



Study on Traditional Beliefs and Practices regarding Maternal and Child Health in Yunnan, Guizhou, Qinghai and Tibet

Research Team of Minzu University of China
April 2010

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Executive Summary



Grand mother, mother and child in Gyamda Hospital, Tibet

Background

With the support of the Spanish Millennium Fund, the UN Joint Programme, China Culture and Development Partnership Framework (2009 – 2011) was launched in April 2009. Within this overall framework, a component of the programme aims to accelerate the achievement of health targets of the Millennium Development Goals (MDGs). The Ministry of Health, National Population and Family Planning Commission, UNICEF, WHO and UNFPA are collaborating to develop an innovative approach to health care and service provision among ethnic minorities in South West China. The project is led by MOH and UNICEF.

Two complementary studies addressing different aspects of maternal and child health were conducted as part of the health component of the project. The first of these was a baseline survey looking at MCH status and service delivery in pilot sites. This was conducted by the National Centre for Women and Children Health in collaboration with the China Population Development and Research Centre, with UNICEF and UNFPA support. The purpose of the quantitative survey was to collect baseline data with which to evaluate overall achievements at the end of the project cycle.

The second study was a piece of qualitative research, conducted by Minzu University of China with UNFPA support. This study was designed to identify and document beliefs and practices in relation to maternal and child health, and health seeking behavior, among six ethnic minorities, and to recommend culturally appropriate interventions to assist in accelerating the achievement of MDG health targets. This report, entitled Traditional Beliefs and Practices regarding Maternal and Child Health in Yunnan, Guizhou, Qinghai and Tibet, is the outcome of that research.

The study was undertaken in the provinces of Guizhou, Yunnan, Qinghai and Tibet and considered the cultural beliefs and practices of selected representatives of six ethnic minority groups - Miao, Dong, Jingpo, Dai, Hui and Tibetans - in relation to key aspects of maternal and child health. It was designed to identify enabling factors that contribute to the uptake of MCH services, as well as any harmful traditional practices or other barriers that impede maternal and child health and utilisation of related services. Information was gathered in relation to religious and traditional beliefs and practices in general, as well attitudes, beliefs and practices in relation to health and nutrition of pregnant women and children. The research team was tasked to identify and highlight

specific practices, beliefs or attitudes – from either demand or supply side - which could be targeted in MCH guidelines, policy and service delivery, in order to enhance access to and utilization of MCH services, thus contributing to improved health targets.

Methodology

A team of researchers from Minzu University of China, worked in close collaboration with selected researchers from the Guizhou University for Nationalities, the Qinghai University for Nationalities, the Yunnan Universities for Nationalities, Finance and Economics, and Science and Technologies, and with the Academy of Tibetan Arts and the Health Centre of Gyamda County. To ensure good understanding of the language and cultural references, each of the six teams included a researcher of the ethnic minority group being studied, with the exception of the Dai. The team leaders conducted 2 day training courses in use of the methodology and survey tools, in each of the capitals of the target provinces. Field work was conducted from June to August 2009.

Three main methods were used to carry out the research: focus group discussions, in-depth interviews

and direct observation. Questionnaires were designed to help guide the FGDs and key-informants interviews.

Guiding questions targeting the ethnic minority respondents addressed the following broad areas: religious and/or traditional beliefs and practices; beliefs and practices in relation to specific aspects of maternal and child health; gender relations and decision making behavior; perceptions of health service provision and providers. Those interviewed included community and religious leaders; traditional medical practitioners and those assisting as deliveries; pregnant women, mothers and guardians of children; young people (aged 15 to 24) with or without children.

Guiding questions targeting local government leaders and MCH service providers addressed perceptions of religious and/or traditional beliefs and practices, and the ways in which they impact on health seeking behaviour; and specific beliefs and practices in relation to maternal health.

The researchers also took whatever opportunities arose during the research period to directly observe traditional practices. Research was conducted in the following sites:

Province	Guizhou	Guizhou	Yunnan	Yunnan	Qinghai	Tibet
County	Leishan	Congjiang	Longchuan	Luxi	Hualong	Gyamda
Ethnic group researched	Miao (50 respondents)	Dong (39 respondents)	Jingpo (44 respondents)	Dai (46 respondents)	Hui (38 respondents)	Tibetan (52 respondents)
Survey site	Xinqiao village	Meide village	Nonglong village	Mangbie village	Gongyi village	Jieba village

Key research findings

Religious and traditional beliefs of the targeted ethnic minorities

The ethnic minorities involved in the study can be roughly divided into two groups. The first are the three minorities whose religious life and spiritual beliefs play an important role in the life of individuals and their communities: Tibetan, Hui, and Dai. The second group consists of the animist minorities, the Jingpo, Dong, and Miao, who believe that souls or spirits exist not only in humans, but also in animals, plants, rocks and other natural phenomena.

The Tibetans, Hui and Dai all closely follow their respective faiths: Tibetan Buddhism, Islam, and Hinayana Buddhism respectively. These three are

institutionalized religions with their own systems and practices. Despite changing lifestyles and standards of living, religion continues to play an important role in the lives of these three minorities, affecting values and attitudes towards morality, perceptions of health and disease. Each religion has its own explanation for ill-health and traditional methods for dealing with sickness, either through prayer or through the application of traditional medicine.

For example, in times of sickness the first reference point for Tibetans is the Lama who will undertake religious rituals at the sudden onset of a disease or if a person has persistent ill health. Perceptions of disease among Tibetans largely fit within the framework of belief in Karma. The Dai are also Buddhists, who believe in Karmic law. The Muslim Hui attribute illness to Allah, believing that ill health is ultimately a test imposed by

Allah. In times of sickness, including during childbirth and immediately after delivery, a Hui practice is to ask an Akhund (Imam) to perform a “du’a” prayer.

The animist Miao, Dong and Jingpo continue to maintain traditional customs and taboos and, along with the Dai, they also practice ancestor worship. These minorities also utilise traditional doctors who use herbal medicines.

Enabling factors

The research findings identified several enabling factors, which could be built on and developed in order to attain better health outcomes.

Despite continued allegiance to religious and animist beliefs and practices, these do not appear to be barriers to the uptake of maternal and health services. On the contrary, the ethnic minority groups involved in the study have not resisted modernization and the advantages brought about by economic growth and development. They willingly utilize maternal health services when they perceive there to be advantage in doing so. In fact, all of the 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 or religious guidance was therefore seen to be complementary to modern medical care, usually addressing different needs from those addressed by health service providers.

Also encouraging was the finding that within all six ethnic minorities evidence was seen of changing attitudes and beliefs indicating a greater interest in, and potential uptake of modern health services. As the benefits of economic development and modernization reach the ethnic minorities, and as exposure to the MCH practices adopted in other parts of the country (such as hospital deliveries) increases, so there is an apparent willingness of those who have been exposed to new ideas to adopt these practices themselves. For example, educated, unmarried young people as well as people who have worked outside their own communities as migrant laborers, indicated that they understood the benefits of maternal health care. They expressed the intention to abandon traditional practices such as having home deliveries, in favour of having hospital-based deliveries. These findings are evidence that cultures are not static but are subject to influence and change once evidence of benefits is understood. Behaviour change does not automatically follow change in knowledge however, and the influence of parents, elders and traditional leaders remains strong, so there tends to be a time gap between people expressing intention to behave differently and actually doing so. The signs are however very encouraging.

A third factor that could contribute towards increased uptake of MCH services is the suggestion made by a number of the ethnic minority respondents, that a collaborative approach to addressing maternal and infant/child health would likely achieve better results. Currently there appears to be a rather limited understanding of the purpose and objectives of MCH services, particularly among the Miao, Dong and Tibetans. It was proposed that collaboration based on mutual respect between MCH providers and traditional and religious leaders, could lead to effective partnership around issues of shared concern. Jingpo, Dai and Hui respondents were already able to cite good practice in this respect. Given the strongly influential role that the Tibetan lamas play within the Tibetan community, such collaboration would likely be particularly effective among this minority group.

Challenging factors

As well as enabling factors, a number of constraining factors were identified that impact on the uptake of maternal health services. These include harmful traditional practices, costs of services (in terms of time, money, loss of labor etc.) and, on the supply side, poor quality of care and negative service provider attitudes. Key findings are briefly summarized:

Traditional practices

Uptake of ante-natal care (ANC) is directly related to acceptance of modern MCH ideas, economic conditions and availability of transportation. Women from all six ethnic groups have little awareness about the need to attend ANC checkups. Despite efforts of the County or sub-County sectors of MCH providers to advocate for the benefits of ANC, their efforts have yielded limited results as women only go to hospital when they have symptoms of ill health. Women from all ethnic groups believe that pregnancy and childbirth are natural phenomena, so they see no reason to seek health care unless they are ill.

There are also significant costs associated with uptake of ante-natal care. Women contribute to family labor and being pregnant does not prevent them continuing to work so they cannot afford the time to go to for ANC, particularly during busy cultivation periods. Transportation in rural areas is limited and expensive. Among the Tibetans it is traditional not to reveal a pregnancy during the first trimester because this might harm the baby. This affects women’s willingness to seek ANC in the early months of a pregnancy. Women from all six ethnic groups are forbidden to eat certain foods during pregnancy, thus impacting on their nutritional status.

Delivery practices identified are of three types: hospital delivery, home births attended by doctors, and home births attended by a family member (usually a mother-in-law). Although hospital delivery is free and the benefits have been publicized by MCH, uptake has been limited. Women of all six ethnic groups expressed a preference for home deliveries. The Dong and Miao prefer to deliver in non horizontal positions. 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. The Miao, Dong, Jingpo and Hui all have practices of burying the placenta after delivery, in some cases associated with providing a 'home' for the spirit of the infant.

A key postpartum practice among all targeted ethnic groups, except the Tibetans, is the custom of household confinement, which usually lasts for a month, although in the cases of the Hui it can last as long as 40 days. Among the Miao, postpartum women are viewed as being 'unclean' and therefore a threat to other members of the community, which makes Miao women from these minorities reluctant to have hospital deliveries or to leave the home for postpartum checkups. Each ethnic group has special dietary practices for postpartum women which would need further investigation to check for dietary imbalances.

Regarding neonatal care, the findings suggest that exclusive breast feeding is not practiced by the Dong, Jingpo, Dai and Tibetans. Partially chewed sticky rice is introduced within a week after birth among the Dong, Jingpo and Dai, and barley soup among the Tibetans. The Miao follow the practice of expelling the colostrum. There is similarity in the identity and role of caregivers among all six ethnic groups, 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 and young children. Among the Tibetans this practice can take place almost immediately after birth during the time when the precious cordyceps fungus is being harvested.

Children's health status is strongly influenced by poor diet according to health service providers and, in the case of Tibetans, concern was also expressed about poor general hygiene. Tibetan and Dai respondents expressed fear of injections and vaccinations which could impact on willingness to participate in immunization programmes.

Gender-related issues

Child sex preference is an issue among the Dong and Miao who prefer sons. This is closely associated with preservation of the family lineage. An increase in the neglect and abandonment of female infants and children

was described among these groups, and the reported sex ratio imbalance is high in southeast Guizhou.

Gender dynamics within the household dictate that girls take on 'female' roles and boys take on 'male' roles from an early age within all ethnic groups. Apart from the aforementioned practice of neglecting girl infants, no evidence was otherwise cited of different feeding practices for boy and girl infants or children.

Decision-making in the family appears to be based on fairly traditional lines among all six ethnic minorities, 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 regarding decision making on maternal health issues, and care of infants and children, among all six groups. Men play a lead role in managing family income, though the extent of this varies between the different minorities. For example, Tibetan women play a relatively strong role in financial decision making, whilst Hui women play a much more limited role in comparison with the other ethnic minorities. Respondents said that women living in nuclear families have increasing control over family income, and that women earning income themselves have most control of all, indicating a development-related change.

Young people's perspectives

Young people 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 away from home. Conversely, Tibetan and Miao young people from remote areas expressed very limited knowledge or interest on reproductive health matters. 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 yet reflected in behavior change. Reference was made by service providers to increased demand for abortion among unmarried young people from the Miao ethnic group in particular. Single people cannot access family planning. Preference for male children appears to be less among young people than previous generations.

Social-cultural barriers between users and providers

Negative and patronising attitudes on the part of service providers were described as barriers to utilising 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', 'primitive', 'not progressive', subject to 'feudal superstition' etc.

Such attitudes were also observed in Tibet where most providers are themselves Tibetan, thus demonstrating how majority attitudes have influenced their attitudes.

Lack of consultation between service providers and traditional and religious leaders was also perceived by the researchers as being a barrier to improved MCH, coupled with no respect for local traditional knowledge and beliefs.

Costs

Many ethnic minority respondents mentioned that although MCH services are advertised as being free (hospital deliveries in particular), in fact there are several related costs that are not covered by government subsidies. There is a feeling therefore the MCH is not being honest about what is being promised. Additional costs include transportation, fees for certain services including IEC materials in some cases, plus high 'opportunity costs' such as loss of potential earnings, loss of agricultural labor etc.

Costs, as well as poor facilities and equipment, lack of trained staff at service delivery points, and negative service provider attitudes, are all aspects that influence ethnic minority people's decisions on whether or not to visit MCH facilities. Comments were also made that sometimes there are insufficient female MCH staff, that many staff are young and inexperienced, that staff do not always know how to operate equipment, or how to perform emergency obstetric care. Additionally, not all 'advertised' services are available at local facilities.

Summarized Recommendations

1. Quality of MCH services and facilities should be improved in target areas to ensure that ethnic minority people can enjoy their rights to health. Outreach services to household level would contribute to greater acceptance.
2. Skills of MCH staff to provide quality services should be improved, more female doctors should be made available, and County level medical personnel should be subsidised. Training on MCH should be introduced more widely.
3. Training of ethnic minority people at village level would enhance acceptability of services by minorities, and village-level medical care should be incorporated into the national medical system where appropriate.
4. MCH should diversify its financial and technical resources and subsidized MCH costs should be expanded to target all ethnic minority groups. Funding should be made available for affirmative action to promote the

health of economically disadvantaged ethnic minority regions in the west.

5. Information on MCH services, modern health concepts and their complementarity with ethnic cultures, should be combined where possible so as to make services more acceptable for ethnic minorities. Innovative communication materials and strategies should be developed and adopted.

6. MCH services need to become incorporated into local life to ensure acceptability. One way to do this would be to collaborate directly with respected religious and community leaders and with traditional practitioners. Another way would be to collaborate with village heads and women leaders to promote MCH.

7. More attention should be paid to empowering ethnic minority women through education.

8. Relationships between County clinics, the family planning sector, and County MCH, as well as the responsibilities of respective leaders, should be clarified and streamlined. County-level management of Spanish Millennium Project equipment should be improved in some cases.

1 Background



1.1 Purpose of study

The study was undertaken in the provinces of Guizhou, Yunnan, Qinghai and Tibet and considered the cultural beliefs and practices of selected representatives of six ethnic minority groups - Miao, Dong, Jingpo, Dai, Hui and Tibetans - in relation to key aspects of maternal and child health. It was designed to identify enabling factors that contribute to the uptake of MCH services, as well as any harmful traditional practices or other barriers that impede maternal and child health and utilization of related services. Information was gathered in relation to religious and traditional beliefs and practices in general, as well as attitudes, beliefs and practices in relation to health and nutrition of pregnant women and children. The research team was tasked to identify and highlight specific practices, beliefs or attitudes – from either demand or supply side - which could be targeted in MCH guidelines, policy and service delivery, in order to enhance access to and utilization of MCH services, thus contributing to improved health targets.

1.2 Basic information about survey sites

The survey focuses on six ethnic groups: Miao, Dong, Jingpo, Dai, Hui and Tibetan. The groups are spread across 6 counties of four provinces, as detailed below:

Province	Guizhou		Yunnan		Qinghai	Tibet A.R
Prefecture	Qiangdongnan Miao and Dong Ethnic Autonomous Prefecture		Dehong Dai and Jingpo Ethnic Autonomous Prefecture		Haidong Prefecture	Linzhi Prefecture
County	Leishan	Congjiang	Longchuan	Luxi Municipality	Hualong	Gyamda
Ethnic group researched	Miao	Dong	Jingpo	Dai	Hui	Tibetan
	Within Datang Township: Xinqiao village	Within Gaozeng Township: Meide village	Nonglong village	Within Fengping town: Mangbie village	Within Qiongke Township: Gongyi village	Within Cuogao Township: Jieba village

1.2.1 Leishan County, Guizhou (Miao people)



Total Population of Leishan *	155,000
Minority Population	151,200
Proportion ethnic minorities (%)	98%
Annual income per capita of rural pop(Yuan)*	2257
Main minority groups	Miao, Shui, Dong, Yao, Yi, Buyi
No. of Townships*	9
No. of villages*	154
No. of Township with motor vehicle traffic*	9
No. of Township with hospital*	9
Hospital delivery rate*	74.4%
Maternal mortality (2008)	0 case
Under-five mortality rate	22.26‰
Infant mortality rate	14.84‰

*Data submitted by Leishan Health Bureau (2008)

Leishan County is located within the Miao and Dong Ethnic Autonomous Prefecture in southwest Guizhou province. The total population of the County is 155,000 and, among them, Miao people represent 84% of the total population. Leishan County is culturally rich and is especially a cultural center for Miao people.

Within Leishan County, we chose to focus on Datang Township given the large proportion of Miao people living in that area (93.63%) and well preserved Miao culture, in terms of language and traditional customs. Datang Township is located south of Leishan County and lies in the mountains at the foot of the Leigong range. The ethnic composition here is Miao, Dong, Yao, Han and other minorities. The Miao here can also be sub-

divided into "long-skirted" and "short-skirted", the latter population being larger than the former. The total area of the Datang Township is 141.58 square kilometres. Forest coverage is 56.58%. The Datang Township governs 18 administrative villages and 52 natural villages, with 3394 households and a population of 14,290. In Datang Sub County, 16 administrative village have concrete roads built already.

Within Datang Township, the data collection was conducted in Xinqiao village: it covers 3 natural villages, 8 working teams, 218 households and 949 persons. Two surname groups, namely, Wang and Huang, inhabit here and they are short-skirted Miao.

1.2.2 Congjiang County, Guizhou (Dong people)



Total Population of Congjiang*	328,000
Minority Population	318,000
Proportion ethnic minorities (%)	97%
Annual income per capita of rural pop(Yuan)*	3329
Main minority groups	Miao,Dong, Zhuang, Yao and Shui
No. of Townships*	21
No. of villages*	294
No. of Township with motor vehicle traffic*	19
No. of Township with hospital*	21
Hospital delivery rate*	45.7%
Maternal mortality (2008)	3 case
Under-five mortality rate	37.95‰
Infant mortality rate	33.62‰

*Data submitted by Congjiang Health Bureau (2008)

Congjiang County is located within the Miao and Dong Ethnic Autonomous Prefecture in southwest Guizhou province. The County governs 7 towns, 21 Townships, with a total population of 328,000. Major ethnic groups include Miao, Dong, Zhuang, Yao, and Shui, comprising 97% of the total population.

Within Congjiang, we chose to focus on Gaozeng Township given that 98% of the population are ethnic Dong.

Gaozeng Township lies east of Congjiang count. The total area is 148.78 square kilometers, and the Township governs two administrative villages, 35 natural villages, and 89 teams. The total population of the Township is 15,325.

The region has risen above the poverty line in 1998. The infrastructure has improved and every village has concrete-paved roads, as well as telephone and electricity services. The major industry in the Township is agriculture and side-industries include tourism, forestry, and husbandry. The region produces rice, potato, and others cash crops such as rapeseed oil, beans, and cotton. The forest coverage is 56.3%.

Within Gaozeng Township, the data collection was conducted in Meide village: it includes 4 natural villages, 9 working teams, 364 households and a population of 1,612. All inhabitants here are ethnic Dong and the village is a typical Dong village.

1.2.3 Longchuan County, Yunnan (Jingpo people)



Total Population*	178,200
Minority Population	99,200
Proportion ethnic minorities (%)	56%
Annual income per capita (Yuan)*	1580
Main minority groups	Jingpo, Dai, Achang, Lisu, Deang, Hui
No. of Townships*	9
No. of villages*	71
No. of Township with motor vehicle traffic*	9
No. of Township with hospital*	8
Hospital delivery rate*	80.1%
Maternal mortality (2008)	0 case
Under-five mortality rate	21.18%
Infant mortality rate	18.82%

*Data by the end of 2008 submitted by Longchuan Health Bureau.

Longchuan County in Yunnan province is located in Dehong Thai and Jingpo Ethnic Autonomous Prefecture. The total population of Longchuan County is 178,200 and major ethnic groups include Jingpo, Thai, Achang, Lisu, De'ang and Hui. Ethnic minorities represent 56% of the total population, of which the Jingpo represent 27.2%.

Within Longchuan County, we chose to focus on Nonglong village given the large proportion of ethnic Jingpo: 96.28% (2000 census).

The village comprises five natural villages and nine working teams, with 396 households and a population

of 1,670 (of whom 1603 are Jingpo).. The average annual income per person is less than ¥ 3,000. In recent years, along with the promotion of sugar cane plantation, the village income has increased. The biggest challenge in this region is transportation: according to local police, only 30% of roads are stone-paved. The rest of the roads are mountainous and people often travel on foot. Many traditional religious practices have been preserved in the village while their forms and contents have changed. Religious professionals are known as "Motao" in Chinese and "Gongsma" in Jingpo language. Although aboriginal officials or headmen no long exist, their descendants still enjoy certain prestige among local population.

1.2.4 Luxi municipality, Yunnan (Dai people)



Total Population*	378,300
Minority Population	186,800
Proportion ethnic minorities (%)	49%
Annual income per capita (Yuan)*	2374
Main minority groups	Dai, Jingpo, Deang, Lisu, Achang
No. of Townships*	11
No. of villages*	80
No. of Township with motor vehicle traffic*	11
No. of Township with hospital*	11
Hospital delivery rate*	85.8%
Maternal mortality (2008)	63.55/100,000
Under-five mortality rate	15.04%
Infant mortality rate	12.07%

*Data submitted by Leishan Health Bureau (2008)

Luxi city in Yunnan province is located in an ethnic frontier city in western Yunnan. The city includes 5 towns and 6 subcounties (among them 1 is an ethnic subCounty), and its population is about 378,300. Ethnic groups here include Dai, Jingpo, De'ang, Lisu, and Achang and their population occupies 49% of the total population. The Dai and Jingpo populations represent respectively 36% and 8% of the total population.

Within Luxi municipality, the chosen focus was on Mangbie village given that the population is 100% Dai.

Mangbie village is administratively attached to Fengping town of Luxi city. It consists of 15 working teams, with 1238 total households and a population of 6,027 (2000 Census). The average per capita income was ¥ 2,497 in 2007.

The Mangbie village is connected to Luxi city by an asphalt road and is located 20 minutes from Luxi city. To most young men, their religious consciousness is

weaker than older generations. Hymayana Buddhism is still pervasive in village culture. The most important festival in the village is still the religious festivals. Elder people are a special group in their culture here. Although they are not directly involved in community management, their opinions still matter to village cadres' decisions. Elder people have their own society and even independent financial institutions. Their activities in village life is through "Zhuangfang"—a public religious facility.

In the Mangbie village men over 40 years of age can choose "Shang Zhuangfang" in which they formally become members of the elder society. They are no longer involved in painful activities and do not participate in village and even family affairs, but instead engage in scripture-reciting. What impressed us the most while staying in Mangbie was their Dai culture.

1.2.5 Hualong county, Qinghai (Hui people)



Total Population of Hualong *	254,000
Minority Population	182,000
Proportion ethnic minorities (%)	72%
Annual income per capita of rural pop(Yuan)*	2998
Main minority groups	Hui, Tibetan, Salar
No. of Townships*	17
No. of villages*	366
No. of Township with motor vehicle traffic*	17
No. of Township with hospital*	17
Hospital delivery rate*	92.3%
Maternal mortality (2008)	18.93/100,000 1 case
Under-five mortality rate	10.98‰ 35cases
Infant mortality rate	10.41‰ 35cases

Source of * data by the end of 2008 submitted by Hualong Health Bureau.

Hualong County is located in Haidong Prefecture the eastern part of Qinghai province. The County consists of 17 administrative Townships, 366 administrative villages. The total population here is 254,000, including 13 ethnic minorities including Hui, Tibetan, Salar and others. Among them, the Hui population occupy 54.5%, Tibetan 21% and Salars 5%. Religion plays a critical role in the daily life of Hui, Tibetans and Salars.

Within Hualong, the data collection was conducted in Gongyi village, administratively attached to Qiongke Township. There are 556 persons and 119 households

in the village and the Hui population occupy 95%. This area is a typical Hui Muslim populated region, religious influence is prevalent.

Hualong County has been nationally identified as a poverty County, with an average income per person of ¥ 2,998.

1.2.6 Gyamda County, Tibetan Autonomous Region (Tibetan people)



Total Population of Hualong *	28,000
Minority Population	24,900
Proportion ethnic minorities (%)	95%
Annual income per capita of rural pop(Yuan)*	4811
Main minority groups	Tibetan
No. of Townships*	9
No. of villages*	88
No. of Township with motor vehicle traffic*	9
No. of Township with hospital*	8
Hospital delivery rate*	51.0%
Maternal mortality (2008)	199.2/100,000 1 case
Under-five mortality rate	
Infant mortality rate	8‰

Source of * data by the end of 2008 submitted by Gyamda Health Bureau.

Gyamda County is located west of Linzhi and southeast of Tibetan Autonomous Region. The County governs 9 Townships with a total population of 28,000, including Tibetans, Han, Hui, Menba, Geba, and others. Among them, Tibetans occupy 95% of the total population. The highest and lowest points in the County are respectively 6691 meters and 3180 meters, with an average altitude of 3,600 meters. The County is rich in resources such as wild plants and animals, forestry, waterpower, mines, and eco-tourism.

Within Gyamda, we chose to focus on Cuogao Township which governs 6 village committees, 295 households, and 1,723 persons who are all Tibetan. The local economy is based on Chinese caterpillar fungus-digging, agriculture, and pastoral activity.

Within Cuogao, the data collection was conducted in Jieba village. The total population of the village is 496 (103 households). The villagers all are Tibetan. Southwest of the village is a famous Lama temple of Ningma sect of Tibetan Buddhism. Each day, thousands of Tibetans go to the temple to worship or to turn the prayer wheels.

1.3 National policy environment



Tibetan villagers receiving care, Gyamda County, Tibet

Health reform

The framework of China's Health Reform was announced on April 2009. Its overall objective is to achieve universal coverage of the population with basic medical services by 2020. The underlying principles are equity, efficiency and a people-oriented approach, combining government funding and commercial medical insurance. The priorities for 2009 to 2011 are to speed up the establishment of a system ensuring basic medical services, strengthening networks at grassroot level for provision of medical services, promoting equal access to public health services and conducting pilot reform in state-owned general hospitals. MCH, FP, prevention of HIV and treatment of HIV/AIDS are on the agenda of the health reform.

