. Every region should formulate detailed training plan for conducting training and retraining, which should include the following elements: objectives, content, target population, time and location, trainers, training agenda, logistical preparations and arrangements, training budget, etc. Please refer to Appendix 4 for the format of plan.

4. Training and retraining should have questionnaires separately for trainees and organizers. Questionnaire for trainees should include questions on the design of training course, training content, training materials, time arrangement of training, logistical services as well as trainer's quality and performance; questionnaire for organizers should include the attendance of trainees, proactive participation in the interactive discussions and the evaluation of knowledge reception.

5. Training summary should be made after each round of training and retraining, which should include the following elements: implementation status of training, evaluation of trainees, status of training participation and knowledge reception, difficulties and problems, experiences and lessons, etc. The summary report should be submitted to the Chinese project office of the family healthcare project within 10 days after the completion of training.

6. Project information should be compiled after each round of training and retraining and sent to the Chinese project office of the family healthcare project and published on the project website.

7. Conduct proper management of the archives of training and retraining, which include: training plan, lesson plan, name list of trainees and training photos.

Section 3 Mechanism for the Application of Family Healthcare Service Information

In the management of family healthcare service data, the most important is to achieve the balance between information application and information storage.

Starting with the results of physical examination, the implementation results of various health services should be recorded by the sequence of time and utilized in receiving medical diagnosis, health education and health counseling. This is very useful for the health management of individuals and families (this application method of information and data is hereinafter referred to as the "primary application"). Upon primary application, consideration should be given to not only application by the health and family planning departments but application by medical institutions, which is the most concerned for households. Therefore, it is necessary to carry out coordination and cooperation with relevant departments of the health and family planning commission for informatization works.

Not only can the health status and behaviors of all households be reflected by the individual and family health information and data that have been accumulated, but new family healthcare services can be explored based on the needs of households in parallel to the appraisal of family healthcare service as well (this application method is hereinafter referred to as the "secondary application").

The NHFPC and other agencies developed the *Guiding Opinions of the NHFPC and the National Administration of TCM on Expediting the Information-based Development of Population Health* in December 2013, which identified the direction of the informatization development of population health. Family healthcare projects should also explore information treatment and application towards this direction and base on the status of progress.

Given the correlation between the guiding opinions and family healthcare activities, the development of electronic health records necessities the coordination between the public health system and the family planning system in their respective lines of services. Meanwhile, for the development of information security protection system, relevant measures should be taken according to the principles established by the guiding opinions.

1. Primary application of the information

Primary application of the information not only enables service recipients to learn about his/her previous health status and the reception of services but provides such data and information to the service personnel as well. When it is necessary, appropriate information may also be provided to the personnel of medical institutions.

For the retrieval of previous information or application of service information by other service institutions, the personal coding system should be created and commitments should be obtained from the information users. One method is to use the number of resident identification card (in China, each and every resident over 16 years old has a fixed number of resident identification card). If the information user presents the number of resident identification card and is informed about the retrieval of previous information, he or she can be permitted to use such information. However, in this situation, for the basic and new information and data stored at service locations or other relevant institutions, the method of retrieval must be safe and reliable. Meanwhile, attention must be paid to future IT development and continuous research should be carried out.

2. Secondary application of information

If the information that identifies personal particulars is deleted from the information and data that have been stored, even if such information is accessed by external users, it will not affect individuals. Such information can be used to acquire useful information and data for the overall health assessment of the region, such as the distribution of diseases and health behaviors. Since it is easy to delete the information that identifies personal particulars (numbers of resident identification cards, birthdates, names, etc.) from the original basic data, each county (prefectural or district) should strive to apply secondary information.

If the assistance of experts from research institutions including local universities can be acquired, the health and family planning department of each county (prefectural or district) should adopt multiple methods such as time sequence analysis and interregional comparative analysis to evaluate the health status of the region as a whole and the effects of healthcare project. Such analysis and evaluation can be summarized and published as the basic information for health education, which will achieve very good effects. Apart from the comparison and analysis of the situations of their own project regions (prefectural or district), provincial and municipal health and family planning departments should conduct analysis also in light of the data from other regions and may apply them in the implementing scheme for project development for the whole province or city.

In the specific application and analysis of information, the following method can be adopted to ensure the public interest of information utilization: create a committee for the authorization of information utilization with the participation of household representatives and experts, etc. within a certain area (for instance, create one such committee for each province) to deliberate information utilization.

3. Proactive response from various project implementation entities

The implementation entity of family healthcare service is the health and family planning

departments of each project region (prefectural or district) and therefore, entities for the management and implementation of such information and data should also be those departments. County (prefectural or district) health and family planning departments should not only properly manage the family health service information of their respective regions but should proactively facilitate information application as well. Thus, in addition to learning about the status of information processing, they should also formulate the standard rules and codes of conduction for information recording and storage. Moreover, secondary application of information including basic service information and baseline survey information should also be carried out appropriately, so that such information can be used as the basis for the revision of healthcare plan and the development of family healthcare education materials.

Service centers or service stations should correctly record service information according to the standards formulated by superior-level authorities and transmit information and data to the health and family planning department of each county (prefectural or district) in addition to the compilation and storage of information.

While guiding the information and data management of projects region (prefectural or district), provincial and municipal health and family planning departments should create information application committee to assess whether relevant information of family healthcare stored by each county (prefectural or district) has been correctly applied and confirm the results of assessment in a timely manner. The composition of information application committee should include information users and experts. Meanwhile, with the help of experts, not only should the status of each project region (prefectural or district) within the province be compared and analyzed, comparison with other regions should be made as well to improve the guidelines and plans for the development of local family healthcare service.

Section 4 Input Assurance Mechanism for Family Healthcare Service

Family healthcare service essentially falls into the scope of public service provided by the government. In the course of project implementation, attention should be given to policy improvement, institutional innovation and the regular, mainstreamed, institutionalized and sustainable development of family healthcare service, while an effective input assurance mechanism provides the necessary guarantee and important support for the continuous development of family healthcare service activities. It is also a key element of policy improvement and institutional innovation.

According to the current situation, the following models of input assurance mechanism can be adopted as following:

1. Input assurance dominated by government public finance investment

Given that family healthcare services are public services in great demand with limited investment and high return, local governments have incorporated family healthcare services into the 12th Five-Year Plan and local public welfare projects to provide funding assurance mainly based on the government fiscal expenditure.

Ji’an county of Jiangxi province as a pilot region in the first-cycle project implemented between 2006 and 2009 is a typical example of the aforementioned mechanism. Ji’an county government formulates an annual plan for the population and family planning department to carry

out family healthcare service and pay relevant funds according to the actual quantity of service from the county finance. After the completion of project implementation stage in 2009, Ji'an county continues receiving government funding assurance to carry out family healthcare services.

Meanwhile, the project implementation entities of many project sites have incorporated family healthcare services into their daily work from different angles (such as high-quality service, benefit-oriented, etc.). For instance, pilot regions of the second-cycle project Zengdu, Beibei, Rongchang etc. have allocated certain amount of their working budgets for the implementation of family healthcare services. For instance, coordination with relevant departments and project townships has been carried out through certain mechanism to secure funding support.

Each level of project regions (provincial, municipal and county governments) also provides certain matching funds to support project implementation.

2. Government procurement of special services

With China's ageing population, government procurement of special services is mainly reflected in the procurement of family healthcare service for seniors. In many parts of China, the government has issued policies to provide family healthcare service such as health examination for seniors over 60 years old from the households that have followed the family planning policy. For instance, in Changzhou city of Jiangsu province and Chengmai county of Hainan province, the government funded and contracted family planning service institutions to offer family healthcare services for local senior citizens.

3. Input assurance for the benign cycle of family healthcare and service revenues

Implementation of family healthcare service has boosted service revenues, which are used to provide health education, counseling and free services of basic examinations. After the implementation of family healthcare service, the service revenues of project sites have improved to different degrees and developed a benign cycle. The service institution in the first-cycle project in Yongchuan district of Chongqing municipality boasts strong resources of specialist. And after the project implementation of family healthcare service, it became more well-known and reputable by offering health education, examinations and counseling for various groups of people and witnessed the substantial increase in the outpatient and inpatient attendances. The benefits and the revenues arising therefrom may also support the continued development of family healthcare service. Qinghe of Hebei province in the second cycle is another typical example.

4. Create an input assurance mechanism to generate revenues from low-paid services

When local health and family planning service institutions carry out family healthcare service, they are able to offer relatively professional health examinations and counseling, where revenues can be generated from low-paid services for some items to provide funding assurance. For instance, while health education and counseling are offered for free, certain items of health examination require fees, or the treatment requires fees once an examinee is diagnosed with disease.

The family planning service station of Changzhou city, Jiangsu province has established the health examination center, which has a list of paid examinations and charges fees of different

amounts according to different items of inspection and the pricing standards are below those of hospitals at the same level.

In addition, the Project also strives to provide certain input assurance for project implementation through different ways. For instance, the specific service activities for family healthcare carried out for three consecutive years aim to standardize and refine the service and promote the rollout of service model; certain facilities have been equipped for the project sites and multiple rounds of national-level trainings and overseas trainings in Japan have been organized to improve the capability of family healthcare service.

Since the creation of the NHFPC, the reorganization of health and family planning administrative departments and the service institutions has brought about new challenges and opportunities for the input assurance of family healthcare service. On the one hand, changes may occur at the decision-making of relevant inputs and operational processes; on the other hand, on the strategy of "Health for Everyone", greater potentials have been gained at the two important dimensions – healthcare services and family development, which is favorable to input assurance as well.

Given that changes will occur in the decision-making and operational processes of relevant inputs, project regions at each level should continue to proactively advocate and ensure the continuity and stability of input assurance mechanism. Project regions at each level should proactively follow, communicate and advocate the greater potentials arising at two important dimensions – healthcare services and family development under the strategy of "Health for Everyone". As noted in the Section 3 Enhancing the Development of Village (Neighborhood) Family Planning Workforce in the *Guiding Opinions of the NHFPC on Enhancing the Basic Work of Family Planning at the Grassroots Level*, the full-time personnel of village (neighborhood) family planning work may concurrently assume the positions of officers for supervision on the New Rural Cooperative Medical System, disease prevention and control and health supervision after training. In the *Notice on Further Conducting the Management of Chronic Diseases in Rural Areas*, Gansu Provincial Health and Family Planning Commission called for the health and family planning administrative departments and service personnel to jointly take part in the prevention and control of chronic diseases and health management. In conducting family planning service and management, project regions at each level should expand their horizons, think innovatively and follow the status of family development and the implementation progress of "New Family Initiative" as well as "Creating Happy Families" at the grassroots level. They should keep updated about the status of basic public health service, demonstration for the prevention and treatment of chronic diseases, health promotion counties (districts), activities of health promotion venues and health family development, the Central Subsidies for the Promotion of Local Health Awareness Initiative and the National Basic Public Health Service and Health Education Project. In addition, project regions at each level should also identify the relevant service functions in optimizing and consolidating the technical service resources of maternal and child health as well as family planning. They should approach the significance of family healthcare service from the perspective of enhancing the development of the grassroots service mechanism which is vital to the medical reform, further clarify project positioning and perfect input assurance.

Chapter 5 Unique and Effective Method Employed in the Japan-China Cooperation Project on Family Healthcare

The Japan-China Cooperation Project on Family Healthcare has employed some unique and effective methods for the promotion of project implementation performance.

Section 1 "Family-centered" Healthcare Service

In the family healthcare project, family healthcare service is defined as family-centered health care service to enhance the health of family and its members through health education, health examination and health counseling, putting premium on the interaction and support among family members". Hence, "family-centered" health service has always been encouraged and continuously explored in the project.

I. Health influence of family

The following influences are exerted by a family on the health of its members through the family's structure, functions, relationships, behaviors and living environment:

1. Influence on the development of health-related behaviors

The health perceptions and living habits of family members tend to mutually influence and bad living habits and behaviors tend to become common problems among family members. Such daily behaviors as diet, smoking and physical exercise are developed under family background and are strongly influenced by the family.

2. Influence on child development and socialization

The most important stage of a person's mental and physical development (aged 0 to 20) is mostly completed in the family environment. Family is the most lasting and important natural and social environment in people's lives and the necessary condition for the physical, psychological and social development of children.

3. Influence on the occurrence of diseases

Many diseases are genetically inherited, such as hemophilia, thalassemia and albinism. In addition, hepatitis B, tuberculosis, venereal diseases, intestinal parasites and skin infections may easily communicate in a family. For adults, mortality is much higher for the widowed, divorced and single inhabitants than for those who are married, which explains the protective effect of marriage and family for health.

II. "Family-centered" health service

Like individual service, health promotion service with family as the unit or target involve the whole process of health from healthiness to sickness and rehabilitation and serve the full life-cycle of the family and all family members. Nevertheless, family healthcare service is differentiated from individual service for the unique "family" service and may reference the following effective methods:

1. Health promotion service provided by professional at the home of the service recipient

There are family sickbed, family visit and family health care, etc. (1) Family sickbed. Family sickbeds have already been available in China and are mostly provided by the family sickbed teams of community health service centers. The teams consist of technical personnel including physicians and nurses of community hospitals with intermediate and junior professional ranks and are backed by community hospitals and two-way referral with superior-level hospitals. According to the conditions and therapy of patients, the teams provide such services as the dispatch of physicians, delivery of medicines, injection and transfusion, oxygen inhalation, medication, catheterization, thoracentesis and abdominal paracentesis, acupuncture and massage, electrocardiograph examination, etc. (2) Home visit. Home visits refer to the health guidance and health examination services delivered by health personnel at the door of families. In China's basic public health services, newborn and postpartum home visit are included as part of maternal and child health care. In addition, the prevention and control of high blood pressure and diabetes also contain the home visit strategy. (3) Family health care. Family health care is more comprehensive than family sickbed and home visit and refers to the provision of medical, nursing, rehabilitation service and daily care to help patients to maintain healthy life at home on a long-term basis.

2. Health promotion and health service based on the unit of family

There are family health education, family health archive, family-centered treatment and care service and family doctor, etc. (1) Family health education, which mainly includes the following two models: first, health education directly targeted at the whole family; second, family health keeper, i.e. all members of the family will be influenced through the training of the primary person responsible for health in the family, i.e. family health keeper; (2) Family health archive. On the basis of storage of personal health archive with the unit of family, family health archive will increase such information as the basic facts of the family, family tree and major problems facing the family. The family health keeper will take stock and analyze the major health problems facing the family and propose comprehensive and specific family health intervention and guidance plan, including the plan, measures and suggestions for resolving the problems; (3) Family-centered treatment and care service. Medical personnel will impart health information and nursing experience to the family members of patients, guiding them to take proper care of patients; (4) Family doctor. Family doctor refers to an integrated medical service focusing on healthcare service based on the family. Family doctor must have the basic knowledge about various specialist clinics and the skills to handle illnesses and emergencies of internal and surgical medicine, pediatrics, gynecology, ENT and psychiatry.

