Reproductive Health
of Ethnic Minority Groups
in the Greater Mekong Sub-region

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Acronyms

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
ATS	Amphetamine-type stimulants
AusAID	Australian Agency for International Development
CST	Country Technical Services Team
DFID	Department for International Development, United Kingdom
GMS	The Greater Mekong Sub-Region
HIV	Human immunodeficiency virus
IEC	Information education and communications
ILO	International Labour Organization
IMF	International Monetary Fund
IUD	Intra-uterine device
MDGs	Millennium Development Goals
MMR	Maternal mortality ratio
NGO	Non-governmental organization
NPDP	National Population and Development Policy
PRSPs	Poverty Reduction Strategy Papers
SAVY	The Survey Assessment of Vietnamese Youth
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TBAs	Traditional birth attendants
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural
UNODC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VHWs	Village health workers
WHO	World Health Organization

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Acknowledgements

Executive summary

The Greater Mekong Sub-Region (GMS) encompasses the watershed of the Mekong River and is comprised of Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam, and the Yunnan Province of China. The Mekong River has historically provided a common link to the culturally, ethnically and linguistically diverse people of the sub-region. The total population of the GMS is just over 264 million. Approximately 200 ethnic minority groups live in the GMS comprising about 75 million people. Ethnic minority groups are typically concentrated in remote and mountainous areas and are usually still dependent on subsistence agriculture.[1] The distribution of each ethnic group extends over national boundaries, with many culturally similar groups represented in several adjacent countries in the region. Many ethnic minority groups have significant cross border migration.

The GMS is one of the fastest growing economic sub-regions in the world and is expected to emerge as an important economic hub in Asia. The rapid economic development process has greatly contributed to infrastructure, energy, telecommunication development, cross-border trade and investment. It has also resulted in increased labour mobility in the GMS. Despite these developments, much of the Mekong's population remains poor and has not benefited from the economic activity resulting from regional integration.[2] A Participatory Poverty Assessment—supported by UNDP and AusAID— indicates that poverty rates among ethnic minority groups in the Mekong Delta decreased by 10 percent between 1998 and 2002 while poverty decreased by 40 percent among the Kinh/Chinese majority during the same period.[3]

Available data on reproductive health and other health indicators of ethnic minority groups in the GMS is limited. Notwithstanding these limitations, a number of sources reviewed confirm that ethnic minority groups in the GMS have poor reproductive health and other health indicators. The primary reasons for poor health are lack of access to education, health and social services combined with limited political and social empowerment to affect changes. Women and girls are particularly marginalized because of low social status, lack of decision-making power and household responsibilities.

Many ethnic minorities face political, policy, strategy and budget allocation barriers including:
- Lack of political representation and participation in decision-making processes at all levels—national, provincial and local.
- Lack of visibility in key policy frameworks, such as Poverty Reduction Strategy Papers (PRSPs).

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[1] ADB 2005.
[2] ADB 2007a.
[3] UNDP/AusAID 2005.

- Lack of citizenship status and legal protection.
- Policies adversely affect land tenure and livelihoods.
- Lack of coordinated multi-sectoral responses in regions with high proportions of individuals from ethnic minorities.
- Budgetary constraints and inability to implement existing favourable policies.

Specific barriers to access and use health services include:
- Physical/geographical constraints and isolation.
- Cost of services and high poverty levels.
- Poor quality and relevance of services provided.
- Lack of knowledge and understanding about the population to be served.
- Language barriers and lack of information and understanding about available services.
- Lack of attention to gender dimensions of health issues.

Recommended actions to strengthen overall policies and strategies within GMS countries to overcome these barriers include:

1. Increase representation of ethnic minority groups in all policy development and planning processes in government and civil society organizations at national, provincial and local levels.
2. Ensure that key policies and strategies—such as PRSPs, MDG roadmaps and national strategies for reproductive health—are reviewed so that the frameworks include references to ethnic minorities and their specific development needs.
3. Ensure that national frameworks promote rights-based approaches, including policies supporting provision of information and social services in minority languages.
4. Ensure that national frameworks respond to priority concerns of ethnic minorities such as lack of health infrastructure and transport, particularly as related to reproductive health.
5. Ensure that national frameworks promote institutional support for the development of appropriate and adequate capacities to implement reproductive health initiatives with ethnic minority populations.
6. Strengthen participatory research and data collection, both qualitative and quantitatively disaggregated by ethnicity, to inform the development of policies and strategies and design coordinated responses.
7. Recruit and integrate health workers and teachers from ethnic minority groups into development initiatives.
8. Review regulations that currently prevent many ethnic minority people from being legally registered. GMS countries should particularly remove obstacles for ethnic minority groups to access full citizenship rights and entitlements.
9. Review definitions and categorization of ethnic minorities and or indigenous people. Definitions need to aim at the elimination of stigmatization, discrimination and exclusion that these groups currently experience in accessing essential health, education and other social

10. Increase cross border sharing of best practices to address policy and programme recommendations so that ethnic minority groups living in political border areas in the GMS can benefit from a regionally effective approach.