Specifically, starting from 2009, the Government will set up additional funds for prenatal and postnatal care with supplies of folic acid, increased hospital deliveries in rural areas and physical examination of children from 0 to 3 years. These specific tasks are to be implemented under the leadership of the Department of MCH & Community Primary Health Care of the Ministry of Health. The central government will make available additional funds for improving the facilities of MCH Stations in China from 2009 to 2011.

Within this context, the Ministry of Health has launched the China Women Health 2020 Strategy. Its objective is to enhance women's health through multi-sectoral preventive and treatment interventions on the major illnesses affecting women. The three phases of the strategy are: by 2010, a network will have been completed for provision of basic health services to women in both rural and urban areas; by 2015, the service capacity MCH network will have been further

strengthened and all births will have been delivered in hospital to reduce maternal mortality rate ; by 2020, all women in China will enjoy basic health services and those in the east and some of the central and western parts of China will be close to or will have reached the level of the middle-income developed countries.

There is therefore a strong national commitment, including financial, to improve MCH and to reduce the gaps and inequities.

MCH policy

To ensure the promotion of MCH, China has established a fairly comprehensive policy and legal framework, comprised primarily of a Law on Maternal and Infant Health Care (1994), a National Program for Women's Development and a National Program for Children's Development. The Ministry of Health has developed a series of regulations to provide standards for MCH service delivery and plans to implement these two programs at all levels and in line with accepted MCH indicators.

According to the MCH strategy, counties have been ranked into four categories, with Category 4 being the poorest and entitled to receive support accordingly (Leishan, Congjiang, Hualong and Gyamda are type 4, Longchuan and Luxi are type 3).

According to the Regulations on Governing MCH Care Organizations issued in 2006, China's current MCH care services are provided by respective health care organizations of various levels. These are specialized, non-profit, and public organizations, aiming at providing public hygiene and basic medical care for women and children. The Ministry of Health is responsible

for monitoring and governing woman and child care organizations within the country. Above County level, various health departments administer MCH care organizations within their own domains.

MCH care organizations are consist of three levels, namely, provincial, city (region), and County-level. The immediate upper-level organization is in charge of technically guiding, training, and monitoring lower-level organizations, assisting them to provide services. Employees from MCH care organization are recruited according to the Employee Standard for Various MCH Care Organizations.

As a result of this framework, IMR and MMR have been continuously reducing and this reduction has contributed significantly to increasing life expectancy. Good coverage of MCH services exists in most areas and China is on track for achieving MDGs 4 and 5. However according to the Joint Review of the Maternal and Child Survival Strategy in China (MOH, WHO, UNICEF and UNFPA, December 2006), infant and child mortality in China is still at the intermediate level globally and improvements are slowing down. Significant disparities exist between urban and rural areas and across population groups, and the MCH system is still unable to effectively address the needs of marginal and vulnerable populations.

2 Methodology

2.1 Background of survey teams

This research was conducted by five survey teams: the team in Yunnan conducted research in both Yunnan counties, while the other four teams focused on one County each. All survey teams had close cooperation with local ethnic minority researchers and coordinated with a provincial academic institution as set out below:

- Both survey teams in Guizhou worked with the Guizhou University for Nationalities;
- The Yunnan team worked with the Yunnan University for Nationalities;
- The Qinghai team worked with the Qinghai University for Nationalities; and
- The Tibet team worked with the Academy of Tibetan Arts (and also the Health Center of Gyamda County).

2.2 Survey tools and methods

2.2.1 Principles for selecting survey sites

The following criteria were applied in the selection of the survey sites:

- the same geographical locations as those of the quantitative baseline survey conducted by NCWCH/CPDRC in order to complement data collected for the base-line
- a significant proportion of the targeted minority among the population
- adherence of the population to traditional ethnic culture and practices;
- poor maternal and child health indicators
- convenience of target sites for travel by research teams

2.2.2 Survey instruments

Focus group discussion (FGD), in-depth interviews, and direct observation were the major methods used for this survey.

A detailed questionnaire designed to guide the discussions and interviews was elaborated in May in close liaison with NCWCH and UNFPA (see Annex)

2.2.3 Process for conducting the data collection

Prior to the commencement of the field investigation, each team leader organized a 2 day training workshop for team members , in the capital city of each of the targeted provinces. During the training, team leaders explained to the researchers their different roles and tasks. They were also trained on FGD facilitation and on conducting interviews using recorders.

Each FGD was implemented with the following steps: after arriving in the targeted communities, discussions took place with relevant community-level persons to agree on the time and place to conduct the FGDs, and to clarify criteria for participation in the groups. Male and female groups for FGDs were established and the researchers recorded every interview. During the FGDs, the background of each participant was carefully documented and a seating table chart was made of the actual meeting. Recorders documented key words and ideas and even body language of the speakers during the meeting, resulting in initial materials. During the FGDs, some participants were identified for further in-depth interviews. The research teams reviewed the processes and outcomes of the FGDs every evening. This enabled cross-team comparisons to be made.

The presence of village cadres was avoided as much as possible during the survey in order to alleviate concerns of the participants. Local networks were used to enter the community.

As FGDs can encounter practical difficulties, such as an insufficient number of interviewees, in-depth interviews were the primary method for this research. They were especially utilized by both teams in Yunnan, Congjiang in Guizhou and Gyamda in Tibet.

The teams were familiarized with the interview outlines and the background of the interviewees. Each interview was conducted within 45 minutes. Recorders were used with the consent of the interviewees.

The interview data was collated and organized on the same day as the interview. In addition to the FGDs and interviews, the investigators systematically observed and recorded specific environments and contexts, human behaviors and discussions. The following are the environments and contexts that were observed: places of religious activities, or ritual sites; MCH medical service organizations and other work environments; family; places of traditional cultural activities (marriage, funeral, and festival ceremonies).

The survey teams were fortunate to be able to observe several important events that, perchance, were happening in local communities: the Yunnan team observed the traditional "Ganjie" ("street market") in Baqu and "Shang zhuangfang" ("going to recite

scripture") in Dai villages. The survey team in Tibet observed the "encircling of the monastery" and the ritual of Lama-worshipping.

2.3 Data collection

Local governmental officials involved in reproductive health were selected according to standard administrative procedures. Interviewees were recommended by key informants through the process of interviewing. For example, informants were asked who the influential people in the community were.

With the ethnic communities, key groups interviewed included: community leaders and/or religious leaders; pregnant women, mothers, guardians for children less than 5-years old; persons relevant to the targeted population (such as mid-wives and sorcerers); people aged between 15 and 24 years, with or without children; MCH service providers or MCH-related local cadres.

Suitably qualified interviewees were selected for the key information interviews through the FGDs. In addition to selected interviewees, their family structures were also carefully investigated and documented.

The Yunnan, Guizhou and Qinghai teams left Beijing on June 26-27, 2009 to conduct field work. The Tibet team started fieldwork on July 11, 2009. All teams returned to Beijing around July 20, 2009. The survey period lasted between 20 to 30 days.

Miao people (Leishan County)



Grand mother, mother and child in Gyamda Hospital, Tibet

In Leishan, Guizhou, the survey term interviewed 33 persons. Among them were: 3 community leaders; 1 government official; 7 local MCH service providers; 3 TBAs, sorcerers, and Miao doctors; 4 young men and

3 young women (between 15 and 24 years old and unmarried or married but without children); 3 pregnant women; 1 new mother; 1 mother; 2 grandmothers; 2 fathers and 3 grandfathers.

Dong people (Congjiang County)



FGD with Dong mothers and grandmothers and Interview with a young unmarried woman

In Congjiang, Guizhou, the survey team interviewed 39 persons. The interviewees comprised: 8 local government officials; 2 community and religious leaders; one traditional doctor; 3 young men (between 15 and 24 years old and without children); 3 young women (between 15 and 24 years old and without

child); 5 mothers and 6 grandmothers; 5 fathers and 6 grandfathers (note: no pregnant women were interviewed due to the local custom that pregnant women should avoid meeting strangers). This team undertook one FGD (involving 14 fathers and grandfathers).

Jingpo people (Longchuan County)



In-depth Interview and Focus Group with Jingpo Women, Longchuan

In Yunnan's Longchuan County, 5 FGDs, 13 in-depth interviews, and direct observation was undertaken 4 times. The interviewees comprised: 1 community and religious leader; 6 local government officials; 6 local MCH service providers (such as doctors and nurses); 1 local TBA, sorcerer, and ethnic doctor; 2 men between

15 and 24 years of age, unmarried or married but without child; 2 women between 15 and 24 years of age, married or married but without children; 13 women including pregnant women, mothers, and grandmothers and 11 men including fathers and grandfathers.

Dai people (Luxi municipality)



FGD with MCH providers and interview of women at Zhuangfang Dai Religious Center, Mangbie Village, **Luxi**

In Luxi city of Yunnan, the survey team conducted 6 FGDs, 8 in-depth interviews and 3 direct observations. The FGD interviewees comprised: 2 are local and religious leaders; 6 local government officials; 3 MCH providers (such as doctors and nurses); 2 midwives, sorcerers, and traditional ethnic doctors; 3 young men

between 15 and 24 years (unmarried or married but without children); 3 young women between 15 and 24 years (unmarried or married but without children); 18 women including pregnant women, mothers and grandmothers and 9 men including fathers and grandfathers.

Hui people (Hualong County)



Interview with Hui young man and FGD with

The team here undertook 5 FGDs: with 3 local officials, 4 local MCH staff; 3 young men aged between 15 and 24 years, unmarried or married but without children; 5 women including pregnant women, mothers and grandmothers; and 4 fathers.

Tibetan people (Gyamda County)



In-depth interview with Tibetan mothers and fathers

The survey team in Tibet's Gyamda County interviewed 52 persons. The interviewees comprised: 12 local government officials; 2 community leaders; 3 religious professionals, 6 young men (between 15 and 24 years old and without children); 6 young women (between

15 and 24 years old and without children); 3 pregnant women; 4 mothers, 8 grandmothers; 6 fathers; 6 grandfathers. The team undertook two FGDs, one with 6 Tibetan doctors and the other with 2 local MCH staff.

2.4 Report writing

Each team wrote its own report between August 1-15, 2009. Yang Zhongdong and Min Junqing wrote the final, comprehensive report on August 15-20, 2009. Yuan Changgeng, Ma Pingyan and Xu Yan assisted the finalization of the report. Professor Ding Hong and Associate Professor Guan Kai organized and edited the final report. The English version was translated by Haiyun Ma, Assistant Professor of the University of North Carolina at Charlotte in the United States.

2.5 Constraining conditions

There were two key constraints on the survey. Firstly, funds were limited, which directly affected the time and quality of the survey. Secondly, FGDs were hard to manage for two main reasons: local community members were not familiar with this method ; in addition, since many young men had left their communities for outside jobs and there were few religious personnel, it was difficult to recruit enough people to conduct FGDs with these 2 groups.

3 Research Findings

3.1 Culture and religion of targeted ethnic groups



Zhuangfang Dai
Religious Center,
Mangbie Village,
Luxi County

There are five-hundred definitions of “culture” in cultural anthropology. In this survey, we propose to define “culture” as the Chinese philosopher Liang Shuming termed “a way of life.” We hold that “culture” includes the following basic aspects:

1. Culture is a complex concept that should include lifestyle, religion and spirituality. Each cultural aspect is inherently connected to other aspects. That is, when discussing one aspect of culture, one needs to consider the interactions with other aspects.
2. Culture is dynamic, not static. When we search for cultural dynamics in a specific social phenomenon, we should not imagine an ideal type of culture and thus exclude it from our discussion. From our perspective, it is improper to imagine a “pure, traditional culture” and discuss its relationship with MCH service. On the contrary, we believed the survey would be strengthened by incorporating cultural dynamics into our interpretations.
3. In each community, the cultural influences are multiple and diverse. Community culture reflects many faces when different cultures merge into the community. Based on the above-mentioned understandings of culture, we should objectively consider the relationship between religions and MCH services. Our teams’ survey data indicates that there is insufficient evidence to support the view that the religions of targeted areas will necessarily impose constraints on the improvement of MCH service quality.

Ethnic minorities in the survey can be roughly divided into two groups. One group is composed of those whose religious culture is important to communities: Tibetan, Hui, and Dai. The second group includes those whose religious culture is not persuasive, namely, Jingpo, Dong, and Miao. Despite their differences, these two groups have not chosen to resist powerful forces of modernization. On the contrary, religious characters have been fully reflected in the sharply delineated, modern division of labor. Religion thus can provide spirituality and solve psychological puzzles. Especially when cultural acquisition is inadequate, religion also plays the role of cultural transmitter. In daily life, religion does not intervene with people’s lifestyles and does not prevent the infusion of modernization into local communities. At the same time, it has to be acknowledged that religion has its own traditions and that its cosmology and values cannot be easily replaced. This also includes religious perceptions of disease, body, purity, life, and death. Even though obvious cultural barriers have not appeared, “culture” always possesses momentum and enables positive adaptation and adjustment.

In general, there are two types of communities based on religious practices in our survey: 1) Tibetan, Hui, and Dai 2) Miao, Dong and Jingpo.

3.1.1 Tibetan, Hui, and Dai

The first group includes Tibetan, Hui and Dai. Tibetan Buddhism, Islam, and Hinayana Buddhism are all institutionalized religions and have their own religious

systems. At present, despite changing lifestyles and standards of living, religion still plays an important role. Religion affects perceptions of values, morality, health, and disease. Based on the study findings, a brief description of the religious or spiritual practices of each ethnic minority group follows, and more details are provided in the subsequent sections:

The lives of Tibetan people are generally governed by religion. Buddha worship, scripture recitation, turning of prayer-wheels, and circumambulation of monasteries constitute important elements of daily life. According to the Tibetan Buddhist concept of Samsara, the circle of life and death are governed by Karma, which guides moral teachings.

The Tibetan medical system is time-honored and has adopted much from Chinese and Indian medical sciences. It is closely linked to Tibetan Buddhism and includes comprehensive theoretical systems and rich clinical experiences. It is particularly famed for treating some local illnesses relating to rheumatics. Due to the fact that Tibetan medical science has a long history and wide influence among Tibetans, it is the preferred and most popular treatment for local Tibetans.

Muslim Hui are deeply influenced by Islam in areas such as values, worldview, and daily life practices such as food and marriage. Islamic laws regulate morals and ethics of Muslims. Justice, forgiveness, submission, piety, and cleanliness are upheld as virtues. Islam is the major factor in Hui identity, clearly distinguishing them from the Han and accounting for the fact that they have not been easily assimilated into Han culture. Their faith also helps the Hui to sustain their Islamic culture in Chinese society.

Dai people, who are closely related to Thai people, practice Mahayana Buddhism. Their public religious space in each village is called "Zhuangfang." Every year, from May 15 to August 15 of their lunar calendar, each elder will go to "zhuangfang" for scripture-reciting every seven days. The end day is called "Chu wa" in the Dai language. On this day, Dai people hold torches and play drums, and young people cook for the elders. Dai villages have preserved their own religious scriptures written in old Dai language. Their scriptures primarily contain moral teachings, where behaviors such as stealing, killing, adultery and drinking alcohol are prohibited..

The Dai medical system holds a special position in the Dai community, being as famous as Miao and Zhuang medicines. Dai medical science is famous for fixing broken bones and liver, kidney and kidney-stone related illnesses are treated by using herbal medicines, with claims of positive results. (A Dai doctor in Mangbie village mentioned that the recovery rate of treating liver-related illness by him is 93%). There exists a

Dai sorcerer in the Mangbie village, called "Mo" in the Dai language. This sorcerer is female and claims to be a Guanyin Boddhisattva who has learned scripture-reciting in her dreams. Since then, she has begun to treat patients. Interestingly, she uses her knowledge of Chinese herbal medicines to treat patients, which could be evidence of a willingness to incorporate external influences when they appear to be beneficial.

3.1.2 Miao, Dong and Jingpo

The second group includes Miao, Dong, and Jingpo who are primarily animists. A large number of traditional customs and taboos have been preserved within their cultures. Economic development is very low among these communities and people's belief systems tend to be more traditional.

Guizhou is a mountainous province and it is said that there is no flat land in the radius of one and half kilometers. The Miao people inhabit the mountains and forests and mountainous terrain results in communities that live in enclosed and isolated cultural units. A village usually comprises an extended family or several families connected by blood. Miao villages and societies are formed on the basis of family and blood, and reinforced by locality.

Villages are situated on mountains or close to rivers and their high-base houses are built in the "Ganlan" style. The first level is often used to store goods and to raise animals and the second level is for human residence. The Miao people mainly engage in agriculture and crops and cultivate rice, corn, potato, and other items. Families often raise pigs or other animals as side products. Undeveloped economies and isolated communities result in lower levels of education amongst the Miao. In the Xinqiao village where the survey was conducted, many elders had received no education at all; the middle-aged group had less than primary school level education, and most young people had received middle school education or lower. Few persons can access a high school education and those who are able to go to university are extremely rare.

In terms of religious beliefs, the Miao people believe strongly in ancestor worship. During funeral rituals, marriage ceremonies and other festivals, ancestors must be first worshipped. The most important ancestor-worshipping festival among the Miao is called "drum-playing festival," which is celebrated every 13 years. The Miao people originally had no surnames and relate to their ancestors by connecting their names together. This practice helps them trace their ancestral generation back to a decade or so, which reinforces their consciousness about succession of blood and prosperity of offspring.

Young Miao people can choose their spouse. The traditional custom dictates that new couples cannot live together directly after the day of wedding. After the wedding, the new bride needs to go back to her parents' house. The husband will invite her to his house to live with him for certain periods of time. Especially in farming seasons, the wife usually goes to her husband's house and does farming work. However, after the work is finished, the wife goes back to her parents' home again. Traditionally their relations remain so until the wife is pregnant. After the wife is pregnant, she will live together with her husband as a couple. In a sense, being pregnant is a precondition for establishment of a new family. If, unfortunately, the wife cannot become pregnant, the marriage would usually come to an end. In this regard, the importance of reproduction among Miao people is clear.

There are no real inheritance rights for Miao women. The Miao people are afraid of a lack of descendants. The concept of "no-offspring" among the Miao simply means "without boys." One cannot sustain family lineage without male descendents, which would result in the loss of family property and discrimination by others. Therefore, sex preference emphasizes male offspring. Other customs among the Miao include paying tribute to stones, trees, and bridges. On the second day of the second month of the lunar calendar, families with children pay tribute to these items, praying for quick growth of their children. Families without children also conduct this ritual and pray for the birth of children.

Dong people mainly engage in agriculture in river basins and valleys. On mountains or hills, they are often involved in forestry. Agricultural products include rice, corn, potato and sticky rice. Crops with an economic value include cotton, tea and pine. Dong people tend to live together. A large village often has a population of five or six hundred, consisting of several surnames. Their villages lie on mountains or close to rivers. The typical house structure is the "Ganlan" style. The bottom floor is used for storing agricultural tools or for raising animals, while the upper floor is for human residence.

Religious practices among the Dong include the worshipping of nature and ancestors, and Dong people believe in many deities. Animism and immortality of the soul are foundations for their religious beliefs. In daily life, there exist some religious legacies of primitive practices such as the worshipping of nature, of ancestors, ghosts and Sasui (a female deity).

The Dong people are animist and hold that the soul still exists after a human dies. Only if ancestors in the other world enjoy peace can surviving descendants have peace and prosperity. Each family and lineage worships their own ancestors and they put ancestors' tablets in niches. During festivals, they offer sacrifices and burn incense.

Among Dong religious practices, the most important is Sasui worship. "Sa" and "Sui" in Dong language mean grandmother and ancestors, respectively. "Sasui" refers to a deceased grandmother or great-grandmother. Sasui is powerful in that it dominates all. Sasui is the female deity who can bring peace and prosperity to the village, and who can provide protection for the Dong people. People pray for everything, from daily life to agricultural production. "Sa" is the protecting deity of the village and all Dong villages contain a Sa altar where people offer sacrifices and pay homage. In Meide village, the Sa altar is located on the highest point, and was built in the 1960s. On January 1, July 14 and August 15 of the lunar calendar, all villagers conduct rituals by presenting sacrifices such as meat, salted fish and tea. When arriving at the altar, village elders recite scriptures and call for ancestors to protect the village.

Nonglong village in Longcuan County, has a strong Jingpo community. It is not a wealthy community, with an average annual income per person of ¥ 3000, but the development of sugar cane plantation, has seen an increase in the income of the villagers. The related work keeps them busy. As one villager stated, We engage in agricultural work of different intensity every day.

In addition to agriculture, villagers usually raise several pigs or other animals as a side industry. Most roads in the region are mountainous and some are only suitable for walking. This region is the core of the Jingpo mountains and the culture is well preserved. Most people can fluently speak the Dashan dialect of the Jingpo language but few people can write in Jingpo. People here usually speak Chinese and are especially fond of Chinese-language TV programs.

The village maintains some traditional religious practices with some adaptations in content and format. The religious professionals are called "Motao" in Chinese and "Gongmsa" in Jingpo. The traditional institution of ethnic leaders no longer exists, although the descendants of these leaders still enjoy certain prestige.

3.2 Perceptions of disease

In the survey there was no group except for the Tibetans, that attributed disease only to the intervention of supernatural forces. Meanwhile, it was observed in these communities that people following traditional medical practices were also interested and willing to search for "modern" explanations for illness that could complement their knowledge. For example, Dai and Miao ethnic doctors often first ask their patients to go to (modern) hospitals for accurate diagnoses before treating patients by their own methods. In community life, there is no clear differentiation between different medical traditions. Modern medical science, traditional medical knowledge, and religious rituals comprise a holistic medical system. Cases have been found among Miao, Dong, and Jingpo people where doctors

at hospitals recommend patients to conduct certain religious rituals to cure certain diseases.

When asked to what extent people rely on sorcerers, a Miao young man stated:

Ten percent of treatment depends on sorcerers while 90% of treatment relies on modern doctors.

With regards to rituals for treatment, a sorcerer's son probably reflects a common view when he says: For those who graduated from school, these practices are hard to believe in. But when you see other people visit sorcerers and you don't, you will feel uncomfortable. If something occurs in the future, it may be because you did not pay enough attention to sorcerers.

3.2.1 Miao people (Leishan County)

The traditional medical system of the Miao is unique in that is convenient, cheap, effective and quick. The knowledge of the Miao medical system is usually orally transmitted from generation to generation. Some knowledge about herbs is transmitted through women. The Miao medical system relies on herbs to cure skin cuts, broken bones and to treat illnesses of women. The Miao doctors use their traditional knowledge to cure these illnesses.

Miao doctors hold that patients should first get a diagnosis from the Western medical system and then get Miao traditional herbal medicines for treatments. They do not oppose the values and ideas of a modern medical health system. They even receive treatment from modern medical services themselves, for example, when they have headaches or fever. There are also cases where one sorcerer would visit another when he or she feels unwell.

Sorcerers play an important role in local Miao life. There is a saying among local people: "Sorcerers, doctors, and teachers will never lose their jobs." Miao doctors believe that weak resistance is the major cause of disease. According to the research findings, sorcerers deploy folk cultural psychology as the foundation for their ritual treatments.

Rituals conducted by sorcerers in the Xinqiao village include: the "bagadeaosai" ritual, namely, offering food to the deceased; funerals; tomb visits; and exorcism called "Wagalu" in Miao language. If a person's soul is stolen near a river, then sorcerers will use fish (or sometimes duck) to conduct rituals; if one loses their soul on the road, then sorcerers will use eggs to call it back. Sorcerers also determine appropriate dates for the commencement of the construction of buildings and for wedding ceremonies. They are able to help people to find what they have lost. Sorcerers even calculate

auspicious dates for people to leave the village for outside work.

Sorcerers often attribute a lack of ancestral worship, or untimely worship, to disease or illness. They assert that reason children become ill is because the ancestral souls miss them. Therefore, the way to treat ill children is to offer sacrifices to the ancestors.

When adults, elders and children are physically unwell for unknown reasons, they often visit sorcerers. Additionally, people who have gone to hospital but have not recovered in one or two weeks consult with sorcerers. People with unusual illnesses (such as lengthy diarrhea) with no clear cause also visit sorcerers. Some doctors recommend patients with injection difficulties to visit sorcerers and then to return to the hospital.

However, Miao sorcerers in the Datang Township have never treated postpartum women and newborn babies. They do not have any special understanding about Miao customs and taboos regarding reproduction. Regarding customs and taboos on delivery, a sorcerer told us:

I know little about pregnancy and delivery. I am unclear about what to eat or what not to eat, or what is good or what is bad, because villagers won't come to me for these matters.

With regards to pregnancy tests, hospital delivery, and vaccinations, sorcerers claim:

It is good to have a pregnancy test and delivery at hospital. Blood transfusion and surgery are totally acceptable.

In remote areas, people visit sorcerers because there is no other option. The availability of quality village-level medical care and affordable fees would however encourage people to use the modern medical system and would improve the health of villages, especially in the area of MCH.

3.2.2 Dong people (Conjiang County)

The Dong people of Meide village have two general understandings of diseases. The first relates to weakness of the body or ingestion of improper food. The second belief is that the intervention of spirits can also make people unwell.

Dong people either take patients to hospital or give them herbal medicine. They also invite sorcerers to conduct exorcisms. If children between 3 or 5 years of age are unhealthy or ill and are unable to recover through modern medical treatment, their parents often take them to the mountains and choose a tree or a stone to be the child's "parents". Before going to the

mountains, they would consult elders to decide what to offer to the stones and trees according to the child's date of birth. After that, on the first or fifteenth day of each month, they would offer sacrifices to them. The children have to be present for the first visit. When arriving at the destination, they pray for their children's health while reciting prayers. For the second visit, parents go there without bringing the children. If the illness is serious, parents will invite sorcerers to come with them and they will recite prayers and eat chicken before returning home.

Dong people accept both Western and Chinese medicine and hold that both Western pills and Chinese herbs are good as long as they work. They also know to choose different treatments for different illnesses. If people have a fever or get a cold, they prefer to go to the village health center for Western pills. If their bones get injured, they would first get an X-ray and then visit traditional doctors in the village.

3.2.3 Jingpo people (Longchuan County)

Religious professionals of Jingpo people hold that human bodies are weakest at the time of the shift from Yin to Yang or vice versa, which is the best time for spirits to penetrate human bodies. If one feels unwell, one should hold rituals to pay tribute to spirits. "Tribute to spirit" rituals vary due to different spirits.

The research findings showed that there appears to be no conflict between modern medical science and traditional Jingpo beliefs. A Jingpo traditional Motao doctor said:

We hope people will go to hospital first for treatment. They can come to us if it does not work.

Indeed, stories were related about how seriously ill patients who had been abandoned by hospitals recovered from treatment by traditional doctors. Sometimes, hospital doctors also persuade the family of patients to try traditional Motao doctors. They even allow them to conduct treatments in traditional ways in hospital rooms. In traditional societies, there is no direct distinction between "tradition" and "modernity." As a villager mentioned:

This (traditional ritual) is superstition while hospital represents science. However, this (offerings to ghosts) functions well. We would visit gongmsa if hospital treatments fail.