III. Exploration of "family-centered" healthcare service through family healthcare project

Aside from health education, counseling and examinations for children, adolescents, population of reproductive age and the middle-aged and elderly provided by family healthcare projects to reflect the service feature of "full life-cycle of family", various project sites have always been encouraged to explore other "family-centered" healthcare services and to date, the following two types of feature services have been explored and relatively successfully implemented:

1. Family health education

Health education is carried out not only for the individuals of primary target population but for other members of the family as well. For instance, in the health education of children, parents should be trained to help their children develop the habits to brush teeth and wash hands and foster the awareness of safety and security. In the health education for adolescents through the parent classes held by schools and "a letter to parents", parents should be informed about the pubertal troubles of their children and how to help them deal with these problems. Through education and advocacy of healthy lifestyles for school pupils and the homework of "parent-child activities", children are encouraged to foster good everyday habits with their parents and urge their parents to quit drinking, smoking and other unhealthy habits. In the health education for the elderly and patients with chronic diseases, education for the prevention and treatment of chronic diseases should be provided not only to themselves but to the main caretakers at their homes for them to know about how to take care of patients with chronic diseases, how to identify risky situations and how to respond, etc. Another example is the "Health Kindling" initiative implemented by project counties. First, the technical personnel of county/township service institutions will train village and neighborhood family health caregivers, who will then carry out all forms of health education for housewives as the "family health goalkeepers."

2. Healthcare service for special family

Due to the unique family structure of some families, their family members are confronted with greater health risks than other families. Given the limited funding of project counties that prevents the scope of services from being expanded at the moment, priority has been given to the delivery of services to high-risk groups of those special families. Among them, healthcare services for the middle-aged and elderly have been widely provided. In some cases, priority has been given to the services for widowed and childless seniors in nursing homes while in some other cases, priority has been given to the elderly who are entitled to family planning awards and special allowances, providing them with health examinations and post-examination counseling services. Some project counties have focused on families with diseased and handicapped children, offering more comprehensive prepregnancy and gestational birth defect prevention services according to their service demands for giving birth to another child. Other project counties have paid greater attention to the families with "left behind children", offering health examinations to the children to help discover their health risks and conduct targeted health education for their custodians.

Section 2 Guidance at the Site of Family Healthcare Service

In addition to conducting training and strengthening supervision, the whole process of training should be overseen at the venue of project site over one theme, and various project stakeholders should participate in the interactions and offer site guidance. For an integrated family healthcare service activity (including health examination, counseling and education), the expert team and project county personnel have drafted, discussed, revised and improved the project plan and implemented and observed, carried out post-implementation summary and discussions, and held trainings on common problems arising from the process of service.

I. Background for the implementation of site guidance

Project sites have successively carried out family healthcare service activities facing children, adolescents, population of reproductive age and the middle-aged and elderly according to the "3×3" framework and annual plan, which have been applauded by service recipients. Nevertheless, after the initiation of project, the national-level project supervision also found some common problems in project service activities. For instance, trainings were not carried out in a very systematic and well-planned manner, teamwork was lacking in the conduct of activities, problems existed in activity data collection and use, and activities were not well recorded.

II. Specific practices of site guidance

Site guidance is generally conducted following the same model, i.e. with the unit of province, a project county is selected as the venue for site guidance (implementing county) and other project counties (non-implementing counties) will dispatch key project personnel (including management and service personnel) to jointly participate. The procedure and content of site guidance are designed generally in accordance with the process of an integrated service activity yet supplemented with expert guidance and the communication and commenting with personnel from other project counties. Please refer to Annex 1 for specific arrangements, which mainly include the following:

1. Formulation and preliminary revision of activity plan

About 10 days prior to site guidance, the implementing county should submit a plan of site guidance service activity, which includes the objectives and contents of the activity, date of activity, venue/scope of activity, target group and the number, organizer and co-organizer, person in charge and participants, form of activity, organizational process, activity site and equipment requirements, budget and instructions, etc. After reading the first draft of plan, project experts will propose the first round of guiding opinions and the implementing county should make initial revision to form the first revised draft and make relevant activity preparations accordingly.

2. Knowledge training of site activity

After project experts and the project personnel of non-implementing counties have arrived at the implementing county, one-day training will be firstly conducted and the experts will deliver a lecture on the theories of activity management in light of problems that have been identified, which include the detailed explanations on plan formulation, questionnaire design, collection of service data and data analysis. The objective is to enable participants to further master the contents, methods and skills for activity design, implementation and summary.

3. Commenting and re-modification of activity plan

Based on expert lectures and previous experience, the project personnel of implementing site should conduct a self-evaluation of the first revised draft and the project personnel of non-implementing site should also make comments on the first revised draft respectively. In the meantime, the facilitator will encourage participants to take part in interactive discussions on the evaluation and the lastly, the expert team will propose suggestions on supplementary revision. After summarizing all the suggestions, the implementing county should make another revision of

the plan and form the second revised draft.

4. Preparation and implementation of activity

The implementing site should re-prepare for the implementation of service activity according to the second revised draft and implement such service in the morning of the next day, while the personnel of non-implementing site and project experts (observers) will arrive at the venue to observe the process of service. All participants are required to observe the whole process, yet their presence should cause as less disruption to the implementation of site service as possible. In the course of activity, the record of site physical examination results should be properly made and questionnaires on the service should be distributed to service recipients. Questionnaire survey is conducted after the implementation of health education, health examination and post-examination counseling, with a view to learn about the knowledge acquisition of recipients and their comments on the service.

5. Activity exchange and data input and analysis

First, the service and management personnel of the implementing site will share their experience about site service implementation and typical cases that have been encountered. And then, observers will share their impressions about site service and comments on the successful and unsuccessful aspects of site service. Statisticians of the implementing site will simultaneously conduct the inputting and statistical analysis of questionnaire data and health examination results.

6. Discussion on the re-improvement of plan and summary of activity

Based on the results of service implementation and site observation, all the personnel who took part in site guidance will jointly discuss the contents of further revision of the plan and re-improve it to form the third revised draft. The person in charge of family healthcare service activity of the implementing site will draft and report an activity summary based on the contents of activity exchanges and the results of data analysis, which should include the following components: status of activity implementation, analysis of the effect of activity implementation/service data summary and analysis (health examination), typical cases in the activity, problems existing in the activity and vision for future improvement.

III. Suggestions on the rollout of site guidance

1. Scenarios for the application of site guidance methods

First, site guidance focuses on the acquisition of certain skills rather than the promotion of advocacy, acquisition of theoretical knowledge or problem solving. Namely, the basic premise for the application of site guidance is the need to improve certain skills. Second, the application of site guidance methods should be based on theoretical training. Through early-stage theoretical training, participants will first acquire relevant theoretical knowledge and familiarize with service management requirements. In this guidance, for instance, participants are required to develop the basic theoretical knowledge about the formulation of activity plan and data analysis, familiarize with the contents of family healthcare service and learn about relevant requirements of activity

management in the project. Lastly, in the course of the activity, participants have the opportunity of equal-footed communication and discussion, allowing them to have sufficient time to express their views based on the roles they assumed and their past experience in service delivery.

2. Role of experts in site guidance

In this site guidance, the Chinese and Japanese experts as one team have made extensive preparations in advance and repeatedly discussed and formulated the activity plan, which was constantly improved according to site guidance and service implementation status. In the future application of site guidance, this study considers it necessary to include at least one "expert" to participate throughout the whole process. The quotation mark for expert means that the expert may not necessarily be from a scientific research institute and refers to a person who is skilled or proficient in one particular field. He or she could be an expert from a research institute, a front-line technician or manager. In site guidance, the "expert" mainly assumes the following roles: (1) analyze and learn about the problems and difficulties in practical operation; (2) design site guidance activity and process in a targeted manner; (3) chair the entire site guidance activity, particularly the discussion and communication session; (4) in site guidance, elicit proactive thinking from all participants and allowing each and every one of them to have the opportunity to express in an equal-footed manner, rather than feeding them with answers; (5) If necessary, timely point out the problems that the participants are not aware of, supplement the knowledge that has not been acquired, and correct the theories that have been misunderstood or misapplied.

3. Role of participants in site guidance

In site guidance, participants are not only trainees but serve as instructors and jointly conduct site guidance together with experts. Their roles are indispensable and reflected in the following areas: (1) point out the problems in practical operation as trainees. They should continuously take the initiative to raise doubts in the course of site operation or express their opinions in order for the expert to identify potential problems, so that through the revelation of problems, experts will learn about specific needs for improvement and make their guidance more targeted; (2) as instructors, they should raise questions and resolve problems. The level of acquisition of theoretical knowledge varies across different participants. Through teamwork, proactive thinking and mutual inspiration in the course of site guidance, they will discover some problems through discussion and communication. For those who are strong in theoretical knowledge or well experienced, they may propose countermeasures to solve problems and their proposals are often more relevant with reality, practical and acceptable than those raised by experts.

4. Selection of participants and control of the number of participants in site guidance

The basic principle for the selection of participants is to ensure that each and every participant as sufficiently takes part and exchanges views on an equal-footed basis. (1) The number of participants cannot be too few, otherwise ideas cannot be broadly port and exchanged and the efficiency of site guidance or not be high. Normally, there should be at least five participants and no more than fifteen. Of course, there is no absolute requirement on the number of participants and certain flexibility can be practiced according to specific situations. As the facilitator, the expert should ensure that all participants are involved and problems are be revealed

according to the number of participants and the status of discussion. (2) Selection of participants. Personnel directly related to the guidance activity should be involved and where possible, they should preferably be selected from the personnel directly engaged in this type of activity and have received relevant theoretical training in advance (such theoretical training may also be conducted prior to site guidance). In addition, participants are required to have good language expression and communication skills.

5. Implementation of site service

Implementation of site service not only tests the effect of the first part of site guidance but provides basis for further guidance as well. Therefore, site service should pay attention to the following: (1) selection of site service. Avoid selecting the most assured or the most desirable site service. Instead, a site service in regular circumstance should be selected in order for the result of guidance to be broadly applicable. (2) Minimize the impact of observation of participants. The presence of observers will cause some impact and even disturbance to service recipients and service personnel, e.g. concerns of privacy protection, overcrowded venue and natural service personnel. Hence, participants should be involved in the role of "service recipients" wherever possible, rather than as completely outside observers. Except for major problems or mistakes that can be immediately rectified, participants should avoid making comments on the site. (3) There must be a summary and discussion on the re-improvement of the plan after site service implementation.

Section 3 Specific Activity of Family Healthcare Service

In order to advance the implementation of family healthcare service activity, explorations and innovations are encouraged in various project regions. According to the characteristics of healthcare services across various project regions and the needs of service recipients, "specific activity of family healthcare service" that suit local conditions should be carried out timely.

I. Objective of specific activities of family healthcare services

The objective of conducting specific activities of family healthcare services is to provide project regions with financing and technical support and carry out effective family healthcare service activities for the specific issues of a special target group through project operation for a certain period of time. These activities include:

1. Facilitate the implementation of family healthcare services in project regions in a science-based, standard and effective manner according to project requirements and enhance the performance and capabilities of services.

2. Further enhance service activities with families as the entry point and develop a model of family healthcare services with local characteristics.

3. Facilitate the development of case studies and typical examples in project regions.

4. Enhance the capabilities of personnel in project regions for the formulation of plans, schemes and documents.

5. Enhance the understanding of superior-level institutions and experts on the status and progress of service implementation under project framework in project regions.

II. Process of specific activities

The process of specific activities of family healthcare services can be expressed with the following flowchart (see Figure 5-3).

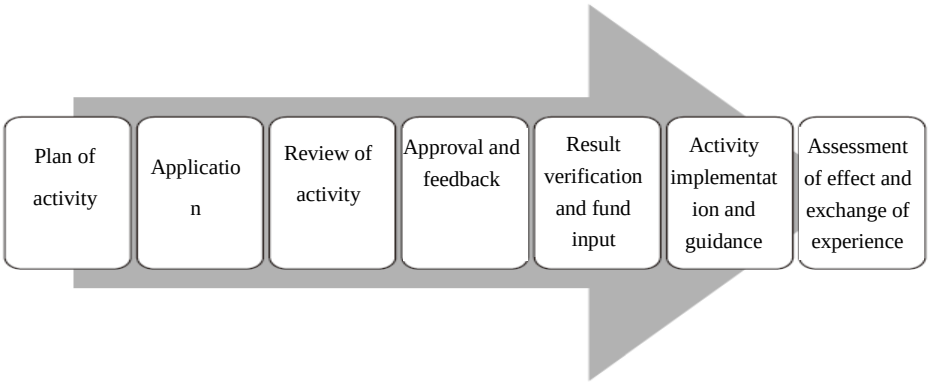

Figure 5-3 Process of specific activities of family healthcare services

III. Plan of specific activities

Project experts should carefully discuss and plan for the implementation of specific activities of family healthcare services. Therefore, the project has formulated and distributed the Application and Implementation Plan for Specific Activities of Family Healthcare Services, which prescribes detailed rules to ensure the successful implementation of specific activities of family healthcare services. Such documents as the plan of specific activity, application for specific activity, detailed rule for activity assessment, fund distribution plan, activity progress requirement, activity supervision plan, activity summary report, and the exchange of experience and summary are also formulated.

IV. Application for specific activities

“Specific activities of family healthcare services” are applied for by individual project regions and require the completion of Plan (Scheme) for Specific Activity of Family Healthcare Services, i.e. application form for specific activities (please refer to Appendix 7), which should be reviewed at various levels and finally submitted to the project office.

V. Review and approval of activities

Various project regions should first submit the applications for specific activities to the superior-level health and family planning or population and family planning administrative departments for the provincial (municipal) health and family planning or population and family planning departments to collect and submit them to the national project office for a joint expert review. The review will focus on the scientificity, logicality and feasibility of these applications and grade them according to the scoring criteria and review results (refer to Appendix 8: Review Items for the Application for the Specific Activities of Family Healthcare Services) before

calculating the average value.

The review will be jointly completed by experts, who will carefully examine the applications for specific activities submitted by various project regions. They will identify areas where expressions are incomplete and plan is not detailed enough and propose opinions and suggestions to project regions. According to the expert feedback, project regions should revise the applications and resubmit the revised applications to the national project office for expert comments.

VI. Review, approval and feedback of activities

Based on the scores given by the expert team to applications for specific activities of family healthcare services across various project regions, the project team will determine the funding and amount of financial assistance to the specific activities.

Meanwhile, the project office should provide feedback and opinions of the second expert review to ensure that various project regions have always understood problems existing in their applications for specific activities, so that the same problem will be avoided in the next application for activities.

VII. Implementation and guidance of activities

Over the past one year of the implementation of "specific activities of family healthcare services", project regions have implemented family healthcare service activities in accordance with the revised applications. The twelve project regions of the Japan-China Cooperation Project on Family Healthcare have selected a certain special group among children or adolescents, population of reproductive age and the middle-aged and elderly population according to local realities to carry out various family healthcare activities for one year involving health education, health consulting and health examination, striving to follow the concept of "family" in the activities to develop a pattern of operation for project activities (refer to Table 5-2).

