CDPF Publication No.16

UN-Spain MDG Achievement Fund
China Culture and Development Partnership Framework

Maternal and Child Health in Ethnic Minority Areas

ADVOCACY TOOLKIT

English Version – December 2010

MDG ACHIEVEMENT FUND IN CHINA

Introduction

UN-China Joint Programme Culture and Development Partnership Framework (CDPF)

The China Culture and Development Partnership Framework is a 3-year (2009-2011) joint initiative of the UN and the Chinese Government, coordinated by the Ministry of Commerce, the State Ethnics Affairs Commission and UNESCO, and funded by the UN-Spain MDG Achievement Fund. Its objectives are to design and implement policies that promote the rights of ethnic minorities, to empower them to better manage their resources and thus to benefit from culture-based economic and social development. The joint initiative is implemented in 6 counties in Yunnan, Guizhou, Qinghai Provinces and Tibet Autonomous Region, jointly agreed upon by the Government of China and the UN system.

Health Component of CDPF: improve Maternal and Child Health in ethnic minority areas

In the framework of the CDPF, the Ministry of Health (MOH), the National Population and Family Planning Commission (NPFPC), UNICEF, WHO and UNFPA are collaborating to develop and test at community level an innovative approach to health care and service provision among ethnic minorities in South West China. The intention is to understand cultural factors influencing health, especially Maternal and Child Health (MCH) seeking behaviour and MCH programmes/services, and to address those for improved health outcomes.

Target audience of the Advocacy Toolkit

The toolkit is primarily designed for health care managers and providers operating in ethnic minority areas. As it encourages culturally-sensitive innovations in MCH programmes, it is secondarily designed for MCH policy makers.

Purpose of the Advocacy Toolkit

The purpose of this toolkit is to encourage the adoption of culturally sensitive approaches in the MCH programmes in ethnic minority areas as per the scope of the programme. It provides basic information on ethnic minorities in China, reviews the main findings of the baseline surveys conducted in 2009 and advocates for relevant implementation of culturally sensitive approaches based on those findings.

Acknowledgements

This toolkit has been elaborated by UNFPA China. The authors appreciate the support and valuable inputs provided by UNICEF China, National Center for Women and Children's Health, China CDC (NCWCH), Minzu University of China (MUC), the China Population and Development Research Center (CPDRC) and UNFPA Asia and Pacific Regional Office (APRO).

ONE

Miao women and girl, Leishan county, Guizhou – MUC

Dong women, Congjiang county, Guizhou – Congjiang Population and Family Planning Bureau

Section One. *Background and commitments of the UN-China Culture and Development Partnership Framework.*

The 2009-2011 *China Culture and Development Partnership Framework (CDPF),* a joint initiative of the UN and the Government of China, is grounded in the plans and policies of the Government of China, which has targeted ethnic minority development as a high priority.

1. Ethnic Minorities in the International and Chinese Legal Framework

The rights of ethnic minorities (EM) are covered in international Conventions and Declarations (see table 1 below), in particular the 1992 *Declaration of the General Assembly on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities,* which summarizes the provisions concerning minorities contained in previous international instruments. This Declaration calls States to protect the existence of minorities and to encourage conditions for the promotion of minority identity. Persons belonging to minorities have the right, among other things, to enjoy their own culture, use their own language and practice their own religion. China has ratified major international instruments pertaining to minority rights:

Table 1. Major international instruments pertaining to minority rights ratified by China	
International Convention on the Elimination of All Forms of Racial Discrimination – 1966	Ratified in 1981
International Covenant on Economic, Social and Cultural Rights – 1966	Ratified in 2001
CEDAW / Convention on Elimination of All Forms of Discrimination against Women – 1979	Ratified in 1980
Convention on the Rights of the Child – 1989	Ratified in 1992
ILO 111 Discrimination (Employment and Occupation) Convention – 1958	Ratified in 2006
ICPD POA / International Conference on Population and Development Programme of Action – 1994	Signed
UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities – 1992 *Not legally binding*	Decl. adopted without a vote
Beijing Declaration and Platform for Action – 1995	Signed
UN Declaration on Rights of Indigenous People - 2007 *Not legally binding*	Vote in favor

Sources: 1. Website of UN Human Rights Council; 2. 2009 "State of the World's Minorities and Indigenous People" from Minority Rights Group International

In addition, China has emphasized the rights of 56 official Nationalities in its National Constitution, which guarantees that ethnic minorities enjoy the same political and economic rights as the majority Han population and are also entitled to freedom of religious belief, the right to use and develop their own spoken and written languages and the freedom to preserve – or change – their cultural traditions and customs. These rights have been reconfirmed in the 2001 *Law on Regional National Autonomy.*

Furthermore, ethnic minority development has been identified as **a high priority in the overall development framework of China,** and since 2000 several important national plans have been launched. These include among others the 2001-2010 *Ten Year Rural Poverty Alleviation and Development Plan, the Western Development Initiative* (which covers 80 percent of the ethnic minority population), the *Development Plan for Small Ethnic Minorities and the 11th Five Year Plan on the Development of Public Affairs for Ethnic Minorities.* Likewise, the recent 2009-2010 *National Human Rights Action Plan of China* lists the additional measures to protect the rights and interests of ethnic minorities.

2. Socio-economic challenges for Ethnic Minorities in China

Ethnic minorities in China comprise **8.5 percent of the national population** – a population of nearly 106 million. Like the rest of the population, they have made definite progress in overall socio-economic and political development; nonetheless ethnic minority regions contain nearly **52.5 percent of the country's poor.**[1] Due in part to the challenge of addressing the needs of those living in rural and especially remote rural areas, they belong to the underserved populations in terms of national health expenditure per capita and medical insurance coverage. Their **lower levels of education and health** are shown by generally poorer social indicators.

A UN-China *Review of the Maternal and Child Health Survival Strategy in China* (2007) found in particular that the maternal, infant and under-5 mortality rates in the 12 Western provinces[2] are significantly higher than the national average. Because they primarily live in remote areas, it is more difficult for health programmes to reach EM effectively. Consequently, they often lack access to good quality and affordable health services, lack knowledge of available services and have higher rates of sickness and nutritional deficiency. Although similar challenges also apply to the Han population living in remote areas, **the uniqueness of the cultures and languages of the EM means that there are additional complexities,** for instance when there is a lack of health information available in ethnic languages.