3.2.4 Dai people (Luxi municipality)

Judging from their practice, it appears that Dai people have similar perceptions of disease to the Jingpo people. Unlike other ethnic groups, the Dai people have a

comprehensive medical system. For this reason, Dai understanding of diseases and illnesses has little to do with supernatural forces. Dai medical sciences include pathological explanations for almost all disease and illnesses. Regarding some mild illnesses, Dai people are able to treat themselves. Although Dai medical knowledge is based on experience, along with religion and traditional practice, it is quite different from animist explanations of illness that are understood to be caused by ghosts and gods. Most interviewees hold that people at ill should visit doctors and there is no particular religious ritual to rely on.

During the study, the researchers interviewed a middle-aged woman who claimed that she conducts rituals to cure diseases and illnesses, and that her medical knowledge was transmitted by a Bodhisattva in dream. However, it appeared that her interpretations were very similar to traditional Chinese medical system. She did not appear to be popular among the villagers and the appointed guide was reluctant to take the research team to her home because, according to the guide, the woman was not trustworthy.

3.2.5 Hui people (Hualong County)

Hui people believe that Allah is responsible for all disease. It is thought that therefore there is no point in fearing or avoiding disease, as this can even worsen the situation. Instead, people should undertake efforts to cure diseases. On the precondition of seeking medication, people should entrust their health to Allah.

When asked why people get ill, an Imam in the Gongyi village answered that it is because people ate unclean food. "Uncleanliness" for Muslims refers to such practices as eating pork, smoking and drinking alcohol. It also relates to those things that have been prohibited in Islamic laws. If a clean Muslim gets ill it is, first, because of Allah's will and, second, because of external negative influences. Excessive eating will make the stomach uncomfortable and people will get ill. Having bad thoughts will also cause people to get ill. One village doctor stated that improper eating causes people to get ill and that now that people eat a lot of food that is not natural, this will cause more illness. He also said that "psychological burden" will also cause illness.

Local Hui hold that if a baby cries at night it must be because the baby is affected by a 'dirty' illness and, to respond to this, they would visit an Imam requesting prayer. The reason is that the baby is scared and becomes ill. Rural society is characterized by a network of connections between acquaintances. People will choose a reliable method to deal with health issues. An Akhund's "du'a" prayer is recognized only by some people and is not generally believed to exert substantial influence on MCH issues.

3.2.6 Tibetan people (Gyamda County)

Disease as an implicit metaphor exists in every society around the world. Tibetans look to a Lama to undertake religious rituals if an illness has taken a long time to cure or during the sudden onset of a disease. Perceptions of disease among Tibetans are largely confined to the framework of Karma. Traditionally Tibetans attribute diseases to issues of Karma. They tend to regard life as a temporary existence, to ignore the “ego” and interpret illness and disease from a spiritual perspective.

Traditional Tibetan medical books hold that the origin of disease in the body is the result of a strong attachment to the “ego.” The attachment to the “ego” can poison the heart and mind resulting in greed, anger and foolishness. Greed can cause excessive air or energy imbalance, the symptoms of which are often located in the lower part of body and characterized as “cold.” Anger can cause kidney imbalance, the symptoms of which are located in the upper part of the body and called “hot.” Foolishness can cause fluid imbalance, the symptoms of which are located on the head and deemed “cold.”

The Tibetan medical system holds that there are 404 human diseases and illnesses. Among them, 101 are temporary and patients will recover automatically. The speed of recovery will be quickened if they receive treatment. The second group of 101 diseases and illnesses are related to the mind/psychology. They cannot be completely treated merely by taking medicine, but rather need psychological treatment. The third group of 101 diseases and illnesses will cause death if they are not treated in a timely way. Only medical treatment can save lives. The last group of 101 diseases and illnesses are incurable and pre-determined.

The Tibetan medical system is closely related to religion. According to the Tibetan hospital in Gyamda County, the birth and development of the Tibetan medical system is closely linked to Tibetan Buddhism. Tibetan medical knowledge has to be learned in Tibetan monasteries. Many Tibetan doctors used to be Tibetan monks and some “living Buddhas” are doctors.

Rituals for medical treatment conducted by Lamas or “living Buddhas” have continued among Tibetans. At the very beginning of the field survey, no respondents were willing to acknowledge that they visit Lamas and they even said that they regarded visiting lamas as superstitious when asked where they seek treatment for illnesses. However, as confidence grew between the researchers and the informants, the respondents became willing to acknowledge that visited Lamas and to describe mysterious recovery from their illnesses. They constantly highlighted the supernatural character of ritual treatments.

Living Buddhas and Lamas are religious leaders, as well as medical professionals. Psychological treatment through rituals, combined with biological treatment from the Tibetan medical system, combine to form a particular treatment unique to the Tibetans, which continues to be used. In Gyamda County, the researchers were informed that living Buddhas and their religious activities have exerted important influences on Tibetan society, life and consciousness. This influence does not however appear to extend to MCH as maternal health decisions are generally made on an individual basis. When encountering serious illness, Tibetans often consult Lamas about where to go to cure it.

It was discovered in the survey that even in communities where traditional consciousness is strongest, perceptions and expressions of “disease” and “health” have also been affected by modern medical discourses to some extent. When they become unwell, people tend to first go to the hospital to seek help. Even traditional religious leaders, when ill, will go to hospital.

3.3 Norms and practices regarding Maternal Health

3.3.1 Prenatal practices

The survey findings showed that uptake of prenatal care is directly related to acceptance of modern MCH ideas, good economic conditions and convenient transportation.

Women from the six ethnic groups have little awareness about the need for prenatal checks. Although the County and Township level MCH care facilities have publicized the benefits of prenatal check-ups, their efforts have yielded little results. Women only go to hospital when they are very unwell. This practice is related to traditional beliefs. Women of all ethnic groups believe that pregnancy and giving birth are natural phenomena so they see no need for prenatal checks-ups.

Another factor is that women from all ethnic groups are important sources of labor within their families and continue to work during pregnancy. They cannot afford the time to seek prenatal care. Dong and Miao people cultivate mainly rice and corn. Hui people cultivate wheat and Tibetans engage in pastoral and herb-gathering activities. Jingpo people cultivate sugar cane and Dai people cultivate rice, sugar cane, corn, and fragrant vegetables. It is a luxury for women in these regions to have a pregnancy test during the busy season.

Furthermore, transportation in many regions is limited and this impacts on women’s ability to access prenatal check-ups.

Miao people (Leishan County)

Pregnant Miao women often work (except for heavy laboring) in the fields until they give birth. Sometimes they even give birth in the mountains. Those Miao that live in the mountains cannot travel easily. MCH services and needed facilities in local regions are poor and outdated. For example, local health centers in Datang Township are only able to measure the weight and growing stomach size of pregnant Miao women..

In terms of food taboos, Miao women in Xinqiao village avoid consuming female pigs in fear that the baby will suffer "female pig" stroke. Miao women's food taboos during pregnancy to some extent affect their nutritional intake.

Dong people (Congjiang County)

Like Miao women, pregnant Dong women often work (except for heavy labor) in the fields until they give birth. When interviewing Dong women, a case was described in which a pregnant woman carried rice and walked for about six kilometers even in her ninth month of pregnancy.

As with the Miao, pregnant Dong women who live in the mountains cannot travel easily. This creates a barrier to their access to quality MCH services, which are usually located at the foot of mountains.

Among the Dong, unmarried girls are not allowed to enter the room of pregnant women. Villagers state that unmarried girls will no longer belong to their original families once they marry. However this taboo is not applied to men and married women because they belong to the same family. No special care for pregnant women was reported. Pregnant women eat what they want and continue their daily work until delivery.

Jingpo people (Longchuan County)

Jingpo women in Longchuan County avoid eating honey, bee larva and hedgehog, believing that they will cause miscarriage during pregnancy. In addition, sour and spicy food, bamboo shoots and MSG are also avoided because it is thought these foods will cause diarrhea.

Dai people (Luxi municipality)

The research team was informed that, even today, some Dai women in Mangbie village work in the morning and give birth in the afternoon. A pregnant woman mentioned:

It is after the breaking of amniotic fluid that [pregnant women] go to hospital.

Another pregnant woman stated:

[Pregnant women] get out of hospital after one or two days if the baby's delivery went smoothly.

Dai women in Mangbie village of Luxi city clearly expressed dissatisfaction towards the Township health center. According to them:

Sterilization [of equipment] is not good. Skills of interns are not good. And injections cause swelling.

Nevertheless, of all the survey sites in the study, prenatal check-up rates among Dai women in Mangbie village was the highest. Once pregnancy is determined, pregnant women will go to hospital with their husbands for check-ups each month. This is probably due to the fact that Mangbie village is close to the city.

With regards to food taboos, Dai women in Mangbie village are prohibited from eating honey and bananas. They believe that eating such food will cause the baby's skin to become gluey and will be hard to wash. Dai women also avoid eating sour and spicy foods during pregnancy.

Hui people (Hualong County)

A middle-aged Hui woman from Gongyi village said: Pregnant women generally won't avoid working. Pregnant women from wealthy families won't engage in work after pregnancy. Women from poor families have to work even close to their due date. If this causes them to have an abortion, they will continue to work only after one or two weeks' rest.

During pregnancy, Hui women in Gongyi village need to avoid certain activities such as attending funerals or marriage ceremonies. A pregnant woman should keep her distance if she encounters a funeral procession.

Tibetan people (Gyamda County)

During the season of digging for Chinese caterpillar fungus, from May to early July, Tibetan women in Jieba village basically work on the mountains and even deliver babies there. There is no prenatal health care at all.

In terms of food taboos, pregnant Tibetan women do not consume meat of male yaks and of animals that were bitten to death. They hold that if this rule is violated, then the newborn baby will become deaf, unintelligent and transsexual. Other taboos include wearing or touching the clothes of infertile women and going to their houses for dinner, which would result in the death of a fetus. It is also a taboo to make one's pregnancy known to others before three months, which is believed to harm the baby. This affects women's willingness to undergo prenatal check-ups. A staff member at the MCH center of Gyamda County stated:

According to our regulations, women in the third month of pregnancy are ready for a pregnancy checkup. But people here won't tell you about their pregnancy

before three months. They hold that if the news about their pregnancy is spread out in this period, gossip will result in a curse that may cause a miscarriage. So they won't tell others about their pregnancy. When they come here after three months of pregnancy, some symptoms have already appeared, such as high blood pressure and others. Lung infection may lead to miscarriage. They won't pay much attention to these symptoms and come only after they become serious.

3.3.2 Delivery practices

There are three types of delivery among the targeted ethnic groups: hospital delivery, household delivery attended by doctors using new methods, and household delivery supervised by the pregnant women's mother or mother-in-law using traditional methods. At present, although hospital delivery is free for all pregnant women, and relevant health authorities have publicized the benefits of hospital delivery, the results are not ideal.

In all six survey sites, if delivery occurs according to traditional methods, the mother-in-law usually functions as a traditional birth attendant. Apart from mothers and mothers-in-law, the existence of no other traditional birth attendants were reported in any of the six survey sites. Sorcerers in some pilot sites can provide psychological comfort and herbal medicines during delivery. There is a possibility to train Dong sorcerers to deliver pregnant women, and send women with potential delivery difficulties to hospital. The Dua's prayer service provided by Hui Arkunds basically provides psychological assistance. It would probably be inappropriate to encourage Arkunds to get directly involved in delivery assistance. However, Arkunds can publicize the benefits of prenatal check-ups and hospital delivery among Muslims in Mosques during sermons. In some regions, Arkunds play an important role in publicizing family planning.

Delivery practices and perceptions of risks during delivery among the six targeted ethnic groups vary as set out below:

Miao people (Leishan County)

Miao people make little preparation for traditional delivery. Delivery tools such as scissors, cotton lace and cloth are not sterilized. During delivery, pregnant women stand aside the bed and hold onto it. They then deliver in a kneeling position. A plastic bag is put on the ground in case blood will soil the ground. The newborn baby falls directly onto this bag and nobody holds the baby before it reaches this bag. If delivery is difficult, pregnant women try harder by biting hair. During delivery, grandmothers or mothers-in-law assists pregnant woman.

After the baby comes out, they will cover the placenta with a cloth and bury it under the pillar of the house. The baby's umbilical cord is cut and bound by lace. They then put the cut cord into a drawer, waiting for it to naturally dry. The new baby is often cleaned with cloth or tissue papers, and ashes will be put on the biblical cord. Then the baby is covered with the father's clothes.

A 66-year-Miao woman said:

Miscarriage is rare here. We would take some herbal medicine to protect the baby if there is a sign of miscarriage. We find this special herbal medicine through local experts.

A doctor in Leishan County also mentioned:

Few pregnant women to go to hospital for checkups, and most women have no awareness of the need to undertake prenatal check-ups. There are few miscarriages here, probably just one or two every year. Village women lack the concept of prenatal check-ups.

Dong people (Conjiang County)

Findings in Meide village suggest that local Dong women have very limited awareness of pregnancy and delivery risks. Despite the County and Township health promotion work, most villagers gain relevant knowledge from previous generations. Women in the village hold that birth-giving is natural for women that women have always been used to delivering at home and that before the existence of hospitals there were few negative incidents. They feel that it is unnecessary to go to the hospital even today. Only when pregnant women feel extremely unwell or something occurs unexpectedly do they go to hospital for a checkup.

Most women have never been to hospital between conception to delivery. Women interviewed stated that they "prefer home delivery." Some families do however invite village health staff to attend deliveries and are willing to adopt new methods for delivery. Some pregnant women go to hospital because of their known weak health condition. However, healthy women believe it is troublesome to go to hospital. They believe that if their first baby was delivered smoothly at home, then there is no need to go to hospital as experience has already been gained from the first delivery.

Dong sorcerers play an important role during delivery. Sorcerers claim to know "certain medical knowledge" and can help women during delivery with herbal medicine. At the time of delivery, they calculate when the baby will come out by using traditional trigrams, and decide whether or not the newborn will survive. During delivery, sorcerers burn incense at the kitchen door while at the same time reciting scriptures. Sorcerers will kill a hen or cock and then distribute the meat for others to eat, except for pregnant women. Sorcerers then present

offerings, a salted fish made by the pregnant women's family, to their ancestors and speak good words about pregnant women and their babies.

During delivery, pregnant women will sit halfway on a long chair, with a cloth put under the chair. The doors to the room will be slightly opened and the pregnant woman will be asked to take deep breaths. An elderly woman will use a clean brush to rub the pregnant woman's back from top to bottom. If a male child is preferred, then they often hold the clean brush with their left hand. They will hold the umbilical cord with a cold prong while reciting "fujihao" scripture (an old Gong text transliterated into Chinese) to pray for the safety of mother and baby. Then they slowly drag the placenta out of the mother's body. Next they cut the umbilical cord leaving three to four centimeters. People then put cotton on the umbilical cord, put some ash around the cut and cover it with cloth. If the umbilical cord is infected, people now use Qingmeisu sterilization for treatment.

If there is a difficult delivery and the placenta remains inside, women will drink water mixed with boiled herb medicine. If delivery causes bleeding, herbal medicine will be used to try to stop the bleeding. If it is hard to get the baby out, sorcerers will be invited to draw "shuifu", in which sorcerers will put water into a bowl and spit it onto the pregnant woman's entire body while reciting scriptures. It is thought that if this is done three times, the delivery will be smooth.

The placenta is often buried on the first floor and under the bed of the pregnant woman. It is sometimes buried in the corner of house. This method of placing the placenta is the same for baby boys and girls.

Jingpo people (Longchuan County) and Dai people (Luxi municipality)

In both the Dai community in Mangbie village and the Jingpo community in Nonglong village, most pregnant women go to hospital only when they feel pain. In the Dehong region, transport is extremely poor, which may lead to the "three delays" and result in maternal mortality.

The delivery process is similar between Dai and Jingpo people. According to the research findings, older women in the village serve as the traditional birth attendants. This is because according to them:

First of all, we have experience of delivery and we have seen other deliveries before.

Tools for delivery include: two lines for binding the umbilical cord; a bamboo slice for cutting the umbilical cord; some cloth taken from men and women's clothes; and some warm water. During the pregnancy, a bamboo

slice will be put close to the fire to make it hot to cut the umbilical cord. If it is a home delivery, the umbilical cord will be covered with banana leaves.

A baby boys' umbilical cord is buried under the major pillar of the house while the baby girl's is buried under another pillar next to the major pillar. If the house is being built, then the umbilical cord will be buried in the yard in line with the pillars of the house and marked with bamboo slices, indicating that this is "my" place of birth. To bury the baby boy's umbilical cord in the middle of house indicates that he is the pillar of the family. To bury the girl's umbilical cord in the marginal position means that she will be outside sooner or later. The burying place is surrounded by bamboo slices in order to prevent dogs from eating the placenta and the umbilical cord.

Jingpo women in Nonglong village often drink water containing white powder taken from banana leaves. They believe such powder can provide them with strength during delivery. They often use this method when they have difficulties in giving birth. During delivery women are also asked to blow air into the small opening of a wine bottle, as this is thought to provide her with strength. The newborn baby's umbilical cord is cut with scissors, without sterilization. Then the baby is washed and wrapped. Villagers state that people in the mountains still utilize traditional methods of delivery.

Hui people (Hualong County)

Hui women in the Gongyi village have limited knowledge about pregnancy and delivery. Although Gongyi village is only about 3 kilometers from Qunke town and the road between is well paved, few women choose to go to hospital for delivery. Even young women tend to stay at home for delivery. Wealthy families and families with experience in operating noodle restaurants outside of the community also like to deliver at home. Only when women encounter difficulties during delivery do they choose to go to hospital, thus increasing delivery-related risks.

In most families, it is the mother-in-law who decides whether the pregnant woman should go to hospital for delivery. A 30-year-old male village stated:

Two days ago, there was a home delivery. The baby came out but the placenta didn't. The woman died on the way to hospital. Their family said that they had no money for hospital and so delivered at home. She was only 20-years-old. We did not pay much attention to this. Death and life is decided by Allah's will.

During delivery, plastic cloth is put under their body. Paper is put above the plastic cloth. Women traditionally sit on the ground in a custom called "earth-sitting."

Before cutting the umbilical cord, scissors will be put through fire to make them hot, and no other sterilization method is taken.

The placenta and other matter that comes out will be buried in the margins of the yard. The major assistant during delivery is the mother-in-law. There is a special custom among Hui people to seek "Du'a [pray for blessing] for facilitating birth." The Hui pack red sugar, millet and tea in a small bag and invite an Arkund (Imam) to recite prayers and ask for blessings. After the prayer, the Arkund (Imam) will blow into a bag three times, which the pregnant woman will inhale at the time of delivery. Pregnant women receive the Du'a prayer the Arkund plays no other role in the delivery.

Tibetan people (Gyamda County)

Many Tibetan women hold that reproduction is as easy as "doing a normal job." Women from poor families believe that there is no need for prenatal check-ups and the baby will come out on the due day. Some pregnant women feel that going to hospital for a checkup is too troublesome due to the long traveling distance. Although checkups are free, transportation costs are not provided. The research team was informed of a recent case where a young mother died from bleeding after delivery in 2008. Her mother believed that bleeding is normal during delivery and did not send her to hospital until she was in a coma. Apparently local doctors had advised them earlier to go to hospital for delivery but they paid no attention.

Traditionally, a simple tent would be erected in the sheep yard for Tibetan women's delivery. They perceive the sheep yard to be "clean land". Babies born in this clean land can resist invasion by spirits and demons. However this phenomenon is rare today and only exists in remote regions. Most women give birth in their homes.

In the past, there was no professional midwife and pregnant women managed their own deliveries. In some families, the mother or mother-in-law helps pregnant woman to deliver. The husband is often not present during delivery. It is said that were the father to be present during delivery, the baby would be shy and reluctant to come out. But in the grasslands husbands need to help their wives deliver if there are no other persons at home.

In targeted rural areas, people generally choose to go to the hospital only when the delivery is difficult or the baby's position is not optimal. Home delivery carries major risks. One of the main factors influencing maternity mortality is the underestimation of the dangers of delivery.

3.3.3 Postpartum practices

Postpartum practice is mainly embodied in the custom of the household "confinement". All ethnic groups exercise this tradition expect Tibetan people. While the confinement period lasts for approximately one month, the exact period of confinement varies among the different ethnic groups. During this time, the new mother remains in the house and her mother-in-law takes care of her and the baby. Couples do not have sex during the confinement period and women cannot touch cold water.

Women face changing social roles after pregnancy and need to observe certain taboos in this period to avoid bad luck brought to the baby and mother. Taboos vary among the different ethnic groups. The most common taboos relate to food and behavior. Such postpartum taboos can impact on women's health to varying degrees.

Miao people (Leishan County)

Miao women practice a one month confinement period, during which time they cannot go anywhere and must stay at home. Some leave their beds three or four days after delivery but remain in the house.

Among the Miao, new mothers can eat nutritional food during the confinement period, though this depends on the family's economic circumstances. The major nutritious food for postpartum women is chicken. Mutton, beef, pork from female pigs and ducks is prohibited for consumption. Further, during the confinement period, women will not eat duck due to a belief that eating duck will cause them to swing their heads in old age. It is also said that consuming female pork during the confinement period will cause old diseases to reappear. Mutton consumption is also avoided for the similar reason that it may cause "sheep" stroke.

The most common foods eaten are eggs roasted with rice wine and chicken soup. Miao people used to think that postpartum women could not eat cold food and therefore rarely provided fresh vegetable and fruits to them. Now, some families have begun to allow women to eat heated vegetables and fruits.

Miao postpartum women are often seen as 'unclean'. They are considered so impure they can only use their own chairs. Postpartum women are advised not to visit others and not to pass by the doorways of other houses. They are charged more when they take a taxi. The concept of the 'dirty' postpartum women not only increases the economic burden on women but also makes pregnant women reluctant to deliver at the hospital. It also affects postpartum checkups and postpartum services.

The director of the MCH center in Leishan mentioned that due to the concept of the 'dirty' postpartum woman:

Many peasants find it troublesome to deliver at hospital. When they go home after delivery at hospital, no car will take them. Back to their village, they cannot pass by other's house, and neighbors even cover their windows and doors with curtains. Even if hospital delivery is free for peasants, they are reluctant to come because there is so much trouble.

Postpartum women do no work after delivery and the mother-in-law takes care of the mother and baby. Postpartum women have to cook food and wash clothes if there is no mother-in-law present. They do not however engage in hard physical labor work.

There are a few other customs regarding postpartum women care. For example, postpartum women often do not have baths or brush their teeth after delivery, although this is not applied rigidly amongst all Miao. Most women understand that after delivery sex should be avoided for a certain period of time.

Dong people (Congjiang County)

During the confinement period among Dong people, new mothers can only eat meat from female hens and pigs. Chicken is mixed with sticky rice and given to the new mother. Sometimes, pork is also provided, which is said to be good for the womb. For the first five days, family members make chicken soup for the new mother. After five days, other foods are added. The new mother eats in her own room, separated from other family members. Food for the new mother is cooked separately. Only after one month and three days can the new mother eat together with other family members. New mothers do not consume meat of cockerels for it is said to cause illness. They do not eat sour and spicy food. After one month, they can eat slightly sour and spicy food.

During the confinement, the new mother does not work. The mother-in-law is responsible for cooking and washing clothes and the new mother cannot touch cold water. When going out, new mothers cover their heads with scarves to avoid catching cold. Forty days after delivery, the new mother can work and have sex with her husband. During the confinement, the new mother usually does not go to others' homes. If the new mother needs medicines, family members visit Chinese doctors and describe the situation and bring back herbal medicine. After the confinement period, doctors can go to the new mother's home for a checkup. Some postpartum women wash their bodies with boiled maple leaves.

Jingpo people (Longchuan County)

Though Jingpo women normally practice confinement, they sometimes have to take care of housework and even go to the field to work seven days after their delivery. At most, they stay in hospital for two days after delivery because they shoulder more labor tasks as Dai women do.

Dai people (Luxi municipality)

In Mangbie village, old traditions dictate that new Dai mothers will take a bath three days after delivery and then have another bath after one month. Borneol is often put in the bath water. After delivery, there are certain taboos. Most postpartum women only eat black-sugar boiled eggs and chicken. Vegetables planted with chemicals and leftover foods are not consumed. The period of confinement for Dai women is one month, during which time they cannot go outside their own home. They cannot leave the village until three months after delivery, and this practice continues today. Dai women are not allowed to leave their own families one month after delivery, a practice that is still strictly observed today. Like the Miao women, this practice affects Dai women's access to postpartum health services.

Hui people (Hualong County)

Hui women exercise a confinement period of 40 days. They eat mutton, chicken, milk and eggs and are prohibited from eating potato, cold and uncooked food. Postpartum Hui women usually do not eat cold food (as classified according to traditional medicine), including fruits, and spicy and sour food.

Postpartum women must exercise confinement for about 40 days, during which time they are prohibited to go outside.

Tibetan people (Gyamda County)

Tibetan women usually drink a special Magu drink that is made of mixed and boiled yak-butter tea, barley-made wine and roasted barley flour. They hold that this will help to increase blood flow. Postpartum women usually drink soup boiled with bone, which makes digestion easy. It should be mentioned that local women drink barley-made wine after delivery.

Tibetan women do not practice confinement after delivery. During the busy season, postpartum women start working after about ten days of resting. However, during other seasons they may rest for about 20 days. During herb-digging season, postpartum women will not stay at home. In this case, the baby is looked after by family elders and mother does not breastfeed.

3.4 Norms and practices regarding child health

3.4.1 Newborn care

All ethnic groups have specific ways of taking care of infants. However, they all share one trait: traditional breastfeeding.

Miao people (Leishan County)

During home delivery among the Miao, the newborn baby will be cleaned with tissue paper or cloth, and ash is put on the umbilical cord. The newborn baby is then covered with the father's clothes. After three days, the baby will be washed with warm water.

Miao women believe that colostrum (early breast milk) lacks nutrition and is even "dirty." Traditionally, mothers pump the early breast milk but never feed it to the baby. However, in recent years, new mothers are being influenced by the campaigns advocating for early breast milk and have begun to accept its health benefits.

In Miao communities, the grandmother or father takes care of the newborn baby after birth. The new mother merely breastfeeds the baby. When she can leave her bed and walk she begins to take care of the baby by herself, while other family members assist her.

Dong people (Congjiang County)

Dong people breastfeed their newborns. They begin to feed babies with rice soup three to five days after they are born and sticky rice at one month. Mothers first chew this food into small pieces and then feed their babies.

Jingpo people (Longchuan County) and Dai people (Luxi municipality)

Early feeding practices among the Jingpo and Dai are basically the same. The following statement is representative of their situation:

Baby takes breast milk. Some parents feed their babies with chewed rice usually one month after delivery (sometimes, salt is added to the rice). At the age of 7 or 8 months, almost everything is fed.