Figure 5-2 List of specific activities of family healthcare services implemented between 2012 and 2014 (part of the activities)

Target group	Name of specific activity of family healthcare services	Year	Project site
Children	Healthy lifestyle for children in kindergartens - "Parent-child interactive" integrated family healthcare service promotion activity.	2012	Zengdu, Hubei province
	"Child health starts from me" - Campus activity.	2014	Neihuang, Henan province
	"Good habits, good health" - Integrated family healthcare services for the promotion of healthy habits and habits among children.	2014	Jingshan, Hubei province
Adolescents	"Youthful health starts from me" integrated intervention services of physical and mental health guidance for adolescents.	2013	Anlu, Hubei province

Target group	Name of specific activity of family healthcare services	Year	Project site
	"Colorful youth, healthy life" - Integrated family healthcare services for adolescents on campus.	2014	Zengdu, Hubei province
	Care for adolescents left behind in the countryside - Journey of health and happiness.	2014	Wuwei, Anhui province
Population of reproductive age	Health education and promotion for population of reproductive age	2012	Huoshan, Anhui province
	"Healthy woman, happy family" healthy life advocacy activity.	2013	Qianxi, Hebei province
	"Care for women, care for health" integrated family service activity.	2014	Xingyang, Henan province
The middle-aged and elderly	"Health promotion for all families" free integrated health examination services for elderly population.	2013	Beibei, Chongqing province
	"Healthy families" advocacy of knowledge for the prevention and protection of chronic diseases and advocacy of healthy life for the middle-aged and elderly.	2014	Qianxi, Hebei province
	Warmth for the middle-aged and elderly, act for family health.	2014	Nanle, Henan province
Mixed group of more than two types	"Treat life with care and care for health" integrated intervention services for high blood pressure and diabetes.	2012	Anlu, Hubei province
	Care for maternal and child health, promote science-based life.	2013	Neihuang, Henan province
	"Care for family health" all-family healthcare service activity	2014	Qinghe, Hebei province

VIII. Appraisal of activity effect

Within two weeks after the completion of specific activities of family healthcare services, various project regions should make written reports following the prescribed format, which should be commented by municipal and provincial administrative institutions. Meanwhile, they should submit "Summary Report of Specific Activities of Family Healthcare Services" (see Appendix 9). This report is not only an overall summary of annual specific activities but the basis for evaluating the effect of project activities as well and thus carries great importance. In order to enrich evidence, various regions often supplement supporting materials in the final summary report, e.g. various video and audio materials for health education and advocacy and courseware made by technical personnel; various counseling records made in providing health counseling; various health examination archives and analysis reports made in conducting health examinations, etc.

Section 4 Household Participatory Activities

In the course of implementing healthcare activities for households according to local healthcare policies, a critical aspect is to enable households to gain a real understanding about their own health conditions. On this basis, households will be assisted to develop the abilities to think independently and bring their ideas into action. Local service personnel focus on supporting the activities carried out by them. The key to addressing health issues is to bring about changes in a person's perception and attitude, while imparting knowledge and information alone will achieve limited effects. Therefore, the actual condition of each and every person should be fully understood for knowledge and information to be provided in different stages accordingly. The opportunities to deliberate with them about specific implementation should be treasured.

In this process, service personnel should carry out relevant health education and counseling activities. Yet through such activities alone, it is still hard for households to develop activity groups naturally. It takes to careful planning and continuous facilitation for activity groups to be formed naturally.

If the group activities of households can be continuously carried out, the coverage of public health for local households will be effectively increased. On the other hand, the promotion of healthcare activities not relying only on the services offered by administrative departments also helps save costs. More importantly, the participation of households and their pleasure to participate imply that the effect of empowerment may also be achieved. Hence, the communication among group members, households and groups will help enhance the overall awareness of the region as a whole and inspire dynamism in the region.

I. Key aspects for the development of household organizations

Early-stage preparations should include the following elements.

Role of service personnel	Early-stage preparations
Assessment of regional health topics	Evaluate what type of household activity groups are needed for the region
Identification of group leader	Identify appropriate candidates through health education classroom or training
Provision of activity venue and organizational development	Arrange the venues for hosting discussions, chatting and activities Propose simple suggestions on the rules to follow
Support to activities	Promote continuous deployment of activities

II. Key aspects for the promotion of activity implementation and continuation

In order to encourage activity groups to continuously carry out activities, the most effective method is to make group members feel the benefits of "happiness", "growing energy" and "making new friends". The key to elicit such feelings is to enable each and every person to find their positions in the activities and play their roles properly, support each other, and develop a

sense of belonging to the group. In contributing their efforts to group activities, their enthusiasm to participate in the activities will be further inspired. Service personnel must be clearly aware of this motivation, respect their awareness of self-initiative and act as their partners to provide continuous support for the successful implementation of activities.

Case study 1 Family caregivers in Qianxi county, Hebei province

1. Role of family caregivers (leaders of family planning groups)

Qianxi county has a total of 1,256 leaders of family planning groups for women of reproductive age and most of them are influential local figures. They have broad connections and influence and are activists among people of reproductive age. They are publicly recognized good grandmas and good wives.

All of them work at the grassroots level. The priority of our family planning work is the grassroots level and so are our advantages. Leaders of family planning groups for women of reproductive age must be involved in order to give play to the role of family planning, and enhance the development of grassroots associations, meet the criteria for the work on family planning featuring "complete organizations, frequent activities, satisfaction services and public acceptance". Due to the work experience at the grassroots level in the countryside, leaders of groups for women of reproductive age are directly in touch with the population of reproductive age. They are at the bottom of the network of family planning associations and a critical link in the communication and the implementation of family planning policies among the general public. The role is inestimable and irreplaceable in building a socialist harmonious society characterized by democracy and the rule of law, trust and friendship, vitality, order and the harmony between man and nature. They are the facilitators in organizing group members, conducting activities and public communication, and realizing "self-management, self-education, self-service and self-supervision". The role as group leader is the key to enhancing the development of village-level association and serves as the cornerstone and assurance for the work of grassroots association.

Family planning is an activity for the general public and directly relates to the immediate interests, physical and psychological health and family happiness of the people. Leaders of family planning groups, who share strong connections with the general public, know and reflect what people think and are able to mobilize the people. They are well-positioned to lead mutual assistance activities for poverty alleviation and literacy and awareness education for local prosperity, striving to resonance between national policies and people's aspirations. They organize group members to lead the general public to assist each other in ploughing land, growing seeds, harvesting crops and arranging for transport and offer services to the families in need.

Family is the smallest cell of a society. The harmony of families and neighbors is the foundation for the harmony of the society at large. The group leaders have played highly positive roles in promoting family unity and good neighborliness. In spite of their various roles in the society as wives, mothers and daughter-in-laws, they have assumed many other roles in improving the relationship between mother-in-laws and daughter-in-laws, caring for the elderly and promoting mutual assistance among neighbors.

2. Transition of the functions of leaders of family planning groups

In 2011, Qianxi county was identified by the National Population and Family Planning Commission as a pilot county for the Japan-China Technical Cooperation Project on Family Healthcare. Implementation of services in connection with the family healthcare project is of great significance to promoting health awareness and healthy lifestyles, reducing diseases and sub-healthiness, prolonging healthy life, and improving the healthiness and happiness index of households in the county. In order to facilitate project implementation, the county population and family planning bureau has decided to assign all the 1,256 leaders of family planning groups for women of reproductive age with the concurrent positions of family caregivers for the family healthcare project. Their salaries were all included in the fiscal budget and allocated at the county finance to the county population and family planning bureau, which then allocated their salaries to townships and neighborhood family planning offices for the latter to pay the leaders of family planning groups for women of reproductive age, according to the assessment results (established a complete examination system, if the leader was not qualified then be recalled). Meanwhile, intensive training of family healthcare was carried out for them, which provided strong organizational and talent assurance. We carried out a total of 340 training sessions for village-level family caregivers, whose knowledge acquisition rate reached 92% of the training. With the progress of work, the leaders of family planning groups became the key personnel for the communication of family planning policies, guidance of prenatal and postnatal care, distribution of contraceptives, and caregivers for happy families and healthy life. Moreover, they became a key force for the promotion of healthy families and healthy countryside.

Case study 2 Grassroots communication team in Anlu city, Hubei province

1. Background

(1) Service demand analysis: data from the baseline survey of 2011

(i) Awareness of innovation knowledge was generally low among the middle-aged and elderly population in this city. At that time, the number of population with chronic diseases tended to increase in the city, while awareness of relevant health knowledge was limited. 46% of the city's population did not receive any health education and 37% received education on the prevention and treatment of chronic diseases. A relatively high proportion of population in the city did not receive any health education, which highlighted the urgency to do so.

(ii) Bad living habits. When asked about the question of whether they will change their bad living habits, 50% of the middle-aged and elderly population in the city said that they may change if they feel they can and 35.7% of them said that they must change.

(iii) Among the middle-aged and elderly population in the city, participation in various physical exercises and sports was infrequent. 89.7% of them never took part in any sports, while 10.3% of them took exercises, including taking strolls (61.9%), dancing (3.7%), jogging (7.4%) and ball games (1.9%). Obviously, in the rural areas of our city, physical labor held sway and most people did not take part in sports. Sports and exercises for the purpose of health were yet to be popular among people.

(iv) Great differences existed in the participation of public square activities between urban and rural areas. According to site survey, the urban districts of Anlu city were characterized by various public square activities with enthusiastic public participation and rapid emergence of public groups for sports and exercises participation. Before the implementation of project activities, among the 16 villages and communities with township offices, there were only 3 to 4 township neighborhoods that had dancing teams and each activity site had 10 to 20 people. The following four factors prevented residents from taking part in collective exercises and sports: rural residents believed that sports and exercises were not necessary since they were engaged in laborious farm work; they were afraid of being ridiculed since their peers did not participate; there was no leader and organizer; no one provided venues for the activities.

(v) Coincided with the government initiative of "healthy Hubei", which required that each village and community create public squares to promote public exercises.

(2) Analysis of service supply

(i) Provision of venues. In the new countryside development, various villages have established service centers for Party members and the general public, and all village committees have spacious activity sites.

(ii) Village family planning cadres can become the backbones of health initiatives. The network of family planning is complete and each and every village has a female family planning cadre familiar with the work of female comrades. They will first mobilize the service recipients of their local villages, and then these service recipients will mobilize their families.

(iii) Public square activities are local activities easy to popularize. In order to expand the coverage of family healthcare education and improve the results of health education, health education should be localized to attract the participation of more people. Since 2012, the family healthcare center of Anlu city has created a pilot village for the 16 township offices to attempt to develop a team of health education and advocacy close to the general public. Thus, the idea of grassroots advocacy team came into fruition.

2. Specific practice

(1) Policy incentive. In order to rapidly create grassroots advocacy teams in pilot villages, the municipal family planning bureau has enacted the policy to deliver equipment, clothing and professional instructors to the countryside, where equipment and activity leaders are lacking, to galvanize public participation.

(2) Selection of personnel. Members of grassroots advocacy teams are private volunteers and one team is organized for each village with one or two leaders who are selected from volunteers with strong organizational capabilities and enthusiastic about public welfare in the villages. They will be appointed after screening by the township family planning office and in general, each team has 20 to 40 members.

(3) Training of personnel. First, the municipal family healthcare service center will provide one or two systematic trainings on knowledge and skills of family healthcare each year; second, the opportunity of monthly meetings of township family planning offices will be utilized for township family healthcare service personnel to timely communicate the concept of family healthcare service and specific practices for the development of volunteer teams; third, distribute relevant books and brochures to guide the independent learning by volunteers and influence people around them to learn about health knowledge.

(4) Implementation of activities. Usually, activities are carried out in the form of public square dances, where grassroots advocacy team members will attract nearby people to get involved in the action for healthy life. Meanwhile, grassroots advocacy team members also take advantage of the opportunities of casual visits to communicate health knowledge.

(5) Creation of systems. Under the leadership of the original municipal population and family planning bureau and with the participation of township government and family planning office, the implementing scheme for grassroots advocacy team has been formulated to prescribe clear rules on the screening and training of personnel, activity organization, evaluation methods and incentives, etc.

(6) Strict evaluation. The municipal health and family planning bureau will conduct assessments on the activities of grassroots advocacy teams of township family planning offices and the results of assessments will be incorporated into the year-end responsibility targets. The general public will be guided to take part in various evaluation activities and for those advocacy teams with outstanding performance in the evaluation, appropriate awards should be given by the municipal health and family planning commission.

3. Activity effects

(1) The number of participants continuously increased. The number of pilot village for 16 townships has been expanded from one to 381 administrative villages. Through the demonstration effect of activity sites, more people in the populous townships and communities are involved. The number of activity venue has been increased from one to the range of 3 to 8 activity venues. The number of persons for each activity venue has been increased from the initial 10 to 20 persons to the current 30 to 50 persons.

(2) Varied forms of exercises. After three years of project implementation, public square dances as the dominant form of grassroots advocacy activities have given way to varied forms of exercises under the guidance of health volunteers practiced according to the habits, health conditions, age structure and gender of different population groups. These forms of exercises include fast working, jogging, health exercises, Taichi boxing, drum dance, yoga, etc.

(3) The number of health volunteers increased. Over the past few years, a cumulative number of more than 1000 persons have been trained as the backbone personnel. In March of this year, the municipal family healthcare center has worked with the municipal women's federation to organize the screening and training of more than 450 family planning cadres, conduct data summary and management training meetings, and share experience of study tours to Japan. Currently, the

number of volunteers for each pilot village has been increased from one to the range of 5 to10 to engage in public-interest health programs, assist the elderly living alone to socialize, be open to new things and learn new ways of exercises from the Internet or from dancing instructors.

(4) The role of volunteers continuously enhanced. The activities by volunteers extended from public square dances to other aspects including healthy psychology, rational diet, moderate exercises and smoking and alcohol control. Volunteers communicate with each other about health information through casual visits and leisure time, e.g. to dispense awareness materials for the prevention and treatment of diabetes and high blood pressure, which have the middle-aged and elderly to develop a clear understanding on the health risks related to their bad living habits. Use of standard salt spoon and oil bottle made residents participating in the activities aware of the importance of salt and oil limitations to the prevention and treatment of chronic diseases. Public square dances not only aim to give residents the opportunity to do physical exercises. More importantly, they are meant to encourage the elderly people living alone and conservative-minded middle-aged and elderly population to be willing to take part in collective exercises and activities to stay healthy and happy.

(5) Gradual development of healthy living habits. Through communication of health knowledge over the past three years, volunteers have continuously increased the health awareness in their neighborhoods. It has been found through observation that the health conditions of those participating in public square dances have significantly improved, which motivated more people to participate, develop healthy living habits and become healthier. Ms. Hu in the industrial and economic development zone is a key member of the grassroots advocacy team of Shimiao village. Through the participation of training, she has acquired more health knowledge and shared her experience with friends and often communicated the topics about healthy life with others. Now, not only does she appear to be happier and more open, her figure is slimmer as well with body weight dropped from 60 kilograms to 55 kilograms. “As long as I stopped taking part in the activities for one day, I would feel confined.” she said.