Miao Woman, Leishan county, Guizhou – MUC

Jingpo woman working and taking care of her child, Congjiang county, Guizhou – Congjiang Health Bureau

Grandmother and her grandchild, Gyamda county, Tibet AR – UNFPA China

[1] Living with less than 1$ per day
[2] A high percentage of the populations living in the Western Provinces are ethnic minorities. These Provinces include Yunnan, Guizhou, Qinghai and Tibet Autonomous Region

3. Objectives and commitments of the CDPF

The CDPF aims to address the task of integrating culture into development specifically for China's ethnic minority population. This is done through building government capacity to undertake rights and culture-based development in the selected sites and through supporting China in designing and implementing policies that promote the rights of its ethnic minority groups.

A main component of the CDPF focuses on Maternal and Child Health (MCH) care. It intends to pilot a modified approach to health care and service provision which includes culturally appropriate strategies developed and tested at the community level, using a participatory approach. The goal is first to understand the intricate relationship between culture and successful achievement of health targets per site, and second to formulate successful results into models to be integrated into health care policy in ethnic minority areas.

The context for MCH is provided by the *2007 Review of the MCH Survival Strategy,* which provides a key foundation for a focus on ethnic minorities by highlighting the prevailing disparities in health indicators in the rural areas where most minority communities are located. The Review concluded that the main determinants of poor MCH in China were poverty, poor education, gender imbalances, financial and cultural barriers to service access. It recommended *"the delivery of a culturally adapted, essential package of MCH-focused health interventions in priority rural areas".*

Central and local level partners have committed to address the herein mentioned aims and issues. The distribution of roles and responsibilities outlined in the Joint Programme Document is as follows:

- **Ministry of Commerce (MOFCOM):** overall coordination of the Programme.
- **State Ethnic Affairs Commission (SEAC):** lead role on coordination of technical aspects of the Programme and implementation of certain Components.
- **United Nations Educational, Scientific, and Cultural Organization (UNESCO):** lead UN agency for coordination and implementation of the programme.
- **Ministry of Health (MOH):** lead national partner of the MCH Component; overall responsibility to work with provincial and local level health bureaus to implement the MCH Component.
- **National Population and Family Planning Commission (NPFPC):** co-implementing partner of the MCH Component; overall responsibility to work with provincial and local level FP bureaus to contribute to the MCH Component.
- **United Nations Children Fund (UNICEF, lead UN agency for MCH Component), World Health Organization (WHO) and United Nations Population Fund (UNFPA):** co-funding UN agencies; provide financial and technical support, advocate on MCH and culturally sensitive programming.
- **Academic institutions:** they are mobilized by national and UN partners to conduct specific researches and provide technical assistance, based on requirements.

TWO

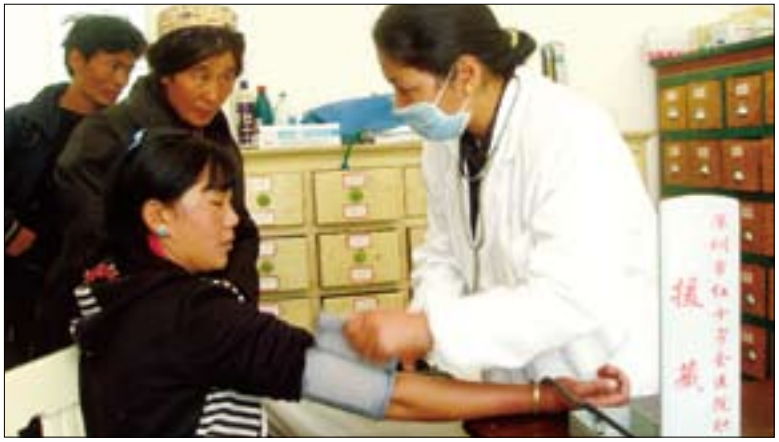
Section Two. *Culturally sensitive programming in the health sector: why is it important?*

Miao women at local health service station, Leishan county, Guizhou – MUC

A culturally-sensitive approach is a policy and programming approach aiming to transform practices from within by using societies and communities' own dynamics of change. It calls for 'cultural fluency': familiarity with how cultures work and how to work with cultures.

1. In the health sector, Culture matters

Culture is "*the set of distinctive spiritual, material, intellectual and emotional features of a society or a social group; in addition to art and literature, it encompasses lifestyles, ways of living together, value systems etc.*"[3] It relates to beliefs, attitudes, norms, behaviors and traditions that are learned and shared in the process of membership and socialization in groups. Cultures are dynamic, responding to change and internal and external stimuli. People are not only products of their cultures, but also active actors who can contribute to change. Not surprisingly, culture deeply influences people's health practice and behavior.



Tibetan woman receiving health care in local health Service station, Gyamda county, Tibet AR – MUC

[3] UNESCO definition

Culture consists of both material and non-material aspects	False assumptions in relation to culture
Material aspects • Settlements and land use • Buildings and monuments • Local design of housing • Crafts and skills • Performing arts • Food **Non Material aspects** • Values and beliefs • Rituals, traditions • Behavior • Language • Folklore and oral tradition	• All communities are homogeneous • Government and local communities share the same goal for development • Availability of health services lead to their use • Knowledge leads to desire behavior change • Traditional forms of health care are easily replaceable

Given the influence of socio-cultural factors, decision making on health issues is not an individual process and health seeking behavior is shaped by social relations at local level. Thus, **the simple availability of health services doesn't necessarily lead to their use and knowledge doesn't necessarily lead to desired behavior change.** In order to be effective and sustainable, change must come 'from within' and must be internalized through community-based consensus building.

International good practices have shown that MCH strategies that are sensitive to cultural values can reduce harmful practices and increase service utilization: MCH practitioners need to have a better understanding of the way people think, believe and behave and use such knowledge as the basis for designing interventions. Understanding cultural realities can help reveal effective ways to challenge harmful practices and strengthen beneficial ones. This is particularly important when addressing the needs of ethnic minorities who, generally speaking, define health in holistic terms, incorporating not only physical, emotional and psychological dimensions but also spiritual perspectives. Practices and values that are non harmful and that maintain ethnic minorities identities should be respected and promoted.

2. Achieving the MDGs 4 and 5 also among ethnic minorities

Specifically addressing the MCH gaps and needs among ethnic minorities are key for the successful achievement of the Millennium Development Goals (MDGs) adopted in 2000 by the international community, because it means addressing important remaining inequalities. In addition to addressing the well-identified gaps in terms of human, financial and material resources, incorporating culturally sensitive approaches in MCH strategies can contribute to positive health outcomes.