Recommendations to specifically improve sexual and reproductive health programme priority areas and interventions include:

1. Strengthen sexual and reproductive health services through increasing rights-based and culturally appropriate approaches.
2. Ensure community participation and inclusion.
3. Integrate reproductive health and family planning in primary health care and other interventions so that they are relevant to the cultural understanding of the health and well-being of ethnic minority groups.
4. Expand strategic communication programming among ethnic minority groups, utilizing local languages.
5. Strengthen prevention of maternal morbidity and mortality through increased access to skilled birth attendants close to the community and by strengthening primary health care at district and sub-district levels.
6. Address key programming gaps in the provision of reproductive health services for ethnic minorities. Develop emergency obstetric care and male involvement in programmes.
7. Address HIV and STI issues not in isolation but linked with other development strategies.

1. Introduction

The Greater Mekong Sub-Region (GMS) is one of the fastest growing economic sub-regions in the world and is expected to emerge as an important economic hub in Asia. The rapid economic development process has greatly contributed to infrastructure, energy, telecommunication development, cross-border trade and investment. It has also resulted in increased labour mobility in the GMS. Despite these developments, much of the Mekong's population remains poor and has not benefited from the economic activity brought about by regional integration.[4] A Participatory Poverty Assessment—supported by UNDP and AusAID—indicates that poverty rates among ethnic minority groups in the Mekong Delta decreased by 10 per cent between 1998 and 2002 while poverty decreased by 40 per cent among the Kinh/Chinese majority during the same period.[5]

The objective of the current report was to improve understanding of the principal factors that contribute to the reproductive health challenges facing ethnic minority groups across the (GMS) and identify ways to improve policies and programme actions. A regional analysis was preferred because, although the ethnic minority groups in the GMS are diverse, they face common socio-economic challenges. A country-specific approach to specific ethnic minorities would be limited since minority populations often spread across political borders. Ethnic minority groups that are

represented across border areas commonly lack access to services and political representation. A broader cross border or regional analysis and approach can achieve greater understanding of the issues and improve efforts to reach ethnic groups on different sides of political borders.

The methodology utilized consisted primarily of a literature review of available reports on reproductive health and reproductive health programmes among ethnic minorities in the GMS. Information was also collected during field visits to complement the literature review of relevant reports. A consultant made field visits to reproductive health projects in Lao PDR, Thailand, Cambodia, Viet Nam, and the Yunnan Province of China.

Subjects covered in the literature review included national policies and frameworks affecting ethnic minority populations and reproductive health status statistics. The study also reviewed some programming examples that address specific challenges facing ethnic minorities.

The UN and development agencies define the GMS as comprised of the countries of Lao PDR, Viet Nam, Cambodia, Thailand and the Yunnan Province of China. A range of terms is used in the literature to

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[4] ADB 2007a.
[5] UNDP/AusAID 2005.

refer to ethnic minorities in GMS countries including "ethnic groups", "tribal groups","upland populations", and "hill tribes". Most governments in the GMS use the term "ethnic groups".

The strict definition of the term "indigenous populations", "indigenous people", or "indigenous groups" does not often fit many of the ethnic minority groups of the GMS. Many ethnic minority groups have migrated across borders and do not fit strict definitions of indigenous people. Most of the reproductive health challenges and proposed policy recommendations apply to any minority population in the region.

1.1 Research and Data Gaps

Despite the reality of ethnic minority vulnerability, very little research has been conducted to analyze vulnerabilities created by the rapid economic development in the GMS that can be used to inform possible responses.

The scarcity of data, both qualitative and quantitative, on the reproductive health of ethnic minority groups formed a major challenge to the drawing of conclusions. Most resources rely on a combination of anecdotal and other types of qualitative information because of a persistent lack of data disaggregated by ethnicity.

Conclusions tend to be drawn from localized research and situations. The sample size of individuals included in most studies and evaluations is too small to draw statistically valid conclusions but are, nevertheless, used to formulate

findings about ethnic minority groups in general. An even greater concern is the paucity of research and data specifically on the sexual and reproductive health issues of ethnic minorities. These problems cause serious limitations for the interpretation of available data on ethnic minorities in the GMS.

The general lack of data related to ethnic groups and reproductive health is the result of a combination of factors. Research on ethnic minorities is difficult. Many obstacles should be overcome to ensure that research is valid and reliable. The non-existence of a standard definition of ethnic groups and the sensitivities related to citizenship and political status are just two of the obstacles. The lack of citizenship of ethnic minority groups can lead to the reluctance of respondents to participate in studies. Potential respondents fear that they may be identified and deported. Some other impediments to good research include language barriers and the remoteness of study area locations. Despite these data limitations, it is still quite evident that ethnic minorities are among the most vulnerable population groups across the GMS.