Dai and Jingpo women are now more likely to have adopted breastfeeding. However, some families still have a different understanding and have difficulty accepting early breastfeeding.

A unique custom among Dai people is that the first breastfeeding should be done by another woman, especially a woman who has given birth to a son.

Jingpo children in Nonglong village are often breastfed for about a year and half. From six to seven or eight months after birth, other foods are gradually added. Babies eat what adults eat after it is chewed. There is a local concept of "babies should eat what their parents eat".

With regard to treatments for baby illnesses, both Dai and Jingpo people believe it is better to go to hospital.

Hui people (Hualong County)

Generally speaking, Hui women in the Gongyi village breastfeed their babies.

Tibetan people (Gyamda County)

Tibetan women feed their babies a barley-based soup shortly after birth, depending on the amount of breast milk available. According to local custom, if the mother's milk is not sufficient, the baby will be fed with barley soup on the third day after delivery. Or if the mother has enough milk, she will wait until after about one month before feeding the baby barley soup. There are two reasons for this practice. Firstly, it is believed that eating fresh yak butter and barley soup is a blessing. Secondly, it is thought that the new mother does not have enough milk immediately after delivery and the baby needs food to grow strong.

During the herb-digging season, women and children go to the mountains to dig herbs, which often results in insufficient breast milk for the new baby. Even a newborn baby is often looked after by grandparents in this season. If there is not enough breast milk, the new baby will be fed yak-butter as a substitute.

3.4.2 Infant/child health, including immunization and nutrition

The research findings suggest that breastfeeding generally lasts for about one year in most communities. As mentioned above, supplementary foods are introduced at different times within the different ethnic groups, often depending on the family's economic conditions. Children with illnesses are taken to the hospital. In the surveyed ethnic groups, there are also times where rituals are used to cure illness.

Miao people (Leishan County)

Miao people feed their babies rice soup if there is insufficient breast milk. Villagers hold that rice is the most nutritious food. Miao doctors in Datang Township said:

The biggest issue for child health is poor nutrition. Children here are small and skinny. Some kids eat sugar all day but not rice. Parents feed only rice, without vegetables, meat, and eggs.

Regarding immunizations, a 75-year-old Miao man said:
I know that immunization can prevent measles. This is all that I know. My grandchildren received immunization at the Township health center and we have relevant documents.

Dong people (Conjiang County)

There is no fixed time for weaning. Mothers who stay at home usually stop breastfeeding when babies are one year old. Mothers who go out for work usually wean earlier. The local hospital encourages at least six months of breastfeeding and discourages feeding meat, rice, or chewed food in early stages in order to prevent infection. However, villagers believe that feeding the baby first with breast milk and then with rice will make them less hungry and they will urinate less frequently, which means mothers will not be bothered during work.

Dong babies are fed poultry meat three months after delivery in the hope that they will become eloquent in the future. Fish is fed when the baby is 6 months and when the baby is 12 months old, it is fed beef.

If the baby gets a cold, some oil is put on the forehead. If the baby cries at night, parents often visit traditional Chinese doctors who will provide a grass-mat to put under the baby and will draw ritual-related pictures to be attached to the village gate.

Common illnesses found among babies include fever, swollen belly and hip, ear inflammation, skin diseases, eczema, etc. Babies delivered by modern methods are less likely to be ill and are generally easier to take care of. By contrast, babies delivered using traditional methods can easily suffer from stomatitis and pain at the umbilical cord.

Inflammation is often treated with ash found on the bottom of cooking utensils. If a baby's illness cannot be treated by the local health center, then people will adopt traditional remedies. Sometimes parents will take the ill baby to find "stone parents" on the mountains. Before going to the mountains, parents will consult sorcerers as to how to practice the ritual. For the first visit, the baby has to be present. Sacrifices include chicken, duck, pork, wine and cooked stick rice. When arriving at the selected destination, they have to recite scriptures while burning incense.

Jingpo people (Longchuan County)

One interviewee speaking on child health in Nonglong village said:

Poor nutrition is common among children here. Most breastfeeding lasts for about one-and-a-half years, and supplementary foods, often chewed by adults, are given at six months.

The kitchen hygiene of Jingpo people is much poorer than those found in the Dai region. It is in this

environment that rice supplement is made for one-year-old babies. If sick babies cannot be treated by local health centers, Jingpo people often adopt a method called "egg-rolling." They roll newly laid eggs over the sick baby's head and body several times and finally put the eggs beside pillows. This practice usually lasts for three days and some elderly people say some lucky words in Jingpo language.

Dai people (Luxi municipality)

Dai people in Mangbie village feed their babies chewed rice. Most women learn how to feed babies with a "rice supplement," in which they grind rice into powder and mix it with water. They mentioned that this feeding makes baby quiet. In fact, according to local professionals this kind of food is hard for babies to digest and babies will not feel hungry for a relatively long period.

In Mangbie village, babies are usually treated in the village's local or Township health centers. Parents visit local "Mo" sorcerers if a baby keeps crying at night. One service provider mentioned that children's health throughout the entire Dehong region is not good because new cases of childhood diseases keep increasing.

A few Dai people in Mangbie village hold the view that childhood diseases and death are related to immunization injections. Thus some parents are unwilling to immunize their babies.

Hui people (Hualong County)

In Gongyi village, people invite an Arkund (Imam) to attend to a baby with a "dirty illness." Arkunds will blow "Du'a" (ask for a blessing) and feed it to the baby.

Tibetan people (Gyamda County)

In Gyamda County, childhood diseases include blood clots, gastroenterology, skin diseases, Hepatitis A, and tuberculosis. Newborns are not fed with breast milk, but with yak butter. There was a case described in which all school children were infected with a sensitive skin disease due to the fact that people do not take baths or change into clean clothes regularly.

Because of the high altitude, adults and children consume under-cooked foods given the difficulty of boiling food adequately. As a result, many parasites were found in their bodies. Also, peasants and nomads often cover the baby's diaper with plastic, which causes eczema, dermatitis and other skin diseases.

Some Tibetan people believe that although immunizations can prevent diseases, they also harm newborns. As a result, some Tibetan villagers look for excuses to avoid immunization shots for their babies.

3.4.3 Identity and role of caregivers



A Miao grandmother with her granddaughter, Leishan

There is similarity in the identity and role of caregivers among all six ethnic groups. In extended families, new mothers and elderly women are the primary caretakers. Older female family members help young mothers staying at home to take care of babies. As more and more young couples leave home for work, herding or digging herbs, the elderly women at home will look after children. Some young couples travel far and return to home only during the Spring Festival once a year or even after several years.

All Miao women carry their babies on their backs. They carry their babies no matter whether working or going outside for the purpose of easy care-taking. In the Xinqiao and Meide villages, mostly old women take care of babies.

In the targeted areas, except for the Dai people in Mangbie village, villagers are almost all children and elderly people. Rarely does one see any young adults. In nuclear families, the husband tends to be more and more involved in child care, and the traditional model of care-taking is changing.

3.5 Gender dynamics



Working Hui and Miao Women, Hualong and Leishan

The gender dynamics within families of the six targeted ethnic groups presents a single model that men are in charge of affairs outside the family, while women take care of domestic chores. This model is deeply rooted in traditional ways of living. Agriculturalists (and

pastoralists) engaged in small-scale economic activity are highly dependent on male labor. In many regions, this type of economic activity can only meet basic needs for survival. In Congjiang and Leishan in Guizhou province, ethnic groups participate in such economic

activity to sustain survival. In these areas, wetlands usually produce rice and dry lands bear vegetables. Daily expenditure can only be met, and meat obtained, through husbandry (pigs and ducks). Although there are differences concerning the details of dynamics within families, males are dominant in all groups. This is even true in Tibetan families where women play important roles.

3.5.1 Decision-making in the family

The dominant role of males in society is largely seen in the economic arena, where males exercise economic power. But in the areas of MCH, childrearing and child education, males tend to “grant” power to females. In this process of re-distribution of power, elderly women possess the dominant power. Even in nuclear families, elderly women play an important role in delivering children and raising them.

With each ethnic group, the followed issues were explored:

Male involvement in family Life

Without exception, the extended model of “male outside” and “female inside” exists in all families of the targeted ethnic groups. “Male in charge of outside” refers to the fact that males in a family basically undertake manual labor such as farming. However, the concept of “female in charge of inside” does not mean that women are exempt from work in the field. Women not only undertake household chores, but also work in the field.

Regardless of age, men of all targeted ethnic groups had little knowledge about MCH and showed little interest in gaining such knowledge. They generally hold that reproductive health is a matter for women.

Control over family income

Generally speaking, control of family income depends on the family type. That is, women in nuclear families participate more in income control than those in extended families.

It was observed that in the six ethnic minorities, income spending is closely related to income control. The right to spend the family’s income differs between extended and nuclear families. In extended families, elders have more to say. In extended families among the Dong in Meide village, and the Miao in Xinqiao village, elderly males often make major decisions. By contrast, in nuclear families, men and women tend to have equal rights. However, large expenditures such as purchasing home appliances are often decided by men.

Who decides when and where to seek medical care?

In all six survey sites, individuals usually make their own decisions on when to visit doctors, depending on the circumstances. However, mothers-in-law have significant influence on decisions regarding pregnancy and delivery, although the influence of the mother-in-law is rarely authoritarian except for among the Hui families in Hualong. Hui mothers-in-law have significant authority to dictate whether the pregnant daughters-in-law go to hospital for delivery or not. Some cases also demonstrated that family decisions regarding the choice of hospital-based delivery, or otherwise, heavily depends on their physical condition and the convenience of transportation.

The survey findings of the six ethnic groups indicated there are no clear patterns regarding who decides where a patient should go for medical treatment. Instead, people take such decisions based on common sense and personal experience. Among the targeted ethnic groups, Western medicine, Chinese medicine, traditional ethnic doctors, and rituals are used inter-changeably for treatment. In Guizhou and Yunnan, sorcerers are common for treatment. In Gongyi village in Hualong County, Hui elders bring children who are scared or crying without reason to Arkunds (Imams) at Mosque to “blow Du’a” (ask for a blessing) or eat Du’a sugar. In all cases in this survey, people choose to go to hospital when access is easy, and tend to turn to traditional medical methods or rituals when the hospital treatment fails to cure.

Who makes decisions about child-care/ children’s health?

Among almost all targeted ethnic groups, women basically take care of and raise children, while the level of male involvement is low.

When couples in Miao, Dong, Hui and Tibetan communities go out to work in the field (e.g. to raise cattle or dig for herbal medicine), grandmothers take care of children’s health issues and often rely on traditional methods. Recent research suggests that those children who are looked after by their grandmothers while their parents work may develop serious health problems, including mental health issues (Zhao, 2009). In the targeted ethnic groups, the impact of modern science on pregnancy, postpartum health issues, and feeding methods for children (including infants) is weak.

Miao people (Leishan County)

Miao village in Xinqiao village undertake the housework, while men contribute little to housework and child raising. It is regarded as normal if men “do no family work.”

In Miao families, husbands, including elderly men, play a dominant role in controlling income. However, many Miao couples mentioned that the family income belongs to both the husband and wife and expenditures of large amounts are decided jointly by couples after discussion. Generally speaking, in families where couples are under 30 years old the wife has more powers of control over family income. In families with senior members, wives have almost no rights to family property and have to follow the husband's decisions.

In traditional Miao society, the mother-in-law decides whether or not, and where, to visit doctors. Since husbands have little knowledge about pregnancy and delivery, mothers-in-law generally makes these decisions. Since elderly people are generally conservative, they often do not want their daughters-in-law to go to hospital. Before the Rural Cooperative Medical Care system was implemented in 2006, the hospital delivery rate was very low.

Along with the implementation of the free hospital delivery policy and the promotion of the wife's status in the family, more and more couples have reached a consensus about where to seek treatment and delivery. Women have increasingly more rights in decision-making. One reason is because of the shift towards more equal gender relations. Another reason is that more and more women begin to have their own income by working outside the village, which helps improve their status at home.

Among the Miao people in Xinqiao village, mothers-in-law are primarily responsible for children's care and health when mothers work outside the village. Mothers-in-law take decisions on almost everything. The husband is less involved in this area. Now that more and more young couples go outside for work, and their children are taken care of by grandparents, almost all health issues are dealt with by grandparents.

Dong people (Congjiang County)

In the Meide village of Congjiang, Dong women are expected to participate in all family-related agricultural work during busy times. When they are free from agricultural work, women go to the mountains in the mornings to gather grass or Acanthaceae roots for dyeing materials, or to look after farm lands. In addition, women need to raise children, and participate in husbandry, weave textiles, dye and make clothes, and cook.

Dong villagers do not have the concept of "health care" as long as they are not ill. With regard to raising children or addressing child health issues, couples do not generally have particular discussions, normally agreeing to follow traditional practices. There is general consensus in the family and everybody will follow it. When encountering serious illness or a difficult delivery, couples are likely to call the doctor or visit the hospital. Husbands are willing to accompany their wives to hospital and there is generally no disagreement on this. In the Meide village, elder's words are very powerful and seen as reliable for those who rely on their opinions. Grandmothers take care of children whose parents work outside the village, and they tend to rely on traditional ways to deal with children's health issues.

Jingpo people (Longchuan County) and Dai people (Luxi municipality)

Both Dai and Jingpo men often described women's hardship and were happy to acknowledge that their wives dominate internal family affairs. Many Jingpo women said:

I manage the housework and control the family income. My words count.

Men also informed the researchers that many family issues will be decided based on consultation. Unlike elders in other societies who play an important role, Dai elders in the Mangbie village have their own society and men over 40 years of age tend to go to "Zhuangfang" (a religious site of the Dai people). They become members of a society for older persons and avoid killing animals and refrain from involvement in village and family affairs, instead concentrating on reciting scriptures.

Along with the increasing number of nuclear families among Dai and Jingpo communities, gender relations tends to be equal and women's status in family decision-making is improving. Men tend to openly admit that their wives manage the family and have to be consulted for family decisions.

In Mangbie village, Dai male and female youths have their own groups and leaders. "Youth leaders"^① have certain influence over young people regarding where to seek treatment. One of our informants said:

If we want to publicize something, we just tell the team leaders. They are more efficient than us.

^① In the villages, there are usually some young generation "elites" who have significant influence and authority over the young villagers. They lead the networks within which young members communicate with each other more frequently and privately and closely share knowledge and information.

Among Jingpo and Dai, elders have a certain influence on MCH. Young women stated that their mother-in-laws will not allow them to eat sour or spicy food, MSG and other foods that are perceived to cause diarrhea in babies. Most women in the Nonglong village deliver at home. They go to hospital only if their delivery at home encounters difficulties.

Among the Dai in Mangbie village, elders and wives take care of children's education. Most women perceive that their family status has changed. As one interviewee expressed, "now women have their own opinions." When asking a Mangbie villager how to deal with the theoretical situation in which family elders oppose child vaccination he answered without hesitation "It is us (parents) who decide on this matter."

Hui people (Hualong County)

In Gongyi village, Hui women take care of housework including washing clothes, cooking food, caring for parents-in-law, and raising children, among other tasks. Meanwhile, women rarely go outside the home and are less experienced in communicating with strangers.

Mothers-in-laws oppose their sons involvement in housework, including helping care for the children. Even those who received education outside their own village as well as those who work in town and those who owned noodle restaurants in other provinces are unwilling to help their wives look after the children. The task of caring for newborns and women who have recently given birth is usually undertaken by elderly women.

Hui men are basically responsible for making money and they play a dominate role in controlling the family's income. In both extended and nuclear families, men control the right to spend the family income, while women must ask husbands for money for daily expenses.

In Gongyi village, the mother-in-law is the most influential person during pregnancy and birthing. Decisions on when and where to seek medical help, especially during pregnancy, lie with the mother-in-law. At the same time, traditions remain very influential.

Tibetan people (Gyamda County)

In Tibetan family life in Jieba village, women undertake housework such as washing clothes, cooking food,

cleaning the house, and raising children. In extended families, the mother-in-law is involved in this work while male members do not participate in housework. However, both men and women are involved in agricultural and herding activities. Family members dig herbs, plant farms, and herd animals. Physical labor is not divided along gender lines but rather decided by the actual situation of the family.

In Jieba village, in 50% of families interviewed family income is controlled by the elders, in 30% of families income is controlled by young male members, and in 20% of families it is controlled by housewives. Nearly 47% percent of women informed on having attended family meetings on money spending and professed that they play relatively powerful roles in decision-making. Along with the improvement of medical conditions, some Tibetans in Gyamda County choose to go to the hospital voluntarily, not depending on decisions made by powerful family members. They would invite local health center staff to come home if they decided on a home delivery.

Along with promoting the Lowering and Eliminating Project^① and the New Type Cooperative Medical Care System in Rural Areas, ethnic minorities have enjoyed certain subsidies, especially for pregnancy checkups and labor and delivery. This preferential policy has had a positive impact on ethnic minority women by encouraging them to go to hospital. Due to traditional customs, lack of knowledge of the risks associated with pregnancy and delivery, and the inaccessible services (e.g., poor transportation), the majority of women only call the doctor for help when they are unwell or unable to give birth. Also, many women cannot precisely calculate their baby's due date and thus are unable to decide when to go to hospital for delivery.

The Tibetan case is rather different regarding the question of whether to send family members to the hospital or to receive surgery. Relatives of patients often consult the Lama first, and not doctors. When pregnant women have difficulties giving birth, they do not immediately go to doctors, but often look towards Lamas to recite scriptures and practice divination through the use of trigrams. When patients encounter difficulties at hospitals, Tibetans invite a living Buddha to consult the divinities for possible places for treatment. In Tibetan society, the grandmother takes care of children's food. The mother and grandmother are responsible for raising children. The specific child-raising methods are related to their life experiences. According

^① In the villages, there are usually some young generation "elites" who have significant influence and authority over the young villagers. They lead the networks within which young members communicate with each other more frequently and privately and closely share knowledge and information.

to information provided from the local health center staff and from the research findings, the local health center's scientific methods which have been widely promoted have not exerted any significant influence on the uptake of modern services.

3.5.2 Child Sex Preference

In the Chinese context, child sex preference refers specifically to the preference for male children. If preferences for boys among ethnic minorities can be listed from strongest to weakest, the following order exists: Dong, Miao, Hui, Jingpo, Dai, and Tibetan. Among ethnicities with child-sex preferences, the mother and child face certain risks if the first child is a girl. In our survey we found that abandoning of baby girls occurs in Dong and Miao communities.

However, all ethnic groups hold that it is best to have one boy and one girl. If a family has one boy and one girl, the family is unlikely to violate family planning regulations and have a third child.

Miao people (Leishan County)

In Leishan, a young Miao woman from Xinqiao village informed us:

Abandoning of babies sometimes occurred in this village. People won't be too surprised at it and they accept such a practice. The mother is certainly upset but there is nothing she can do about it.

Almost every interviewee from Xinqiao village knew of cases of abandonment of female infants.

The researchers were unable to acquire data regarding the abandonment of infants in Leishan County. However, the total number of babies adopted by foreigners in nearby Zhenyuan County since 2001 is 78. All of them are girl infants and some of them had been abandoned by their parents. There was a report in the Guizhou city newspaper on August 24, 2007 about the release of information regarding 14 abandoned babies, indicating a serious sex imbalance. The younger the age, the larger the sex ratio imbalance.

Dong people (Congjiang County)

Interviewees stated that in Meide village, people hope to have a baby girl first and then a baby boy. The rationale is that girls are diligent, family-oriented, filial, and can help the family at the age of five to carry water or take care of children. After a girl marries and moves out, the family needs boys to farm, care for elders, inherit family property and continue the family lineage.

The research team was informed of a case in the past two years involving a family that wanted a son. The wife gave birth to several daughters, all of whom were killed by drowning. The family kept changing the location of their residence, complaining about its feng shui, which led to their impoverishment. The family had also conducted an abortion on the wife at home, thus threatening her life. This family finally had a son this year.

Interviewees said that it was not uncommon in the village for a mother to commit suicide after conceiving several girls, believing that she is incapable of conceiving a son.

Jingpo people (Longchuan County), Dai people (Luxi municipality) and Hui people (Hualong County)

Although Jingpo, Dai, and Hui communities to some extent have a preference for sons, no cases were described of the abandonment or drowning of girl infants. The government's preferential policies towards families with two daughters have not been positively received by those ethnic groups with preferences for sons.

Tibetan people (Gyamda County)

According to information received, Tibetans generally do not have child sex preferences and the desire for more children is not strong. Many Tibetan families whose first two children are girls decide not to have a third child as permitted by the government. The implementation of the family planning policy does not appear to be difficult among the Tibetans.

3.5.3 Different treatment of male and female children

The "men outside" and "women inside" model of gender dynamics dictate from beginning of life how a family treats their male and female children. Girls from a very young age stay at home helping their mothers, while boys, mirroring their fathers, have little involvement in housework. Government statistics show that female-dominated occupations basically entail unskilled labor, long working hours and intensive work, but offer little pay. This social practice is closely related to the division of labor within families. Respondents reported that if a family has a son and a daughter, they are both fed and treated equally. One villager said:

School-aged boys and girls will all go to school.

Although differential treatment of boys and girls exist in every ethnic culture, these do not lead to different

behaviors regarding child health care. Improvements in living standards and decreasing numbers of children in families enable parents to provide equal nutrition for their children, both boys and girls. Among the six ethnic groups, no evidence was found of boys being better nourished than girls.

In the area of education, many parents with both a son and a daughter stated that they would support whichever child studies hard. However, the cultural environment that prefers boys to girls and the intensive housework responsibilities of girls has negatively affected girls and resulted in more girls dropping out of school. In Guizhou province, among the population with at least a middle school education, girls are represented less frequently than boys. This imbalance is even more obvious among those with a university education. The problem of a relatively low education levels among women/girls can be found among all six ethnic groups.

Miao people (Leishan County)

The Miao hold a naming ceremony after the birth of a son to honor relatives and guests, while such a ceremony will not be given for the birth of a daughter. There is another custom practiced among Miao people in which the family will often find a "stone mother" for a child. The ceremony for inviting a "stone mother" for a boy requires a pig, while a duck is needed for a girl. For the purpose of being blessed, Miao people will plant a cuckoo tree for their sons, but not for their daughters.

The research findings in Xinqiao village indicated that Miao elders tend to have had no education, middle-aged people tend not to have had a primary school education and young people usually have, at the most, a middle school education. High-school graduates are few and those who are able to go to university are extremely rare. When it comes to female students, the situation is even worse. Indirect evidence is that female professionals in some high education-related circles are far fewer than male professionals.

Dong people (Congjiang County)

When the Dong in Congjiang County gives birth to their first child, a symbol will be hung on the door of the house. If a son is born, then biu grass and red peppers will be hung on the door. If a daughter is born, then a colorful cloth or ribbon will be hung.

Jingpo people (Longchuan County) and Dai people (Luxi municipality)

Neither the Jingpo nor the Dai showed visible signs of differential treatment between male and female children.

Hui people (Hualong County)

In Gongyi village, the Hui tend to pay more attention to and to invest more in their sons' growth. In Hui families, girls are assigned more household-related duties and work.

Tibetan people (Gyamda County)

By contrast, there were few ways identified in which Tibetans treat sons differently from daughters. Both males and females (and even son-in-laws) are able to inherit family property.

The research findings identified only one clear case of differential treatment of baby boys and baby girls. When Tibetan babies are named, parents usually invite a living Buddha to name their sons, while parents themselves name their daughters. Except for this phenomenon, there appears to be no obvious differential treatment between male and female children among Tibetans.

3.6 Young people's perspectives



In-depth interview of a Hui young women, Hualong County

Young peoples of all six ethnicities reported obtaining knowledge about reproduction primarily from older generations. As products of their specific ethnic cultures and traditions, young people are consciously or sub-consciously influenced by traditional beliefs and practices, especially those who have lived in rural or pastoral regions. In recent years, as more and more young people have left their homes to study or work, their concepts and ideas concerning reproduction and maternal health have to some extent changed. Young people who have received a higher education or traveled outside their communities have a higher degree of acceptance of modern maternal health practices and higher levels of reproductive health knowledge.

Along with China's economic development, widespread education, improved living standards, changes in family decision-making patterns, availability of maternal health care and awareness rising about gender inequities related to sex preference can all contribute to improving the uptake of MCH services. More and more young people are practicing joint family decision-making. More women have begun to accept modern ideas regarding MCH. The preference for male children among young people is weaker than that held by previous generations. Research findings suggest that young people are generally accepting of the idea of modern medical interventions, such as pregnancy tests, hospital delivery, postpartum checkups, and immunization, in order to improve maternal health.

However, there is still a gap between acceptance and application of these modern treatments. Unmarried young people interviewed were found to generally lack knowledge about MCH and to show no particular interest in actively gaining it. Modern ideas are in many ways still

"alien" and have not become part of local way of life. Positive changes in thinking are not necessarily reflected in people's behavior, as reflected by continued early marriage practices, early pregnancy and low hospital delivery rates. Hospital delivery rates remain very low in the majority of the field sites. In Jieba village in Tibet, where hospital delivery is free, and even subsidized, the rate is only 37.8%. The hospital birth rate in Congjiang County in Guizhou is 38.8%.

Among ethnic groups, such as the Dong in Meide village, the desire to have a son among young people is less strong than their ancestors due to their contacts and connections with outside world, through work, study, or business. However, the idea of having a male child to preserve the family lineage is still popular. Amongst the Mao in Xinqiao village, although young people are able to accept the idea of male-female equality, social pressure and family expectations force them to still prefer sons to daughters. One villager states:

I don't care about the sex. But if my wife has a baby girl in future, my parents will be disappointed. I oppose the idea of preferring boy to girl. But I am unable to change the minds of the older generation.

As the research findings indicate, although traditional lifestyles still play a significant role in the targeted ethnic communities, the modern/metropolitan way of life has already profoundly impacted upon the local life, particularly with regard to the younger generation. The research team believes that in order to take advantage of these changes, MCH services should do more to accommodate the traditional as well as the more modern cultural elements existing in those communities.

3.6.1 Miao people (Leishan County)

Miao young women have a high degree of acceptance of prenatal information and hospital deliveries. Interviews with Miao women between 15 and 24 years of age and without children indicate that there are three main characteristics of young women:

Firstly, they have certain knowledge about biology and hygiene. Secondly, they know very little about pregnancy and delivery. For example, Ms Wang (a 20-year-old with high school education) was indifferent to and felt shy about the questions regarding pregnancy and delivery and often answered "I don't know." A 16-year-old girl said:

Knowledge about marriage can only be told by a mother or mother-in-law after marriage. Elders also can talk about it, but we are too shy to listen to it.

Thirdly, young women have a high acceptance of the value of hospital delivery. Almost every young woman interviewed mentioned that she would be willing to deliver at a hospital. A postpartum woman who just delivered at the Datang Township health center stated:

It is safer here. I don't completely feel comfortable with my mother-in-law's assistance during delivery. I discussed it with my husband and my mother-in-law supported it.