Distribution of an apron wirth MCH messages to women, Leishan county, Guizhou – Leishan Population and Family Planing Bureau

Interview of Jingpo mother and grandmother(left), Longchuan county, Yunnan – MUC

MDG 4 / REDUCE CHILD MORTALITY

Target 4: Reduce mortality rate among children under 5 by 2 thirds by 2015

- **Indicator 4.1:** Under 5 mortality rate
- **Indicator 4.2:** Infant mortality rate
- **Indicator 4.3:** Proportion of 1 year old children immunized against measles

MDG 5 / IMPROVE MATERNAL HEALTH

Target 5A: Reduce the maternal mortality ratio by 3 quarters by 2015

- **Indicator 5.1:** Maternal mortality ratio; Indicator
- **Indicator 5.2:** Proportion of births attended by skilled health personnel

Target 5B: Achieve universal access to reproductive health by 2015

- **Indicator 5.3:** Contraceptive prevalence rate
- **Indicator 5.4:** Adolescent birth rate
- **Indicator 5.5:** Antenatal care coverage (at least 1 and at least 4 visits)
- **Indicator 5.6:** Unmet need for family planning

Outreach health education in village, Hualong county, Qinghai – Hualong Health Bureau

China continues to make outstanding progress in its drive to achieve the MDGs. As highlighted in *the China's Progress towards the Millennium Development Goals 2010 Report,* many targets have been achieved ahead of the 2015 deadline, including those relating to reducing child under 5 mortality rate. China is also on track to reduce maternal mortality by 2015.

Despite these considerable achievements, a number of significant challenges remain concerning MDG 4: *the China's Progress towards the Millennium Development Goals 2010 Report* acknowledges that *"there are still huge disparities in child mortality rates across different regions and populations in China. Although the mortality gaps have decreased numerically, mortality in poor western provinces and regions remains higher than that of the wealthy eastern provinces (…) infant and child mortality is almost 2.7 times higher in the western than eastern region".* Most ethnic minorities live in the Western provinces. The Report adds that *"there are still differences in the quality of accessible healthcare services available. Sub-standard services tend to affect rural and poor populations, the floating population and children of ethnic minority families".*

Concerning MDG 5, *the China's Progress towards the Millennium Development Goals 2010 Report* underlines that although China may indeed reach its target of reducing Maternal Mortality Ratio *(*MMR) by 75%, *"regional differences remain, with the MMR in western provinces and regions remaining far higher than that of eastern provinces".* In the challenge's section, the Report adds that *"disparities in access remain fairly considerable. As far as the poor populations, floating populations and ethnic minority people are concerned, there are big differences in terms of access to services, not to mention quality of service".*

THREE

Interview of Hui young girl (left), Hualong county, Qinghai – MUC

MCH education to Miao women, Leishan county, Guizhou – Leishan Population and Family Planning Bureau

Section Three: *Maternal and Child Health situation in 6 ethnic minorities areas of China*

The *China Culture and Development Partnership Framework* is implemented in 6 counties jointly agreed upon by the Government of China and the UN system:

- Longchuan county and Mang city in Yunnan Province *(Jingpo and Dai are the main ethnic minorities living in these counties)*
- Leishan and Congjiang counties in Guizhou Province *(Miao and Dong people)*
- Hualong county in Qinghai Province *(Hui people)*
- Gyamda county in Tibet Autonomous Region *(Tibetan people)*

1. Survey on Maternal and Child Health situation in the 6 pilot sites of the CDPF Program

Two studies were conducted in 2009 in the Counties of the CDPF. The first was a quantitative survey[4] looking at MCH status and service delivery which confirmed huge disparities, even higher than official figures.

At communities' level:

- **Low health status.** The rate of anemia[5]-51 percent-among women of reproductive age was extremely high in the 6 sites (the national rural average being 25 percent[6]). Similarly, the anemia rate of 57 percent (national rural average being 19 percent[7]) and the malnutrition among children under 5 were found to be severe.
- **Low health utilization.** One time ante natal care (ANC) coverage in project counties was 77 percent (national rural average: 91 percent); the proportion of pregnant women receiving at least 4 times antenatal check-ups of 5 essential items was 48 percent. The hospital delivery rate in project counties was 61 percent (national rural average: 92 percent) and, of particular concern, 77 percent of the non-hospital deliveries were not attended by a skilled birth attendant.
- **Low health awareness.** The knowledge of the local population about MCH issues was poor: low awareness of danger signs of pregnancy, low awareness of danger signs of childhood illnesses.

At health services' level:

- **Low capacity and quality of the local MCH system.** The technical capacity of local MCH system was insufficient. While only 37 percent of townships hospitals provided basic emergency obstetric care in terms of skills, only 59 percent of obstetricians and 30 percent of pediatricians passed the knowledge and skills assessment[8]. Only 23.5 percent of respondents had received a postpartum visit, provided by village level doctors or township level MCH workers.

The main MCH findings of the baseline survey[9] are summarized in the Table 2 below:

Table 2. Key findings related to MCH in the 6 CDPF Counties

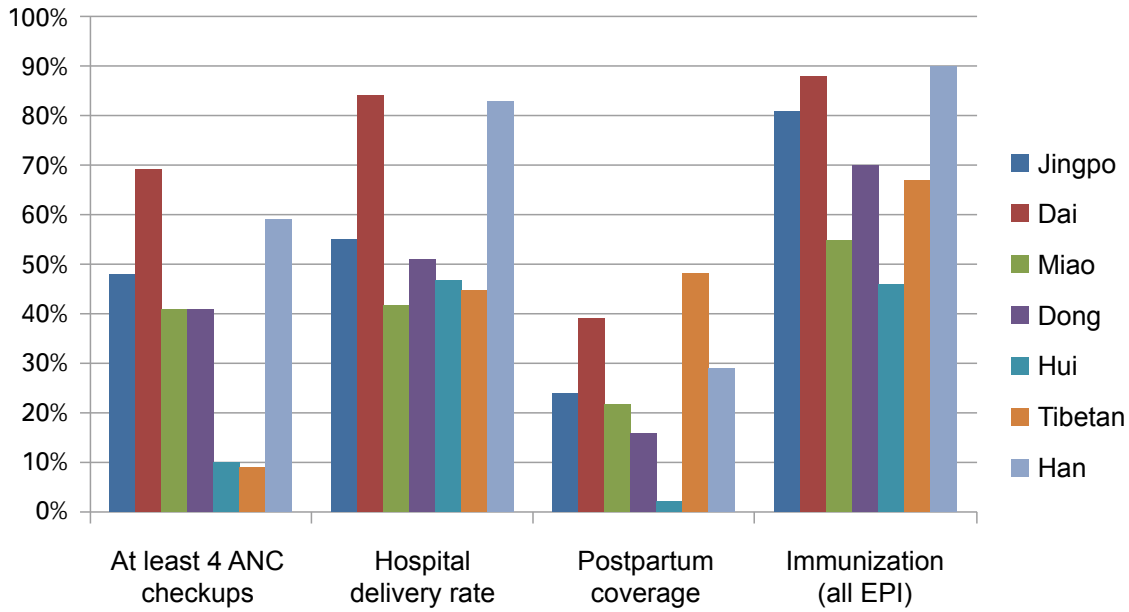
Name of county, Name of province	Longchuan, *Yunnan*	Mang city, *Yunnan*	Leishan, *Guizhou*	Congjiang, *Guizhou*	Hualong. *Qinghai*	Gyamda, *Tibet*[10]
Proportion of ethnic minority vs. total population[11]	56%	49%	98%	97%	72%	95%
Main minority groups	Jingpo, Dai, Achang, Lisu, Deang, Hui	Dai, Jingpo, Deang, Lisu, Achang	Miao, Shui, Dongm Yao, Yi, Buyi	Dong, Miao Zhuang, Yao, Shui	Hui, Tibetan, Salar	Tibetan
Maternal health (pregnant women and mothers)						
Prevalence of anemia among mothers of children aged 24-59 months	High (61%)	High (47%)	Significant (33%)	Significant (38%)	Very high (87%)	Very high (90%)

