REPRODUCTIVE HEALTH matters

Reducing high maternal mortality rates in western China: a novel approach

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Abstract: *Among the Millennium Development Goals, maternal mortality reduction has proven especially difficult to achieve. Unlike many countries, China is on track to meeting these goals on a national level, through a programme of institutionalizing deliveries. Nonetheless, in rural, disadvantaged, and ethnically diverse areas of western China, maternal mortality rates remain high. To reduce maternal mortality in western China, we developed and implemented a three-level approach as part of a collaboration between a regional university, a non-profit organization, and local health authorities. Through formative research, we identified seven barriers to hospital delivery in a rural Tibetan county of Qinghai Province: (1) difficulty in travel to hospitals; (2) hospitals lack accommodation for accompanying families; (3) the cost of hospital delivery; (4) language and cultural barriers; (5) little confidence in western medicine; (6) discrepancy in views of childbirth; and (7) few trained community birth attendants. We implemented a three-level intervention: (a) an innovative Tibetan birth centre, (b) a community midwife programme, and (c) peer education of women. The programme appears to be reaching a broad cross-section of rural women. Multilevel, locally-tailored approaches may be essential to reduce maternal mortality in rural areas of western China and other countries with substantial regional, socioeconomic, and ethnic diversity.* © 2014 Reproductive Health Matters

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Among the Millennium Development Goals (MDGs), progress on achieving MDG 5, which seeks to reduce the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015, and to improve access to reproductive health, has been especially difficult. Although better access to contraception and declining fertility rates in many countries have lowered the lifetime risks of maternal mortality,[1] observers predict that few countries will achieve the MDG 5 target by 2015.

The reasons for the slow progress on MDG 5 are varied. One reason is that the MMR has *increased* in eastern and southern Africa due to HIV/AIDS.[2] A second reason is the complexity of providing universal antenatal and delivery care. Low-income women, those from marginalized groups, and women in remote rural areas often lack high quality, accessible delivery care when they need it.[3–5] Deliveries occur on their own schedule and complications can be hard to predict. The low status of women in many parts of the world also increases the chance of potentially risky pregnancies (e.g. pregnancy at very young ages or at high parity), inadequate nutrition before and during pregnancy, and poor or non-existent antenatal and delivery care.[6–8]

In contrast to many countries, China has made considerable progress in reducing maternal mortality

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and the nation as a whole is on target to meet MDG 5 by 2015.[1] Remarkably, the nationwide MMR declined an average of 5.7% per year between 1990 and 2011, a pace which is three times higher than the average decline for developing countries in this period (p.1153).[1] China's strategy has focused on "institutionalization" of childbirth, i.e. ensuring that *all* deliveries occur in hospitals. To this end, China has implemented media campaigns, improvements in maternal-child health infrastructure, oversight, staff training, and referral networks at township and lower-level hospitals.[9,10] Subsidies to pregnant women and hospitals for institutional deliveries have been available in many areas.[9,11,12] Other strategies, such as community midwife programmes, have been discouraged in order to concentrate resources on hospital deliveries.[9] Institutionalization of delivery and subsidies for hospital delivery have been employed in other countries, such as India,[13] but with more limited success in reducing maternal mortality.

By 2008 in most regions of China, institutional delivery was virtually universal.[11] However, despite this overall success, poor rural areas, particularly in western China, continue to have lower rates of hospital deliveries and higher MMRs.[9–11,14–17] Although maternal mortality has declined in all regions, it remained significantly higher in 2010 in the western region than in other areas: 46.1 per 100,000 live births, compared with 29.1 for the central region and 17.8 for the east.[18] Post-partum haemorrhage remains the most common cause of death,[18] suggesting that women with emergencies do not receive medical help in time. Less frequent use of hospitals (and higher maternal mortality) in remote western counties may be due to poor infrastructure, scarce human resources, long travel distances to reach hospitals, lack of access to caesarean section and blood transfusions in some local hospitals, and reluctance of women, particularly from ethnic minorities, to deliver in hospitals because of discomfort with the delivery practices used.[11]

Thus, although institutionalization of deliveries has accomplished a great deal in most of China, it is unlikely to lower maternal mortality in poor, under-resourced rural western regions to levels found elsewhere in China in the next several years. The persistence of higher maternal mortality ratios in western China suggests that a single universal approach may not be sufficient in all areas of a country as diverse as China. In this paper, we argue for an alternative approach for western China – a multi-level maternal health programme – and describe its implementation in Rebkong (Chinese: Tongren) County, a predominantly Tibetan area in Qinghai Province, China. The programme was designed and implemented by Tso-ngon (Chinese: Qinghai) University Tibetan Medical College (TUTMC) in collaboration with the international non-profit organization Tibetan Healing Fund (THF), and local health authorities. The approach overcomes a number of barriers to high quality local delivery care in rural areas of western China. We also believe that it can serve as a model for poor, rural, hard-to-reach and ethnic minority areas elsewhere in the region, e.g. other rural areas of western China, Nepal, northern India, southeast Asia and Bangladesh – as well as middle- and low-income countries in other regions.[5,13,19,20]

In this paper, we first describe the rural area where we have been working and outline the results of formative research we carried out there. Then we outline our approach to reducing maternal deaths there, briefly summarize results from an evaluation, and conclude by considering our approach in a larger context.

Qinghai Province and Rebkong (Tongren) County

Qinghai Province is in western China on the Tibetan Plateau and is part of the traditional Tibetan region of Amdo. It is one of the poorest provinces in China with a per capita GDP in 2003 of US$1814 for urban areas and US$483 for rural areas.[21] In 2000, Qinghai's MMR of 139 was exceeded in China only by MMRs in neighbouring Xinjiang (161) and the Tibetan Autonomous Region (467).[14] The MMR declined to 104 in Qinghai by 2005, but it remained considerably higher, especially in rural areas, than the rate of 20 per 100,000 in Shanghai, Beijing, and Jiangsu, and Zhejiang provinces.[15]

The population of Qinghai province is ethnically diverse: in 2010, 53% were Han, 24% Tibetan, 15% Hui, and 8% other groups.[22] The majority of rural residents in 2000 in the province were Tibetans and other non-Han ethnic groups, with Tibetans being the largest group.[23] Cities and towns, where hospitals and health care are more common, were predominantly inhabited by Han residents.[23] The rural Tibetan population make their living either as farmers or as nomadic herders. The nomadic population, in particular, has to travel long distances over dirt paths and mountainous

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