2. Socio-political situation of ethnic minority groups

2.1 Demographic and geographic overview

The Greater Mekong Sub-Region encompasses the watershed of the Mekong River and includes Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam, and the Yunnan Province of China. The GMS is culturally very diverse. The history of the migration of the many ethnic groups to the region is complex. The GMS includes about 200 ethnic minority groups comprising approximately 75 million people.

The distribution of ethnic groups does not fall neatly within national boundaries. Many socio-culturally similar groups are represented in adjacent countries. The languages spoken in the region belong to several ethno-linguistic groups: Sino Tibetan, Austro-Asiatic (including Mon Khmer), Tai and Hmong. Ethnic minority groups—typically concentrated in remote mountainous areas—frequently still depend on subsistence agriculture.[6]

The five countries and one province of the GMS extend over a land area of 2.34 million square kilometres. The total population of the GMS in 2004 was just over 264 million people, most of who live in rural areas. The Mekong River has historically provided a means to link the culturally, ethnically and linguistically diverse people of the sub-region. The GMS shares a rich and diverse natural resource base that has supported economic development and sustained rural livelihoods in the sub-region. Forests cover approximately one-third of the GMS, an additional 40 per cent of the surface area consists of rich agricultural cropland. The GMS has significant mineral deposits (especially coal and petroleum reserves) and a high potential for hydropower development.

2.2 Rapid economic development and social issues

The GMS is economically one of the fastest growing sub-regions in the world. The region is expected to emerge as an important economic hub in Asia. The real Gross Domestic Product (GDP) in the GMS grew by almost eight per cent in 2005.[7] The economic rise of India and China enhances strategic geo-political comparative advantages by creating synergies between the GMS and these two growing economic powers.

Regional development plans in the GMS revolve around the implementation of extensive infrastructure networks that integrate all of the GMS countries into a dynamic growth area. A network of trans-national roads and railroads linking transport systems, power grids and markets is expected to facilitate participation of

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[6] ADB 2005.
[7] AusAID 2007a.

GMS countries in the regional and global economy. Three economic corridors—North-South, East-West, and South—as well as number of alternative routes linking major cities and ports across the sub-
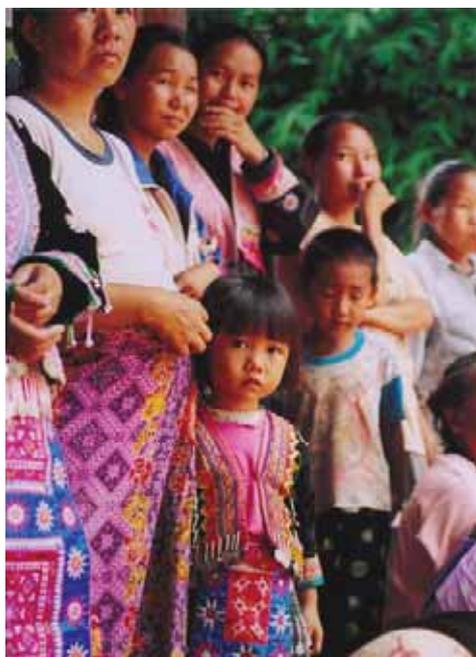
Credit: © 2004 Joshua O. Stream, Courtesy of Photo-share
 A young Hmong girl in Thailand during a festival in her mountaintop village.

region are currently under construction.

The new infrastructure corridors are intended to function as channels for economic activity. The corridors will contribute to reductions in transportation costs while stimulating cross-border trade and investment among GMS countries. The corridors are expected to provide improved access to the larger markets of China, India and other South-East Asian countries while enhancing competitiveness as

an economic bloc.

The Asian Development Bank and other funding agencies have contributed significantly to infrastructure, energy, telecommunication development, enhanced cross-border trade, investment, and greater labour mobility in the GMS since the early 1990's. Despite all of these development efforts, however, much of the Mekong's population remains poor and has not benefited from increased regional economic activity.[8]

An ADB supported study indicated that there are significant social costs to regional economic integration despite important benefits such as enhanced cross-border commerce and increased access to education.[9] Social costs include heightened risk of HIV transmission, human trafficking and drug smuggling. The ADB supported study also states that cross-border labour is the most significant form of economic interaction for the border poor and at the same time, it is the most problematic.[10] The illegal status of poor cross-border workers is a major impediment to fair socio-economic development in the area. The Mekong Institute reports that many regional infrastructure projects have had an impact on marginalized groups, particularly local communities and ethnic minorities.[11] Many people who were displaced for highway construction and road expansion did not receive fair compensation.

[8] ADB 2007a.
[9] ADB 2007b.
[10] Ibid.
[11] Mekong Institute 2006.

2.3 Increased cross-border migration

Increased cross-border migration influences the social vulnerability of ethnic minority groups. The development of transport infrastructure in previously remote areas has created opportunities for migration both within and across national borders. Opportunities are, however, not accompanied by fundamental investments to develop skilled labour, technical upgrading and adaptation to changing global market standards.