[4] Conducted by the National Center for Women and Children's Health, China CDC (NCWCH) and the China Population and Development Research Center (CPDRC) and supported by UNICEF/UNFPA
[5] The anemia rate was calculated according to the WHO Anemia Standard.
[6 and 7] According to the 2005 China Food and Nutrition Surveillance Report
[8] These percentages were calculated based on the results of the exam on a small scale health staff (54 people).
[9] Sample size: 1,239 children under 5; 774 mothers of children under 5
[10] Sample size in Gyamda was very small: results may not be significant and should be viewed critically
[11] Data were provided by Longchuan, Mang Leishan, Congjiang, Hualong, and Gyamda County (City) Health Bureaus.

Coverage and completion of antenatal checkups (% at least 1 visit, % completion of 4 visits)	Comparatively better (95%, 47%)	Comparatively better (94%, 71%)	Low (65%, 44%)	Low (57%, 40%)	Relatively good 1st visit, poor 4 visits (80%, 7%)	Relatively good 1st visit, poor 4 visits (74%, 6%)
Hospital delivery rate	Comparatively better (80%)	Comparatively better (76%)	Very low (37%)	Low (53%)	Low (58%)	Very low (28%)
Post partum visits' coverage (at least one visit)	Very low (22%)	Low (33%)	Very low (23%)	Very low (18%)	Very low (8%)	Comparatively better (48%)
Skilled birth attendance at non-hospital deliveries	Very low (22%)	Very low (20%)	Very low (15%)	Low (27%)	Very low (13%)	Comparatively better (52%)
Awareness of at least 3 danger signs of pregnancy (among women and caregivers)	Very poor (7%)	Poor (23%)	Very poor (2%)	Very poor (2%)	Very poor (2%)	Very poor (0%)
Child health (children under 5)						
2-week prevalence of morbidity (% diarrhea, % cough & % suspected pneumonia)	Significant (22%, 31%, 8%)	Significant (14%, 30%, 9%)	Significant (18%, 29%, 2%)	Significant (13%, 24%, 4%)	Significant (14%, 32%, 13%)	High (25%, 63%, 35%)
Prevalence of anemia (% moderate + severe)	High (69%)	High (58%)	Comparatively low (15%)	Significant (35%)	Very high (92%)	Very high (100%)
Prevalence of malnutrition (% underweight –moderate + severe- and % stunting)	High (37%, 63%)	High (42%, 51%)	High (42%, 73%)	High (44%, 62%)	Significant (21%, 40%)	High (13%, 58%)
Breastfeeding practices (% early initiation, % exclusive breastfeeding for 6 months & % continued at 1 year)	Poor (12%, 4%, 8%)	Comparatively better (50%, 18%, 33%)	Poor early initiation (8%, 31%, 62%)	Poor early & exclusive (11%, 15%, 52%)	Poor (16%, 18%, 6%)	Poor (5%, 0%, 50%)
Immunization coverage (5 EPI vaccines: BCG, measles, hepatitis B, DPT, CPV)	Comparatively high (81%)	Comparatively high (88%)	Insufficient (55%)	Insufficient (70%)	Insufficient (46%)	Insufficient (67%)

The survey collected systematically ethnic-disaggregated data in order to examine possible disparities between the different ethnic groups living in one area. The findings illustrated wide differences among the groups (see table 3 below). Home deliveries without skilled birth attendants remain worryingly high in Gyamda, Leishan, Congjiang and Hualong Counties. Notably, the Han and Dai people living in the 6 areas have on average better indicators than the other groups.

Table 3. Comparison of MCH coverage disaggregated by ethnicity in the 6 pilot sites



* Post partum visits' coverage: at least one visit. Number of visits ranged from 1 to 8, average was 2.14

* Immunization coverage: completion of all EPI means that the child under 5 has received hepatitis B, Measles, BCG, DPT & CPV

Miao girls in Congjiang county, Guizhou – UNFPA China

Jieba village in Gyamda county, Tibet AR – UNFPA China

Miao Boy in Congjiang county, Guizhou – UNFPA China

2. Study on traditional beliefs and practices regarding Maternal and Child Health (MCH)

The second survey undertaken was a qualitative study to identify beliefs and practices in relation to MCH among the 6 main ethnic minorities in the pilot counties. The study[12] revealed that socio-cultural factors and traditional beliefs and practices play a significant role in health related behaviors.

At communities' level:

Enabling factors identified.

- Despite continued allegiance to religious and animist beliefs and practices, these do not appear to be barriers to the uptake of MCH. On the contrary, the groups involved in the study do not resist the advantages brought by development. They willingly utilize MCH services when they perceive there is an advantage in doing so. In fact, all groups seek medical and spiritual guidance from their own traditional and religious leaders, at the same time as they consult MCH services, recognizing that each plays a valuable role depending on the nature of the problem. Spiritual guidance was therefore seen to be complementary to modern medical care, usually addressing different needs.
- As the benefits of economic development reach them and as exposure to modern MCH (such as hospital delivery) increases, so there is an apparent willingness of those who have been exposed to new ideas to adopt these practices. These findings are evidence that cultures are not static but are subject to influence and change once evidence of benefits is recognized. Young people in particular from the six ethnic groups indicated a growing acceptance of 'modern' ideas regarding maternal health care, particularly those young people who had worked or studied

[12] Conducted by the Central University for Nationalities (MUC or Minzu University) supported by UNFPA

Ambulance on the way to a village, Congjiang county, Guizhou – Congjiang Health Bureau

away. This is an opportunity for the health system. However even though some young people expressed willingness to attend ANC and to have hospital deliveries, most said that parental influence is very strong and takes precedence over individual preferences. This means that changes in thinking among young people are not necessarily reflected immediately in behavior change.