Another mother with a 5-month-old baby said:

We chose hospital delivery because we don't know how to do it by ourselves. There is no mother-in-law. Hospital delivery is safe and convenient. We put our trust into doctors and won't worry about anything.

These two mothers' opinions represent opinions of most local women we surveyed.

However, there is a gap between females and males concerning maternal health care. In general, young women have some knowledge about daily care during pregnancy and delivery. Interviews of young men between 15 and 24-years-old indicate however that they understand little about women's health and are not very interested in gaining such knowledge. They think:

Giving birth is a matter for women, and men certainly know little.

A 24-year-old, unmarried young man said:

Elders in the village don't talk about it, and I know little about women's matters.

Some young couples choose to deliver in hospital and do not resist hospital delivery. Their attitudes towards health are more influenced by modern medical care ideas. Young women have a better understanding of risks during delivery. Young women are willing to go to hospital when they get illnesses, particularly related to female specific health issues.

Young Miao men in Xinqiao village hold the view that the local health center can only treat simple illnesses such as colds and diarrhea. When people are ill, they usually like to go to County level for treatment. Local Township services are poor and attitudes are bad. Regular patients may receive preferential treatment while outsiders will be treated in an offhand manner by doctors providing medicines or injections. Interviewees reported that the facilities are outdated and skills of local staff are not good. They hope that conditions in local health centers can be improved by more investment, information, human resources and materials, so that local women may have more reproductive knowledge and services. They also hope that staff in local health centers can improve their service attitudes and quality. Many young men have no knowledge about MCH services and policies.

3.6.2 Hui people (Hualong County)

In Gongyi village some young Hui expressed a willingness to choose hospital delivery and will not resist it. Furthermore, their ideas about health are influenced by modern medical sciences.

A young man surnamed Ma from the Gongyi village said:

I will take my wife to hospital for delivery in the future when I get married. This is because it is safe now to deliver in hospital.

A married man stated:

We had our baby delivered in the County hospital. When my wife was pregnant, we gave her enough nutrition such as chicken, fish, mutton, and beef.

Another young villager said:

The noodle economy has developed in recent years, more and more young people go to economically developed provinces or cities for work, such as Beijing, Shanghai, and Guangzhou. Along with increased knowledge, young people's thinking in our region changed. We decide whether or not to have a baby. We will consult our parent's opinions but ultimately we make our own decisions.

Young Hui people now know more about the risks associated with pregnancy and delivery. This knowledge is especially important for women. These young women are willing to go to hospital if they have gynecological illnesses. A 25-year-old Hui woman said:

If there is a sign of gynecological illness, then I will go to hospital for a check-up and to receive medical treatment.

A young man mentioned:

Condoms are not distributed to every family. It is located there (at the hospital), and nobody takes them for it is embarrassing. Last year, condoms were sent to each family. Now they are gone. New couples will take them but sometimes they cannot get more since they are gone. They have to buy from shops.

3.6.3 Tibetan people (Gyamda County)

In Jieba village in Tibet, as a group who can more easily accept new ideas, young people demonstrate a higher degree of awareness of, and a willingness to embrace, knowledge concerning MCH than any other ethnic group. However, this tendency is not universal among Tibetans. It is easier for young people with a higher education or for those who have gone out of the region to work or conduct business to understand and accept knowledge about maternal health. Young women are generally very positive about the future rights and status they will enjoy in society and in the family.

By way of contrast, those young people who have lived for a long time in the region have not been educated and have been deeply influenced by the local culture are indifferent to the health information promoted by local health departments. For example, Gengsangciren, who is 25 years old with 2 children and 20-year-old Zhaixiluobu have no knowledge whatsoever about MCH care. They responded indifferently to the researchers when they introduced the topic of modern maternal health practices.

3.7 Social-cultural barriers between users and providers

3.7.1 Perceived barriers to access and utilization of MCH services (users' perspective)

According to the survey results, the six communities share certain common traits that prevent people from gaining knowledge of modern MCH concepts. There are also ethnic and regional differences. Regarding access to and utilization of MCH services, the local communities'

major complaints regarding MCH services can be summarized as follows:

1. *MCH providers transmit service costs to local villagers in order to solve their own problem of limited resources, which makes it harder to build trusting, cooperative relationships.*
2. *MCH staff distance themselves from local knowledge and even attempt to establish their authority by promoting their "advanced" status. In fact, this status influences MCH providers' ability to promote modern medical knowledge in a way acceptable to local populations.*
3. *MCH departments have not received sufficient resources for local health services, which means in turn, that they cannot generate sufficient interest among local people about the "modern" medical system.*
4. *MCH staff generally cannot implement the services that their health messages promote. New ideas promoted do not meet the expectations of the local people. There is no dialogue between MCH staff and local people and it is hard for MCH to become accepted locally.*

Perceived barriers to access and utilization of MCH services by the specific ethnic groups are set out below: Miao people (Leishan County)

Traditional health practices

Local Miao know little about modern MCH concepts, the positive aspects of hospital delivery and relevant government policies. This is especially a problem among people under 30 years of age and those who are unmarried.

Women also feel shy regarding being pregnant and will not go outside their homes. They try to work in the home. In large families, pregnant women will not go to field. However, in families with few laborers, women have to work in the field. Furthermore, during the one-month confinement period women are seen as being 'unclean'. Many villagers feel that it is troublesome to go to hospital even if they do not have to pay for services.

Facilities

Although many people are satisfied with the quality of services in the Xinqiao health center, all those interviewed said that the facilities are too outdated. Interviewees noted that some kinds of check-ups cannot be done there and that for serious conditions people prefer to go to County or even prefectural hospitals. The Miao in Xinqiao village in Leishan complain about outdated equipment still being used by local clinics.

Costs

The Miao respondents raised a number of issues regarding the costs of services. Even for an ultrasound check costing 20 yuan, people have to spend another 10 yuan on transportation to the County clinic. Some villagers complained that the prices for medicines at the local clinics are expensive. In addition, local clinics claim that delivery is free. However, since the official subsidy does not fully cover medical costs, local clinics charge a certain amount of money if pregnant women deliver babies there. This leaves the villagers unsatisfied.

Dong people (Congjiang County)

MCH information

In Congjiang County, local governmental sectors incorporate family planning health messaging into local Dong operas to publicize health policies and messages. Interviewees said they enjoyed watching them but do not care too much about the specific messages and will not follow the publicized health messages.

The researchers were advised that when doctors mobilize people to follow specific health policies, people listen but do not take action. The reason is that these people have lived according to their own ways for several generations. Also, since the impact of these policies on their lives is still unknown, people feel that current policies will have no effect on them. Nobody has seen the benefits of the publicized health messages and, in the meantime, they are satisfied with their current lives. Interviewees asked why then, they should they bother to adopt “meaningless” practices?

Costs

The Dong in Congjiang described facing difficulties in transportation. Meide village is about 27 kilometers from the County clinic, but there is only one bus in service in the morning and one in the evening. For ordinary people, it is hard to go to the city or town. Meanwhile, women are busy with housework. Especially during the busy season, they have to engage in agricultural work and will not go to city or town unless they encounter critical health situations.

Jingpo people (Longchuan County) and Dai people (Luxi municipality)

Community relations

In Jingpo and Dai communities in Nonglong and Mangbie villages, people tend to seek help from the local family planning sector. Their relationship with the family planning staff is close and even harmonious.

The researchers were advised that women in the Mangbie village are not satisfied with local MCH services, which is why they are willing to seek assistance from the family planning sector. According to them:

Some doctors have bad tempers. Interns' skills are not good and their injections often cause inflammation. Sterilization [of equipment] practices are not good.

Another villager stated:

Sterilization [of equipment] is not good. Skills of interns are not good. And, injection can cause swelling.

Since the public has limited knowledge about maternal health, local views of MCH undoubtedly lacked “depth.” However, observations made by the researchers indicate that local people are very passive when deciding whether or not to select the limited MCH facilities available.

Hui people (Hualong County)

Facilities and staffing issues

Regarding Hualong MCH services, a 40-year-old Hui man said:

Unlike interior regions, Qinghai is on a plateau. Policy implementation is not easy here, and the quality of medical services is less than those of interior regions. Cadres engaged in this area, as a whole, are not qualified. They only work for their salary. They even don't talk to you if you have no money.

Service providers' attitudes

Regarding MCH services, a 36-year-old man from the Gongyi village said:

We don't want to go to hospital because their attitudes are not good. The working staffs are young girls and their facilities are old and their skills are bad. We tried to take out an IUD several months ago in this town. My wife had no gynecological illnesses previously but she has them now. It is said that she has an infection. We then went to Xining to have a B-style ultrasound and she got another infection. We heard that the local health center do not have sterilized equipment. We spent 4,000 to 5,000 yuan to travel to Xining. There are only one or two female doctors in our town, their facilities are poor, and their attitudes are bad. It is far from here to the County seat (60 kilometers) and close to Jianzha (20 kilometers). Jianzha health center is said to have good attitudes and be rich in experience in this matter.

Traditional health practices

A 62-year-old woman with a daughter who was 5-months pregnant, when asked where her daughter would deliver, responded:

We won't go to hospital. It is convenient at home. There are outsiders present in a hospital delivery. If

she is unable to deliver at home, then we need to go to hospital. We need to first try a home delivery.
A 30-year-old Hui woman said:

My two children were delivered in our home. We did not go to the local health center because I am shy.

Tibetan people (Gyamda County)

Traditional health practices

Tibetan life is centered on religion and religious values constitute the core of Tibetans' cultural and cognitive system. Tibetan Lamas do not marry nor have sexual intercourse with women. Therefore, they know little about maternal and child health and even reject learning about it because it may be a taboo subject for them as monks. Due to their influencing role, this thinking restricts Tibetan peoples understanding of MCH and RH. This system regards this knowledge as a private matter and not appropriate for public discussion. Tibetan society, influenced by religion, is to some extent psychologically distanced from MCH.

Therefore despite the County health center's health promotion work, there has been very limited effect on the local population. Because the local population has no interest in this knowledge, even if they heard the health promotion messages, they are unlikely to care much or discuss basic MCH concepts because it is seen as improper.

MCH information

The research findings showed that relevant health promotion materials are only present at the village health center. Since the village health center basically does not function, these materials are just stored there. Some County officials claim that people have actively requested information materials and they have put up information posters. However, this was not been verified during the survey.

Community relations

MCH services and villagers have limited interaction and have even come into conflict. This uneasy relationship seriously affects the performance of MCH services, especially in these resource-scarce regions.

Costs

Tibetan women living in the grasslands of Gyamda County hold that their pastoral land is far from the County clinic and it takes a long time to travel. They stated that it is too troublesome to go there just for a check-up. Although check-ups are free, they have to pay for transportation. In terms of transportation, there are several villages in the Cuogao Township where people can only ride a motorcycle in the summer after flooding subsidies.

For pregnant women in pastoral lands, usually only the couple is at home. If the wife goes to hospital for delivery, then there is nobody to take care of the animals at home. Additionally, as nomads some of them frequently relocate and have no fixed residence. They do not know how to calculate the due date for delivery. All these factors are a barrier to their acquisition of MCH knowledge and uptake of services.

3.7.2 Perceived barriers to MCH Service Provision (service providers' perspective)

Service providers in all six project counties agreed that the main barriers to MCH service provision are funding, personnel shortages and the outdated mentality of local people:

Funding issues

MCH staff raised concerns regarding the lack of funding provided to the MCH system at the County and Township level.

Personnel shortages

For MCH providers, the biggest challenge is the lack of professional medical personnel. The state regulations require each village to have a local health worker, but these local workers are not well-paid. Health workers in the villages are now willing to stay in the position despite low payment, but they often have to engage in agricultural activities to make a living.

The state requires that medical persons engaged in MCH services must have graduated with majors in MCH. Guizhou province as a whole does not have enough persons who meet the state requirement. There are fewer and fewer such qualified people at the County and Township levels.

Qualified medical staff are reluctant to stay in these regions because the government does not provide them with satisfactory financial and housing conditions.

The poor skills and abilities of medical staff means they often cannot operate relevant medical equipments donated by others, such as B-type ultrasound machines. Some equipment has not been used since there are no staff who know how to operate them. Some pieces of equipment have minor problems and have to be abandoned since no-one is available to fix them. Only recently have the Township health center staff received outside training on how to operate this equipment.

To recruit outsider workers is also problematic due to the harsh conditions in the villages and the poor payment. Capable persons will not wish to come and people with poor skills cannot be employed. Although counties

attempt to train and recruit people, there is very limited stable working staff. In fact, there are just a few people who are sufficiently educated and qualified to participate in the training courses.

Because of the lack of skilled staff, the current situation of MCH services cannot be substantially changed. Transportation is another factor affecting MCH work there. Although every village is connected, villagers cannot travel when it rains due to poor quality of the roads.

Outdated mentality of local populations

MCH staff noted that the traditional beliefs and practices of local ethnic groups create barriers to the uptake of MCH services. Local people are still profoundly influenced by traditional customs regarding MCH.

Specific feedback from MCH staff in each of the project counties is set out below:

Miao people (Leishan County)

The health staff and local leaders in Leishan County have identified eight barriers to the local villagers' uptake of quality MCH services:

1. Local people do not trust the hospital due to their outdated ideas and beliefs. They would rather deliver at home than go to the hospital.
2. Families who remain in the local area are poor since many young people have left the area. Even though hospital delivery is free for them, they still do not want to go to the hospital because they have to cover transportation and other expenditures.
3. Medical equipments is outdated or insufficient. Professional workers are also lacking. When pregnant women come to the Township health center for prenatal check-ups, the center can only measure the increasing size of the mother's stomach and the mother's weight. The County health center lacks equipment for measuring the fetus's mineral level, and the center needs new B-type ultra-sound machine (the current one was purchased in 1995), fetus monitoring (the current one was purchased in 1995). The old ambulance does not work well and a new one is needed to transport pregnant women. The ambulance purchased through the Spain Project is kept at the bureau, not at the local center.
4. The villagers have not learned enough information about preferential policies due to limited promotion. For example, free hospital delivery is still unknown to some villagers.

5. Pregnant women are generally young and have to listen to family elders, who choose home delivery. Family members want a home delivery for reasons of convenience.

6. There is sex preference for sons. If the first child is a girl, then the pregnant women will not want a hospital delivery for the second child, which affects the hospital delivery rate and also leads to the abandoning of babies. If a family's two children are both girls, then the parents will try their best to secretly have a son to take care of them when they are old.

7. There are not enough professional doctors who can perform surgery, which means greater risks facing pregnant women.

8. County-level MCH center lacks funding. If materials are publicized and distributed in villages, a certain amount of money from the clinic services has to be charged.

Dong people (Congjiang County)

When talking about the barriers that MCH encountered, various government staff and MCH providers mentioned the following problems: lack of professional MCH staff; lack of manageable plans at local level for MCH projects; inadaptability of certain facilities provided by some projects to local conditions and waste of resources; irrelevance of MCH to local people and a disconnect between Dong traditional doctors and village clinics.

Jingpo people (Longchuan County) and Dai people (Luxi municipality)

Government workers identified the following issues affecting MCH services in the Longchuan County (Jingpo) and Luxi municipality (Dai): lack of money, lack of personnel, outdated concepts held by the local population and the local population's passive use of MCH services.

Hui people (Hualong County)

The researchers were informed by a MCH service provider in Hualong County that:

There are not many people who actively have prenatal check-ups. This is because of lack of awareness of self-care. Few Muslim women go to hospital for check-ups because their religious beliefs dictate that their bodies cannot be shown to outsiders. Besides, MCH service in our County cannot follow the march of time. There is no custom for regular check-ups among

the populace. We used to depend on administrative means to require them to take check-ups. Now that has changed, and we can only publicize it. It now totally depends on themselves for check-ups, which bring about difficulties and weaknesses in our work.

The vice director of the Qunke town's MCH center mentioned:

There are 29 villages in this town. Among them, a dozen of them have their own village health center. Each village is not far from the town MCH center. Villagers usually come to MCH centers for treatments. Some go to neighboring centers. Most working staff in the centers are Hui. It is hard to persuade the Hui because of their religious beliefs and traditional thinking. Our job is busy, and we are in charge of family planning, disease control, and health. Our major difficulty is financial problems. We do not have enough staff. Currently, there are six staff members, while the others are temporary workers. Their salaries are paid through the profit the MCH center makes.

Tibetan people (Gyamda County)

The researchers were informed that factors affecting MCH services in Gyamda County are as follows:

1. The MCH system is incomplete and government funding is limited. Service networking in Gyamda County is incomplete in that there is only a health center responsible for health, immunization, MCH, and the family planning. There is no clinic in the biggest town, Gyamda town, and there are insufficient village doctors and reproductive health specialists. Meanwhile, the annual County budget for MCH is only RMB 3,000, which cannot meet the needs of MCH daily expenditures. Therefore, the special government funding must be increased. Also, although the local health center has done much propaganda regarding MCH, the impact has been minimal. It was suggested that propaganda materials should be made as printed souvenirs with useful MCH knowledge, and that propaganda materials should be distributed from house to house.

2. Female doctors and obstetricians are lacking. There is no official assignment for working staff at the MCH center. Medical personnel and MCH professional staff face shortages and an unstable commitment on the part of workers. There are only two MCH workers responsible for the whole County and they provide basic medical services for 2,000 people in Gyamda County.

3. The annual budget for the County MCH system is merely 3000 Yuan. This money is far from meeting the center's daily expenditures.

4. There are only two personnel in each sub County MCH center. They are also responsible for immunization, medical treatment and medical care. Meanwhile, staffing at the sub County MCH centre is so unstable that people often cannot find doctors there.

5. The quality and skills of MCH workers is not satisfactory. Many doctors at the County level are not professional doctors and have received no professional training. They work in this sector merely because they have experience in medical treatment. Doses for children's medicine are often made according to their own experience.

6. Although the County provides X-ray equipment and other types of brand-new equipment to the sub County MCH centers, the equipment cannot be utilized by local doctors as their knowledge of the equipment is limited.

7. There is poor accessibility of MCH services. Limited medical personnel tend to be concentrated in the People's Hospital. Due to the pastoral way of life and the long distances between communities, local MCH health promotion information and services often cannot be reached by these people.

8. Medical equipment is insufficient and the infrastructure of sub County MCH centers needs substantial improvement Tibetan women have to leave the Cuogao MCH center one day after delivery because the center has no room for them. If there are too many people waiting for injections, some people simply buy the injections and let village doctors inject them.

3.7.3 Suggested ways MCH services could become more 'user friendly' (users' perspective)

The researchers were advised by villages that services would be more 'user friendly' and popular if the services:

- were convenient;
- had reasonable prices;
- provided effective treatments;
- involved improved local medical facilities;
- treated all patients equally.

Attitudes of service providers

Interviewees mentioned the gap between MCH service providers and users. The research teams were informed that in order for MCH services at the local level to be improved, medical staff must learn to respect local traditional medical knowledge and avoid adopting

attitudes of superiority. This would make MCH clients feel that MCH services were being sincerely provided. Jingpo, Dai, and Hui cases demonstrate good examples of collaboration and mutual respect between MCH providers and receivers.

Findings in Gyamda County indicated that service providers and receivers are primarily Tibetans themselves, who are deeply influenced by their culture. In this case there is no obvious cultural barrier between service providers and receivers as ninety percent of County leaders, MCH staff, and health center staffs are Tibetan.

However, in the process of providing services, it has been hard for the service providers to shake off the stereotypes of Tibetan culture taught in school textbooks. Thus, there is an oppositional dichotomy between underdeveloped and advanced, as well as conservative and opened-minded, cultures. Cultural relativism should be introduced and strengthened.

In Tibetan regions, Tibetan Buddhism, living Buddhas, the environment, and the Tibetan population comprise are inseparable. To ensure that health information benefits the physical and psychological health of Tibetans, MCH messages must be effectively incorporated into local society by taking on a relevant meaning in the context of local social forces. Firstly, the roles of Lama, living Buddha, and other medical personals have to be recognized and respected. It appears that throughout Tibetan society; there is a conflict between religious ideas and modern maternal health information. However, the living Buddhas are similarly tasked with responsibility for saving lives, as are doctors. Therefore, the role of living Buddhas as traditional doctors should be emphasized and they should be encouraged to understand about maternal health issues in order that the Tibetans do not suffer embarrassment when MCH information is being publicized. Additionally, local people will be more receptive to MCH knowledge and more willing to adopt MCH practices if this information is presented in ways that are familiar to them.

3.7.4 Suggested ways MCH services could become more 'user friendly' (providers' perspective)

According to the opinions of government and MCH staff, the following issues should be addressed to make MCH services more accessible and receptive to local populations:

Facilities and service quality

Township medical equipment should be updated and service quality should be improved by ensuring the

availability of qualified medical professionals. Convenient location of services will help increase local people's trust of MCH and will encourage people to use these services.

Funding

The government budget should be increased and MCH's dependence on fees and profits should be reduced to lower the associated costs for patients. Co-payment at the hospital should be included and reimbursed in the new rural insurance scheme, making MCH services cheaper for villagers.

The Leishan County government proposes to provide special services for Miao people, to pick up and transport pregnant women without charge which will contribute to reducing psychological pressure and the economic burden on the local population.

Community relations

Regarding the role of traditional community leaders among the Dai, MCH staff in Dehong prefecture mentioned:

There used to be cooperation between the local bureaucracy and traditional authority. Just one word from an influential community leader will solve problems. The state health promotion for ethnic minorities cannot rely on laws alone and has to take account of personal connections. Local cadres have their own advantage in that they can use family and personal networks to carry out their work.

4 Problems and Recommendations

4.1 Summary of problems facing MCH in the target areas

4.1.1 Health-related harmful practices

In targeted ethnic areas, traditional medical knowledge and religious rituals comprise an organic and comprehensive curative system, which is to some extent incompatible with modern medical practices.

When a disease is seen as a cultural metaphor, the search for meaning leads some ethnic minority people to believe that rituals can treat illness. These rituals will not however prevent patients from simultaneously seeking help from modern medical sciences. Traditional practices can in some ways be seen as supporting the psychological health of ethnic communities. In some cases, however, totally putting faith in religious rituals or traditional practices may cause delay in patients seeking care when it is most needed, or might even result in the abandonment of modern medical treatment if it is not seen to be efficacious.

It is beyond the scope of the authors to comment in any depth on the health-related risks of some of the traditional practices described by the respondents, but a few key areas should be mentioned:

Early marriage, early birth, and engaging in hard labor work among women are common among all ethnic minority groups. During delivery, the lack of hygienic practices poses risks to both the mother and newborn. The absence of exclusive breast feeding from birth is also of concern. Dietary taboos during pregnancy and the post-partum period contribute to poor nutrition in women and poor diet affects the health of children among some groups.

4.1.2 Facilities

In these regions, medical facilities are unsatisfactory. For ethnic minorities who inhabit mountainous areas such as the Miao, Dong, and Jingpo, transportation difficulties prevent them from seeking medical help apart from sub-County medical centers. Some sub-County health centers, because of the lack of facilities, can only conduct weight and fetus measuring which results in potential clients not being interested to use the services. Major causes of dissatisfaction among ethnic minority women include poor facilities, the limited skills of doctors and overall weak service provision at local town or sub-County health centers.

4.1.3 Costs

Medical costs are another factor that prevents ethnic minorities from utilizing MCH services. In this regard, the new rural medical system is a big help to ethnic minorities in some regions. However, some minority groups, especially those who inhabit mountainous areas, are still extremely poor, and their income is very low. There are also opportunity costs, such as related expenditure for family members or servants who take care of the patients, and the loss of income in terms of time and work. These factors make patients reluctant to go to hospitals. In Tibetan areas, although medical costs are free, the cost for patients to go to hospital is still high in terms of lost time, due to the wide distribution of Tibetan population and distance from the facilities.

4.1.4 Availability of trained staff

Medical teams in these regions are villager doctors and assistants who have only received limited medical training. There are insufficient professional staffs and the staffs currently based in the regions tend to have a passive work style and do not proactively reach out to the local communities.

In the face of large populations, the local MCH network is extremely vulnerable. Although the poorly skilled and equipped local medical service personnel do their best in difficult circumstances, their achievements are limited due to the remote geographical locations and dispersed populations. Even in the best cases only the most basic medical needs can be met.

4.1.5 Policies

Although the practice of the new rural medical system has recently increased opportunities for ethnic minorities to enjoy medical care, the "standardization" of the system does not recognize the diversity of the ethnic groups in the different regions. To minority groups with good economic conditions, such as the Dai, their main expectation is for improved MCH service quality. For other groups, with poor transportation, such as the Miao and Jingpo, their main requirement is for convenient transportation to be made available from their communities to the medical service centers. These different expectations or requirements can be met by local medical centers taking into consideration the specific local situations and conditions. National policies do not however seem to have any flexibility in terms of balancing the different needs for different ethnic groups

and regions. The result is that the MCH services in the more inhabited region determine the quality of medical services, whilst not being sufficiently modified for those in the remoter regions.

4.1.6 MCH information

All ethnic groups are potential beneficiaries of MCH services. However, due to psychological barriers, MCH cannot always fulfill its mission to serve the people. In order for new ideas to be accepted by and absorbed into the existing local cultures, there needs to be a better understanding on the part of the policy makers about existing holistic social structures among the ethnic minorities. Social structure in this respect refers to the existing network of relations between humans; the environment and society which is how many of the ethnic minorities perceive their 'world'.

4.1.7 Attitudes of service providers

The existing health promotion network is basically comprised of government staff, which local people are not always comfortable with as they are not always familiar with these networks. Attitudes of service providers in general reflect a sense of superiority and authority which is not welcoming to local people.

Working staff in the health sector in Congjiang County include cadre leaders from rural areas. Several of them came from the Meide village where the study was conducted. Although they came from rural areas and have become local leaders, their words subconsciously reflect an absence of respect for local customs and traditions. When talking about traditional rituals and why women are reluctant to go to hospital, during the survey they frequently used words like "feudal superstition," "outdated ideas," "unscientific," "un-enlightened and enclosed," "primitive," "not progressive." This shows how their attitudes have been influenced by majority Han culture, even though they have been familiar with the local customs and rituals since childhood. As firm supporters of modern sciences they have not considered whether or not traditional medical knowledge is useful

4.1.8 Community relations

The current situation indicates that there is a deep gap between MCH service and local populations. Interaction between the two is lacking, coupled with the absence of any mechanism for feedback. In comparison with the way in which pregnant women seek help from the family planning authorities, it has to be acknowledged that MCH service have not yet become fully integrated in local ethnic communities in the same way as family planning has, and nor are the advantages of MCH services yet common knowledge.

Current health promotion activities targeting culturally diverse ethnic groups are not ideal. The activities involve unoriginal materials which do not specifically target the different groups. MCH publicity and related activities will not be sustainable unless this is addressed.