Millions of people in the GMS have now become mobile in areas where people previously lived in relative isolation (see Figure 1). Mobility has caused many people, particularly those from ethnic minority groups, to face the challenge of adapting their livelihoods to achieve security for themselves and their families. These changes have taken place at a dramatic pace over the last fifteen years. Estimates of the numbers of migrants for 2005 range from 1.8 to 4 million. Ethnic minority groups living in mountainous border areas in the GMS have been the most challenged by increased migration outflows and returnees.[12]

Migration and mobility are important factors influencing the reproductive health and other aspects of the lives of many people from ethnic minorities in the GMS. Three main patterns of mobility characterize the GMS, internally within countries, across borders in the sub-region and with countries outside the sub-region. These often inter-linked types of movement are difficult to differentiate since they frequently overlap and involve many of the same people.

Figure: 1
Migration patterns in the Greater Mekong Sub-region[13]

The boundaries and names shown and the designations used on this map do not imply official endorsement of acceptance by the United Nations.

Migration in the GMS is often described as consisting of "one-step, two-step" dynamics. Previous personal experiences of internal and temporary migration influence decisions to migrate across borders or further abroad and for longer periods of time. Many of those who move across borders also move frequently within their destination country. Those who migrate abroad often do not go back to their communities of origin when they return to their country.[14]

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[12] Caouette et al. 2006.
[13] Figure adapted from Caouette et al. 2006 . Figure 6 Page 19 . Previously published in Asia Migrant Center (AMC) and Mekong Migration Network (MMN), 2005, Migration in the Greater Mekong Sub-region; A Resource Book, Hong Kong:AMC
[14] Caouette et al. 2006

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The increased cross-border flows that have resulted from the creation of the unique economic growth area in the GMS have also had some unforeseen effects on the region's shadow economy. The region's shadow economy is diversified into a multitude of activities. These range from the smuggling of artefacts, guns, narcotics and wild animals to gambling, money laundering and human trafficking for the manufacturing and sex industries.[15]

Narcotics trafficking and the use of narcotics are areas of particular concern within the shadow economy. Drug consumption in the region is not a new phenomenon. Opium cultivation became widespread among ethnic minorities in the mountainous border areas of the GMS after its introduction in the 19th century. Opium production became especially common in the so-called Golden Triangle at the juncture of Thailand, Myanmar and Lao PDR. Opium production flourished to the point of acquiring global relevance under the influence of colonial trade interests. In recent years, the circulation of opiates in the GMS has declined considerably as reported by the United Nations Office on Drugs and Crime (UNODC) in its 2007 World Drug Report. The GMS remains a frontrunner in the global narcotics trade, however.

The geographic location of the GMS in between the two industrial giants of China and India is being exploited for the production of drugs. Commonly produced drugs include heroin and amphetamine-type stimulants (ATS). ATS refers to amphetamines and Ecstasy, especially in the form of tablets ('yaba' in Thai) and "ice" methamphetamine (crystal metham-phetamine). Methampheta-mine tablets and, increasingly, also crystals are popular in Thailand. The use of ATS is rising steadily in the other GMS countries, with a dramatic upsurge among youth in urban and peri-urban areas.

2.4 Ethnicity and vulnerability

The governments of the GMS have become more aware of the need to address social and human development challenges if economic development is to be sustained and poverty significantly reduced. The Government of Lao PDR has, for example, accorded the highest priority to human resource development in their Sixth National Socioeconomic Develop-ment Plan. The plan stresses the need to strengthen positive linkages between economic growth and social development. Similarly, the overriding goal of Viet Nam's latest Socioeconomic Development Plan is to reduce poverty incidence as measured against the national poverty line from 28.9 per cent in 2002 to 15–16 per cent by 2010. The poverty reduction strategies of Mekong

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[15] Sciortino 2007.

countries promote pro-poor growth (with major emphasis on transport and agriculture), social development (particularly focusing on health and on indigenous people), and natural resources development as major sector areas for poverty reduction.[16]

The situation of ethnic minorities is still of great concern despite these types of encouraging pro-poor policy frameworks. Minority ethnicity appears increasingly associated with heightened vulnerability in the face of economic change. A Participatory Poverty Assessment supported by UNDP and AusAid indicates that general poverty rates among ethnic minority groups in the Mekong Delta decreased by 10 per cent between 1998 and 2002 compared to a decrease of 40 per cent among the Kinh/Chinese majority during the same period.[17] Ethnic minorities in the Mekong are the most acutely affected by changes in the natural resource base; their inability to compete in new types of agriculture and new commerce; and by rapid cultural change.[18]

Complex dimensions of vulnerability perpetuate disparities and inequalities among many ethnic minorities including:
- Poverty
- Lack of citizenship status
- Lack of access to education
- Lack of culturally appropriate information in minority languages
- Cultural and social breakdown within some communities
- Forced relocation
- Forced changes in land use

practices impacting access to natural resources
- Non-traditional drug use
- Low literacy rates
- Vulnerability to human trafficking for exploitation