4. Future development

(1) Establish standard private health volunteer associations to ensure the orderly implementation of activities. In the transitional stage when the association of volunteers is yet to be created, the community family planning cadres of each village will organize the timely communication of healthy life concepts with the unit of communities and report the frequency of community activities for the village and the number of participants and foster a team of health volunteers to prolong the healthy life of residents in the city and improve the quality of life for the elderly.

(2) Create a long-term evaluation mechanism. In the preliminary stage of the establishment of grassroots advocacy teams, efforts will be led by the government, supported by the management and coordinated by special personnel of various family planning offices. The evaluation mechanism will be included in the responsibility targets for year-end evaluation of various villages and communities, and grassroots advocacy teams will be continuously developed and strengthened.

(3) Jointly carry out various evaluation activities with civil groups, for instance, “dancing Anlu”

public square dance competition, annual anniversary of Taichi boxing association, performance of the elderly art troupe, public square activities of fitness centers, etc. All opportunities should be utilized to encourage healthy lifestyles among the public.

Appendix

Appendix 1-1 Project Design Matrix (PDM)

Ver. 4 Date of revision: March 20, 2015

Project name: continuously enhancing family healthcare service and giving play to its role in the health education for the prevention and treatment of communicable diseases

Project duration: five years (January 2011 - January 2016)

Project provinces: Hebei, Anhui, Henan, Hubei and Chongqing (four provinces and one municipality)

Project regions: (1) Qinghe county of Xingtai city, Hebei province, (2) Qianxi county of Tangshan city, Hebei province, (3) Wuwei county of Wuhu city, Anhui province, (4) Huoshan county of Liu'an city, Anhui province, (5) Nanle county of Puyang city, Henan province, (6) Xingyang city of Zhengzhou city, Henan province, (7) Neihuang county of Anyang city, Henan province, (8) Jingshan county of Jinmen city, Hubei province, (9) Anlu prefecture of Xiaogan city, Hubei province, (10) Zengdu district of Suizhou city, Hubei province, (11) Rongchang county of Chongqing municipality, and (12) Beibei district of Chongqing municipality (12 counties in total)

Target groups: the National Health and Family Planning Commission (NHFPC), provincial, municipal and county health and family planning or population and family planning commissions (bureaus), municipal and county family healthcare service centers (family planning service centers), township community health service stations or family planning service stations, village health offices or family planning service offices, local residents

Project summary	**Indicator**	**Method for indicator acquisition**	**External conditions**
Overall goal Enhance systematic healthcare prevention and treatment activities in project provinces through the implementation of family healthcare service	Five years after the end of project 1. Policy documents of the NHFPC contain explicit statements about family healthcare service 2. Proportion of counties having initiated the implementation of family healthcare service in all counties of target provinces (more than 40%) 3. Increased proportion of households in project provinces with improved health awareness (exerting influence on the priority areas of family healthcare activities)	1. Relevant documents of the National Health and Family Planning Commission (NHFPC) 2. Relevant reports of project provinces 3. Relevant reports of project provinces	
Project objectives Create a model of family healthcare service in project regions compatible with local	By the end of project 1. Project provinces have enacted administrative documents on the extensive rollout of family healthcare service for their	1. Relevant documents of provincial Health and Family planning	No major change

Project summary	Indicator	Method for indicator acquisition	External conditions
needs Model: follow the 3×3 framework for family healthcare service based on regional analysis, continuously enhance corporation with relevant departments, and create a system of plan, do, check and act (PDCA cycle) system that can be rolled out	provincial jurisdictions. 2. Increased the level of satisfaction among households for family healthcare service. 3. Increased the proportion of households in project regions with improved health awareness (exerting influence on the priority areas of family healthcare activities)	commission 2. Baseline survey and end-line survey reports 3. Baseline survey and end-line survey reports	occurs in the policies of the NHFPC concerning family healthcare service

Continued

Project summary	**Indicator**	**Method for indicator acquisition**	**External conditions**
Results: 1. Improved family healthcare service standards (philosophies, concepts, scope, standards, etc.) 2. Improved operation and management of family healthcare plan in project regions 3. Improved implementation capabilities of family healthcare service institutions and personnel (management, technology) 4. Enhanced household awareness of participation in family healthcare service and health awareness	1-1. The guidance and handbook have been recognized by the NHFPC 1-2. Whether recommendations have been made on the implementation and application of family healthcare service system according to the results of applied study (such as recommendations on the qualification certification of institutions and personnel) 1-3. Number of promotion and exchange seminars (once a year) 2-1. All project regions have released documents on the creation of steering groups and project offices 2-2. "Regional family healthcare plan" has been formulated according to the results of survey and analysis carried out in all project regions 2-3. Formulate the "plan of regional annual implementation activities" based on the results of survey and analysis carried out in all project regions 2-4. Increased proportion of high-quality annual activity reports (with analysis and written in a clear manner) in project regions 2-5. Proportion of project regions with conformant supervision (provision of service programs) (over 80%) 3-1. Proportion of personnel who have achieved training effects (knowledge) (over 80%) 3-2. Proportion of evaluation conducted before and after retraining in project regions (over 80%) 3-3. Proportion of project regions with conformant supervision	1-1. Relevant documents of the NHFPC 1-2. Minutes of discussions of the joint coordination committee 1-3. Project report 2-1. Relevant documents of project regions 2-2. Family health plan in project regions 2-3. Annual activity plan of project regions 2-4. Report of annual activities in project regions 2-5. Supervision report 3-1. Test result of training effects 3-2. Report of annual activities in project regions 3-3. Supervision report 4-1. Interview 4-2. Results of household demand survey and comparative survey	Project implementation system can be improved on an early date in the new system after the restructuring of the NHFPC Trained personnel can continuously participate in project activities

Project summary	Indicator	Method for indicator acquisition	External conditions
	(retraining programs) (over 80%) 4-1. Higher participation of personnel from government and relevant departments in family healthcare service 4-2. At the localities of project regions where family healthcare service has been carried out, the proportion of households with improved awareness of participation and health has increased.		

Continued

Project summary	**Indicator**	**Method for indicator acquisition**	**External conditions**
Activities (Improvement of standards) 1-1. Analyze existing handbooks (guidance), etc. 1-2. Establish the philosophy of family healthcare service and improve relevant concepts 1-3. Identify the scope of service for family healthcare service institutions at each level and formulate relevant technical standards 1-4. Formulate the standards of human resources, equipment and facilities for service institutions at each level 1-5. Improve the operation, management and supervision systems for family healthcare service 1-6. Formulate and revise family healthcare guidance and family healthcare service handbook of reproductive health according to the aforementioned elements 1-7. Popularize family healthcare service standards using the aforementioned guidance and handbook 1-8. Supervise the promotion of the guidance, handbooks and family healthcare service standards 1-9. Analyze the implementation status of reproductive health consultants in project regions 1-10. Propose recommendations on the implementation and application of family healthcare service systems of project regions (qualification certification, etc. of institutions and personnel) 1-11. Summarize the experiences of project activities and formulate selected family healthcare service cases and other	Input from the Chinese side <Personnel input> · The Department of International Cooperation and relevant line departments and bureaus of the National Health and Family Planning Commission (NHFPC) · Divisions and offices of provincial health and family planning commissions responsible for the project · Municipal/county health and family planning or population and family planning commissions (bureaus) · The experts group of the Chinese side · Personnel of the Chinese project office <Equipment> · Training equipment · Health examination equipment <Necessary funding> · Project activity funding · Relevant funding of project long-term expert office (office venue, electricity and water bills, etc.) · Travel expenses and counterpart	Input from the Japanese side <Personnel input> Long-term experts: Chief expert Regional healthcare Business coordination/training plan Short-term experts: 1. Health education, examination and counseling 2. Survey methods and epidemiology 3. Regional healthcare plan 4. Prevention of lifestyle diseases/healthcare for the middle-aged and elderly 5. Supervision and evaluation 6. Training and guidance methods 7. Health policies 8. Health promotion 9. Others	Cooperate and coordinate with relevant departments to ensure that no problem occurs Family healthcare services are accepted by residents in project regions

Project summary	Indicator	Method for indicator acquisition	External conditions
project outcome materials 1-12. Hold national-scale promotion and exchange seminar to share experiences and lessons 1-13. Project provinces carry out evaluation and validation of activities carried out in project regions and establish a management system for the promotion of such activities in their provincial jurisdictions			

Continued

Project summary	**Indicator**	**Method for indicator acquisition**	**External conditions**
(Formulate regional family healthcare plan) 2-1. Select project regions 2-2. Create steering group led by the relevant departments (health and family planning, education, civil affairs, women's federation, etc.) under the leadership of government at each level in project regions 2-3. Establish project office under the steering group 2-4. Collect and analyze the basic information of health and family planning service institutions in project regions and comparative regions 2-5. Collect and analyze relevant social and economic information (income, industries, etc.) and healthcare and medical information (statistics of diseases and mortality) in project regions and comparative regions according to the relevant yearbooks 2-6. Conduct sample survey of household needs (evaluation of sanitary environment of families, living habits, health knowledge and medical behaviors, etc.) 2-7. Determine the priority issues of family healthcare in pilot counties based on the results of 2-4 to 2-6 2-8. Determination of family healthcare plan by steering group 2-9. Formulation of annual plan for family healthcare service by the project office 2-10. Organize the provision of family healthcare service (health education, health examination and health counseling) according to the aforementioned annual implementing plan of 2-9 2-11. Regularly carry out mentoring and supervision over service activities and personnel 2-12. Conduct sample inspection of the mentoring and supervision results of 2-11		<Equipment> · PC · Printer · Photocopier · Projector · Digital camera · Video camera · Advocacy and education equipment · Training equipment · Health examination equipment	Precondition Other departments or individuals will not oppose the implementation of family healthcare service activities

Project summary	Indicator	Method for indicator acquisition	External conditions
2-13. Regularly evaluate the quality and influence of the service (in reference with relevant surveys, etc. in Japan) 2-14. Conduct end-line survey according to 2-4 to 2-6			

Continued

Project summary	**Indicator**	**Method for indicator acquisition**	**External conditions**
Capability enhancement [management and technology]) 3-1. Evaluate training needs of county level service personnel according to the family healthcare service standards. 3-2. Formulate the plan of managerial and technical training and draft text book. 3-3. Carry out operational and managerial training for administrative personnel and directors of county-level service stations. 3-4. Conduct technical training for county-level service personnel (training for instructors). 3-5. Secondary training for service personnel below township level conducted by county-level service personnel 3-6. Epidemiological survey and scientific research training conducted by national and provincial experts 3-7. Check the effects of various trainings from 3-3 to 3-6 (self-appraisal and evaluation of trainees on the instructors and the content of lecture). (Increase the participation awareness and health awareness) 4-1. Advocacy for the government and relevant departments at each level 4-2. Carry out various forms of family healthcare service advocacy and education activities (competition, health festivals, home visits, etc.). 4-3. Draft family healthcare handbooks, textbooks and relevant materials for the residents.		<Necessary funding> · Project activity funding · Office operation funding for long-term experts · Funding for the recruitment of assistants · Local counseling fees	

Appendix 1-2 Format for the Formulation of PDM plan (five-year plan)

The Japan-China Cooperation Project on Family Healthcare

_____county (city or district) _____ population

Family Healthcare Plan (PDM)

Date of completion: _____ (mm/dd/yyyy)

I. Service demand analysis

Local demographic characteristics and health conditions;

Knowledge, attitudes and behaviors of target groups;

Service demand of target groups

(*This part should analyze the health conditions, knowledge/attitudes/behaviors and service demand learned about from the baseline survey of this project and services previously carried out)

II. Analysis of service supply

Status of provision of health education, health examination and relevant services;

Description of resources that can be utilized (existing, developable, human resources, material resources, etc.);

(*This part should record the actual quantity of services provided.)

III. Policies of superior-level departments

Write the leader's requirements, laws and regulations; analyze whether the direction of five-year plan is consistent with the requirements of superior-level authorities and how should the plan be revised if the requirements are not consistent.

IV. Project PDM (see the next page for the format)

Project design matrix (PDM)

Ver. _____ Completion date: _____ (mm/dd/yyyy)

Family Healthcare Plan for _____ Population

Duration: ____ years (from _____(mm/yyyy) to _____(mm/yyyy))

Project region:

Target population: direct target population _____

indirect target population _____

Hierarchy and description of goals and objectives	**Measurement indicator***	**Data sources**	**External conditions**
Overall goal	Within five years after the end of the project. 1. 2.		

Continued

Hierarchy and description of goals and objectives	**Measurement indicator***	**Data sources**	**External conditions**
Project objectives	By the end of project completion 1. 2.		
Outputs (results) 1. 2. 3. 4.	 1-1 1-2 2-1 2-2 3-1 3-2 4-1 4-2	 1-1 1-2 2-1 2-2 3-1 3-2 4-1 4-2	
Activities 1-1 1-2 1-3 1-4 2-1 2-2 2-3 3-4 3-1 3-2 3-3 3-4 4-1 4-2 4-3 4-4	Inputs Personnel: Equipment: Funds:		

Appendix 1-3 Format of Annual Activity Plan

The Japan-China Cooperation Project on Family Healthcare

Annual activity plan of ____ (year) for _____ population in ___ ___ county (city or district)
Completion date of the plan _____(mm/dd/yyyy)

I. Objectives and outputs of five-year project (*extracted from the PDM)

Hierarchy of objectives	Objectives	Indicators (target value)
Project objectives		
Outputs (results)	1.	
	2.	
	3.	
	4.	
	x.	

II. Problems and advantages of the previous year and directions of this year's activities
(*Complete the <VI. Identify the direction of future activities based on the analysis of this year's problems and advantages> in the annual report of the previous year)

III. Activity plan for this year
(I) Annual project objectives, outputs and indicators

Hierarchy of objectives	Objectives	Indicators (target value)
Project objectives	(Same with the PDM objectives or intermediate objectives from the PDM objectives that should be accomplished this year)	(In writing indicators same with those of the PDM, the target values supposed to be achieved this year should be provided, or the indicator values of the intermediate objectives of PDM should be provided)
Outputs (results)	1. Same requirements with "Project objectives"	Same requirements with "Project objectives" 2.
	3.	
	4.	
	x.	

(II) Summary of each activity

<Summary>

Output (result)	Activity	Date	Place	Target group	Person in charge (implementing entity)	Collaborative entity	Budget (yuan)
Output 1. (Fill in the output in III (1).)	1-1. (Name of the activity plan contributing to [left side])			State such information as target population or project site, number of people, etc.)			
	1-2.						
	1-3.						
	1-x.						
Output 2.	2-1.						
	2-2.						
	2-3.						
	2-x.						
Output 3.	3-1.						
	3-2.						
	3-3.						
	3-x.						
Output x.	x-1.						
	x-2.						
	2-x.						
Activities other than the above	9-1.						
	9-2.						
	9-x.						