- Another factor that could contribute towards increased services' uptake is the suggestion made by a number of respondents that a collaborative approach would likely achieve better results. Collaboration based on mutual respect between MCH providers and traditional leaders and healers could lead to effective partnership around issues of shared concern.

Challenges identified.

A number of constraining factors were identified that impact on the uptake of services:

- **Antenatal practices:** women from all groups have little awareness about the importance to attend ante-natal care (ANC). The efforts of local health bureaus have yielded limited results as women only go to hospital when they have symptoms of ill health. Moreover, opportunity costs[13] are high: women contribute to family labor and being pregnant does not prevent them continuing to work, particularly during busy cultivation periods, so they cannot afford the time to go for ANC.
- **Delivery practices:** although hospital delivery is free and the benefits have been largely publicized, many women still expressed a preference for home deliveries. Some practices associated with home deliveries constitute a threat to infant health, such as cutting the umbilical cord with bamboo, putting ashes on the wound etc. These are challenges at

[13] An 'opportunity cost' is the cost of an alternative that must be forgone in order to pursue a certain action. It refers to the benefits one could have received by taking an alternative action.

community level. Some other practices are not harmful but are a challenge at service level, since they may require adaptations from the health system: some Dong and Miao respondents mentioned for instance preferring to deliver in non horizontal positions (this is a practice common to many indigenous communities around the world), yet the health facilities usually allow the horizontal position only. The Miao, Dong, Jingpo and Hui communities have practices of burying the placenta and umbilical cord after delivery, in some cases associated with providing a 'home' for the spirit of the infant. It should therefore be ensured that parents are allowed to bring the placenta and umbilical cord home if they deliver at the hospital.

- **Postpartum practices:** among all targeted ethnic groups, except the Tibetans, a key post partum practice is the custom of household confinement, which usually lasts for a month. Among the Miao, postpartum women are viewed as being 'unclean', which makes them reluctant to leave the home for postpartum checkups. This is a challenge for the health services: confinement should not prevent women from getting post natal checkups, a good outreach programme needs to be in place. The quantitative survey showed that postpartum visits are conducted by village doctors or township MCH workers to check-up the health status of the newborns and the postpartum women. On average, the first postpartum visit was 9 days after delivery, i.e. during the confinement period. However, also according to the survey, only 23.5 percent of respondents had received postpartum visits: the outreach program for postpartum checkups needs to be strengthened and expanded.

Miao Woman, Congjiang county, Guizhou – UNFPA China

- **Neonatal care:** exclusive breastfeeding is not practiced by the Dong, Jingpo, Dai and Tibetans. Partially chewed sticky rice is introduced for the baby within a week after birth among the Dong, Jingpo and Dai, and tsamba[14] paste among the Tibetans. Current medical evidence however recommends exclusive breastfeeding for 6 months without any soft, semi-solid or solid food.

[14] Tsamba is made of barley flour. Barley is a cereal, of the family of grasses used for food and for making malt

Gender dynamics.

- **Gender dynamics** are fairly traditional of a patriarchal society: they dictate that girls take on 'female' roles and boys take on 'male' roles from an early age within all ethnic groups. There is similarity in the identity and role of caregivers, with new mothers and elderly women being the primary caretakers. In cases where women are employed outside the home, increasingly older women are responsible for looking after infants. Decision-making in the family appears to be based on fairly traditional lines, with women responsible for decisions in the domestic domain and men for matters outside the home. The role of mothers-in-law is very important among all six groups regarding decision making on maternal health and care of children.
- **Child sex preference** is an important issue among the Dong and Miao who prefer sons. This is closely associated with preservation of the family lineage. The abandonment on female infants was mentioned among these 2 groups, and the reported sex ratio imbalance is high in southeast Guizhou. No evidence was cited of different feeding practices for boy and girl infants or different access to medical treatment.

At health services' level:

Quality of services.

- **Low quality of health services:** condition of facilities and equipment, presence of trained staff at service delivery points and friendliness and attitudes of service provider attitudes are all aspects that influence people's decisions on whether or not to visit MCH facilities. Comments were made that sometimes there are insufficient female MCH staff, that many staff are inexperienced, that staff do not always know how to operate equipment or how to perform emergency obstetric care (the quantitative survey confirmed the gaps in terms of resources, equipment and skills).

Barriers between users and providers.

- **Health workers' attitudes:** patronizing attitudes and lack of respect for non-harmful traditional practices on the part of service providers were mentioned as barriers to utilizing MCH services by many respondents. This was confirmed by direct observation on the part of the researchers. Service providers in all target sites described ethnic minority people in terms such as 'unenlightened', 'not progressive', subject to 'feudal superstition' etc. Such attitudes were also observed in sites where most providers are themselves ethnic minority people, thus demonstrating how providers' "mindsets" influence even attitudes of ethnic minority providers. The lack of recognition of the importance for parents to be able to bring the placenta back home may for instance impact on their willingness to deliver at the hospital.
- **Lack of consultation:** the lack of mutual support and respect between service providers and traditional and religious leaders were also perceived by the researchers as being a barrier to improved MCH. Providing effective health services, especially preventive care, depends also on the ability of the health staff to accommodate cultural understandings, perceptions and practices. A collaborative and community-based approach is likely to achieve better results.

Concern over costs.

- **Affordable services:** there are several related costs that are still not covered by government subsidies. Additional costs include transportation, fees for certain medical services plus high 'opportunity costs' (see note 13) such as loss of potential earnings, loss of agricultural labor etc.