Ethnic minorities in the GMS have achieved limited political and social empowerment. As a result, they have a limited ability to influence policies, programmes, and project interventions designed to meet their needs. Ethnic minorities across the GMS generally have little influence on the allocation of resources for social services. The lack of political and social empowerment also significantly increases their vulnerability to environmental destruction. Deforestation, erosion, decline in water quality, lost biodiversity, and changing agricultural practices have changed the cultures and economic opportunity of many ethnic minority villages. These issues pose policy and programme challenges for managing natural resources and human settlements, promoting good health, and valuing the culture and practices of ethnic minority populations.[19]

Many of the ethnic minorities do not use the national language and speak a vast number of distinct languages, usually unwritten.[20] Children from minorities that do not speak the national language are at a disadvantage in education

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[16] ADB 2006.
[17] UNDP/AusAID 2005.
[18] OXFAM 2007.
[19] ADB 2001.
[20] UNESCO 2006.

systems that use the majority language. Adjustments to assist ethnic minority language students to transition into the majority language education system are rarely made.

The literacy levels of ethnic minorities in Thailand, Lao PDR, Cambodia and Viet Nam are significant lower than the national average. Research in Viet Nam and Lao PDR indicates that schoolchildren from ethnic minorities have difficulty entering the early primary grades due to language constraints. Many drop out before the third grade as a result of frustration and lack of success in learning. The time invested in attending school is simply not seen as sufficiently worthwhile.

A large proportion of ethnic minority communities in the GMS primarily function in a language other than the national language. Children from such communities have difficulty succeeding in schools that use programmes using a language that is different from their mother tongue. Adults are also constrained by the need to use the "foreign" language in everyday life to communicate with outsiders. People from ethnic minorities in Cambodia have, for example, difficulty operating in local markets using the Khmer language. [21]

2.5 The feminization of poverty

Ethnic minority groups in the GMS generally have lower levels of reproductive health and health indicators. Women and girls are

Credit: © 2005 Bui Khac Vu, Courtesy of Photoshare
Children of the H'Mong Dao ethnic minority group attend class in an education center in Ho Thau, Tam Duong District, Lai Chau Province, Viet Nam.

particularly marginalized because of their numerous household responsibilities, low social status and lack of decision-making power.

A significant lack of data disaggregated by ethnicity and gender exists. Official data fails to capture the extent of poverty among these groups. IMF and the World Bank representatives observed a review of Viet Nam's progress report to implement its PRSP, "The report presents data on poverty in ethnic minority areas that suggests very rapid rates of poverty reduction over the past two years. These data, which in fact are not clearly disaggregated by ethnicity, may

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[21] ADB 2001.

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Child School Dropouts

My name is Mong Pong, I am Tampoeun. I live in Chhree Village, Yeak Loam Commune, Banlong District in Ratanakiri Province. I have been married with a woman from the same ethnic group as I since 1981. I have eight children, three are daughters and five are sons. I used to help as a school volunteer helper in my village and later I was elected to work as a commune council member.

In my community, there was a family with six children of which three are sons and three are daughters. None of these children attended school. The father was really old and did not allow any of his children to go to school. He said, *study eats rice, and not study also eats rice.* The wife does not have much idea about this so she just followed her husband.

The family is really poor; the parents are illiterate and cannot read and write. They never received any education or training. They only did farming every year and could not earn much. They could not afford to buy pens, books or clothes for their children. One day during the new school year registration I asked one of the older sons in the family why he did not go to school. The son answered, *"I really wanted to go to study, but my parents did not allow me."*

After some time the teacher in my village wanted me to give some support because there were quite a lot of students who were registered but only a few actually came to school. The teacher wanted me to go to the families who stop their children from going to school and educate them so that they will send their children back. I went to each family that the teacher indicated. Later I went to the child I had talked to before and met with his mother. The mother said that she also wanted her children to study but she was very poor but the most important reason was that her husband did not allow it. So I could not do anything else to get all the children into school.

I wish the government or others organizations would disseminate information widely to my community so the people know and understand about the importance of education. The government should do something to help the poor families who cannot afford to send their children to school them.

Interview/photograph by Nuon Sopheak, HU Advocacy Officer
Source: Health Unlimited 2007.

lead to the conclusion that past policies towards ethnic minorities have been more successful than is true in reality and may not motivate the most effective strategies in the future."[22]

Two-thirds of the poor in rural areas and in urban settings are women. Increasing numbers of women migrate internally and abroad because of their high poverty levels. This has resulted in the feminization of the workforce in emerging industries.[23] Women migrants tend, however, to have fewer technical skills and are most commonly engaged in low level and poorly paid work.