Implementation method and description of each activity

Activity	Description
1-1. (The activity written in the above summary)	Method for implementation: Description of activity (Relevant diseases or themes/times): (It is not necessary to make a detailed record of the process. Please only provide a simple description from activity preparation to the final wrap-up meeting, etc., including the completion date, method, times, relevant diseases and form of activity (e.g.: health education of diabetes). Record can be made in another form if completion in this form is difficult).

Continued

Activity	Description
1-2.	Method of implementation: Description of activity (Relevant diseases or themes/times):
1-3.	Method of implementation: Description of activity (Relevant diseases or themes/times):
1-x.	
2-1.	Method of implementation: Description of activity (Relevant diseases or themes/times):
2-2.	
2-3.	
2-x.	
3-1.	
3-2.	
3-3.	
3-x.	
x-1.	
x-2.	
x-x.	
9-1.	
9-2.	
9-3.	
9-x.	

Appendix 1-4 Format of Annual Activity Report

Japan-China Cooperation Project on Family Healthcare

Annual report of ____ (year) for _____ (population) in _____ county (city, district)

I. Completion of annual objectives and results

Hierarchy of objectives	Objectives	Indicators (target value)	Indicators (actual value)
Project objectives	(Annual objectives in this annual plan.)	(Target values of indicators in the annual plan.)	(Current status corresponding to the "target values of objectives" on the left side.)
Outputs (results)	1. (Outputs of this annual plan.)	Targets of indicators in the annual plan)	(Current status corresponding to the "target values of objectives" on the left side.)
	2.		
	3.		
	4.		
	x.		

II. Implementation status of annual plan

Outputs (results)	Activity	Target group (planned)	Target group (actual)	Implementation status
Output 1. (Output in the annual plan)	1.1 (Activity in the annual plan)	(Target group and number of people in the plan.)	(Actual number of people intervened in the activity)	Date of implementation: Venue of activity: Implementing entity: Method of implementation: Description of activity (relevant diseases or themes/times): Effect: very good/good/average/poor/very poor If there are effects, what specific effects can be seen? (It is not necessary to make a detailed record of the process. Please only provide a simple description from activity preparation to the final wrap-up meeting, etc., including the completion date, method, times, relevant diseases and form of activity (e.g.: health education of diabetes).

				Record can be made in another form if completion in this form is difficult).
	1-2.			Date of implementation: Venue of activity: Implementing entity: Method of implementation: Description of activity (relevant diseases or themes/times): Effect: very good/good/average/poor/very poor If there are effects, what specific effects can be seen?
	1-3.			Date of implementation: Venue of activity: Implementing entity: Method of implementation: Description of activity (relevant diseases or themes/times): Effect: very good/good/average/poor/very poor If there are effects, what specific effects can be seen?
	1-x.			
Output 2.	2-1.			Date of implementation: Venue of activity: Implementing entity: Method of implementation: Description of activity (relevant diseases or themes/times): Effect: very good/good/average/poor/very poor If there are effects, what specific effects can be seen?
	2-2.			
	2-3.			
	2-x.			
Output 3.	3-1.			
	3-2.			
	3-3.			
	3-x.			
Output x.	x-1.			
	x-2.			
	2-x.			
Activities other than the above	9-1.			
	9-2.			
	9-x.			

III. Existing problems, causes and mitigation measures

(Describe which aspects fall short of the plan and analyze specific problems and the reasons according to "I. Completion status of annual objectives and results" and "II. Implementation status of annual activities". Formulate future mitigation measures according to the reasons that have been identified.)

Existing problems	Causes	Mitigation measure

IV. Relatively successful annual activities and analysis of key success factors

(Based on "I. Completion status of annual objectives and results" and "II. Implementation status of annual activities", if the completion status is good, reasons for the success should be analyzed in light of specific examples.)

V. Vision for policy improvement

VI. Identify future direction of activities based on this year's problems and analysis of success factors

(Direction of future activities should be identified based on "III. Existing problems and reasons" and "IV. Achievements that need to be particularly recorded and major success factors.")

Attach activity record materials (videos, photos, leaflets, etc.)

Appendix 2 Family Healthcare Service Supervision (Inspection) Form

This Family Healthcare Service Supervision (Inspection) Form is formulated in order to enhance project management in a standardized manner and ensure the achievement of expected project results and objectives.

The supervision (inspection) work of services is completed by the project steering committee and project experts at each level. Their supervision (inspection) work should be carried out carefully according to various elements and requirements in the supervision (inspection) form. The conduct of supervision (inspection) should adhere to the principle of fairness, justice, objectivity and transparency.

The Family Healthcare Service Supervision and Inspection Form consists of three forms and one supervision (inspection) report. The supervision (inspection) team should give scores in the three forms according to the results of supervision (inspection), calculate the total score based on the weights of each form, and write the site supervision (inspection) report. Each form has a total score of 100 points. Upon consolidation, the weight of Table 1 is 0.35, the weight of Table 2 is 0.2, and the weight of Table 3 is 0.45. When the time of supervision (inspection) is limited, priority areas of supervision (inspection) can be carried out according to selected parts of the forms.

Key methods of supervision (inspection) include: enquiry of project literature, site observations, interviews and questionnaires. Project regions should make careful and solid preparations according to the requirements of supervision (inspection) forms.

After each round of national, provincial or municipal supervision (inspection), the results should be reported to the relevant project regions within one month and practical guiding opinions on the project work should be given. Each project region should provide feedback on the opinions of supervision (inspection) within one month.

This form may also be referenced in conducting provincial or municipal supervision (inspection).

Guidance for Family healthcare services

Table 1 Service management (weight 0.35)

Category	Description	Site and target group	Data source and methods	Project requirements	Full score	Actual score
1. Progress of project institutional development	Provincial/municipal/county-level project steering groups (project steering committee), project management office (located at the health and family planning commission/bureau of project sites), relevant project documents and systems	Provincial/municipal/county-level project steering groups and offices	Inspect project documents	There should be special documents released for project implementation; There should be interdepartmental coordination and joint release of documents for the implementation of a specific service; There should be meetings and documents of project advocacy; There should be statements that put project work under the objective responsibility system; There should be documents for timely adjustments and enhancement of project implementation mechanism (project steering committee and project office).	25	
2. Project management activities	Project scheme and plan	County project office	Inspect project documents	They should be project implementation scheme and annual work plan.	10	
	Attention from county (municipal, district)-level leadership	Project steering group	Inspect project documents and listen to reports	County-level leaders should hold at least one or two meetings each year to deliberate project work and address practical problems in the course of project implementation.	10	
	Project document management	County project office	Inspect project documents	There should be complete and well-managed project documents; There should be activity plan and record sheet after each project activity; Project annual summary report should be drafted each year.	15	
3. Project supervision and guidance	Provincial/municipal supervision on project counties	Provincial/municipal/county project office	Inspect project documents and interview project management personnel	There should be proper provincial/municipal supervision with supervision reports and feedbacks.	10	
	Regular supervision of counties over townships	County project office	Inspect project documents and interview project management personnel	There should be county-level supervision over project townships each year with supervision reports.	10	
4. Project input assurance	Project matching fund and fund management; Personnel	County project office	Inspect fund allocation documents, invoices and financial records, and interview management personnel	Project special matching funds should be in place; Funds should be used for intended purposes with clear accounts; Project personnel should be in place	15	
5. Project equipment management	Management, usage and maintenance of supported equipment	County project office and county and township service	Inspect the records of equipment reception and usage, observe the status of equipment	Management, usage and maintenance of supported equipment should meet the requirements.	5	

		institutions				
Total					100	

Table 2 Development of service capability (weight 0.2)

Category	Description	Site and target group	Information source and method	Project requirements	Full score	Actual score
1. Participation in the national-level project training	Assign personnel to take part in the training	Training venue Trainees	Training record	Number and competence of trainees should meet requirements and should have continuity	5	
	Performance of trainees	Training venue Trainees	Training record	Trainees take part in training and maintain good attendance Participate proactively in training and perform well	5	
	Training effects	Training venue Trainees	Training record, questionnaire	Trainees meet the study requirements of the training course, communicate and interact with others proactively, and demonstrate a good command of the training content	5	
2. Organize retraining	Develop retraining	County project office	Inspect project documents	There should be a plan and scheme for each retraining	5	
	Early-stage preparations of	County project office	Inspect project documents	Prepare the teaching materials, instructors (mainly assumed by personnel who took part in national-level project training), funding, etc.	10	
	Organize the implementation of retraining	County project office	Inspect project documents	There should be retraining record, summary, etc.	15	
	Effects of retraining	County project office	Inspect project documents (including questionnaires),	Number of participants, coverage of training, examination result of retraining	15	
3. Capability building	Capability building plan	County health and family planning administrative departments and service institutions	Inspect project documents; interview relevant personnel	There should be a development plan of the service institution and implementing scheme (including skills development plan and implementing scheme)	10	
	Carry out daily business training	County and township health and family planning administrative departments and service institutions	Inspect project documents; interview relevant personnel	Service institutions mainly responsible for project implementing should have training plan, training record and summary, and the scope of training should be updated annually to meet the needs of health and family planning work. County service institutions should have the plan for conducting business training of township service institutions, together with training record and summary, etc.	20	
	Organize further study and daily business training	County and township health and family planning administrative departments and service institutions	Inspect project documents; interview relevant personnel	There should be a further study plan, record of the plan's implementation and summary There should be a plan for daily business training, record of the plan's implementation and summary	10	
Total					100	

Table 3 Family healthcare 3×3 services (weight 0.45)

Category		Description	Site and target group	Information source and methods	Project requirements	Full score	Actual score
1. Service environment and equipment		Relevant clinics that reflect the requirement of 3×3 service model; equipment necessary for the conduct of services	County and township service institutions	Site observation Inspect laboratory registration book Interview service personnel	There should be relevant clinics with reasonable area and conformant layout. Indoor space should be quiet, tidy, ventilated, comfortable and in appropriate temperature. Required equipment should be complete and well functional.	5	
2.Service capacity	Basic knowledge	Basic theories and knowledge about relevant services	Service personnel	Site observation and service personnel interview	Service personnel at all levels should master the basic theories and the knowledge about 3×3 services	5	
	Basic skills	Basic skills for relevant services	Service personnel, inspection personnel	Site observation and service personnel interview	Service personnel at all levels should master the basic skills of 3×3 services	5	
3. Service provision	Focus on service recipients and families		Service personnel, service recipients	Site observation and interview	Able to provide human-centered and individualized services and respect various rights of service recipients	5	
	Management system and practice	Service-related system	County and township service institutions	Inspect relevant documents	Various service management systems should be complete and compiled into hardcopy documents	5	
		Flow chart		Site observation and document inspection	There should be service flow chart posted on the service venue	5	
	Child health care services	Health education	Service personnel, service recipients, county and township service institutions	Site observation, document inspection, interview with service recipients	There should be health education plan and service record; health education should be provided according to the Guidance and Handbook; coverage and effect of health education should be focused on	10	
		Health counseling			Provide standard counseling services according to the Guidance and Handbook; there should be service record.	5	

Guidance for Family healthcare services

		Health examination			In light of the demand and service capability, conduct standard health examinations according to requirements of the Guidance and Handbook and pay attention to the feedback of examination results.	5	

Continued

Category		Description	Site and target group	Information source and methods	Project requirements	Full score	Actual score
	Pivotal health services	Health education	Service personnel, service recipients, county and township service institutions	Site observation, document inspection, interview with service recipients	There should be health education plan and service record; standard health education should be provided according to the Guidance and Handbook; coverage and effect of health education should be focused on	10	
		Health counseling			Provide standard counseling services according to the Guidance and Handbook; there should be service record	5	
		Health examination			In light of the demand and service capability, conduct standard health examinations according to requirements of the Guidance and Handbook and pay attention to the feedback of examination results.	5	
	Health services during reproductive period	Health education	Service personnel, service recipients, county and township service institutions	Site observation, document inspection, interview with service recipients	There should be health education plan and service record; standard health education should be provided according to the Guidance and Handbook; coverage and effect of health education should be focused on	7	
		Health counseling			Provide standard counseling services according to the Guidance and Handbook; there should be service records	5	
		Health examination			In light of the demand and service capability, conduct standard health examinations according to requirements of the Guidance and Handbook and pay attention to the feedback of examination results.	8	
	Health services for the middle-aged and elderly	Health education	Service personnel, service recipients, county and township service institutions	Site observation, document inspection, interview with service recipients	There should be health education plan and service record; standard health education should be provided according to the Guidance and Handbook; coverage and effect of health education should be focused on	8	
		Health counseling			Provide standard counseling services according to the Guidance and Handbook; there should be service record	5	

		Health examination			In light of the demand and service capability, conduct standard health examinations according to requirements of the Guidance and Handbook and pay attention to the feedback of examination results.	7	

Category		Description	Site and target group	Information source and the methods	Project requirements	Full score	Actual score
	Service characteristics		Service personnel, service recipients, county and township service institutions	Site observation, document inspection, interview with service recipients	Should be able to reflect the characteristics of health education, health consulting and health examination as integrated services; and reflect the characteristics of service provision with families as the unit.	5	
4. Service effects	Comments on service effects		Service recipients	Interview with service recipients, activity record (including questionnaire upon activity), service record	Questionnaires should indicate that the health knowledge and awareness of service recipients have increased and that their health attitudes and behaviors have changed Overall comment on the service: level of satisfaction according to service recipients	5	
Total						100	

Note: at least three groups should be selected for service provision for each project region of each project. If services are provided for all the four groups of population, the three groups with relatively good service delivery will be selected for the calculation of total score.

Report of Site Supervision (Inspection) on Family Healthcare Service

Drafted by: _____ Date of submission: _____

I. Date of supervision (inspection): from (mm/dd/yyyy) to (mm/dd/yyyy)

II. Location of supervision (inspection):

county (city/district), province (autonomous region/municipality)

Ⅲ.Other members of the supervision (inspection) group

IV. Description of supervision

V. Key participants at the level of province, municipality, county (city)

VI. Description of supervision (inspection) process, including supervision (inspection) method (such as meeting, site inspection, home visit, etc.)

VII. Findings of supervision (inspection)

(I) Status of service implementation (which activities have been carried out and how)

(II) Major achievements (experience, highlights)

(III) Existing problems (including difficulties encountered by project regions)

(IV) Suggestions (comments for improvement)

VIII. Final score of supervision (inspection) (calculated based on supervision and evaluation form)

Appendix 3 System of Indicators for the Evaluation of Family Healthcare Services

I. Requirements of family healthcare project (see attached form)

1. Overall requirements

Comprehensively carry out 3×3 family healthcare service

Service recipients include: children/adolescents, population of reproductive age, and the middle-aged and elderly population

Service methods include: health education, counseling (guidance) and examination

2. Requirements of healthcare service for "children/adolescents"

According to local needs (with reference to baseline survey), select no fewer than three items from the primary service catalogue of healthcare for "children/adolescents" and no fewer than six items from the secondary service catalogue for the provision of services. The service coverage for townships and the proportion of population having received the service should increase annually to achieve basic full coverage by the end of the five-year project cycle.