4.1.9 Gender inequalities

Among the 6 targeted ethnic minorities, males are dominant in gender interactions and they control the family economy. In family decisions regarding MCH related issues, such as where to deliver and how to take care of the newborn, older women (mother-in-laws) tend to have more say and control over decision making. It was found that the Dong, Miao, Hui, Jingpo, Dai, and Tibetans have differing degrees of preference for male children. There is obvious discrimination against female infants among the Dong and Miao which is reflected in the sex imbalance between these two groups among children and young people.

4.2 Recommendations to the Six Target Areas



Miao women waiting for physical examination in Datang Township Hospital, Leishan

The following recommendations are aimed at increasing access to and utilization of MCH services.

4.2.1 Cultural sensitivity of MCH services

- MCH services are distanced from local knowledge and practice. There is no dialogue between the providers and their clients, and it is hard for MCH to become integrated into local life. Therefore, the

cultural alienation between ethnic villagers and MCH service should be addressed.

- Local people should be encouraged to contribute to the creation of an environment in which they can adopt MCH knowledge in ways that are familiar to them.
- The relationship between MCH service providers and local villagers needs to be mutual trustworthy. This can be achieved by means of more community involvement and ethnic participation.
- Efficient promotion of messages in ethnic languages
- Creative mechanism could be established for youth involvement in MCH services, in particular regarding MCH advocacy and information sharing.

4.2.2 Facilities and available services

- Facilities at the County and Township level should be improved.
- MCH service centers in local communities should be established to ensure remote villagers have access to MCH services.
- The quality of prenatal and postpartum services should be improved.
- MCH awareness raising on should be in line with the interests and beliefs of local populations.
- Outreach services in remote areas should be promoted.

4.2.3 Costs

- MCH should lower the cost of medical services for villagers, in particular the poor families.
- Foreign funding should be utilized and new equipment should be procured.
- Hospital delivery should be subsidized for all ethnic minority groups, as in the Tibetan regions, in order to increase hospital delivery rate among minority ethnic groups.

4.2.4 Availability of trained staff

- The skills of village staff and professional medical staff at the County level should be improved.
- The proportion of female and ethnic doctors at the local level should be increased.

• Qualified doctors from urban hospitals should be encouraged to work in Township hospitals for the medium and short term, at same the time their urban posts should be reserved.

• Medical staffs need to learn how to respect local traditional medical knowledge and avoid giving an impression of superiority.

4.2.5 Policies

• Special preferential financial policies towards the Township hospitals located in remote areas should be provided in order to make the allocation of medical resources more fair.

• A mechanism of resource sharing should be developed between Family Planning & MCH.

4.2.6 MCH Information

• Due to insufficient knowledge about modern health care, some ethnic minority people some bias and misunderstandings with respect to their perception and practice in terms of MCH. MCH services, ethnic cultures and modern health concepts should be combined in an appropriate manner.

• The gaps perceived by the ethnic villagers between the imaginations/expectations about the "modern" medical system and the reality of current service provision need to be addressed.

• The existing propaganda network is basically comprised of government staff, which creates a sense of alienation for local young people. It is recommended to build a creative mechanism of youth involvement in MCH services, in particular regarding MCH advocacy and information sharing.

• Primary/middle/high schools should establish MCH-related courses.

4.2.7 Attitudes of service providers

• Respect of cultural dignity and identity should be promoted.

• All patients should be treated equally.

4.2.8 Gender inequities

• Women's education and health rights should be promoted and improved.

• Improvement of female social status should be promoted among certain ethnic groups.

4.2.9 Management issues and community relations

- The relationship between the County clinic, family planning sector, and County MCH should be properly managed. Responsibilities of leaders should be clarified. As some officials mentioned, County-level management of equipment provided through the Spanish Millennium Project is problematic, which negatively affects MCH services.
- Village-level medical care should be incorporated into national medical system where appropriate.
- Local female villagers could be encouraged and assisted to form Cooperative Groups for Pregnancy aiming to change the practice of pregnant women having heavy work loads.
- In the absence of exceptional circumstances, puerperal women usually will not go to hospital after confinement. They usually only take the traditional ways for recovery at home. To solve this problem, advocacy activities are needed with mother-in-laws who play significant roles in decision making. Facilitated discussion groups among mothers-in-law at community level could be initiated.

4.2.10 Recommendations to MCH in Guizhou

General Recommendations to MCH in Guizhou

1. At national level, the State should implement preferential policies towards these economically underdeveloped regions.

The total economy and average income of Guizhou is far lower than those of other regions. Guizhou's average income is the lowest among China's 31 provinces. Objectively speaking, it is impossible to economically develop this province in a short period of time. However, MCH services cannot wait. Only if special targeted state policies are implemented in this region will MCH be substantially improved.

2. Village-level health care centers should be improved and the income of local medical personnel should be increased

Southeast Guizhou is located in a remote, mountainous area with poor transportation. Improvement of infrastructure and village transportation is important to improving MCH and, more broadly, local health conditions.

Suggestions for MCH services among the Dong in Congjiang County, Guizhou

1. Local health centers should cooperate with traditional doctors

In Meide village, there is no communication between traditional doctors and the local health center. If they can cooperate then the problem of short-staffed medical personnel can be addressed and the economic burden on villagers can be reduced.

2. Provision of economic incentives to increase rate of hospital delivery

Each midwife should be economically rewarded if she brings a pregnant woman to the local hospital. Pregnant women from ethnic minorities should be subsidized if they go to hospital for delivery. This will improve the hospital delivery rate to some extent.

3. MCH should work with people who conduct birth rituals

Since traditional practitioners play an important role within the Dong communities, local health centers should actively work with them in order to promote health care.

Suggestions for Leishan County, Guizhou

1. The relationship between the County hospital, family planning sector and County MCH should be properly managed, and responsibilities of leaders should be clarified

Survey findings indicate that these three sectors have different but related tasks and their relationship is not harmonious. For example, some officials mentioned that there is no clear designation of responsibility for the Spanish Millennium Project, which does not assist the effective implementation of services.

2. TV and other media should be used to publicize MCH services

Conventional health promotion strategies are ineffective due to the low education levels of the local people. Multimedia should be used to promote health messages in an easy, entertaining and enjoyable manner.

3. Village heads and women leaders should be involved in MCH services

Village heads and women leaders are close to the people and are qualified to participate in MCH work. Survey findings suggest that otherwise village-level committees are not mobilized in MCH services.

4. Local health centers should provide free transportation for Miao pregnant women

Free transportation would be a short cut to assist local villagers to access MCH services.

5. Traditional local leadership should be highlighted

Traditional community leaders should be encouraged to include MCH principles into their own practice and customs. Local community leaders should be mobilized to influence uptake of MCH services.

4.2.11 Recommendations to MCH in Yunnan

1. Traditional dichotomy of “tradition” and “modernity” should give place to multi-culturalism

Among the Dai and Jingpo peoples, their pursuit of modernity does not affect their following of traditional ritual practices, such ancestor or spirit worship. In terms of medical care, they are willing to take advantage of the state medical system on the one hand and continue to rely on traditional medical knowledge on the other.

There is harmony as well as conflict between “tradition” and “modernity.” The Dai and Jingpo e still maintain their distinguishing characteristics.

2. The construction of MCH network in Dehong region cannot rely on administrative or market distribution of resources

In the foreseeable future, the transportation in this region cannot be substantially improved and it will remain a barrier to the uptake of MCH services. Village-level MCH centers should be established at local level so access can be guaranteed.

3. MCH services should lower costs shouldered by local population as much as possible

This includes medical and transport fees, and associated costs.

4. Multiple forms of publicity should be used in order to make MCH part of local culture

Cultural media such as TV, local administrative networks, religious and communal societies, and others should be used to increase interaction between MCH services and local users.

5. Local traditional leadership should highlighted

Among some Jingpo people, traditional ethnic officials are still influential. Their reputation and authority should be used to promote MCH work. The role the

leaders of older age groups have played is appreciated by local governments. To increase local participation, cooperation with these local leaders is essential.

4.2.12 Recommendations to MCH in Qinghai

1. Strengthen promotion of the marriage law
Early marriage, arranged marriage and even commercial marriage among Hui people in Hualong County continue to take place, which disadvantages the status and health of women. Early pregnancy poses a risk to their health.

2. Religious professionals should be used to hasten change in family decision-making

Local Hui women have little involvement in family decision-making. Husbands and mothers-in-laws make decisions on matters such as the number of children, the delivery place, sex preference, and attitudes towards girls. Since local religious and ethnic affairs departments are led by Arkunds, it would be useful to work with Arkunds to encourage them to preach about MCH so as to promote women’s health.

3. Traditional practices should be respected

Traditions should be respected and re-activated. Regarding the traditional concept that “the private body cannot be seen by outsiders”, it is not enough that medical personnel in the local health centers are female. Religious professionals should preach that hospital delivery and the presence of outsiders do not violate religious laws.

Some elders are concerned that a pregnant women’s private body will be seen by outsiders. Health promotion materials should specifically target elders and should consider their feelings and thoughts.

According to local Muslim attitudes towards illness, no matter what the disease, it is Allah’s will. It is thought that it is of no use to fear or avoid treatment and that effort should be taken to treat illnesses. This attitude is useful for promoting treatments for recovery. But the belief that death and life is Allah’s will could also affect health care negatively. Health promotion messages should focus on the rational relationship between rights to health and life, and the rational relationship between religion and MCH.

4. Publicity about MCH should be strengthened

Current publicity efforts do not address the needs of local people and health promotion efforts should be strengthened by relying on religious networks such as through mosques.

4.2.13 Recommendations to MCH in Tibet

1. The influence of Lamas rituals should be considered

Since local people often visit lamas when they are ill, consideration should be given to the way that modern medical science can be combined with traditional Tibetan culture and religion to promote MCH services. In this regard, the role of local ethnic and religious departments should be considered.

2. The tradition of medical assistance in Tibetan regions should be continued

The doctors from Quanzhou who have assisted the Gyamda County have greatly improved local medical treatment. This practice should be continued. It is also necessary to organize local doctors to be trained in interior regions in order to improve their skills.

3. Traditional Tibetan medicine should be highlighted

Traditional Tibetan medicine should be combined with modern medical sciences in order to create a new MCH model. Since Tibetans trust Tibetan medicine, this future model is highly desirable.

4. Servicing methods should be changed, mobile services should be strengthened

Mobile services should be strengthened for traveling nomads and villagers. Meanwhile, in relatively populated villages, health services for nomads and

peasants should be arranged. Health staff should change their attitudes from waiting for patients to come directly to them, to instead reach out to patients.

5. Promotional materials should be localized

Formal and technical texts, even in Tibetan language, will not achieve the expected purpose. It was found during the survey that local people prefer IEC materials such as souvenirs imprinted with MCH messages. They also like materials that can have an additional, useful purpose. They simply throw away official publicity materials which are only brochures with basic text. It is better to have pictures printed on promotional materials. Audio and visual products are also effective.

6. Publicity materials about MCH should reach the family

Since local people prefer home deliveries, health staff should go to people's homes and teach basic skills to help them, such as how to sterilize equipment, which will greatly reduce risks of infection. Meanwhile, reproductive matters are seen as a personal matter which should not be publicly discussed as this is seen as being improper. During the interviews in the Jiebang village, 50% of the interviewees knew little about the contents of health promotional materials because of this belief. Information dissemination into these homes is very important.

5 Conclusion

Sixty years after the founding of the People's Republic of China, the country's ethnic minorities have begun to feel the heartbeat of new life. China's economic development and preferential policies have pumped new energy into village life. Villagers have the right to decide what to grow on their lands and to realize the "good life" that they desire. Adequate food and clothes are not their main concerns. Children's education, a healthy lifestyle, and convenient communication and transportation have become important measures of their quality of life.

Through interviews, observations, and discussions, the researchers found that younger generations have gradually begun to distance themselves from the traditional ways of life followed by their ancestors, in order to search for new meaningful lives. They have left their hometowns and travelled. What they brought back was not merely cash, but also narratives of what can be considered a "good life."

At the same time, there is a strong sense that villagers in these communities have treasured and protected their old traditions. Religious beliefs, rituals, and ancestor traditions continue to play an important role in their lives. A tradition of multi-cultural medical practices exists in ethnic areas. Taking the Tibetan region, for example, physical and psychological treatments are jointly conducted by Lamas and Living Buddhas. In addition, there has been a combining of Tibetan and Western medical sciences. Lamas and Living Buddhas are respected, and the holy status with which they are accorded can be transformed into power to treat patients. This is described by local Tibetans as a mysterious phenomenon that science cannot explain. These religious leaders and their relationship with the local population comprise a united body. However, modern thinking' does not understand or appreciate this and even creates an ideological bias against it.

This creates a binary opposition between “tradition and modernity”. However, local, multi-cultural medical systems contain not only their own logic and rationale, but also wisdom resulting from experimental practices that fit local customs and the environment. These form an intrinsic part of local societies, and contribute to the continued strength of local ethnic cultures. Thus these ethnic cultures should be tolerated and respected, and could form the basis of a multicultural medical model and practice. Ethnic cultural concepts and traditional medical practices should not be labeled as “underdeveloped” or “inferior.” Awareness raising and application of MCH knowledge must recognize and acknowledge local beliefs and traditions, where it is not harmful, in order to avoid conflict and to become acceptable to the ethnic minorities.

China’s local medical construction has achieved significant progress, and is contributing to improved health among those who previously had no access to doctors and medical care. The implementation of new cooperative medical care policy in rural areas has greatly reduced the burden of medical expenditures for peasants. It is not yet possible to evaluate its overall contribution to the health of those living in China’s rural areas since the reforms are only gradually being rolled out. However, one thing is for certain: along with the improvement of China’s infrastructure, the country’s medical services in rural areas are entering a new era. The main tasks ahead include improving the underdeveloped medical service networks, boosting service quality, and increasing public awareness of the advantages of modern medical care.

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7 Annexes

7.1 Composition of research teams

The composition of the survey teams in each province is set out below:

7.1.1 Guizhou

The Leishan team in Guizhou team with Guizhou University for Nationalities. Their division of labor is as follows:

- Shi Kaizhong (Han, Professor at Guizhou University for Nationalities): academic guidance, and rules for surveys;
- Yang Zhongdong (Hui, MUC Ph.D): team leader, interviewing men and writing sub-report;
- Jiang Jianing (Hui, MUC Master's student): interviewing women and writing sub-report;
- Wang Zhixin (Miao, Master's student at Guizhou University for Nationalities): assisting Jiang Jianing; Wang Yuqiang (Miao, Xinqiao villager from Datang Township, with a high-school education): translation and recording.

The Congjiang team in Guizhou cooperated with Guizhou University for Nationalities, and the division of labor is as follows:

- Mei Jun (Miao, Lecturer at Guizhou University for Nationalities, MUC Ph.D student): team leader and investigator;
- Ma Pingyan (Hui, MUC Master student): vice-team leader, investigator, sub-report writing;
- Shi Yinchuan (Han, MUC Master's student): investigator, sub-report writing;
- Wu Chenxia (Dong, Master's student in the School of History and Cultural Studies at Guizhou University for Nationalities): translation.

7.1.2 Yunnan

The Yunnan team had cooperation with the Yunnan University for Nationalities, which provided background data and personal training. Local ethnic members helped the survey team with interpretation and explanation of specific cultural practices such as rice-planting, sugar-planting, and the use of various tools. The detailed division of labor is as follows:

- Guan Kai (Manchu, Associate Professor in the School of Ethnology and Sociology at the Minzu University of China(MUC): survey designing, FGD and in-depth interview host;
- Chen Gang (Han, Professor at Yunnan University of Finance and Economics): academic guidance;
- Yuan Changgeng (Han, MUC Master's student): literature review, report drafting;
- Wu Jie (Miao, MUC Master's student): FGD and in-depth interview host for women's team;
- Lu Xu (Han, MUC Master's student): finance, recording;
- Chen Xiuqin (Jingpo, Master's student from Yunnan University of Sciences and Technology) Wu Dayun (Jingpo, community police of Qingping Township, Dehong prefecture), and Zhou Wei (community police of Luxi municipality, Dehong prefecture): assisting with survey.

7.1.3 Qinghai

The Qinghai team in Hualong cooperated with Qinghai University for Nationalities, and the division of labor is as follows:

- Xu Yan (Hui, MUC Ph.D student): team leader, organizing and coordinating team members and contacting locals;
- Ma Chengjun (Salar, Professor at Qinghai University for Nationalities): academic guidance, familiarizing survey members with local culture and report writing;
- Gong Fang (Hui, MUC Master's student): survey member, collecting sources on Hui traditional culture, writing report;
- Ma Liang (Kirgiz, MUC Master's student): survey member, collecting sources on Islamic traditional culture, translator, interview write-up, and writing reporting;
- Geng Yali (Han, MUC Master's student): survey member, collecting sources on reproduction and child-rearing, interview and report writing;
- Ma Cheng (Salar, Vice Director of Hualong health center): providing local sources and information about informants;
- Ma Long (Hui, publicist for the family planning clinic at the Gongyi village in Hualong): translation;
- Ma Zhixiang (Hui, student at Al-Azhar, Egypt): interpreter, introducing characteristics of local religious culture.

7.1.4 Tibet

The survey team in Tibet cooperated with the Academy of Tibetan Arts and the Health Center of the Gyamda County. The members from the Minzu University of China conducted surveys while the Academy of Tibetan Art and the local health center assisted the surveys by coordinating with people in the field and providing translation. The detailed division of labor is as follows:

- Min Junqing (Hui, Ph.D, Chinese Islamic Association): team leader, survey training, interviewing male group, and report writing;
- Wang Yan (Han, MUC Ph.D student): interviewing female group, report writing;
- Ma Hong (Hui, MUC Master's student): interviewing male group, report writing;
- Zhang Bin (Han, Director of the County health bureau): coordinating survey fields and arranging language interpretation;
- Sangjidongzhi (Tibetan, master student from the Academy of Tibetan Arts): investigator and interpreter;
- Quzhen (Tibetan, villager from Cuogao Township): interpreter.

7.2 Literature review

7.2.1 Western literature review

In recent years, research on how religious beliefs and practices influence individual attitudes and behaviors that lead to changes in physical health outcomes for mothers and children has made great strides as outlined in details by Jennifer Brooke Barrett (2008) in her dissertation. Areas of the research include: religion and fertility (Janssen and Hauser 1981; Mosher et al. 1992; Dharmalingam and Morgan 2004; Agadjanian and Yabiku 2005;), attitudes toward and use of contraception (Amin et al. 1992; Paul 1990; Zavier and Padmadas 2000); attitudes toward and use of abortion (Ellison et al. 2005; Henshaw and Kost 1996; Rosenhouse-Persson and Sabagh 1983); religious context or convictions and women's access to reproductive health services (Rance 1997; Abdel-Aziz et al. 2004; Orr and Forrest 1985); religion and prenatal care and/or maternal mortality (Koenig et al. 2001; Kaunitz et al. 1984; Spence et al. 1984); religion and birth outcome (Magana and Clark 1995); religion and disparities in infant mortality (Gregson et al. 1999; Ghuman 2003; Kaunitz et al. 1984; Spence et al. 1984); negative impact of religion and affiliation-based differences in utilizing health care (Asser and Swan 1998; Cauffman et al. 1967; Horwitz et al. 1985).

As Jennifer Brooke Barrett (2008) mentions, researchers have put forth a few theories or hypothesis to explain the links between religion and reproductive, maternal, and child health outcomes. These include the characteristics hypothesis theory which states that any positive or negative relationship between religion and fertility is actually spurious, and can be “explained away” by controlling for socioeconomic factors (Goldscheider 1971); particularized theology hypothesis which claims that the effect of a particular religion on reproductive behavior can be explained by interpretations of its official writings or teachings regarding procreation, contraception, and abortion (Knodel et al. 1999); minority group status hypothesis which points out that minorities (including religious minorities) often face multiple barriers to advancement in society and so they have to either limit births to increase resources available for each member of the group (Goldscherder 1971; Goldscherder and Uhlenberg 1969) or to increase fertility in order to avoid declining in relative population size (Knodel et al. 1999); social network theory that argues when religious doctrine is unclear on its position on contraceptive use and childbearing, interactions promoting or discouraging contraceptive use in the context of a religious group may be more social than religious (Agadjanian 2001); interaction hypothesis which claims that as development advances, religion will become less important and the growing economic forces acting on larger society to encourage smaller family size will eventually reach members of all religious groups (Chamie 1981).

Apart from religion and MCH, another research area that has drawn attention is ethnicity and MCH. Though in recent years, an increasing number of countries have succeeded in improving the health and well-being of mothers, babies and children, large disparities exist between countries, between the poor and the rich within countries and between races or ethnic minority and majority groups. Inequalities in access and utilization are particularly strong in maternal health care services such as antenatal care, skilled birth attendance, and clinic delivery. In many countries, ethnic groups often live in remote areas and lack access to services including MCH services and political representation. Researchers have identified major barriers to access and use health services, including physical/geographic constraints, cost of services and poverty levels, lack of coordinated multi-sectoral responses, budgetary constraints and inability to implement policies, language barriers and lack of information and understanding about available services, lack of knowledge and understanding about the population to be served, poor quality and relevance of services provided, lack of attention to gender dimensions of health issues (UNFPA 2008a). Some researchers found that in some ethnic communities, commune clinics did not have adequate equipment and facilities and skilled health care workers; understanding of the birth giving practices and customs of the ethnic

minority remains poor among health workers; the existing reproductive health services are not relevant to the local customs and practices (UNFPA 2008b). These researches suggest that the use of all types of maternal and child health care services in ethnic communities leads to improved survival chances of both mother and child.

7.2.2 Traditional beliefs and practices regarding MCH

Mou Zhongjian, a famous scholar specializing in religion in China, has generalized the characteristics with respect to the beliefs among ethnic minorities in China: First, the components of religious beliefs are complicated. Christianity including Catholicism, Protestantism and Orthodox, Buddhism including Mahayana Buddhism, Hinayana Buddhism and Tibetan Buddhism as well as many sects of Islam all exist in Chinese ethnic communities. In some regions, such as in Yunnan Province, there exist different religions even among one ethnic group. Second, compared with Han people who are mostly antitheists (no more than 5% Han people have religious belief), the minorities commonly have beliefs. For example, almost all the Tibetans, Hui people, Uygurs and Dai People believe in a religion. Third, due to some historical reasons, the religions of the ethnic minorities are characterized with much color of ethnicity. The ethnic minorities are deeply influenced by their beliefs, from values to the details of daily life. In other words, religion is the main tie in term of ethnic sentiment maintenance. Fourth, the ethnic minorities are mainly located in the borderlands and it is frequent for them to make religious communication with their neighboring countries. (Mou Zhongjian, 2002) When discussing the religious characteristics of Chinese ethnic minorities, Jia Zhongyi argues that it is needed to pay more attention to the enhancement of the ethnic minorities’ religious beliefs since the reform and opening-up which produce significant influences towards various realistic problems. (Jia Zhongyi, 2004) In addition, some scholars put forward that many ethnic minorities with religious beliefs had historical experiences of merging religion with politics. Although the socialist regime has already been set up for half century, the inertia force of history cannot be ignored. While making policies and dealing with some local issues, the government should care about the relationship between the policy-making and the traditional religious custom. Or else, it may escalate conflicts and thus have adverse consequence. (Bao Guizhen, 2003)

7.2.3 Social change in minority areas

The enormous change since the reform and opening-up in China has always been a concern at home and abroad. Nowadays some intervention programs about social development also strive to be established in

the reality of social change in order not to make the result opposite to the original intension. It has been widely accepted in the academic circle that the social change occurring in minority areas of China is a kind of structural change with a great degree and a far-reaching effect. (Li Puzhe, 2008) To be specific, we can analyze this situation from several aspects as follows:

First, structural change of minority communities throughout these years. The reason for this change originates from the eased restriction of the population movement. The migration movement of population in 1990s has greatly changed the original population structure in minority areas. The obvious phenomenon of women outflow and labor outflow exerts great influence on the community's vitality. (Yang Zhuhui, 2006) Population movement, especially the generalization of intermarriages is apt to cause the culture conflicts. (Li Puzhe, 2008) In addition, in the respect of the social division of labor, with the effect of the urbanization, the social stratification in minority areas becomes more complicated and the income gap widens and the urban-rural dual structure is impacted. (Wang Tiezhi)

Second, since the reform and opening-up policy, great changes have taken place in the economic structure of the minority areas, which is the same as the other parts in China. Since the reform of the economic system, the traditional development patterns which depend on the planned economy stepped off the stage of history. Market becomes the base strength to allocate and smooth the resources, which leads to the diversification of the ownership system and the enlargement of sources of income. And what is more, the readjustment of the local industrial structure has changed original livelihood and life styles in communities, including people's hygiene practices and reproductive mode. (Li Puzhe, 2008; Yang Zhuhui, 2006)

Third, the gradual diversification of the local political pattern. With the transition of the economic base, the political power in the minority areas becomes more diversified. The political culture becomes more complex and various trends of thoughts interact with each other. (Li Puzhe, 2008) In recent twenty years in China, the establishment of a civil society has achieved preliminary results. In minority areas, the power of various NGOs has been developed and some traditional religious groups gradually regain a position to play a role in the social activities. With the transformation of the mode of political operation, the traditional authorized politics has faded out due to the lack of national elites. Minority people's sense of ethnic identity, rights and interests and legal awareness have been enhanced and the regional conflicts become more serious and pressing. (Yu Jianrong, 2009)

Forth, the social change is bound to have an impact on the direction of the cultural development. The

diversification of the material cultures promotes the change of national values. In the meantime, more and more people begin to advocate the protection of the ethnic cultures. Hence, no matter what kind of means will be adopted, such as state-predominated "project" mode and marketization approach, people from the academic circle, the political circle and local elites all reach a consensus as to the culture protection and development, which can be seen from the fact that the applying for the status of national intangible cultural heritage in recent years is in full swing. (Li Puzhe, 2008; Qi Qingfu, 2004)

Fifth, Ethnic minorities areas have become the main stage of resource and energy development along with the implementation of Development of the Western Regions Strategy. In the process, contradictions are increasingly getting serious in ethnic minorities areas. The destruction of ecological environment has discontinued the traditional livelihoods (Zhong Hong, 2008). Some large-scale projects such as water and electricity plants has caused fundamental change of ecological environment, thus disrupting traditional communities and endangering their lives as well as the continuity of traditional culture (Li Qicai, 2003). So far as the current situation is concerned, no satisfactory solution has been found out. The conflicts between ethnic communities and interest groups continue to be intense in predictable future.

In a word, the minority areas nowadays have a close relationship with the social change. They are not living in the "culture islands" as described in the Anthropology textbooks.

7.2.4 Traditional cultural ideas regarding MCH

The ultimate goal of the cultural development is to influence the social members' value judgment on their own activities so as to lay a social foundation for the fair and civilized development in the future.