Only a few poverty assessment studies among ethnic minorities have been conducted in the GMS. In LAO PDR, the Participatory Poverty Assessment of 2002 found that ethnic minority women and girls represented more than 50 per cent of the total female population and were the most disadvantaged segment of Lao society. Women and girls also constituted approximately 70 per cent of the illiterate population of Lao PDR and have very limited access to public services. [24]

Gender disparities contribute to intersecting problems of poverty and social exclusion. These problems are particularly relevant within the rapidly changing economic environment in which traditional livelihoods are increasingly under pressure to adapt to the market economy. In Lao PDR, for example, factors such as low literacy levels, lack of numeracy, and inability to speak the

Lao language limit decision-making power. Women from ethnic groups are also reluctant to participate in non-agricultural economic activities such as selling goods at markets.[25]

The multidimensional interplay of ethnicity and gender with poverty was also highlighted in an Asia Development Bank study on ethnic minorities and poverty reduction in Viet Nam (2002). The study results indicate that, "Most of the households identified by the communities as the poorest are either headed by a woman or by persons with a disability or poor health. Lack of working capacity due to disability or poor health is always cited as the first sign of poverty."[26]

This reality appears to be echoed by the findings of Viet Nam's Household Living Standards Survey of 2004. The Survey indicated that approximately 60 per cent of ethnic minorities live below the poverty line the survey also indicates that at least one-quarter of ethnic minority women are illiterate.[27] One-fifth of ethnic minority young women reported that they had never attended school. Poverty and social exclusion contribute to high infant and child mortality rates in the

[22] IMF 2006.
[23] Caouette et al. 2006.
[24] World Bank 2002.
[25] Ibid.
[26] ADB 2002. p. 34
[27] Vietnam General Statistics Office 2004.

Northern Mountainous region that are twice the rates found in the Red River Delta region.[28]

2.6 Country overviews of ethnic minority groups and policies

Viet Nam[29]

The main ethnic group in Viet Nam is the Kinh who constitute approximately 87 per cent of the total population. Ethnic minorities constitute approximately 13 per cent of the population and are concentrated in 13 provinces in the Northern and Central Highlands.

Ethnic minorities are disproportionately at risk of poverty, they represent 14 per cent of the population but account for 29 per cent of poor people. The regions in which they live have the slowest economic growth. The proportion of ethnic minorities among Viet Nam's poor is likely to rise to over one third by 2010.

A number of social policies and political programmes address the situation of ethnic groups. The Communist Party of Viet Nam has guidelines to support ethnic minorities based on the concepts of equality, unity and mutual help. The Constitution acknowledges the position, rights and obligations of ethnic groups living in Viet Nam, including rights related to language and writing systems.

The National Committee for Ethnic Minorities has a status equal to that of a government ministry. The Department of Policy in the National Committee drafts government policy on ethnic groups and supports other Ministries to ensure ethnic minority group issues are included in their policies. The Department of Policy also provides advice on ways to address issues facing ethnic minorities. The Committee is, further, mandated to implement and manage policies on ethnic minority groups. The Committee is responsible for advising government structures on the situation of ethnic minority groups, ensures strategic collaboration between different sectors (such as education, health, finance), and initiates development projects. The Committee structure is represented in levels from the national to the district level. The Comprehensive Poverty Reduction and Growth Strategy for 2001 – 2010 sets 11 goals, 6 of which deal with gender and ethnic minorities.

Yunnan Province, China [30]

Groups of over 4,000 people constitute an ethnic group according to Chinese law. China has 56 ethnic groups, of which 25 are found in Yunnan Province. Sixteen ethnic groups are specific to Yunnan, including the Dai, Wa, Lisu, Achang, and the Raj. Minority ethnic groups constitute one third of the population of Yunnan. Approximately 77 per cent of the population in the province live in rural areas and are generally from ethnic minority groups. Many cross-border ethnic groups reside in remote mountainous areas. Such groups can be found in Myanmar, Lao PDR and Thailand.

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[28] ORC Macro and Committee for Population, Family and Children, Viet Nam 2003.
[29] Sources for Viet Nam Country Overview: ADB 2001. AusAID 2007a, ADB 2002
[30] Sources for Yunan, China overview: Traditional Culture and Reproductive Health, Yunnan RH Research Association, English Abstract

Yunnan has an enabling legal and policy framework. Ethnic groups with a population of less than 100,000 receive special support to preserve their cultures and receive new opportunities for development. This includes enjoying some exemptions from the one-child policy that applies to the Chinese population, receiving special scholarships for education, free primary and secondary school for cross-border immigrants. Minority ethnic groups thus enjoy additional rights and support to access education and health care.

Ethnic groups have achieved representation at several levels of the provincial civil service, although their representation in high-level positions in the Party structure is still very limited.

The socio-economic and cultural development of ethnic groups in Yunnan Province is uneven. The status of ethnic minority group women varies considerably in terms of social position and reproductive health status. Many customs have been reversed by governmental policy and rules.