3. Requirements of healthcare services for "population of reproductive age"

According to local needs (with reference to baseline survey), select no fewer than four items from the primary service catalogue of healthcare for "population of reproductive age" and no fewer than eight items from the secondary service catalogue for the provision of services. The service coverage for townships and the proportion of population having received the service should increase annually to achieve basic full coverage by the end of the five-year project cycle.

4. Requirements of health care services for the "middle-aged and elderly population"

According to local needs (with reference to baseline survey), select no fewer than three items from the primary service catalogue of healthcare for "middle-aged and elderly population" and no fewer than six items from the secondary service catalogue for the provision of services. The service coverage for townships and the proportion of population having received the services should increase annually to achieve basic full coverage by the end of the five-year project cycle.

II. System of indicators for the evaluation of family healthcare services

(I) Assurance indicators

1. Relevant policy documents on the implementation of family healthcare service promulgated by the government

In conducting project supervision and evaluation during project implementation, the national, provincial and municipal-level supervisors should inspect relevant documents to investigate the substantive support given by the government in such aspects as institutional systems, policies and inputs, such as development of functions and coordination mechanism, etc.

2. Readiness ratio of matching fund committed by the government at each level

$$\text{Readiness ratio of matching fund} = \frac{\text{Actual reception of project matching fund}}{\text{Project matching fund committed by provincial (municipal, county) government}} \times 100\%$$

3. Institutional development and implementation of family healthcare service institutions

In conducting project supervision and evaluation, national, provincial and municipal-level supervisors should inspect whether the systems of service institutions are complete and whether their system implementation is powerful enough.

(II) Process indicators

1. Coverage of family healthcare for various groups of population in townships (villages, neighborhoods), reception by target groups, cooperating entity (see attached form)

2. Whether there are standard service procedures, lists and records

3. Status of collection, analysis and utilization of service information (note: see analysis report)

4. Number of health education lectures held by township and neighborhood service institutions and participants

5. Number of health education activities carried out by county service institutions using radio, TV, the Internet and mobile phone

6. Types of outpatient health counseling and number of attendances

7. Number of health consulting activities carried out at the grassroots level

8. Number of health counseling telephones received

9. Types and quantities of health education materials dispensed by the county-level service institutions

10. Times and durations of health education audiovisual materials played by county-level service institutions

11. Creation and update of health education advocacy board (by township neighborhood organizations and village committees)

(III) Indicators of results

1. Coverage of health education

2. Proportion of each target group having received health examinations

3. Ratio of health record creation

4. Health knowledge awareness

5. Ratio of health behaviors

6. Level of satisfaction for family healthcare service

Note: specific target values should be created according to the result of baseline survey.

Attached form: Quantified requirements of family healthcare service (reference)

Target group (item)	**Method of service**	**Coverage for township (Village, neighborhood) (%)**					**Ratio of service reception by target groups in township (Village, neighborhood) (%)**				
		2011	**2012**	**2013**	**2014**	**2015**	**2011**	**2012**	**2013**	**2014**	**2015**
Children/adolescents (Primary catalogue ≥3) (Secondary catalogue ≥6)	Health education	30	50	70	85	95	50	60	70	80	90
	Health counseling						—	—	—	—	—
	Health examination						—	—	—	—	—
Population of reproductive age (Primary catalogue ≥4) (Secondary catalogue ≥8)	Health education	40	60	80	90	95	50	60	70	80	90
	Health counseling						—	—	—	—	—
	Health examination						60	80	90	95	95
The middle-aged and elderly (Primary catalogue ≥3) (Secondary catalogue ≥6)	Health education	30	50	70	85	95	50	60	70	80	90
	Health counseling						—	—	—	—	—
	Health examination						50	60	70	80	90

Note: requirements for specific indicators of each project region should be determined according to the results of baseline survey.

Appendix 4 Template of Training Plan for Project County (City or District)

_____training plan for family healthcare project in _____county (city or district)

According to the work requirements and annual plan arrangements of the Japan-China Technical Cooperation Project on Family Healthcare, a training course is scheduled to be held at _____ (venue) from _____ to _____ (mm/dd/yyyy).

Specific arrangements are as follows:

I. Objectives of training

II. Scope of training

III. Method of training

IV. Target group of training

V. Instructors

VI. Method for training evaluation

VII. Textbooks and reference documents, etc.

VIII. Training agenda

_____ Training agenda of family healthcare project for _____county (city or district)

Date		Time	Description	Training method	Instructor	Remark
Day, month ( )	Am					
	Pm					
Day, month ( )	Am					
	Pm					
Day, month ( )	Am					
	Pm					

IX. Budget

This training has a total budget of _____yuan, with specific breakdown as follows:

_____ Budget details of family healthcare project for _____county (city or district)

Item of cost	**Unit price**	**Quantity**	**Total**	**Remark**
Accommodation				
Lecture				
Meal				
Photocopying				
Transportation				
Other 1_____				
Other 2_____				
Other 3_____				
Total				

X. Logistical arrangements

Appendix 5 Plan for the Provision of Family Healthcare Services for the Middle-aged and Elderly

Plan for the Promotion of Family Healthcare Service for the Middle-aged and Elderly

I. Background

China is home to the largest number of ageing population and the rate of China's population ageing is among the highest in the world despite China's status as a developing country yet to achieve prosperity and prepare for the ageing process. By 2013, China's population aged above sixty already exceeded 200 million, accounting for 14.9% of the total population. They include about 150 million patients with chronic diseases, 44.16 million seniors with disabilities and 37.5 million disabled elders. Demand of the elderly population for health care service is much higher than the average level for the general population and is far from being satisfied today. The selection of provinces for the Japan-China Cooperation Project on Family Healthcare reflects the same demographic characteristics and indicates that the incidence of chronic diseases is high for the elderly population, while the health knowledge and access to healthcare service are significantly lacking. For instance, according to the baseline survey of 2011, 40% of the middle-aged and elderly people in China have at the least one chronic disease and almost 50% of them suffer from high blood pressure. About 60% of the middle-aged and elderly do not receive any health education, more than 75% are not well informed about high blood pressure, and roughly one third of them are not well informed about diabetes. Some 75% of the middle-aged and elderly did not receive any health examination over the past one year, and respondents considered that "screening of chronic diseases" is the first choice of health examination. Nearly 80% of the middle-aged and elderly did not receive any health counseling over the past one year.

Various administrative and service institutions of the former population and family planning system carried out family-centered integrated service activities focusing on the elderly care as one of the priorities over the past few years, with a view to addressing population issues and promoting family development, and achieved preliminary results. The first cycle of the Japan-China Cooperation Project on Family Healthcare initiated in 2006 identified the 3×3 family healthcare model with children and adolescents, population of reproductive age and the middle-aged and elderly as target groups and based on the service methods of health education, health examination and health counseling, developed the Handbook and Guidance of the project, and made initial explorations of family healthcare service for the middle-aged and elderly. The second cycle of the Japan-China Cooperation Project on Family Healthcare initiated in 2011 enhanced the standardization and systematic structure of family health service activities for the middle-aged and elderly at twelve project sites, and put the healthcare service for the middle-aged and elderly under a benefit-oriented mechanism. These activities have gained certain experience.

The National Health and Family Planning Commission (NHFPC) newly created in the institutional reform of 2013 further enhanced the planning and arrangement on healthcare and

ageing population. In March 2014, the NHFPC established the Steering Group for the Work on Health, Family Planning and Ageing Population, whose office is housed at the Department of Family Development; promulgated the Plan of the NHFPC for Division of Work in the Implementation of the Opinions of the State Council on Accelerating the Development of Elderly Care Services; included relevant provisions on the integration between medical resources and elderly care resources into the Outline for the Planning of National Medical and Health Care Service System (2015-2020), and jointly promulgated Opinions on Enhancing the Development of Talents for Elderly Care Service Sector and Notice on Accelerating the Development of Health and Elderly Care Service Project; implemented the "New Family Plan" including family healthcare, science-based parenting, elderly care and cultural development; and jointly released the Notice of the Implementation of "Care For The Elderly Award" in the Health and Family Planning System, which calls for "proactively offering convenient, priority in the preferential medical and health care service for the elderly", "exploring the green channel of medical treatment, health examination and counseling for the elderly", and "providing health education and counseling for the elderly"; launched pilot programs of family planning and home-based elderly care and the integration between medical resources and elderly care resources. These pilot programs include the following project sites of the Japan-China Cooperation Project on Family Healthcare, including Xingtai, Puyang and Jinmen, which are home to the project sites of Beibei, Qinghe, Nanle and Jingshan.

The Japan-China Cooperation Project on Family Healthcare has gained a more supportive policy environment and also faces practical and urgent requirements for service standardization, promotion and service model development. In order to take stock of family healthcare service for the middle-aged and elderly carried out under the Japan-China Cooperation Project of Family Healthcare, since October 2013, we have carried out four rounds of interactive discussions with experts from (in addition to the Chinese and Japanese experts under the project, other experts include those from the Chinese Academy of Social Sciences, Peking University, Renmin University, Nankai University, Beijing Hospital, China Population Society, etc.) and project personnel in Jingshan of Hubei province, Nanjing and Beijing taking advantage of the opportunities of site guidance and national-level training to make the framework of this service model clearer and richer in its contents.

II. Principles for family healthcare service for the middle-aged and elderly under the Japan-China Cooperation Project on Family Healthcare

1. Promote healthy and active elderly live as the very purpose in conducting family healthcare service for the middle-aged and elderly and reflect this intent throughout the process of service. Follow the principle of government leadership and cross-departments cooperation.

2. Provide integrated family healthcare service. Guided by the strategy of promoting universal coverage of healthcare and promoting healthy elderly live, efforts should be made to provide integrated service of health education, health examination and health counseling; identify health problems through the entry points of health examination and expanding healthcare coverage, promote health education, health consulting and health guidance, highlight the fostering of healthy life, health knowledge and healthy attitudes and behaviors, and pay attention to the daily care of chronic diseases for the middle-aged and elderly.

3. Adhere to systematic planning and resource optimization. Properly carry out the systematic planning, cross-departmental coordination and resource integration under the local framework of

planning for public welfare, promote the exchange and interaction with pilot programs of the New Family Plan, family planning and home-based elderly care", and enhance institutionalized development.

4. Adhere to the project management paradigms. Properly carry out plan formulation, scheme design, service implementation (including quality control, follow-up activities, etc.), supervision and evaluation according to project requirements.

5. Seek support from families and communities. Pay attention to the interaction and mutual support among family members in the process of family healthcare service, the integration of communities and community resources in the process of family healthcare service, as well as the protection of rights and interests and gender sensitivity in the process of family healthcare service.

6. Extend into care and nursing service in light of actual conditions, highlighting the improvement of family care capabilities.

III. Target population, objectives and indicators of family healthcare service for the middle-aged and elderly under the Japan-China Cooperation Project on Family Healthcare

(I) Target population

Primary target population (service recipients)

1. General service recipients

The middle-aged and elderly population above the age of forty-five. The 3×3 framework initially determined under the project has identified the middle-aged and elderly as target population for the following considerations: first, to be linked with the population of reproductive age as the traditional service recipients of the former population and family planning system; second, existing basic public health services are targeted at those above the age of sixty-five, while age-related health problems require attention before the age of sixty-five years. According to relevant studies, due to physiological changes, the middle-aged population is vulnerable to many health problems and therefore, differentiated family healthcare services should be offered to them.

2. Specific target groups

(1) The middle-aged and elderly people from families that have followed the family planning policy or impoverished families that have followed the family planning policy (families whose children have migrated to cities for jobs, leaving behind the elderly family members). Considering the reality of policy environment and budget, efforts can be made to provide family healthcare services first to the middle-aged and elderly population from families that have followed the family planning policy or impoverished families that have followed the family planning policy. After the accumulation of experience and influence, further policy and funding support will be sought to carry out family healthcare services for all the middle-aged and elderly.

(2) The elderly living in welfare causes. Highlight to care for the underprivileged, integration between medical and elderly care resources and coordination with relevant departments including civil affairs departments.

Secondary target population (service providers)

Service personnel of relevant service institutions, including service personnel from the former population and family planning departments, family members identified as "health responsible persons", personnel of relevant community institutions and volunteers.

(II) Objectives and indicators

Overall goal: to enhance the health level of the middle-aged and elderly and the family

healthcare service capabilities for the middle-aged and elderly in project regions.

Specific objectives and indicators:

1. Increase the coverage of family healthcare service for the middle-aged and elderly (health examination, education, counseling and guidance) by at least fifteen percentage points by the end of project implementation over the level of local baseline survey. Methods for indicator measurement include relevant project plans and statistical reports, etc.

2. Promote the creation of health-related knowledge, attitudes and behaviors for the middle-aged and elderly. Mainly the awareness of health knowledge in four aspects including lifestyle (nutrition and diet, sports and fitness), safety and incident prevention, health care for chronic diseases and medical treatment, as well as the ratio of healthy attitudes and behaviors. For each of the above-mentioned aspects, one or two indicators that reflect health knowledge, health attitudes and health behaviors should be created. By the end of project completion, the awareness of health knowledge and the ratios of healthy attitudes and healthy habits should increase by at least ten and five percentage points respectively over the levels of baseline survey. One or two indicators should be created for each aspect and the total number of indicators is between four and eight. These indicators should increase by at least ten percentage points on average at the end of project compared with the level of local baseline survey data, as measured by questionnaires. Nevertheless, the baseline survey does not include data of accident prevention and medical treatment, so a small-scale survey can be carried out under project guidance at some project sites.

3. Promote the awareness and skills of the middle-aged and elderly for the daily care of chronic diseases. For the daily healthcare of people with high blood pressure and diabetes, the two indicators of medication according to doctor’s advice and frequent measurement of blood pressure and blood figure should be determined according to baseline survey data. By the completion of projects, these indicators should increase by at least ten percentage points over the baseline survey data, as measured by questionnaires.

4. Promote the participation of family members in family healthcare service for the middle-aged and elderly. Each project site should select two or three villages as pilot programs, focusing on the provision of integrated family healthcare service with the joint participation of family members and particularly the health responsible persons of families. This aims to enhance the communication and activities of family members over the topic of health care. Method of measurement is to increase relevant indicators in service records and carry out qualitative interviews.

5. Improved service capabilities of personnel and service rating. Self-evaluation and the baseline survey for family healthcare service capabilities for the middle-aged and elderly should increase by no less than ten percentage points and the result of service evaluation should increase by no less than ten percentage points. The frequency and the coverage of relevant training activities should increase as well. The results should be measured by questionnaires and statistical reports.

6. Progress of institutional development of family healthcare service for the middle-aged and elderly. Methods of measurement include inspection of documents, meeting records and project materials.