Those practices which mean to effect the social members' cultural ideas is not a novelty in the field of the ethnic research. As early as more than ten years ago, some scholars and NGOs adopted the idea when dealing with thorny problems such as drugs and AIDS in minority areas. With good familiarity with the local cultures and resources, those scholars and organizations could easily enter the target community and forward the community mobilization as possible as they could, and promote the coordination and cooperation including the local government and other relevant departments so as to make the policies or external intervention more effective. It has been proved that the exploration of the new mode indeed reached the expected target. A project with the participation of the traditional religious authorities or the local elites can cut down the resistance

in the promotion process and meantime eliminate the opposition and misunderstanding between the local community and the external power. (Hou Yuangao, Munaireha, Chen Guoguang, 2004) The maximum strength of that mode is that it can revive the subjective activity of the local communities which are considered as disadvantaged groups and make the project more pertinent and effective. (Hou Yuangao, 2000)

In addition, when discussing the plight of education development in minority areas, some scholars find that the ignorance of local knowledge, especially the religious traditions and other conventions, is one of the main reasons why the policy intervention is difficult to take effect in that area. In some examples about Lisu ethnicity, it is easy to detect that local knowledge in minority areas pose a great challenge to today's concepts of "knowledge system" and also cast doubt on the external intervention strategies. (Qian Ning, 2008) In the article, the author discussed the concept of "endogenous development" put forward by UN and pointed out that the external development intervention, such as the education reform did not necessarily involve bringing in some new things but combine the modern and local knowledge together and seek for a proper presentation in order to make the target population accept it. (Qian Ning, 2008)

However, the development ideas based on culture still confront the challenge of social situation. For example, on the basis of research on the change of the cultural protection system in Southeast Guizhou Miao-Dong Autonomous Prefecture, some scholars point out that it is an optimum distribution to combine the culture and its development, but we should first realize that there appear some new tendencies in the process of ethnic cultural inheritance. First, the traditional cultural inheritance has been broadened from the family lineage to the communication among different minorities. Second, the concentrated expression of the cultural needs for ethnic groups is the need for production technology or other things which can bring about direct economic benefits. Third, in the process of globalization and economic integration in China, the tendency of ethnic cultural marginalization will become more serious and the psychological gap caused by that could not be neglected. (Liu Zongbi, 2008)

7.2.5 Community-based MCH and advocacy of Social Gender

In China's ethnic policies, it is a commonplace to advocate the improvement of the sanitary conditions and promote the modern medicine in minority areas. But judging from the present situation, issues of maternal and child health rank in the pending problems in the field of minority public health, such as drugs, AIDS and diseases of genital system. But in the state or

regional laws and regulations, there is hardly any special provisions on that. (Hou Yuangao, 2009)

In terms of the researches in China, researches on ethnic maternal and child health mainly focus on cultural fertility study. (Yang Zhuhui, 2006:358) In the study, the ethnic fertility culture is not only an event in the process of life, but also involves a viewpoint of life and death. Song Zhaolin says that the fertility and maternal and child health in minority areas are based on a full set of world view, values and religious cultures. Hence, in order to understand the fertility culture or the idea of fertility and heal care, we must survey the basic background knowledge (Song Zhaolin, 1998:134-180).

Since the reform and opening-up policy, especially with the influence of one-child policy, the evaluation on the policies about maternal and child health in minority areas is insufficient. As for the available materials, they are all used to illustrate the correspondence between the reproductive culture and the state policies. Some analyses point out that we should guide the reproductive culture so as to help promote the one-child policy, create a good demographic environment for building new socialist countryside and lay a foundation for realizing a much better life for peasants (Chen Jing, 2007).

In conclusion, the researches on the policies of ethnic maternal and child health in China mainly concentrate on cultural fertility study and put more emphasis on the relationship between the traditional cultures and moral ideas and modern culture of medical care.

7.2.6 External intervention and evaluation of its impacts on MCH in minority areas

The state government attaches more importance to the maternal and child health in minority sanitary work. Generally speaking, the government still dominates the resource allocation in most fields of China's public life. The government puts more emphasis on improving the medical infrastructure, increasing the infant livability and controlling fertility in the minority maternal and child health. (Qian Ning, 2008). However, while elaborating on the existing problems, the government also obscurely admits that it is the reproductive ideas and gender discrimination in the traditional culture that become primary obstacles in minority sanitary work. (Qian Ning, 2008)

In recent years, besides some projects led by the government, many NGOs and other organizations have made a lot of efforts in the respect of community development and gender demand, women's health, small-amount credit loans, women skill training and safeguarding the rights and interests of women. They advocate the idea of gender equity and promote the mainstreaming of social gender identity. In the

meantime, they also exert more efforts on enforcing women's ability and creating a sustainable system by which fair allocation of social resources between men and women can be secured. (Shen Meimei, 2007; Tan Santao, 2008)

The principal plights those organizations have confronted can be generalized as follows. First, there is traditional colonialism ideology implied in the international NGOs' paradigm and the project sponsors identify the western culture with civilized, developed and progressive culture. It seems that it is their responsibility to give financial support to help out the developing countries from poverty. (Wang Xingjuan, 2009) But the selection of projects does not mainly depend upon the actual condition of the developing countries but depend on so-called digitized "developing index" they have already obtained and gaps through comparison, such as the overemphasis on the materialism poverty which is opposite to affluence and the unscrupulously indiscriminate blame to the environmental deterioration in developing countries neglecting the mismatched economic system with the premise of transfer of the place of production. All in all, it is apt to form an asymmetrical relationship between sponsors and beneficiaries. (Shen Meimei, 2007)

Besides that, in minority areas, NGOs have to face the problem how to cope with the structural mechanism in the respect of social gender in China. The traditional livelihood for minority people is agriculture and animal husbandry in which the mode of gender division is characterized by androcentrism in centuries-long history. In other words, since men take the leading role in social division of labor, it is men who can determine the flow direction of resources. As things stand, it is difficult for the NGOs' projects in minority areas to overcome the existing structural limits so that they have to implement the projects or allocate resources which originally are aimed at women with the help of men. In that process, there appear many deviations which are hard to grasp and complicated to solve. (Zhao Lingxue, 2009; Shen Meimei, 2007) In conclusion, we should consider the role local cultures play in the mode of international development. (Zhu Jiangang, 2007)

7.2.7 Literature review of each survey site

Guizhou Province

Guizhou is the province where many minorities live. The health problems of women and children in Guizhou is closely related with low status of women and affected by the traditional culture. The works on health issues of women and children in Guizhou are not many. The book: *Interpreting Wrong Way—A Study on Divine Miao Women in Hunan-Guizhou Boder* (Ma Yongbing, 2006) focuses on the witch culture of Miao women.

The content of the book includes the songs of witch, conjuration, curses and so on. Miao people have a long history for advocating "witch and ghost" The author mainly described the witch , especially the mysterious customs of releasing poison and analyzed the phenomena of primitive religion in the perspective of anthropology, and attempt to analyze the impacts exerted by this special group of "witch" on local society and women themselves.

The book, *A Study on Minorities Women in Guizhou* (Nationality study Institute of Guizhou Province, 1995), tries to carry out a full range of research on the minorities women situation in Guizhou province from different perspectives. One of essays entitled *Miao women and traditional medicine* in the book discusses briefly the important role and the outstanding contributions of Miao women in the course of development of their ethnic traditional medicine, especially in the fields of obstetrics, gynecology, pediatrics and so on. The article *Influence and Countermeasure on Fertility of the Ethnic Minorities Women in Guizhou* represents that many aspects of traditional culture in ethnic minorities who reside in Guizhou province have impacts on women's reproductive and neonatal feeding.

The article, *Study of the Unbalanced Sex Ratio at Birth among the Miao and Dong Minorities in the Autonomous Prefectures of Southeast Guizhou Province*(Xin Liping, 2002), relates the main contents of study of ethnic women in ethnic investigation of "Six Mountains and Six Rivers", including the study of the status of minority women and ethnic culture, as well as ethnic minority women in the market economy tide. The author points out the important significance the study has for having a comprehensive understanding of the current situation of women in Guizhou Province. The paper, *Status of Women and Traditional Culture of Ethnic Minorities in Guizhou* (Cao Duanbo, 2008), represents that female ancestor worship is universal in traditional culture of ethnic minorities in Guizhou. On one hand, Women play an important role in both family and society; on the other hand, there are some restrictions on the freedom of women in traditional culture. The writer pointed out: to protect women's rights and improve the level of women's health, a number of national culture and customs should be enhanced on one hand; on the other hand, the concept that does not adapt to the reality need to be adjusted. In the article *Strengthening the Communication with Outside , the Key to Improving the Making of Minority Women* (Li Mei, 2007), the writer discusses: limited by history and living environment, minorities have formed the quality of closeness and conservatism in the long river of history, which are obviously reflected in minority women. These have greatly hindered the improvement of the quality of minority women and the process of social modernization.

To change this status and to eliminate the obstacle of their own , it is essential to introduce new culture and new ideas to improve the self - consciousness of minority women.

Miao people (Leishan County)

As a poverty area, in Leishan County, there are many problems to solve in the field of maternal and children health, such as economic backwardness, lack of medical resources and shortage of knowledge about health care. The paper, Present Life Condition of Peasants in Western Poor Rural Areas and Their Expectation for the New Socialist Countryside Construction—A Survey on Villagers in County Daozhen and Leishan, Guizhou Province (WenYong, 2008), analyses the basic living situation of peasants in poverty rural areas in Guizhou was made in the perspective of economic situation, living surroundings and health status, based upon 1093 questionnaires, to reach an understanding of their expectation and needs for the New Socialist Countryside Construction . Some recommendations were also raised in the paper. The article, The Building of a New Countryside and Women's Reproductive Health in Poor Areas—Taking Daozhen County in Guizhou Province as an Example (Yin Qin, 2007), analyses women's knowledge of, behavior in and attitude toward family planning/ reproductive health in the poverty- stricken areas according to the base line survey at Daozhen County in Guizhou Province,. The research shows that while focusing on economic development, importance should be attached to the improvement of there productive health of women at child - bearing age.

Dong people (Congjiang County)

The studies on health problems of women and children of Dong people in Congjiang County mainly focus on the research in Zhanli village, which is well known as "the first village for family planning in China". The paper, On Customary Law of Marriage and Childbirth in Zhanli Village of Cong jiang County (Pan Zhicheng,2008) mainly discuss a customary law that is gradually formed from their ancestors in Zhanli village, including village endogamy, clan exogamy, restrictions on divorce, birth control .The customary law of marriage and childbirth in Zhanli village relies on not only the old walled discussion with the public to maintain impunity, but also the internalisation of concepts. The paper, Achievements and Benefits of Implementing Family Planning: Lessons from Dong Village Zhanli (Yang Junchang, 2001) summarizes the results and achievements of the family planning in Zhanli village , analyses the effective social mechanism and Specific methods to put the family planning into practice ,as well as how to maintain the population constant. The writer believes that the sense of equalitarianism , reproductive culture and practice experience of Dong are significant and valuable

to population problems and family planning in other minority areas.

In the report Harmony and Conflict—a Field-work Study from Zhanli Village, Qiandongnan Autonomous Prefecture, Guizhou Province (Liurong, 2007), the writer visited the village which has long history and sought the reason why it could retain its unique heritage of traditional fertility culture by participant observation.

In this paper, The Cultural Value of the Dong's Birth Customs at Zhanli and Its Comparisons to the Han's Traditional Customs (Liu Zongbi, 2006), the writer analyses: traditionally Dong people at Zhanli of Congjiang County, Guizhou Province have a custom of controlling their births and population. As a result , very few changes have happened to the number and gender balance of the population there. That is the result of their special medicines as well as their thought of keeping a harmonious relation to each other and to nature. This kind of thought is superior to the traditional thought of the Han people and is constructive even in modern society. The book,the Fertility Culture of Ethnic Minorities in China (Cheng Changping, Cheng Shengli, 2004) mainly discusses the fertility culture of ethnic minorities. One of chapters introduces Dong people's reproductive culture. The writer makes special reference to Zhanli village of Congjiang County, Guizhou province. There is a rang of special methods of population control including contraception and child Sex selection. The book, Social Mechanisms and Methods of Family Planning of Dong Peole in Jian Village (Shing Kaizhong, 2001), introduces the relationship of customary law with population control, the social mechanisms and methods to control population. Particularly, a herbal medicine named " Huanhuacao" which is widely used by Dong people for population control in local society is mentioned.

The text, A Cultural Analysis of Child-Bearing will of Han People and Ethnic Minority Groups (Xiangchunling,2003) , plans to compare the culture of child-bearing between the Han people and Tibetan, Dong people of Guizhou, analyze the rational culture value of these ethnic groups child-bearing will, probe into the negative consequences of Confucianism child-bearing culture in family plan policy and the limitations of the divisions of the dual structures of child-bearing mode as tradition-modern-of the present days.

In the study, Current Situation of Sex Preference in Ping Village inhabited by Dong People in Guizhou Province (Shenjie, 2008), the writer conducted a survey in Ping Village of Congjiang County, Guizhou Province by collecting the data of population condition and analysed the origin of sex preference. She also found that sex preference does exist in Ping Village and it may result from their special custom.

Yunnan Province

The population of the ethnic groups in Yunnan province accounts for more than 30% of the total population. Due to historical and other reasons, Yunnan has been faced with environment and poverty problems. Therefore, the researches and projects for ethnic development never stops since after the founding of the PRC. (Shen Haimei, 2007)

The phenomenon of the reproductive worship and maternity worship is widespread among ethnic groups in Yunnan province. Many ethnic groups attach importance to fertility and nurture and set up a series of social norms for them. Therefore, the fertility and nurture is considered an important standard to measure the value of the women (Zhao Jie, Zhang Tuanxian, 1998). Because of complexity of nature and human conditions, Yunnan minority women have richer experiences in fertility. These experiences led to a variety of taboos which reflected not only the traditional concept of gender, but also the complexity of understanding about the nature, society and the sacred space. (Fang Hui, 1995) Various ethnic groups accumulated a great deal on the local knowledge of maternal and child health in history because they value the reproductive health of women and children. For example, some ethnic groups such as Jingpo and Jinuo has their own prescription to prevent abortion. Bai people have had special skills for women to treat gynecological diseases since Nanzhao period. (Fang Hui, 1995) Dai people have relatively superior technology of oxytocin and post-natal health care (Jiang Yingliang, 1983: 596).

The studies on women and children of Yunnan minorities were put on the right track after the World Conference on Women in Beijing, 1995. Since then, a series of research institutes have been established and meanwhile a considerable number of development projects have been implemented (Yang Guocai, 2005) At the same time, some Non-government Organizations began to pay their attention to Yunnan. Several development projects were brought into acts, such as Women and Social Sex Research, which was carried out by Yunnan University, Yunnan Minzu University and Kunming Medical Academy in cooperation, together with the Construction of University Women's Studies and the Upgrading of the Capability of Rural Minority Women raised by Minority Women and Social Sex Research Institute of Yunnan Nationality University, were considered as the start point of international outside intervention for Yunnan's health care of women and children. Both research projects were sponsored by Ford Foundation. (Shen Haimei, 2007)

Jingpo people (Longchuan County)

Longchuan County has always been the most important port for trade and business in sino-Burmese border since ancient times. Yet there is no any of natural barriers between Longchuan County and Burma, so as mentioned above, this place has been faced with the severe drug using and dealing problems since the reform and opening up policy was initialized. (Jiang Lingyue, 2007)

Longchuan County is somewhere that has the largest Jingpo population all over the country. Historically speaking, Jingpo People mainly held belief in primitive religion. However, as the missionaries came into this area spreading Christianity during modern times, big changes occurred in the traditional culture. Some scholars believe that Christianity has already become the most important bond in maintaining the Jingpo's ethnic identity. (Bao Hongguang, 2004) When elaborating on Jingpo's culture, scholars acknowledge that it is characteristic of the co-existence of Christian culture and primitive beliefs. For the significance of its progress, Christianity had indeed greatly promoted the local development in rational ideology, culture accumulation, ethic cohesion among Jingpo People. But it also shouldn't be overlooked that the persistence on traditional culture in Longchuan is not easy to shake because of Jingpo People's slow change in livelihood transformation and the specific geographic location. (Li Huaiyu, 2003)

Compared with the nearby areas, it is obviously that Longchuan has lagged behind in social development. The reasons can be divided into four points as follows: 1) Difficulties in industrial structure transition. The County still mainly depends on the agriculture up to the present, although the border commerce is highly developed, influences towards local areas are extremely limited; 2) A large number of school-aged drop-outs and the severe population outflow and lower educational level. People there can hardly provide promotion force to the community development; (Li Huaiyu, 2003) 3) The inferior conditions of public sanitation and grave drug-use and AIDS problems, for no effective solution pattern carried on hitherto; 4) The adaptation conflicts between traditional culture and modernization. There are plenty of contradicts in ideology among people, so executing the state policies and development programs is difficult. (Bao Hongguang, 2004)

So far as maternal and child health is specifically mentioned, demographer Luo Chun suggests that, there are several challenges facing to the Jingpo

People in Longchuan area: 1) the early-aged marriage and childbirth are still harsh; 2) high order births phenomena is at large and the population pressure is heavy; 3) elderly childbearing is common; 4) among traditional culture exists mystified explanations to women reproduction, as a result, many old conceptions kept in the work of local maternal-child health care and reproduction, which thus counteract the popularization of modern medicine in local area. She has especially points out, the essential reason that why it is difficult to practically promote the state maternal-child health care policy in Longchuan, compared with the successful practice in Dai regions, is the blockage of traditional culture.

Dai people (Luxi municipality)

Half a century ago, one of the early typical works on ethnic research, *Religious cults of Pai-I along the Burma-Yunnan border*, was written in Luxi municipality. This work represents local Dai people's faith on Buddhism and the significant role religion plays in local social life from the perspective of an external scholar.

After the founding of New China, Luxi municipality, which belongs to Dehong Prefecture, has been no longer as important as before for research of Dai people. Recently, people pay close attention to Luxi mainly because of problems of its drug growing and AIDS. Luxi, as well as Dehong Prefecture, which is located on the border of China and Myanmar, has been suffering from the harassment of the drug problem because of its special location, serious poverty, inconsistent of infrastructure construction and economic development, as well as low quality of education and the population since China's Reform and opening. In addition, foreign religious infiltration of the region makes the situation more complicated. All of these make it more difficult to achieve a comprehensive sustainable development of society. (Liao Yuanchang, 2008) However, Dai communities in Luxi municipality have had an effective way to control the drug problem although they are in such a complex environment. The conclusion is given by the scholar who compares Dai community here and other ethnic communities after field work: the reason of the fewer drug problems than other areas is the thick atmosphere of Theravada Buddhism, strong self-control ability of the community and the rich spiritual life of Dai people.

Dai people in Luxi municipality believed in Primitive religion in history before Buddhism was introduced. As Theravada Buddhism spread, they became Theravada

Buddhists. So Buddhism has significant influence in this region. For example, individuals of the community have to go through the most important turning point of life stage in the temples. Besides, the public life, seasonal arrangements and social control mechanisms are established on the basis of Buddhism. The most important point is that Buddhism tenet is an extremely effective means of self-regulation for Dai community and religious leaders have a high status in local communities. So the residents' recognition of religious constraints can not be replaced by outside criteria. (Yangguangyuan, 2002). Thus it can be seen that local knowledge has a decisive influence on society. An effective promotion of a project is mainly determined by its adaptability to local belief and culture.

Qinghai Province

Special religion belief distinguishes Hui from Han in life style. Compared with Gansu and Ningxia where Hui people living more concentrated, fewer researches were carried out on Hui ethnicity living in Qinghai Province.

Xiao Mang in the paper *The 'Wugong' of Islam and the Women's Health of the Hui Ethnicity*(Xiao Mang,2001) shows that the old Islamic women are generally in good health condition. This is not only because that they have food taboo and keep hygiene habit, but also because that Islam asks all believers to do 5 basic exercises. As a ritual Wugong is taken regularly, and it is the refreshment of one's mind or body. So incidences of many age-related diseases in older Hui women are lower.

Of *Methodology of Research on Northwestern Minority Women*(Wang Lan, Li Yuhong, 2007) says that in ethnic minority areas, women are relatively disadvantaged groups to men. It is necessary to given women special concern to empower them to get equal opportunities and rights with men.

Rural Hui women's views of fertility (Ma Guihua, 2007) found that, it is difficult to change their concept of fertility unless promoting development of rural economy. On the other hand, women are the main body of reproductive. Therefore Government should attach great importance not only to educating people to practice family planning, but also to creating the economic and cultural conditions for women to show self-worth.

There are other relevant studies in this area, such as *On the Female View of the Huis and its Characteristics* (Zhao Chunxiao, 2008), *Researches about Guaranteeing the Rights and Interests of Ethnic Minorities living in*

scattered communities—Take Hui Ethnicity for Example (Li Anhui, 2007), The Uniqueness of Northwestern Minority Women Study and its Empirical Reflection (Wang Lan, 2007), and so on. The first report considers that for a long time marginal status of the Hui women had influenced their self-improvement and social development. In the second paper, the speaker takes the case of the Hui people living in scattered communities, and elaborates the rights and interests which Hui women have in marriage and family, social security, religion, and so on. This is beneficial to understand the female culture of the Huis. The last report is concerned with specific recommendations on improving the living conditions of ethnic women. This is helpful to get the overview of the Hui women's living in our pilot.

Hui people (Hualong County)

So far, there is rare and scattered background information about MCH project in HuaLong region known only in some early records.

The chapter Maternal and Child Health among "Survey of Hualong Hui Ethnicity Autonomous Region" (1984) mentioned MCH Station was established in Hualong County in 1953. The government pays close attention to maternal and child health, and has trained birth attendants to promote new methods for child delivery, and alleviate maternal pain and reduce neonatal mortality rate since 1950. Every year, the station conducted census of Uterine prolapse, proctitis, then treated the patients free. They also served physical examination to children in pre-school and kindergarten on Eve of children's day.

The Record of Hualong Country (1994) notes that since 1950 new methods for child delivery was launched throughout the country. In Jan. 1951, the 7th brigade of Central Epidemic Disease Prevention Committee and Ministry of Health Department for women and children trained 158 midwives in Hualong. Until 1952, there were 10 Delivery Station and 239 midwives in countryside. In 1956, National immunization team assisted the health sector of Hualong in popularizing MCH knowledge and training birth attendants. Since 1981, MCH Station of Hualong has conducted a comprehensive health survey with the County hospital and commune health centers on 83 preschool children, and who suffered from rickets, roundworm, trachoma, tuberculosis and other diseases were treated free of charge.

Tibet Autonomous Region

Since 1990s, the issue of Tibetan women and children health is getting attention in academic circle. In the

early 1990s, through 8 town field works in four (city) counties--Shannan, Nyingchi, Xigaze, and Lhasa--Lou Binbin researched living environment, family economy, production conditions, labor intensity, as well as medical health of Tibetan farmers and herdsmen. He found that Tibetan women's reproductive concept, who live in farming and pastoral areas, had significantly changed, as most of women had adopted contraceptive measures of their own will. However, due to financial, medical personnel and transportation difficulties, family planning and MCH services were far from meeting the women's needs. (Lou Binbin, 1996) According to field surveys and the documentary materials, Wang Jinhong preliminary approached Tibetan women's marital status and family status, especially elaborating women's reproductive decision-making and reproductive status in the report Contemporary Tibetan women's marital status and family status--survey of 200 families in Lhasa and Shannan.(Wang Jinhong,1999)The latest study shows that the work of MCH still has many difficulties in Tibet Autonomous Region, such as imperfect systems, undeveloped MCH care institutions, inadequate MCH professionals, low-quality personnel, particularly weak for emergency obstetric care and gynecological services, and serious lack of funding for MCH, etc.(Wang Jianpeng,2006)

At policy level, we can hold an optimistic attitude toward this problem-solving issue. In 2001, according to the national Program for the Development of Chinese Women (2001-2010), the Tibet Autonomous Region Government formulated and promulgated the "Program for the Development of Tibet Autonomous Region Women (2001-2010)"(hereinafter referred to as PDTW). Six areas are defined in PDTW as priorities for development, namely: women and the economy, women in decision-making and management, education of women, women and health, women and the law, women and the environment, in total six prior development areas. PDTW puts forward some implement measures on women's health problem, and ensure that women have access to basic health-care services, in order to improve the health level of women. (2001)"Tibet Autonomous Region Government Work Report in 2008" said that the Government would invest 120 million RMB to improve the medical and health conditions in Tibet. Under this back ground, the government held three conferences on Tibetan women and children development in 2005: "Symposium of Tibetan Women's Development TV Forum" "the Press conference of development of Tibetan women and children" and "The second conference on Tibet women and children work". Attendees reviewed the improvement of maternity and child care in last 40 years. Moreover, they discussed and planned the blueprint of promoting the Tibetan maternal and child health.

In 2006, Tibet began to implement the programme "Maternal and Child Health project 2006-2010 cycle" which was based on cooperation of National Ministry of Health and the United Nations Children's Fund. Its purpose is on improving the quality of Maternal and Children Health Care, paying attention to poverty and floating pregnant women and children, facilitating improved equally and lasting access to and utilization of health services. By the year 2010, the maternal, children aged 0-5, and their parents could accept the MCH service in pilot areas, in this case to improve the children's health status and reduce the incidence of disease.

Tibetan people: in Nyingchi (State capital of Gyamda)

In 1990s, the research on MCH in Nyingchi, One of the pilot areas, was started. MCH Status and Countermeasures in Nyingchi(Xu Qingfeng,1999) and brief discussion on MCH Status and Countermeasures in Nyingchi(Chen Shangwei, wanza Dorje, Hong Jieying, Zhang Yuchun, 2001) both point out that in Nyingchi the work of MCH were quite arduous, additionally, "three high and one low" phenomenon--high birth rate, high infant and child mortality rates, and low population growth rate—remain serious. The articles also explore ways to improve the level of MCH in Nyingchi.

Papers Analysis of census data on 628 women in Nyingchi(Hu Nanying,1999) and Analysis of Gynecopathy census data on 420 women in Nyingchi (Cuoyong, 2002) both are based on the survey about women workers in Agencies and Institutions and women individual households but carried out in different times. These two articles indicate that: it is an important way for women to keep healthy that detecting Gynecopathy regularly by mass screening and treatment.

In the report Analysis of SDT prevalence in Nyingchi 2001-2006 (Gaisang Wangmo, 2008), the author states the prevalence of SDT and the implementation of SDT control in recent years. Furthermore, the paper 25 cases of pregnancy-induced hypertension Nursing in Nyingchi (Soinam cuomu, 2009) notices that religious beliefs, life styles and physiological characteristics of the plateau are major causes why women suffer more serious pregnancy-induced hypertension in Nyingchi.