Thailand [31]

Twenty of Thailand's 76 provinces are inhabited by ethnic minorities, mainly in the northern provinces. Highland populations live in Chiang Mai, Chiang Rai, Mae Hong Son, Tak, Nan and Kanchanaburi. Ethnic minorities often referred to as hill tribes, constitute approximately 1.2 per cent of the total population of Thailand. Several different hill tribes populate northern Thailand although data varies on exactly how many. Mae Hong Son has the largest population of ethnic groups

Credit: © 2004 Andrea Jones, Courtesy of Photoshare
A group of Akha boys in a Hill Tribe village in northern Thailand. The Akha people still live in rural villages in the mountains of Thailand. The villages rarely have electricity, and only sometimes have proper sanitation and clean water sources. While these four boys look happy and healthy, children in the Hill Tribe villages often suffer from poor nutrition.

with 41 per cent. The main ethnic groups include Pga Ker Yaw (Karen), Hmong, Lahu, Lisu, Lien, Akha, Lua, Htin and Khamu.

Many highland populations are not recognized as full citizens, which limits access to health, education, employment, and legal protection. Women and young people are particularly vulnerable. They can be arrested if they travel and may have to pay bribes to officials. Many hill tribes or highland populations remain excluded from Thailand's data on achievements in education and health.

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[31] Sources for Thailand country overview: ADB 2001, CEDAW 2003, and Buaddaeng et al. 2001.

Minority ethnic groups have varying educational levels. There is a high demand for education among the Hmong population, for example, but less among other groups. A number of non-formal education programmes are provided in local ethnic languages. The Hill Areas Education programmes offer targeted and tailored approaches to ethnic minority group members. Many ethnic minorities are unable to access governmental health services because of lack of Thai citizenship or lack of registration documents.

Thailand faces increased urban migration of ethnic minority groups. Contributing factors include increased land scarcity for agriculture due to expansion of protected forest areas, transfer of land from farming purposes to urban development and perceived better job opportunities in cities. Many young people are also reluctant to return to the social restrictions of village life following exposure to urban lifestyles. Some youth migrate to seek higher education opportunities and to take advantage of the new trade routes between the Mekong countries.

Cambodia [32]

Policy documents in Cambodia use the term "indigenous peoples" to define ethnic minority groups residing in mountainous hilly areas. The Department for Ethnic Minorities in the Ministry for Rural Development also defines ethnic minorities as "groups who live in a community, from a specific location and have lived in the same area for many years". In other documents, "migrants" include minorities such

Credit: © 2005 Stéphane Janin,
Courtesy of Photoshare
A father and child attend a maternal nutrition discussion held by a Pharmaciens Sans Frontières (PSF) health education team at a remote village in Stung Treng province, Cambodia.

as Vietnamese, Chinese and other groups even though they have lived in Cambodia for generations and some hold passports. Another definition of "ethnic groups" includes the Cham, Lao, Vietnamese and Chinese, the range of definitions complicates analysis. Statistics on ethnic groups are scarce and mostly based on estimates. "Hill tribes" or "indigenous populations", for example, are mainly concentrated in the four north-eastern provinces; Stung Treng,

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[32] Sources for Cambodia overview: ADB 2001, ADB 2002, and DFID 2002.

Kratie, Ratanakiri, and Mondolkiri. The proportion of ethnic minorities is approximately 6 per cent. The "Cham" group is the largest ethnic group, followed by Vietnamese, Chinese and Lao.

Literacy rates are low in areas where ethnic minorities are concentrated. The literacy rate in Ratanakiri is 23 per cent, in Mondolkiri 33 per cent, and in Stung Treng, it is 48 per cent. Primary school enrolment levels are very low, especially among young girls. Health indicator percentages for ethnic minorities are very meagre compared to the rest of the country. It should be noted, however, that it is difficult to develop an accurate understanding of the health status of ethnic minorities as Cambodia does not collect data disaggregated by ethnicity.

Cambodia is a signatory to a number of international human rights conventions, including the International Covenant on Civil and Political Rights and International Convention on the Elimination of All forms of Racial Discrimination. There are also guarantees in the Cambodian Constitution for ethnic minorities. Two ethnic minority members of the national parliament were elected from Ratanakiri and Mondolkiri.

A policy on ethnic groups is currently being developed which may result in increased focus to address their needs. The Inter- Ministerial Committee for Highland Peoples Development operates to assist and coordinate activities with national and international institutions working in the north-eastern provinces targeting indigenous populations.

Lao PDR[33]

The 1995 Population Census recorded 47 different ethnic groups in Lao PDR. The Lao are the largest group constituting 52.5 per cent of the total population and live mostly in the low land areas of the country. Other sources suggest that

Credit: © 2002 Myles F. Elledge, Courtesy of Photoshare
A Hmong ethnic village in Vientiane Province, Lao PDR. These Hmong children collect water for their family after leaving their village primary school. This one water tap - the village's only source of drinking water - is used by 400 people.

distinctive ethnic groups comprise up to 70 per cent of the population and belong to four ethno-linguistic

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[33] Sources for Lao PDR overview:
World Bank 2002, UNFPA 2000, and WHO 2002.