IV. Family healthcare service activities for the middle-aged and elderly under the Japan-China Cooperation Project on Family Healthcare

Activity 1: learn about and analyze the characteristics of the demands of target population for

family healthcare service and the methods of service provision, and formulate an overall plan of health care service for the middle-aged and elderly in the region. Conduct detailed analysis using the data of project baseline survey and the data of relevant local line departments (health and family planning, civil affairs and human resources and social security, etc.), identify overall goal, specific objectives, annual targets and measurement indicators, as well as key elements and entry points of service.

Activity 2: carry out and advocacy for evidence-based medicine to local Party and government leaders and relevant departments according to the above results of demand analysis, acquire policy and funding support, establish the working mechanism for cross-development coordination, and determine the working mechanism for policies, funding and cross-department coordination in the form of government document.

Activity 3: formulate the annual plan of family healthcare service activities for the middle-aged and elderly, and identify the time, location, number of participants, scope and funding arrangements for the service activities of the year. Design the scheme for the first service activity. Service activities scheme should be designed in a way that is friendly, preferential and convenient to the families.

Activity 4: carry out integrated family healthcare service activities for the middle-aged and elderly. Service activities include health education and lectures, examinations (basic items of examination should be included), and counseling (the results of health examination should be informed to the examinees with explanations and advises). Standard procedure should be formulated for each type of activities. Effective quality control should be in place. Service venue is generally at the county or township service institutions. In coordination with benefit-oriented activities, family healthcare services can be provided to families that have followed the family planning policy. Attention should be paid to reflect family in service delivery. For instance, wife and husband are encouraged to jointly receive integrated family healthcare services for the middle-aged and elderly; healthcare service cards that can be shared for family members should be provided to the middle-aged and elderly from families that have followed the family planning policy or impoverished families that have followed the family planning policy, so as to encourage their family members to take part in health education and health counseling; village-level service personnel should take part in health education of integrated service to learn about the results of health examination for the middle-aged and elderly and share and communicate health knowledge with the families of the middle-aged and elderly as follow-up activities; create and utilize health archives for the elderly as part of family health archives.

Activity 5: carry out “centennial exercises” and fitness activities with local characteristics in combination with family healthcare service activities, so as to advocate fitness activities with families and communities as the unit. Attention should be paid to the continuity of activities and the observation of effects and data collection that reflect unique characteristics and demonstration effects.

Activity 6: special points of time such as the Double Ninth Festival and the High Blood Pressure Day should be utilized to carry out health education and counseling activities for the middle-aged and elderly. Family healthcare education activities should be carried out by distributing health education materials through various channels and in various forms such as multi-media. Family members should be encouraged to jointly participate in the health education and counseling activities for the middle-aged and elderly in various flexible forms and share

health knowledge and determine healthcare rules in their families. Attention should be paid to the tracing of post-activity effects and the evaluation of activities by service recipients.

Activity 7: provide health counseling and health guidance in combination with the home visits of family planning and maternal and child health care and family doctors of community health service.

Activity 8: promulgate documents related to the healthcare for the middle-aged and elderly.

Activity 9: take part in national-level training and carry out retraining and enhance the capabilities to provide health education, examination and counseling in the family healthcare service for the elderly.

Activity 10: supervision, self-appraisal and guidance. Pay attention to put service under performance management and establish a coordination mechanism for the network of family healthcare service.

Activity 11: advocacy and rollout.

V. Effects of family healthcare service activities for the middle-aged and elderly under the Japan-China Cooperation Project on Family Healthcare

1. Proactive tendency is demonstrated at the level of policies and institutions.

2. Developed abundant convincing cases that have been widely applauded.

3. Data reported by various projects sites support the expansion of coverage of family healthcare service for the middle-aged and elderly.

4. Quantitative data (questionnaire and self-evaluation) support the improved service capabilities, yet more objective and convincing data are required to support the improved capacity of health education, examination, counseling and health guidance.

5. Complete and systematic quantitative data for the evaluation of service effects are lacking. Relevant data needs to be identified.

VI. Evaluation, improvement and rollout of service model

1. The service model is compatible with existing policies and demonstrates proactive policy guidance effects with the following innovations: promotion of family healthcare for the middle-aged and elderly from both the missions of public health and family development; emphasis of the role of families and family members; coordination with benefit-oriented mechanism, etc.

2. Practical significance can be confirmed and the service model can be extensively rolled out and applied and is thus sustainable.

Relevant cases

Case 1:

In September 2012, Mr. Li aged sixty-one was found to have high blood pressure during the itinerary service activity conducted at Weixing village, Zhangguotun Township of Nanle County. His blood pressure was initially measured to be 160/96 mmhg. He was advised by the doctor to have his blood pressure measured at the village health center every morning for three days in a row, and finally his condition of high blood pressure was confirmed. Mr. Li said that “were it not for the village health examination, how could I have known that I suffer from such a condition. Sometimes I felt uncomfortable in my head but I thought it was caused by poor sleep, and I would never consider measuring my blood pressure”. In the follow-up service, we provided one-on-one health guidance for him and told him to take antihypertensive drugs on time, avoid smoking, drink

less, avoid salty food, and take strolls more often. In the itinerary service activity in February 2013, Mr. Li's blood pressure was measured to be 138/82 mmhg, which means that his high blood pressure has been effectively under control. Mr. Li is very happy about the control of his condition and said to everybody he met that "I ate whatever I wanted without paying attention, but now I've quit smoking and avoid eating pork. Finally, my blood pressure is stable and I feel much better than before. Our government sets good policies and there are guys now minding the well-being of our folks, and it's free and even those in charge of family planning have changed!"

Case 2:

Mr. Xiao, a resident of Shuitu town, Beibei district, aged sixty-three, became bedridden four years ago due to cerebral vascular disease and completely lost the capacity to take care of his everyday life. In 2012, he was assessed to be "heavily disabled" and thus entitled to a monthly allowance of 400 yuan offered by the district finance office. Meanwhile, in order to provide better family health and care service for him, the district population and family planning commission requested the service station to carry out training of daily care for disabled elders in accordance with the Handbook of Reproductive Health and Family Healthcare Service. Later, family healthcare service was provided to Mr. Xiao to guide his family members to frequently turn him over, pay attention to sanitation and hygiene and prevent bedsore. His family members have been instructed to massage him to prevent muscle atrophy, pay attention to nutrition and feed him with more fresh vegetables and fruits; avoid accidents; communicate with him, read newspapers to him, tell him about the things happening outside and keep him feel optimistic. Mr. Xiao and his family members are very appreciative of the service.

Case 3:

Ms. Liu, fifty-seven, is a resident of Beibei district, Chongqing municipality and works at a nightclub. She had been suffering from abdominal pain for many years, which became more severe after having intercourse. The cause of her condition was not revealed after repeated diagnosis. Earlier this year, the family healthcare center of Beibei district carried out health examination and education activities for the members of the club. In receiving type-B ultrasonic examination, Ms. Liu was found with hyper-echogenic shadow in her uterine cavity. Our physician asked about her medical history, performed further examination and confirmed that the condition was caused by residue of an intrauterine device. The district family healthcare center conducted surgery for her free of charge and a residual metal ring of one centimeter long was successfully taken out. After surgery, Ms. Liu recovered very well and the symptoms of her abdominal pain disappeared. She was very happy and applauded the family healthcare project, which not only relieved her of pain but made her aware of the importance of health examination and healthy life. She wrote a poem to express her gratitude.

Appendix (suggested references):

I. Health Standards of China for the Elderly Population (2013)

II. Health Guidance of China for the Elderly Population

III. Guidance for the Family Healthcare and Nursing of Elderly

IV. Service Handbook of the Japan-China Cooperation Project on Family Healthcare - Healthcare for the Middle-aged and Elderly

Appendix 6 Plan for Provision of Family Healthcare Services for Adolescents

Plan for the Promotion of Family Healthcare Services for Adolescents under the Japan-China Cooperation Project on Family Healthcare

I. Background

According to the Sixth National Demographic Census, China has an adolescent population of 175 million aged between ten and nineteen, accounting for 13.1% of the total population. They are in the pubertal period of physiological and psychological development and their health conditions have always been the focus for families and the society at large. Health services for adolescents have been provided by China's health and family planning departments, educational departments, the communist youth league committees, family planning associations and other non-governmental organizations and individuals. However, according to domestic survey, adolescents still face various health problems including myopia, obesity, sleep disorder, accidental pregnancy and communicable diseases. Due to lack of health knowledge, some adolescents have unhealthy lifestyles including having no breakfast, lack of sleep, smoking and Internet addiction.

Among family healthcare project regions of central and western China, the health and family planning commissions of ten counties/districts have already operated with educational departments to successfully carry out health education, counseling and examination services for adolescents and especially students. According to the survey data and cases of some regions, these project activities have effectively enhanced the level of health knowledge among adolescents, promoted the creation of their health awareness and identified some adolescent health problems on an early date. The Seventh Cycle of Reproductive Health/Population and Development Project of the China/United Nations Population Fund and China Family Planning Association also carried out successful explorations of adolescent reproductive health services. The National Health and Family Planning Commission (NHFPC) after the institutional reform boasts better technology and network resources and should therefore play a bigger role in the health protection of adolescents. Thus, the family healthcare project will, in the expansion cycle between 2014 and 2015, continue to carry out and promote family healthcare services for adolescents based on the path of services that have been already explored and with reference to the experience of the adolescent project of the population fund and the Pilot Programs of Science-based Parenting and Healthy Adolescent Development under the adolescent project of China Family Planning Association and the NHFPC.

II. Objectives and the significance

Overall goal of the project is to enhance the adolescent health level in project regions.

Healthy adolescents are an important basis for family harmony and social development. The implementation of "family-centered" family healthcare activities for adolescents will not only promote the health protection capacity of adolescents but promote the capacity building of their families to provide health support to adolescents to help them successful experience their puberty and become healthier today and in the future.

III. Principles for the implementation of family healthcare services for adolescents under the Japan-China Cooperation Project on Family Healthcare

1. Joint provision of health services for adolescents led by the government and supported by multiple stakeholders. Healthcare services for adolescents should be supported not only by the health and family planning departments, which are only part of the resources for health care services for adolescents. Through specific projects and with government leadership, efforts must be made to explore and establish a mechanism for the provision of health services through collaboration with education departments, schools, communities and social organizations.

2. Systematically design service activities based on demand. Still in the development stage and experiencing physiological and psychological changes, adolescents of different ages and social environments have different health problems and service needs. For instance, in the junior middle school stage, adolescents should pay more attention to their physical changes and adolescents in high school should pay more attention to interactions with the opposite sex. For those adolescents who have left school, they should be more mindful of the knowledge to prevent accidental pregnancy. Therefore, the project should learn about the characteristics of adolescents of different types and systematically and scientifically design activity plans based on their needs.

3. "Pro-adolescent" family healthcare services that promote the proactive participation of adolescents. Instead of passively receiving project service, adolescents should be encouraged to take part in the whole process of project demand survey, activity design, service provision and service evaluation. In a service environment pleasant to adolescents, the health problems of adolescents should be addressed using service methods that are easy to accept for adolescents. Such participation will help design and provide "pro-adolescent" family healthcare services that are more acceptable to them.

4. Enhance the mutual health support capacity between parents and adolescents following a family-centered approach. Through health education conducted for parents, parents will learn more about the physiological and psychological development characteristics of adolescents, pay attention to their health behaviors, and create a favorable family support environment for adolescent health. Meanwhile, adolescents may also communicate the concept of health to their family members and influence them with their healthy lifestyles.

IV. Target groups and objectives of family healthcare service activities for adolescents under the Japan-China Cooperation Project on Family Healthcare

Primary target population: adolescents in project regions (aged between twelve and eighteen). Most of adolescents are students with a great deal of unsatisfied health demand and it is relatively easy to carry out healthcare services for them. Hence, project regions may give priority consideration to conducting interventions on adolescent students and when conditions are ready, shift the attention to employed adolescents, jobless adolescents, migrant adolescents, etc.

Secondary target population: parents of adolescents in project regions, health and family planning service personnel, school health instructors and other stakeholders.

Overall goal: to improve the health level of adolescents in project regions.

Project objectives:

- Improve the level of health knowledge for adolescents and help them foster scientific health concepts. Indicator: among surveyed adolescents, their health knowledge correctness ratio has increased by more than xx percentage points over the baseline level;

- Guide adolescents to cope with the pressures brought about by their pubertal changes, and gradually develop positive and healthy self-awareness and attitudes. Indicator: among surveyed

adolescents, the ratio for the formation of health behaviors and attitudes exceeds xx %;

- Foster good and responsible healthy lifestyles among adolescents to lay a solid foundation for their future health in adulthood. Indicator: among surveyed adolescents, the ratio of the formation of healthy lifestyles has increased by more than xx %.

Note: the indicators of above objectives are assessed through questionnaire survey, baseline survey and end-line assessment and survey. Specific target values will be determined according to local conditions.

V. Family healthcare service activities for adolescents under the Japan-China Cooperation Project on Family Healthcare

Activity 1: call upon the whole society to pay attention to family healthcare services for adolescents

The health and family planning administrative departments should carry out adolescent health services and advocacy for government officials, educational departments, schools and teachers and parents (at least once a year) using baseline survey data, project service data (including cases), as well as such forms as joint meetings, survey reports, lectures, public square activities and notice boards.

Activity 2: formulate the plan of family healthcare services for adolescents

In light of the service resources and capacity in project regions, the overall plan of family healthcare services for local adolescents should be formulated to determine project objectives and indicators, as well as major methods of implementation and activities; according to the overall plan, the implementation plan for the next year will be formulated at the end of each year to identify the date, venue, target groups, service providers, description and funding of each service activity for the current year.

Activity 3: pubertal health education and counseling for parents of adolescents

1. The health and family planning service institutions should collaborate with schools or the family planning/reproductive health services for women of reproductive age and provide health education at least once a year for each parent in relation to the content of classroom health education. Such health education may take the form of lectures, leaflets or parent handbooks, etc.

2. The health and family planning service institutions should provide parents of adolescents with pubertal health education, outpatient counseling, telephone counseling, QQ counseling or webpage-based counseling, etc. according to local conditions.

Activity 4: carry out health education demonstration lessons

County/district health and family planning service institutions should design the plan for health education demonstration course according to the needs of school teachers and organize experts to open health education demonstration course for the school teachers (at least twice a year).

Activity 5: community activity of “adolescent family healthcare”

County/district health and family planning commission, health and family planning service institutions and communities should join hands to organize community health promotion activities for families with adolescents and promote the health awareness and mutual health support of all family members through the organization of such activities as the “family health” games, reading and competition with joint participation of parents and adolescents.

Activity 6: adolescent health education services

1. School teachers should provide health education and counseling services for middle school

and primary school students at all grades according to local education outline.

2. The health and family planning service institutions carry out health education in the form of the leaflets, notice boards, newspapers and television for relatively serious or widespread adolescent health problems in the locality (at least twice a year).