FOUR

Village in Leishan county, Guizhou – MUC

Interview of Miao women, Leishan county, Guizhou – MUC

Section Four: *Recommendations for culturally sensitive Maternal and Child Health in ethnic minorities' areas*

Based on international best practices and on the findings of NCWCH-CPDRC survey and MUC study in the 6 sites, UNFPA prioritizes implementation of the following recommendations, aimed at increasing access to and utilization of MCH services and at promoting health behavior change. There are complementary to the recommendations included in the 2007 *Review of the MCH Survival Strategy*[15]. **Some of the below recommendations are currently being implemented in the 6 sites by the local health and FP authorities: the results will be carefully evaluated at the end of the CDPF.**

1. Recommendations for the consideration of the local health providers:

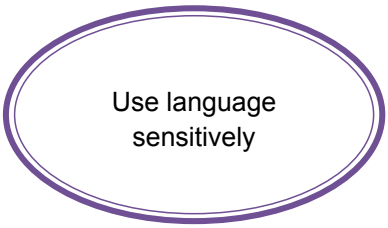
RESPECT LOCAL CULTURES, VALUES AND BELIEFS

Invest time in knowing the culture in which you are operating

- Understanding how values, practices and beliefs affect human behavior is fundamental to the design of effective MCH programmes. It is also important to show understanding for the roles and functions of community leaders and groups, avoiding attitudes or language that may be perceived as judgmental or patronizing: hear what the community has to say, demonstrate respect and avoid value judgments.

[15] In this Review, the UN agencies and the MOH made recommendations for improving the MCH strategy. Most of the recommendations, particularly those targeting rural areas type III and IV, remain relevant for ethnic minority areas.

- China has demonstrated that traditional medicine can complement modern medicine and contribute to the psychosocial well-being of people. The MUC study has evidenced that traditional health systems are an integral part of local cultures and that a high proportion of the ethnic minorities rely upon traditional healers and health practitioners: they are the depository of local health knowledge and they provide counseling and care, alongside health professionals. In Gyamda (Tibet) or in Leishan (Guizhou) for instance, it is important to acknowledge the influence of Tibetan traditional medicine or the Miao medical system and to consider collaborating with traditional practitioners on health promotion activities.



- It is crucial to ensure that health information and services (particularly counseling) are available in local language, written and oral. This is particularly challenging in multi-ethnic areas such as Longchuan county and Mang city in Yunnan Province, but it is important to ensure that health messages are understood and acceptable to all beneficiaries, not just those who understand the majority language. In addition if messages reflect negatively on local practices or knowledge, these will not be acceptable to the target community and might create unnecessary misunderstandings between service providers and the community.

WORK CLOSELY WITH THE COMMUNITIES

- Both harmful and positive practices are found in all societies. When working with communities to promote behavior change, emphasize positive practices that are found before drawing attention to any harmful practices. Some practices such as praying amongst the Hui, keeping the placenta or offering tributes amongst the Jingpo in Longchuan (Yunnan) are not harmful from a medical perspective, and are positive from a psychological perspective. Accepting such practices and encouraging their inclusion where possible can help generate ownership of the MCH programme.

- Winning over those who have influence power in a community, whether they are community-based organizations, women's groups, religious leaders or elders, can be a crucial step in modifying behaviors at the grass roots. It is important to rely on local individuals or partners that have the legitimacy and capacity to influence and mobilize a community, and work around positive messages. Such partners have the added advantage of knowing what local people are likely to accept. Collaboration with respected community leaders can provide 'entry points' for promoting health messages, introducing new practices and contribute to increase community acceptance.

Potential local allies

Partnerships between health bureaus and community-based institutions and leaders can create effective strategies to promote MCH:

o **Religious leaders.** They can collaborate within their own sphere on how to promote safe MCH, raise awareness on unsafe practices and work with health workers to address these: consider establishing two-way referral systems in recognition of the role they play in supporting psycho-social health. In Hualong for instance, consider collaborating with local imams (*Arkunds*) to hasten change in MCH-related issues (marriage age, delivery place). In Gyamda, consider collaborating with Lamas. In Leishan and Congjiang, consider collaborating with those who conduct birth rituals when conducting MCH promotion activities.

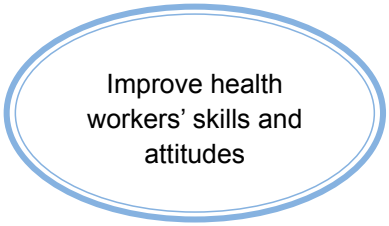
o **Care-givers/decision makers.** Mothers, mothers-in-law, grandmothers play a key role in influencing reproductive health decision making. They can be sensitized to address key maternal and infant health issues: breast feeding, neo-natal care, nutrition, promotion of hospital/skilled attendant deliveries, etc.). In Leishan and Congjiang, acknowledge traditional community and women leaders and involve them in MCH programs.

o **Men and village level cadres,** so as to increase male understanding and involvement. In Longchuan and Mang city (Yunnan) for instance, acknowledge the influence of local traditional leaders and healers and involve them in MCH programs.

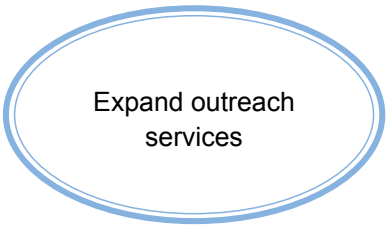
o **Community based organizations** that represent, or are accepted by, ethnic minority stakeholders and can provide value-added through partnership.

- Actively involve ethnic minorities in design, implementation and monitoring of health programmes; develop mechanisms for community participation at decision-making levels (establish local health committees, client feedback mechanisms, etc.). Reinforce a sense of ownership and ensure sustainability by strengthening the skills of community members, including traditional practitioners and peer educators.

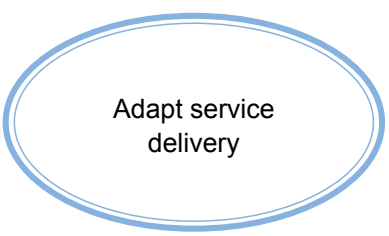
PROVIDE FRIENDLY AND CULTURALLY SENSITIVE SERVICES



- Quality of care includes facilities, equipment and supplies, technical skills but also, importantly, attitudes of the service providers. The capacity building of the health professionals working in ethnic minority areas should not only focus on building technical skills. Staff could also be trained in how to deliver client-friendly' services, which could include respect and understanding for local beliefs and knowledge. Involvement of ethnic minority representatives in programme design and training courses would be a way of ensuring that services are culturally sensitive.



- The MUC study has shown that Miao, Hui and Dai women have one month confinement post during which new mothers rarely leave their homes, or that Tibetan women go to work during herb digging season even during the post partum period. Since these women do not seek services at these times, services should come to them. Different options could be considered. Outreach services could be expanded to increase the coverage and meet the needs of those who are reluctant or unable to come to service delivery points. Alternatively, village level health workers could be trained with responsibility for providing health information and promoting ANC, HD and PNC within their own communities. In areas where services are not located nearby, mobile clinics could be established to enhance the availability of services. In Gyamda, Leishan or Hualong, consider expanding existing outreach services particularly for ANC.