7.3 Survey instruments

Qu. no	FGD questions	In-depth interview questions
Traditional beliefs –general, religious-		
Q 1	<p>What do most Dai/Dong, Hui, Jingpo/Miao/Tibetan people believe in? (Prompt: nature, ancestors, ghosts, gods)</p> <p>In what form do they practice their beliefs? (Prompt: sacrifice, witchcraft, divination, curses, taboos)</p>	<p>What do most Dai/Dong, Hui, Jingpo/Miao/Tibetan people believe in? (Prompt: nature, ancestors, ghosts, gods)</p> <p>In what form do they practice their beliefs? (Prompt: sacrifice, witchcraft, divination, curses, taboos)</p>
Q 2	<p>Who, within the Dai /Dong/ Hui / Jingpo /Miao/Tibetan community, practice most their traditional beliefs? (Prompt: gender, age group, occupation, education level, social status)</p> <p>What is the scope of believers? (Prompt: individuals, families, communities, the whole ethnic group)</p> <p>What is their profile? (Prompt: age, gender, occupation, level of education)</p>	<p>Who, within the Dai /Dong/ Hui / Jingpo /Miao/Tibetan communities, practice most their traditional beliefs? (Prompt: gender, age group, occupation, education level, social status)</p> <p>What is the scope of believers? (Prompt: individuals, families, communities, the whole ethnic group)</p> <p>What is their profile? (Prompt: age, gender, occupation, level of education)</p>
Q3	<p>Who are the religious practitioners of the Dai /Dong/ Hui / Jingpo /Miao/Tibetan community?</p>	<p>Who are the religious practitioners of the Dai /Dong/ Hui / Jingpo /Miao/ Tibetan community?</p>
Q4	<p>What kind of support and/or services do these religious practitioners provide to families? (Prompt: ceremonies, mediation, advice, education)</p> <p>How do local Dai/Dong, Hui, Jingpo/Miao/Tibetan people usually value their role?</p>	<p>What kind of support and/or services do these religious practitioners provide to families? (Prompt: ceremonies, mediation, advice, education)</p> <p>How are their services remunerated?</p> <p>What are the sources of their income? How do local Dai/Dong, Hui, Jingpo/Miao/Tibetan people usually value their role? What is their status in the community? (Prompt: privileges, moral authority)</p>

Q5	<p>Can you describe the context in which you perform your religious activities? Is the external environment supportive or constraining? (Prompt: outside pressure or restrictions)</p> <p>If constraining: what kind of restrictions?</p>	<p>Can you describe the context in which you perform your religious activities? Is the external environment supportive or constraining? (Prompt: outside pressure or restrictions)</p> <p>If constraining: what kind of restrictions?</p>
<p>Degree of influence of traditional/spiritual leaders in decision making on practices related to maternal and infant health Perceived conflict of interest between belief system and MCH service provision that may impact on utilization of MCH services</p>		
Q6	<p>In which situations or occasions do Dai /Dong/ Hui / Jingpo /Miao/Tibetan people require the intervention/help from traditional/spiritual leaders?</p> <p>Please describe the kind of support requested (Prompt: fertility, birth, newborn initiation...)</p>	<p>In which situations or occasions do Dai /Dong/ Hui / Jingpo /Miao/Tibetan people require the intervention/help from traditional/spiritual leaders? Please describe the kind of support requested (Prompt: fertility, birth, newborn initiation...)</p>
Q7	<p>What are the main Dai /Dong/ Hui / Jingpo /Miao/Tibetan traditions & norms in relation to pregnancy and birth? Please describe (Prompt: taboos, breast feeding, nutrition, timing, sex preference...)</p>	<p>What are the main Dai /Dong/ Hui / Jingpo /Miao/Tibetan traditions & norms in relation to pregnancy and birth? Please describe (Prompt: taboos, breast feeding, nutrition, timing, sex preference...)</p>
Q 8	<p>Who in the family, or community, usually takes decisions about whether to follow traditional practices?</p>	<p>Who in the family, or community, usually takes decisions about whether to follow traditional practices? About when to have children? Other decisions in the home? Who decides where a woman should deliver her baby?</p>
Q9	<p>Can you tell me anything about national maternal and child health policy?</p> <p>Have you any comments to make about the MCH services provided by the MOH in your Township/village?</p>	<p>Can you tell me anything about national maternal and child health policy? Have you any comments to make about the MCH services provided by the MOH in your Township/village? Can you suggest anything that could be done to improve MCH services within your community? Is there something that you, as traditional/religious leaders, could do to promote MCH services? (if yes: specify) Do you collaborate in any way with local MCH/FP providers? (if yes: specify ; if not: why)</p>

Representation of health and illness		
Q10	<p>In your opinion, what are the reasons that people sometimes fall ill?</p> <p>For what reasons might a pregnant woman, or a woman who has just had a baby, fall ill?</p> <p>For what reasons might babies and children get ill?</p>	<p>In your opinion, what are the reasons that people sometimes fall ill?</p> <p>For what reasons might a pregnant woman, or a woman who has just had a baby, fall ill?</p> <p>For what reasons might babies and children get ill?</p> <p>Can you describe any things that people could do to avoid falling ill?</p>
Q11	<p>In Dai /Dong/ Hui / Jingpo /Miao/Tibetan culture, what is dirty / impure?</p>	<p>In Dai /Dong/ Hui / Jingpo /Miao/Tibetan culture, what is dirty / impure?</p> <p>In your opinion, is this meaning the same as the modern scientific meaning?</p>
Traditional medical practices		
Q12	<p>What do most Dai /Dong/ Hui / Jingpo /Miao/Tibetan do when they fall ill?</p> <p>Who do you go to for help? (Prompt: community center, hospital, traditional doctor, use own experience)</p> <p>What would you consider a "serious" disease?</p> <p>What do most Dai /Dong/ Hui / Jingpo /Miao/Tibetan do when they fall "seriously" ill, whom do they turn to?</p>	<p>What do most Dai /Dong/ Hui / Jingpo /Miao/Tibetan do when they fall ill?</p> <p>Who do you go to for help? (Prompt: community center, hospital, traditional doctor, use own experience)</p> <p>What would you consider a "serious" disease?</p> <p>What do most Dai /Dong/ Hui / Jingpo /Miao/Tibetan do when they fall "seriously" ill, whom do they turn to?</p> <p>When would you decide to go to a clinic or hospital?</p>

<p>Q 13</p>	<p>In your community, is there anyone who provides traditional medicine to treat patients? (Prompt: medicine man, witch)</p> <p>If yes: Tell me about the traditional doctors in your community? (Prompt: identity, social status, full/part time)</p> <p>What help do these traditional doctors provide to pregnant women, or women in labour, or for newborn babies?</p>	<p>In your community, is there anyone who provides traditional medicine to treat patients? (Prompt: medicine man, witch)</p> <p>If yes: Tell me about the traditional doctors in your community? (Prompt: identity, social status, full/part time)</p> <p>What help do these traditional doctors provide to pregnant women, or women in labour, or for newborn babies? What drugs do they use/prescribe? (Prompt: herbal medicine, western medicine)</p> <p>Do these traditional treatments help people to recover?</p>
<p>Q14</p>	<p>In your opinion, what makes traditional medicine different from western medicine? Which one do you prefer to turn to? why</p>	<p>In your opinion, what makes traditional medicine different from western medicine? Which one do you prefer to turn to? why</p>
<p>Q15</p>	<p>Can you describe the context in which you practice your traditional medicine? Is the external environment supportive or constraining? (Prompt: Are these practitioners allowed to practice their traditional practices?)</p>	<p>Can you describe the context in which you practice your traditional medicine? Is the external environment supportive or constraining? (Prompt: Are these practitioners allowed to practice their traditional practices)</p>
<p>Q16</p>	<p>Is there any non-traditional medical intervention that you would not want to undertake? (Prompt: blood transfusions, injections, surgery, gynecological check ups, hospitalization)</p> <p>If yes: why? (Prompt: afraid, male doctor, cost)</p>	<p>Is there any non-traditional medical intervention that you would not want to undertake? (Prompt: blood transfusions, injections, surgery, gynecological check ups, hospitalization)</p> <p>If yes: why? (Prompt: afraid, male doctor, cost)</p>

Q17	<p>Generally, what is the relationship, if any, between TBAs/traditional doctors and MCH providers?</p> <p>Can you describe any positive examples of collaboration between traditional practitioners and MCH staff? (Prompt: exchange of information, IEC, referral, collaboration)</p>	<p>Generally, what is the relationship, if any, between TBAs/traditional doctors and MCH providers?</p> <p>Can you describe any positive examples of collaboration between traditional practitioners and MCH staff? (Prompt: exchange of information, IEC, referral, collaboration)</p> <p>Can you think of any ways in which TBAs or traditional doctors could work together with MCH staff to improve maternal and child health?</p>
Taboos		
Q18	<p>Are the staff in your local MCH services mostly men or women? Would do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women prefer to be attended by male or female staff? Why? (Prompt: gynecological exams, antenatal check ups, delivery)</p>	<p>Are the staff in your local MCH services mostly men or women? Would do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women prefer to be attended by male or female staff? Why? (Prompt: gynecological exams, antenatal check ups, delivery)</p> <p>Can you make any suggestions about this could be improved?</p>
Q19	<p>Can you tell me about anything that women must, or must not do, according to your traditions/culture during pregnancy, birth and in the days after birth ? (Prompts: Are there some particular foods that women must eat, or cannot eat?)</p>	<p>Can you tell me about anything that women must, or must not do, according to your culture/traditions, during pregnancy, birth and in the days after birth? (Prompt: Are there some particular food that women must eat, or cannot eat?)</p> <p>Who in the community or in the family defend these taboos? (Prompt: husbands, other women, TBAs, religious leaders)</p>

Decision – making in the home		
Q 20	<p>In most Dai/Dong, Hui, Jingpo/Miao/Tibetan families who looks after the family income/ money? (Prompt: husband, wife, other person)</p> <p>In most families, who makes decisions about how the family income should be spent? (Prompt: the husband, wife, other person)</p>	<p>In most Dai /Dong/ Hui / Jingpo /Miao/Tibetan families (in your community), who looks after the family income/ money ? (Prompt: husband, wife, other person)</p> <p>In most families, who makes decisions about how the family income should be spent? (Prompt: the husband, wife, other person)</p> <p>Who in the family decides whether to spend money on occasional 'big' items, such as school fees, medical bills, household furniture, farming equipment etc? Who in the family decides how to spend money on regular items, such as food, small things?</p>
Q 21	<p>In most Dai /Dong/ Hui / Jingpo /Miao/Tibetan families, who decides how many children to have? (Prompt: husband, wife, local officials, other)</p> <p>How do husbands and wives limit the number of children they have?</p> <p>In most families, who looks after the child/children on a daily basis? (Prompt: mother, father, relation, sibling....)</p>	<p>In most Dai /Dong/ Hui / Jingpo /Miao/Tibetan families, who decides how many children to have (Prompt: husband, wife, local officials, other...) How do husbands and wives limit the number of children they have? (If the respondents mention family planning, ask : Who decides which family planning method to use? In most families, who looks after the child/children on a daily basis? (Prompt: mother, father, relation, sibling...)</p> <p>Why does (this person) look after the children?</p>

<p>Q 22</p>	<p>When a Dai /Dong/ Hui / Jingpo /Miao/Tibetan woman is pregnant, do she and her husband talk about her health during pregnancy? What sorts of things do they talk about? (Prompt: for example, do they discuss what she eats? Things that are unhealthy (smoking and alcohol)? her work responsibilities (in the house, in the fields?)</p> <p>If they don't discuss her health Can you think of things it would be useful for a husband and wife to discuss when she is pregnant? Why are husbands and wives unable to discuss these things together?</p> <p>Who goes with a pregnant woman when she goes for ante-natal care?</p> <p>Can you describe any things that might go wrong during pregnancy or child-birth? (Prompt: for example when things do not seem to be progressing normally?)</p> <p>What would you do in such a situation?</p>	<p>When a Dai /Dong/ Hui / Jingpo /Miao/Tibetan woman is pregnant, do she and her husband talk about her health during pregnancy? What sorts of thing do they talk about? (Prompt: for example, do they discuss what she eats? Things that are unhealthy (smoking and alcohol)? her work responsibilities (in the house, in the fields?) If they don't discuss her health Can you think of things it would be useful for a husband and wife to discuss when she is pregnant? Why are husbands and wives unable to discuss these things together? Who goes with a pregnant woman when she goes for ante-natal care? Can you describe any things that might go wrong during pregnancy or child-birth? (Prompt: for example when things do not seem to be progressing normally?) What would you do in such a situation? When would you decide to seek help? Who would you go to get help? (Prompt, mother/mother-in-law, local/traditional practitioner, health service provider, MCH clinic, hospital? (If not local) How would you get there and who much would it cost? How much would it cost to see that person?</p>
	<p>Maternal and child health (Part I) Purpose: to 1) understand the cultural practices in aspect of pregnancy, birth, neo-natal care, infant care and sex preference, family planning and nutrition; 2) to evaluate the MCH-related practices and put forward suggestions on how to figure out cultural approaches to improve the MCH.</p>	

Ante-natal practice		
Q 23	<p>Are there particular foods that pregnant women are not allowed to eat in y Dai /Dong/ Hui / Jingpo /Miao/Tibetan culture? What are they?</p> <p>Do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women work when they are pregnant? Do they carry on working up until the baby is born?</p> <p>Do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women receive health check-ups when they are pregnant? Who from?</p>	<p>Are there particular foods that pregnant women are not allowed to eat in Dai /Dong/ Hui / Jingpo /Miao/Tibetan culture? What are they? Why is a pregnant woman not allowed to eat these foods?</p> <p>Do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women work when they are pregnant? Do they carry on working up until the baby is born?</p> <p>Do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women receive health check-ups when they are pregnant? Who from? What kind of advice or medicine do they receive?</p> <p>Is it normal for husbands and wives to continue having sexual relations up until the time the baby is born?</p>
Child birth		
Q 24	<p>Where do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women usually give birth?</p> <p>Who decides whether a woman should deliver her baby at home or at a clinic/hospital?</p> <p>If at home Who assists with the delivery? (Prompt: TBAs, village doctors, midwives, village MCH workers, grandmother...)</p> <p>If something goes wrong during the delivery what would people normally do?</p>	<p>Where do Dai /Dong/ Hui / Jingpo /Miao/Tibetan women usually give birth?</p> <p>Who decides whether a woman should deliver her baby at home or at a clinic/hospital?</p> <p>If at home Who assists with the delivery? (Prompt: TBAs, village doctors, midwives, village MCH workers, grandmother...)</p> <p>If something goes wrong during the delivery what would people normally do? Where would you go for help? Who would decide where to go for help?</p> <p>If a woman needed to go to a hospital how would she get there? How much would it cost? Would you get any help from the village leaders/community if there was a problem (Prompt: help with costs, transport etc)</p>

Post-natal care / practice		
Q 25	<p>Can you describe any special care that is provided to the mother after the birth of the baby?</p> <p>Are there any foods she must eat, or that she is not allowed to eat, immediately after she has given birth?</p> <p>Are there any traditional or religious rituals or ceremonies that a woman needs to do after she has given birth?</p>	<p>Can you describe any special care that is provided to the mother after the birth of the baby?</p> <p>Who provides this care?</p> <p>How often?</p> <p>Are there any foods she must eat, or that she is not allowed to eat, immediately after she has given birth?</p> <p>Are there any traditional or religious rituals or ceremonies that a woman needs to do after she has given birth?</p> <p>In general, how soon after delivery do husbands and wives start having sexual relations again?</p>
Neo-natal care /practice		
Q 26	<p>Who takes care of the baby immediately after the birth?</p> <p>How is the baby looked after?</p> <p>(Prompts: washed/not washed, wrapped in clothes, put to the mothers breast, any traditional practice?)</p> <p>After the baby is born who cuts the umbilical cord?</p> <p>Is anything put on the baby's wound to help it heal? If so, what?</p> <p>Does the baby start to breast feed immediately after birth?</p> <p>If no</p> <p>Why not? When does the baby start to breast feed?</p> <p>When are additional liquids or foods first given to the baby?</p>	<p>Who takes care of the baby immediately after the birth?</p> <p>How is the baby looked after?</p> <p>(Prompts: washed/not washed, wrapped in clothes, put to the mothers breast, any traditional practice?)</p> <p>After the baby is born who cuts the umbilical cord?</p> <p>Is anything put on the baby's wound to help it heal? If so, what?</p> <p>What is done with the placenta after delivery?</p> <p>Does the baby start to breast feed immediately after birth?</p> <p>If no</p> <p>Why not? When does the baby start to breast feed?</p> <p>How long are girl babies breast fed for?</p> <p>How long are boy babies breast fed for?</p> <p>If there is a difference ask</p> <p>Why?</p> <p>When are additional liquids or foods first given to the baby?</p> <p>When is the baby given its first solid food/rice?</p>

Q 27	<p>Who looks after the baby if the mother has to go back to work?</p> <p>What are most common kinds of illnesses newborn babies in your village/ community get?</p> <p>If a baby gets sick where would you go to get treatment? (Prompt: hospital, traditional doctor, use own experience?)</p>	<p>Who looks after the baby if the mother has to go back to work?</p> <p>What are most common kinds of illnesses newborn babies in your village/ community get?</p> <p>Have you ever heard of babies getting sick and dying in your village/ community? What did they die from?</p> <p>If you had a baby that got sick what would you do?</p> <p>When would you decide to seek help from someone else?</p> <p>Where would you go to get help? (Prompt: hospital, traditional doctor, use own experience?)</p>
Child sex preference		
Q 28	<p>In your village/community do people usually prefer to have boy or girl children? Why?</p>	<p>In your village/community do people usually prefer to have boy or girl children? Why?</p> <p>Have you ever heard any stories about people choosing to have an abortion, or abandoning a baby, if the child is not the preferred sex? Can you describe what happened?</p> <p>Do practices like this even happen among the Dai /Dong/ Hui / Jingpo /Miao/ Tibetan people?</p>

Child health care / practice	
<p>Q 29</p>	<p>In most Dai /Dong/ Hui / Jingpo /Miao/Tibetan families who usually gets to eat most food? Then which person? Then which person.....etc. (Prompt: explore if male and female children have the same access to food)</p> <p>Have you heard about vaccinations that children can have to protect them from illnesses? What do you think about these vaccinations? Do children in your village/community get these vaccinations?</p> <p>Can you describe any illnesses that children in your village often get? If a child gets sick what would you normally do?</p> <p>Where is the nearest primary school? Which children get to go to school? (Prompt: girls, boys, both)</p> <p>In most Dai /Dong/ Hui / Jingpo /Miao/Tibetan families who usually gets to eat most food? Then which person? Then which person.....etc. If there is meat, fish, egg, tofu who gets to eat it? (Prompt: explore if male and female children have the same access to food)</p> <p>Have you heard about vaccinations that children can have to protect them from illnesses? What do you think about these vaccinations? Can you name any vaccinations children in your village have received? Where do children get vaccinated? How often? Do families have vaccination record books for their child/children? Can I see one?</p> <p>Where is the nearest water source for your village/community? What is the water used for? (Prompt: washing, drinking, animals...) Do you need to do anything to the water before drinking it? What?</p> <p>Can you describe any illnesses that children in your village regularly suffer from? Why do you think they get this/these sickness/es? If a child gets sick what would you normally do? Who would you get help from? Why would you go to that person?</p> <p>Where is the nearest primary school? Which children get to go to school? (Prompt: girls, boys, both)</p>
	<p>Maternal and Child Health services (Part II) Purpose: to 1) address the implementation of projects in medical services by local medical institutions, non-governmental organizations and international organizations (if there is);2)identify respectively the awareness and expectation of local people and service providers in terms of external intervention in order to work out the potential cultural approach to enhance the effectiveness of the MCH project implementation.</p>

Knowledge about MCH services		
Q 30	<p>Can you describe any health facilities or services that are available in your vicinity? Which services are available and where? How much do the different services cost?</p> <p>Which services people in your village/community regularly choose to go to MCH for?</p>	<p>Can you describe any health facilities or services that are available in your vicinity? Which services are available and where?</p> <p>Which services people in your village/community regularly choose to go to MCH for?</p> <p>How much do the different services cost? Where do the people in your village/community find the money to pay for these services?</p> <p>Can you tell me about the quality of the health care services and facilities? (Prompt: Are you normally satisfied with the services you receive? Do you get a choice of contraceptives? Are drugs available?)</p> <p>Tell me about the skills of the staff? (Prompt: do they offer good information and advice? Are you treated with respect? Are they friendly?)</p>
Q 31	<p>Can you tell me any government policy or regulation about marriage, childbirth and the MCH promotion? What is the legal age for marriage?</p>	<p>Can you tell me any government policy or regulation about marriage, childbirth and the MCH promotion? What is the legal age for marriage?</p>
Q 32	<p>Can you tell me any information you have received from staff of local hospitals or maternal and child health stations about maternal and child health care?</p>	<p>Can you tell me any information you have received from staff of local hospitals or maternal and child health stations about maternal and child health care?</p> <p>Is the information given by MCH service providers similar to Dai /Dong/ Hui / Jingpo /Miao/Tibetan traditional beliefs about maternal and infant health and care? In what ways is it different?</p> <p>How do you choose when to follow your traditional practices, and when to go to the MCH services?</p>

<p>Q 33</p>	<p>Can you suggest any ways in which MCH services could be changed or improved to better suit Dai /Dong/ Hui / Jingpo /Miao/Tibetan people? (Prompts: for examples, types of services available, availability of drugs; cost of services, drugs; knowledge or attitude of staff etc.)</p>	<p>Can you suggest any ways in which MCH services could be changed or improved to better suit Dai /Dong/ Hui / Jingpo /Miao/Tibetan people? (Prompts: for examples, types of services available; availability of drugs; cost of services, drugs; knowledge or attitude of staff etc.)</p>
<p>Q 34</p>	<p>Has there ever been a time when someone from your village/community has gone to the MCH services and not been satisfied with the treatment they received? Describe what happened. Why do think this happened?</p> <p>Can you suggest any ways in which things could be improved to make sure this does not happen again? (Prompt: address language barriers, staff attitudes, train different people, need more female/male doctors etc.)</p>	<p>Has there ever been a time when someone from your village/community has gone to the MCH services and not been satisfied with the treatment they received? Describe what happened. Why do think this happened?</p> <p>Has there ever been a time when someone from your village/community has gone to the MCH services and felt they had not been treated fairly? Describe what happened. Why do you think this happened?</p> <p>Can you suggest any ways in which things could be improved to make sure this does not happen again? (Prompt: address language barriers, staff attitudes, train different people, need more female/male doctors etc.)</p>
<p>Q 35</p>	<p>If you have any comments or suggestions to make about the MCH service providers or other public health projects, who would you speak to? Can you describe any times when someone from your village/community has tried to do this? What happened? What changes came about as a result of raising this problem?</p>	<p>If you have any comments or suggestions to make about the MCH service providers or other public health projects, who would you speak to?</p> <p>Can you describe any times when someone from your village/community has tried to do this? What happened? What changes came about as a result of raising this problem?</p> <p>Can you suggest any ways that MCH officials could make communication better between Dai /Dong/ Hui / Jingpo /Miao/Tibetan people and health officials?</p>

<p>Q 36</p>	<p>Can you describe a time when Dai /Dong/ Hui / Jingpo /Miao/Tibetan people from your village/community were consulted about public health matters?</p> <p>How did this consultation take place? (Prompt: village level meetings; representatives from the village meeting regularly with health authorities; surveys conducted by the authorities about people's needs/priorities; citizen's feedback mechanism?)</p> <p>If community consultations take place Can you tell me which level of government or organization staff have discussed health matters with people from your village/community? (Prompt: Township, County, prefecture, province, national departments; media, NGOs, volunteers etc)</p>	<p>Can you describe a time when Dai /Dong/ Hui / Jingpo /Miao/Tibetan people from your village/community were consulted about public health matters?</p> <p>How did this consultation take place? (Prompt: village level meetings; representatives from the village meeting regularly with health authorities; surveys conducted by the authorities about people's needs/priorities; citizen's feedback mechanism?)</p> <p>If community consultations take place Can you tell me which level of government or organization staff have discussed health matters with people from your village/community? (Prompt: Township, County, prefecture, province, national departments; media, NGOs, volunteers etc)</p> <p>Can you tell me how this consultation improved (or did not improve) the knowledge or health situation for people from your village/community? How could the consultation process be improved?</p>
<p>Service provider attitudes</p>		
<p>Q 37</p>	<p>What do most Dai /Dong/ Hui / Jingpo /Miao/Tibetan people in your village/community think about the MCH services and staff that are available locally? (Prompts: are they satisfied/dis-satisfied? Do they use the services? If not, why not?)</p> <p>How would people from your village/community like things to be different?</p>	<p>What do most Dai /Dong/ Hui / Jingpo /Miao/Tibetan people in your village/community think about the MCH services and staff that are available locally? (Prompts: are they satisfied/dis-satisfied? Do they use the services? If not, why not?)</p> <p>How would people from your village/community like things to be different?</p> <p>Can you make any suggestions about how MCH services or staff-patient relations could be improved?</p>

<p>Q 38</p>	<p>Can you describe any ways in which local culture/traditions seems to conflict with the practices recommended by the MCH officials?</p> <p>Can you describe any times when health service providers or local officials have consulted with community leaders/religious leaders/traditional practitioners about how to improve maternal and child health?</p>	<p>Can you describe any ways in which local culture/traditions seems to conflict with the practices recommended by the MCH officials?</p> <p>Can you describe any times when health service providers or local officials have consulted with community leaders/religious leaders/traditional practitioners about how to improve maternal and child health?</p> <p>Do you have any suggestions about how MCH officials could work with community leaders/religious leaders/traditional practitioners to improve maternal and child health?</p>
<p>Officials/health staff</p>		
<p>Q 39</p>	<p>Can you tell me whether you know any ethnic people from the local community who work for MCH services? What kind of jobs do they have?</p> <p>Can you think of any advantages of having more ethnic people working as service providers? Can you think of any disadvantages?</p>	<p>Can you tell me whether you know any ethnic people from the local community who work for MCH services? What kind of jobs do they have?</p> <p>Can you think of any advantages of having more ethnic people working as service providers? Can you think of any disadvantages?</p> <p>What do you think are the practicalities that would need to be considered if more ethnic staff were to be recruited to work with MCH?</p>
<p>Q 40</p>	<p>Can you describe what changes have taken place in terms of the MCH since the New Rural Cooperative Medical System was implemented?</p>	<p>Can you describe what changes have taken place in terms of the MCH since the New Rural Cooperative Medical System was implemented?</p>
<p>Q 41</p>	<p>Can you describe any ways in which local medical institutions have received help in relation to maternal and child health from national and international institutions/organizations? Who provided the help? Can you describe the results?</p>	<p>Can you describe any ways in which local medical institutions have received help in relation to maternal and child health from national and international institutions/organizations? Who provided the help? Can you describe the results? What, if anything, have you heard about the forthcoming maternal and child health project of the United Nations? Do you have any suggestions to make on how this project could be designed to help improve the maternal and child health of local people?</p>



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.

For more information, please refer to our website:

<http://www.un.org.cn/cms/p/jointprogrammes/84/1047/content.html>.