3. The health and family planning service institutions should jointly organize with schools various parent-child activities with the theme of "family health" to promote health negation and discussion between parents and their children, enhance their attention to mutual health problems, and jointly resolve health problems (at least twice a year).

Activity 7: adolescent health counseling services

School teachers and health and family planning service institutions should provide health counseling at school, outpatient counseling at the health and family planning service institutions, hotline counseling and webpage-based counseling, QQ and WeChat communication and counseling platforms for adolescents in light of local conditions.

Activity 8: student health examination services

In light of local policy regulations, the educational commission, schools, hospitals and health and family planning service institutions should jointly provide standard health examination services for middle school and primary school students. The items of health examination should be determined according to the requirements of educational departments and local service capabilities. Health archives should be created for students and the results of health examination should be reported to students and their parents. In addition, further health guidance should be offered to families with adolescents.

Activity 9: training of service personnel of health and family planning service institutions and school teachers

The health and family planning administrative departments should carry out training of adolescent healthcare services for relevant service personnel of health and family planning service institutions and school teachers at least once a year according to the plan for the training of instructors for a duration of no less than two days.

Activity 10: supervision and guidance

The health and family planning and educational administrative departments should create a mechanism for the supervision of family healthcare services for adolescents according to the requirements of project supervision and carry out regular and random supervision activities.

Activity 11: summary of service model and policy rollout

After one year of project implementation, the model of adolescent health care services should be summarized and developed according to local conditions and elevated into adolescent health policy for regular implementation of activities and provision of services for adolescents and relevant groups.

Note: in designing local adolescent health project activities based on this model, various localities may select service elements, service methods and activity evaluation methods for different types of adolescents and enforce standard supervision and management of services and activities with reference to the Family Healthcare Service Handbook and the Guidance for Family Healthcare Service Management of the Japan-China Cooperation Project on Family Healthcare, the Guidelines of the Ministry of Education for the Health Education of Middle and Primary Schools (issued by General Office of the CPC Central Committee [2007] No.7) and Guidance for Adolescent Health Development of the pilot program for science-based parenting and adolescent

health development of the NHFPC.

Appendix 7 Plan and Application for "Specific Activity of Family Healthcare Services"

No. of application for specific activity:

Plan and Application for "Specific Activity of Family Healthcare Service"

Activity:_____

Application for funding:_____yuan_____

Period: from _____(mm/dd/yyyy) to _____(mm/dd/yyyy)

Application entity:_____

Person in charge of the project:_____

Address:_____

Postcode:_____

Telephone:_____

Fax:_____

E-mail:_____

Date of submission:_____(mm/dd/yyyy)

Guidance for Family healthcare services

Made by the Family Healthcare Project Office

Annual project objectives	(Fill in the annual project objectives for corresponding target groups in the annual plan)		
Services carried out previously and recent service plan	(Description of services carried out previously and activities to be carried out in connection with this activity)		
Analysis of current situation and guidelines for the implementation of specific activity	(First, analyze the current situation and identify problems. Identify the implementation guidelines for the specific activities of family healthcare services based on the description of conditions and capabilities for implementation, services previously offered and the plan of relevant service areas, information for the promotion of changes in knowledge and attitudes, etc.) Analysis of current situation: Identify problems Select target groups for the specific activity: Implementation guidelines for the specific activity:		
Service model characteristics of family healthcare activities	(What are the characteristics of this activity with the theme of "family healthcare"? What are the advantages compared with other activities? Please describe the characteristics of this activity. Also comment on whether the activity can be widely carried out in the future.)		
Target population of specific activity	(Fill in the target groups of this specific activity and their size determined in the target groups of selected specific activity in the above "analysis of current situation and guidelines for the implementation of specific activity."		
Objectives of specific activities	(Objectives to be achieved through this specific activity)		
Evaluation indicators for the objectives of specific activities	Evaluation method (may attach questionnaire)	Before activity (Current status)	After activity (Target Value)
1. Describe the objectives and indicators of the specific activity using texts and figures	□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )	Description should be made by figures where possible	Description should be made by figures where possible

Continued

Evaluation indicator for objectives of specific activity	Evaluation method (may attach questionnaire)	Before activity (Current status)	After activity (Target value)
2.	□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )		
3.	□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )		
X.	□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )		

	Specific activities	Indicator
Description of specific activities	Specific activity 1: Description of activity to achieve specific objectives, including the target groups and their number	(Correspondence between activities and relevant indicators)
	Specific activity 2:	
	Specific activity 3:	

	Specific activity X:	

Schedule management	Schedule management (activity progress schedule can be otherwise attached)			
Chief implementation officer	Name	Affiliation	Duty/position	Division of work

Activity Cost Estimate

Unit of measurement: yuan

Item	**Basis of calculation**	**Amount**	**Covered by the Chinese side**	**Covered by the Japanese side**
1. Air travel				
	Subtotal (1)			
2. Travel cost (excluding air travel)				
Train				
Gasoline, etc.				
	Subtotal (2)			
3. Accommodation				
	Subtotal (3)			
4. Lecture fee				
	Subtotal (4)			
5. Meals				
	Subtotal (5)			
6. Others				
Venue rent				
Banner, etc.				
	Subtotal (6)			
	Total			
Applicant’s comments	(Seal) Signature: (mm/dd/yyyy)			

Commitments of Institutions at Each level and Their Suggestions and Comments on the Plan

Institutions	**Suggestions and opinions**
Municipal population and family planning commission	□ Commitments □ Suggestions and opinions on the plan Signature: Date: (mm/dd/yyyy)
Provincial health and family planning commission	□ Commitments □ Suggestions and opinions on the plan Signature: Date: (mm/dd/yyyy)
NHFPC and Japan-China experts group	□ Commitments □ Suggestions and opinions on the plan Signature: Date: (mm/dd/yyyy)

Appendix 8 Review Items for the Application for the Specific Activities of Family Healthcare Service and the Scores

Review Items for the Application for the Specific Activities of Family Healthcare Service and The Scores

Item of review	Focus of review	Score
Previous work and plan for recent work	Provide a simple analysis of the activities previously carried out (project activities and specific activities) and the correlation with this activity	5
Analysis of current status, identify problems and guidelines for activity implementation	Analysis	
	Can effectively utilize the data of relevant departments	5
	The specific activity on the application can reflect the analysis and utilization of the results of existing family healthcare services (health examination, health education, health counseling)	
	Identify problems	
	Assess and identify problems to be resolved according to the severity, scope and solvability of problems	5
	Select target groups of the specific activity	
	Determine the target groups of specific activity after comprehensive assessment of the problem	5
	Determine the size of target groups based on the above analysis and such factors as human resources and budget	
	Implementation guidelines for the activity	
	Should include activity implementation guidelines with significant effects and families as entry points	5
	Can reflect regional characteristics and embody policy implications	
Service model characteristics of family care activities	(What are the characteristics of this activity with the theme of "family healthcare"? What are the advantages compared with other activities? Please describe the characteristics of this activity. Also comment on whether the activity can be widely carried out in the future.)	10
Objectives of specific activity	Specific objectives designed to resolve the above-mentioned problems	10
	Specific activities should contribute to the objectives of annual activities	
	In order to test the completion of objectives of a specific activity, specific indicators and their values should be determined in the application	
	There should be feasible and appropriate methods for the acquisition of indicators (evaluation method)	

Guidance for Family healthcare services

Item of review	Focus of review	Score
Description of Specific activities	Specific activities should be correlated with their objectives.	5
	Activities should be designed with "family" as entry point to highlight health promotion in a family or implemented with families as the unit	10
	Activities that can reflect innovation	
	Health education methods appropriate to the characteristics of target groups should be designed based on analysis of target groups	15
	Items of health examination closely related to the achievement of activity objectives should be selected	
	Design effective activities of health guidance and counseling on the basis of current status and demand analysis	
	Reflect the integrated, systematic and logical nature of health education, health examination and health counseling	
	Work with other departments to optimize resources and ensure cost effectiveness	5
Schedule	Feasible schedule arrangement	5
Activity cost estimate	Budget meets estimation (estimation directly related to the activity)	5
Commitments and comments of institutions at all levels	There should be suggestions and comments of municipal superior-level departments	5
	There should be suggestions and comments of provincial health and family planning commission	5
Total		100

Appendix 9 Summary Report for Specific Activities of Family Healthcare Services

Summary Report for Specific Activities of Family Health Services

Code of project activity _____

Name of activity _____

Approved budget _____(10,000 yuan)

Executing entity (seal)_____

Person in charge of the project (signature)_____

Date of completion: (mm/dd/yyyy)

Made by the Family Healthcare Project Office

Objectives of specific activity	(Fill in the information of the plan and application for activity. In order to assess the completion of overall goal from an evaluative perspective, fill in the overall goal of activity once again in the report.)
Target groups of specific activity	(Fill in the information of the plan and application for activity)
Status of activity completion	Specific activity 1
	Description of activity (target group, number and description of activity) (Respectively write the elements of activity according to the specific objectives, so as to clarify the relationship between objectives and specific activities.)
	Specific activity 2
	Description of activity (target group, number and description of activity)
	Specific activity 3
	Description of activity (target group, number and description of activity)
	Specific activity X
	Description of activity (target group, number and description of activity)

Competition status of specific objectives	Completion status of specific objective	Evaluation indicator	Evaluation method (Questionnaire attached)	Before activity (Current status)	Target value	After activity (actual value)
	1.——(Fill in the specific objectives of activity plan here) Completion status: (confirm the actual completion status according to specific objectives in the plan") (Describe the specific objective achieved by the project or the reason why the planned objective was not achieved with detailed facts.)	(Write the specific objectives in the activity plan here)	□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )	(Fill in the specific objectives in the activity plan here)	(Fill in the specific objectives in the activity plan here)	(Actual data of increase after activity)
	2.—— Competition status:		□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )			
	3.—— Competition status:		□ Questionnaire □ Early/late-stage test □ Interview □ Site survey			

	X._____ Competition status:		□ Questionnaire □ Early/late-stage test □ Interview □ Site survey □ Other ( )			

Other results of activity	(If there are other results and achievements in addition to those mentioned above, please write here)
Service model characteristics of family healthcare activities	(Analyze the characteristics of this activity that can serve as "model of family healthcare activities." What are the significant achievements of this activity with families as the entry point? Whether the mutual interaction among family members has enhanced activity effects? State in which aspects is this activity more effective in comparison with previous activities)
Possibility for the extensive rollout in the future	(Whether it is feasible to extensively carry out this activity judging by the results of this activity? What improvements are necessary if extensive rollout is difficult? In addition, if it is possible to so, state the methods for future implementation on a wide scale.
Problems and suggestions	Question 1: (review specific activities and identify problems)
	Suggestion: (analyze each and every problem, and raise suggestions. Write the opinions of relevant persons)
	Question 2:
	Suggestion:
	Question 3:
	Suggestion:
	Question X:
	Suggestion:

Continued

Share activity experience	(Activity experience, improvise)
List of appendices	(List the documents, technical materials, photos, etc. that can prove the activity process below by type and the sequence numbers. Other materials should be made into a compact disk as attachment to be submitted together with the summary report. The name of each document or photo should clearly indicate its content.
Final account of cost	Please refer to Final Accounts of Activity Funding
Report the review opinions of leaders (ask the leaders at each administrative hierarchy the provide specific opinions)	County: Review comments: Signature: _____ Date: _____ City: Review comments: Signature: _____ Date: _____ Province: Review comments: Signature: _____ Date: _____

Activity Budget

Activity duration: _____

Activity venue: _____

Unit: yuan

Item	Basis of calculation	Amount	Covered by the locality	Covered by the Project Office
1. Air travel				
	Subtotal (1)			
2. Travel cost (excluding air travel)				
	Subtotal (2)			
3. Accommodation				
	Subtotal (3)			
4. Lecture fee				
	Subtotal (4)			
5. Meals				
	Subtotal (5)			
6. Others				
	Subtotal (6)			
	Total			

Epilogue

The writing of this *Guidance* started at the beginning of the second cycle of the Japan-China Cooperation Project on Family Healthcare and lasted for four years. During this period of time, the Chinese and Japanese project experts and the service and management personnel of project regions took part in the discussion for many times. Therefore, this Guidance is the joint achievement of the family healthcare projects and family healthcare service participants.

The first draft of the *Guidance* was completed by the end of 2012 and mainly drafted by the first Japanese chief adviser Mr.Hidetaka Ieyasu (家保英隆), director of the Chinese experts group Dr. Ru Xiaomei, deputy director Professor Wen Yong, project member Associate Professor Zhou Jianfang, project officer Mr. Song Bing, et al. It was finally edited by Mr.Hidetaka Ieyasu and Professor Wen Yong. Japanese long-term expert Ms. Miki Yoshimoto (吉本美纪) took part in the discussion and text editing of this Guidance. Since the beginning of 2013, this *Guidance* was used on a pilot basis at twelve project sites. In the second half of the same year, we began to collect feedback on the use of this Guidance from these project regions and their opinions and suggestions on the revision of this *Guidance*. Between October and December 2013, two workshops were held with the participation of project experts and personnel from project provinces, cities and counties, which were followed by the first revision of the *Guidance*. In April 2014, discussions with relevant personnel of the "New Family Initiative" were made at the "Family Development and Family Healthcare" seminar. The first revised draft was read and edited by Dr. Ru Xiaomei. Considering the continuous progress of institutional reform and other developments, the opinions and suggestions of project regions on the revision of the *Guidance* were collected for another time in the second half of 2014 and the second revision was made to the *Guidance*. Based on the summary of project experience, two revision workshops with the participation of project experts were held in the first half of 2015 to initiate the third revision and supplement, which made minor adjustment to the structure, supplemented the content and made multiple rounds of improvement through cross-review and cross-revision. In this stage, the second Japanese chief adviser Mr. Yukio Honma (本间由纪夫), Japanese long-term expert Ms. Fujimoto (藤本) and Ms. Tomohiro Uchiyama (内山智寻), as well as Chinese project experts Dr. Shu Xingyu, Professor Zou Yan, Professor Wu Shangchun et al. successively participated in the writing and discussion of the *Guidance*.

For the current final draft of the *Guidance*, various chapters and appendices are written by: Chapter I by Ru Xiaomei, Hidetaka Ieyasu, Zhou Jianfang; Chapter II by Zhou Jianfang, Hidetaka Ieyasu, Chapter III by Wen Yong, Hidetaka Ieyasu, Michiko Fujimoto (藤本美智子), Yukio Honma; Chapter IV by Hidetaka Ieyasu, Zhou Jianfang, Tomohiro Uchiyama, Ru Xiaomei; Chapter V by Shu Xingyu, Zhou Jianfang, Zou Yan, Tomohiro Uchiyama, Yukio Honma; appendices by Ru Xiaomei, Wen Yong, Yukio Honma, Fujimoto Michiko), Tomohiro Uchiyama , Zhou Jianfang, et al. The final draft was compiled by Yukio Honma with the assistance of Professor Wen Yong.

October 8, 2015