- Services should be adapted or modified to reflect the preferred practices of ethnic minority people. For example, religious or spiritual practices that are essential features of local culture could be accommodated within the services, especially where these provide psychological support, or help a client to avoid breaking a cultural taboo. Practical adaptations that are not harmful could also be adopted, such as preference for delivery in certain positions, or practices such as massage or drinking certain herb teas during the onset of delivery. In Leishan and Congjiang, the scale of the preference for non horizontal delivery position could be investigated in depth, and if the preference is strong, allowing it in the local health facilities should be considered. In Hualong facilities, pay attention to respect and accommodate Hui people' sense of privacy concerning the naked body. In Hualong, Congjiang, Leishan, Longchuan and Mang city, allow Hui, Dong, Miao Jingpo and Dai, people to bring the placenta and umbilical cord home if they wish. In areas where remoteness remains a key obstacle to access to and update of services, consider establishing subsidized maternity waiting rooms.

- Communication strategies should include working with key community level stakeholders and local popular expressions to promote specific health messages. In addition, communication channels should be tailored to minorities' values and norms. This would include producing materials that address behaviors/practices not in line with standard MCH norms so that a balance between ideas is provided and clients can see their own practices and views also represented. Consultation with targeted groups in selection of culturally acceptable channels for communication, and full involvement in design of story lines/messages according to local interests can improve the impact of the health promotion efforts. All health promotion materials should be pre-tested with the target audiences before being adopted.

2. Recommendations for the consideration of the Government:

Disaggregate health data by ethnicity

- **Disaggregate health data by age, sex and ethnicity.** Limited data is disaggregated by ethnicity in China. There is little comparative socioeconomic analysis of the well being of China's minorities or descriptive research available about the health of different minority populations. It is crucial however to disaggregate data along ethnic as well as other lines (gender, age, socio-economic status, cultural affiliation and language) in order to better understand the profiles of those with poorer health status and underserved needs. Statistics can be used to show patterns of disparities, which are critical in identifying gaps suffered by minorities as well as by other marginalized groups, such as migrants, people with disabilities, and even young people. Budget analysis can be used to determine whether governmental policies are appropriately funded in ethnic minority areas. The Government could enhance its capacity to use statistical data and analyse social progress through various ethnic-disaggregated social indicators. Similarly, the specific situation of ethnic minorities could be analyzed for each goal in MDG reports.

Village health clinic, Congjiang county, Guizhou – Congjiang health bureau

Reduce financial and opportunity costs

- Specific additional resources still need to be allocated to overcome the wide disparities between ethnic minority areas and others areas of China. In addition it is important to recognize that even though a service might by considered 'free' by the Government and service providers, there may still be significant costs that have to be met by the client. These include direct costs such as travel and medicine, as well as 'invisible costs' such as loss of earnings and cost of child care. At Provincial level, there is a need to ensure that the New Cooperative Medical Scheme reaches those in targeted ethnic minority areas. Consideration could be given to expanding subsidies to costs associated with uptake of services, in particular transportation costs, user fees for certain services and other related out-of-pocket expenditures. At county level, local communities could be assisted to establish social insurance schemes, revolving funds (or equivalent) to cover out-of-pocket costs related to attending MCH services.

Consider a Midwifery Program for remote areas of China

- In the 2007 *Review of the MCH Survival Strategy,* a series of institutional reforms were recommended to ensure the successful delivery of a basic package of MCH services and achieve equitable accessibility, particularly in the poorest areas. One of them was to develop a strategy for human resource development, in order to solve the problem of the poor distribution of qualified doctors and

nurses: *"a new cadre of nurse-midwives could be created to provide basic obstetric and neonatal care at township level".*

In light of the focus of the health reform and in light of the findings of the CDPF Program, the midwifery strategy is one which could be appropriate for ethnic minority areas. Despite the numerous promotion efforts undertaken by local health authorities of the 6 pilot sites, a significant proportion of women still choose to deliver at home, for a variety of reasons that are largely beyond control of the health sector (distance, opportunity costs etc.). Most of these home deliveries are not attended by skilled health personnel, or are attended by traditional birth attendants living in the community whose qualifications are uncertain. Yet properly trained members of the community could assist those women during pregnancy and childbirth, making the home delivery attended by someone with certified midwifery skills.

Midwives are trained professionals in normal pregnancy and birth, but also trained to recognize possible problems. If a problem arises, they call in an obstetrician or organize the prompt referral to a clinic providing obstetric care. **They are used, worldwide, in communities hard to reach.** They can play a central role in health service delivery – promotion, prevention, treatment and rehabilitation – in areas of great health need, where they may be the only frontline providers of health, especially in remote areas. They offer a low-technology but high-quality solution to the need for skilled care during pregnancy and birth, with the potential for meeting communities' broader reproductive health needs and contributing to universal primary health care for all. In particular, midwives can be most useful to help ensure that services reach those in greatest need, the poor and hard-to-reach communities. It is estimated that they can prevent up to 90 percent of all maternal deaths if they are well trained and authorized to apply their skills. Beyond playing a crucial role assisting with pregnancy and childbirth, they can address a variety of issues, including provision of family planning, care for newborns and children, nutritional support, counseling and prevention of mother-to-child transmission of HIV.

International evidence

"Midwives and others with midwifery skills have a pivotal role in addressing the first two of the "three delays that eventually lead to death from pregnancy related complications, by working with and empowering women and communities and providing basic emergency obstetric care. They also contribute to reducing the third delay by providing prompt, high quality, essential midwifery care, and by giving first-line treatment while waiting for medical practitioners with obstetric and or neonatal skills. Many reports show that women would use a skilled midwife or other healthcare provider with midwifery skills, if they were readily available and affordable, and offered culturally acceptable services. Midwives and others working at the community level contribute to delivery of essential primary and reproductive healthcare and can deliver many of the needed interventions to save the lives of mothers and babies"

(Campbell, Graham, 2006, de Bernis et al., 2003)

"Midwives who live and work in the community attend births and react appropriately in case of complications, and are more able to make a contribution to safe motherhood. Investment in midwifery care in the community has additional benefits: a referral system set up for maternal and newborn care used for transferring other seriously ill or injured members of the community"

(Predhan et al., 2002. Razzak, Kellermann, 2002)

As mentioned in the 2007 *Review of the MCH Survival Strategy,* **UNFPA invites MOH to consider strengthening midwifery services in remote areas of China.** Global standards on education and regulation of midwives are available. The steps could include: improving education and training; elaboration of policy, regulations and midwifery associations; and enhancing the recruitment and retention of midwives. If these actions are prioritized, further progress is possible towards achieving the health-related MDGs in the remote areas of China.

FIVE

Dai women, Mang city, Yunan – MUC

Focus group discussion with Jingpo women, Longchuan county, Yunnan – MUC

Section Five. *Tools and resources available for culturally sensitive programming.*

To effectively apply culturally sensitive approaches, it is important for health professionals to possess the following **cultural competencies:**

1. Open and willing mindset to learn a new approach, to develop the necessary skills and competencies, and to internalize it conceptually and operationally;
2. Set of attitudes, knowledge and skills that enable to work effectively in a culture- specific situation;
3. Understanding of cultural differences and similarities within and between groups;
4. Willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable persons from the community in implementing the programme.

Tool 1: CHECKLIST (is your MCH Programme culturally sensitive?)

The "culturally sensitive checklist" is a tool for the integration of culture into programming:

Programme design

- Has your programme identified and analyzed the existing mainstream and various sub groups norms, attitudes, practices and beliefs related to maternal and child health objectives?
- Has your programme undertaken a stakeholder analysis that identifies the existing power structures and those who influence decision making and behaviors, as well as those who are powerless?
- Is the socio-economic situation of various groups of women and their needs being assessed? Are the specificities being identified in connection with ethnicity, socio-economic, age factors?

Programme implementation

- Is your programme using positive entry points within culture and community?
- Has your programme identified the most vulnerable and what kind of outreach has been designed to meet their needs?
- Is your programme supporting capacity development with local NGOs?
- How is your programme building community ownership?
- How is your programme mitigating resistance to the program?

Programme monitoring and evaluation

- Is the monitoring of gender and cultural considerations integrated into the programme?
- Is the data gathered disaggregated by sex, ethnicity, socio-economic status? Are monitoring systems also using disaggregated data?
- What are the constraints/challenges that are preventing community stakeholders from meaningfully participating in the processes?
- What changes have actually been achieved at the community level within a certain time frame (changes in beliefs, attitudes, practices)?

Tool 2: the CULTURE LENS

The Culture Lens is a tool of analysis that helps decision makers, planners and practitioners in the health sector to better understand the context within which they deliver their programmes, and to make sound assumptions and judgments regarding the possible positive/negative impact of cultural factors on interventions, including MCH ones. The strategy is to work within the communities to build a broad base for MCH objectives.

The Culture Lens suggests investing on exploring in depth **4 knowledge areas:**

1) knowledge of the needs and aspirations at the community level;
2) knowledge of the factors that lead to community acceptance and ownership;
3) knowledge of the local pressure groups & power structures;
4) knowledge of the legal, political, social, economic and cultural realities.

It also emphasizes strengthening health professionals' **skills in 2 areas:**

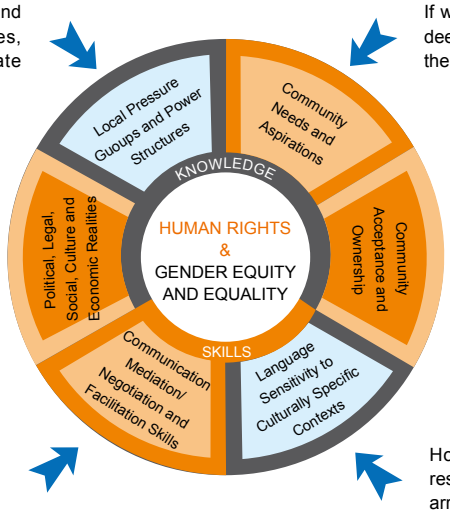
1) Language sensitivity to culturally specific contexts;
2) Communication, mediation, negotiation & facilitation Skills

The Culture Lens is presented below:

Build a solid knowledge of these groups, analyze the convergences and divergences regarding MCH issues, and develop strategies to facilitate their participation.

Who are we to tell people what is best for them? If we are to service the people, it is vital then to deeply understand the needs and aspirations of the community in MCH programming.

Conduct research to develop knowledge about these realities. It empowers MCH professionals to understand possible dynamics of change, within the cultural contexts they work in.



What are the beliefs and practices within the community that can facilitate the acceptance & ownership of our programme?

What are the skills needed for trust building, using a positive and pragmatic approach? Communication skills are critical for communicating genuine curiosity, building trust, and serving as facilitators.

How to properly convey our messages with respect, without being condescend or culturally arrogant? This facet reflects the importance of how messages are communicated.

Source: UNFPA Culture Lens

AVAILABLE DOCUMENTATION

General

- **Joint Review of the Maternal and Child Survival Strategy in China** (MOH, UNICEF, WHO, UNFPA publication, 2007); *English and Chinese*
- **24 Tips for culturally sensitive programming** (UNFPA publication, 2004); *English and Chinese*
- **Working from within culturally sensitive approaches in UNFPA programming** (UNFPA publication, 2004); *English*
- **Cultural programming: reproductive health challenges in East and South-East Asia** (UNFPA publication, 2005); *English*
- **Integrating human rights, culture and gender in programming: participants training manual** (UNFPA training material, 2009); *English*

CDPF Program

- **Baseline survey on maternal and child health in Longchuan, Mang city, Leishan, Congjiang, Hualong and Gyamda** (NCWCH-CPRDC Report-working version-, 2009); *English and Chinese*
- **Study on traditional beliefs and practices regarding maternal and child health in Yunnan, Guizhou, Qinghai and Tibet** (MUC Report -working version-, 2009); *English and Chinese*

The above materials are available at UNFPA China office: china.office@unfpa.org

Content

The **China Culture and Development Partnership Framework** (CDPF) is a three-year (2009-2011) joint initiative of eight UN Agencies (UNICEF, UNFPA, UNESCO, UNDP, WHO, ILO, UNIDO, and FAO) and the Chinese government funded by the UN-Spain MDG Achievement Fund. Its objectives are to design and implement policies that promote the rights of ethnic minorities in Guizhou, Yunnan, Tibet, and Qinghai and to empower them to better manage their cultural resources and thus to benefit from culture-based economic development. It is not only the first Joint Programme of its kind on culture and development in China but also a significant step forward in the efforts of the UN in China to deliver as one unified and coherent system and to better align its work with national development goals and policies.

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity.

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UNFPA China
Add: 1-161 Tayuan Diplomatic Office Building
14 Liangmahe Nanlu, Beijing 100600, China
Tel: 86 10 6532 0506
Fax: 86 10 6532 2510
Email: china.office@unfpa.org