Groups - Tai Kadai, Austro Asiatic (mon-Khmer), Hmong-Mien (Miao-Yao) and Sino Tibetan (Tibeto-Burman). The Tai Kadai group is the largest group.

Article 8 of the Lao PDR Constitution states that the state cannot discriminate against people based on ethnicity. A policy entitled "Resolution of the Party Central Organisation Concerning Ethnic Minority Affairs in the New Era" was adopted in 1992. The policy aims "to push strongly for increased production and open channels for distribution in order to change the natural or semi-natural economic system towards one of production of goods, promote and expand the strengths of uplands areas, and improve the quality of life of the citizens".

Ethnic groups are disproportionately highly represented among the poorest of Lao society despite existing policies and numerous development initiatives.

In 1999, the Government adopted the National Population and Development Policy of the Lao PDR (NPDP). The NPDP promotes a balanced distribution of population between urban and rural areas and between different regions of the country. The policy includes a

framework of initiatives for ethnic minorities.

Myanmar [34]

Myanmar has numerous ethnic groups, located mainly along the border areas of the country. Some studies suggest that Myanmar has over 135 different ethnic groups, while others suggest 67 separate ethnic groups with different languages, dialects, customs and traditions. The main languages spoken are Arakanese, Burmese, Chin, Kachin, Karen, Karenni, Mon, Sha, Wa, English and minority dialects. The 1948 constitution gave each nationality (i.e., population

Credit: © 2004 A. K. Moe, Courtesy of Photoshare
The Red Cross and other NGO members in Myanmar help a pregnant woman receive the care she needs.

groups) representation in a Chamber of Nationalities at the national level. The constitution specifically recognised only four nationalities, i.e., for the Karen,

[34] Sources for Myanmar overview:
Rak Thai Foundation 2004, Smith 2002, and Amnesty International Burma (Myanmar) 2002.

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Karenni, Shan and Kachin. Some other ethnic minority groups are not represented. Most ethnic groups in Myanmar are economically marginalized while their social, cultural and religious rights are suppressed.

Myanmar has a number of laws protecting women, such as Suppression of Prostitution Act, the Myanmar Buddhist Women's Special Marriage and Accession Act and the Myanmar Maternal and Child Welfare Association Law. The government has signed the Convention on the Elimination of All Forms of Discrimination against

Women. There are discrepancies between the protection offered through the legal framework and their enforcement. Women from ethnic minority groups are more vulnerable in this situation and enforcement of laws lags behind in the areas where they live. Many ethnic groups are in conflict with the central government. Other groups have signed cease-fire pacts and are not subjected to persecution. The protracted situation of conflict in the country further contributes to exacerbate the situation for many ethnic minorities.

3. Equity, access and the health of ethnic minorities

3.1 Political representation and visibility of ethnic minorities in key policy frameworks

An ethnic audit of the PRSP of Lao PDR, Viet Nam, and Cambodia conducted by the ILO in 2005 found that strategic frameworks were mostly "ethnic-blind". The frameworks appeared to mirror a belief that, even though poverty causes and processes may vary by group, the solutions to address poverty need not be different or accommodate diverse needs and expectations. The audit found that only the PRSP of Viet Nam included specific indicators for ethnic minorities or indigenous people. The Viet Nam PRSP suggests that the national poverty indicators be disaggregated by ethnic origin.[35]

The lack of reference to ethnic minorities in PRSP documents is indicative of the limited participation of these groups in broader political processes and institutions. Ethnic minority group members are under-represented in parliaments and other national and local government institutions.

Most countries in the GMS are undergoing processes of adminis-trative decentralization. Decentral-ization has the potential to provide new opportunities for more equitable and ethnically inclusive development approaches. This can only happen, however, if eligibility requirements for election in local government bodies do not reflect cultural and ethnic biases. In Cambodia, for instance, the requirement that candidates for commune councils' elections must read and write in Khmer automatically excludes a large proportion of people from ethnic minorities. [36]

3.2 Lack of citizenship status and legal protection

The lack of legal status and legal protection of ethnic minority groups frequently prevents them from accessing essential services. Legal issues limit the effectiveness of existing policies and the technical capability of service providers to address the needs of minorities. A lack of political will to address the legal status of ethnic minority groups is a leading impediment to the access of services. Research by UNESCO indicated that lack of citizenship is the single greatest risk factor for highland minority girls and women in Thailand to be exploited. Without citizenship, they are often employed in informal and exploitative labour arrangements. Residence and travel restrictions are imposed on young ethnic minority people and as a result, they tend to travel further away from their home communities. Increased distance from their communities results in increased vulnerability to poverty and poor health.[37]

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[35] ILO 2005.
[36] Ibid.
[37] UNESCO 2007.

3.3 Policies affecting land tenure and livelihoods.

Some GMS countries have implemented relocation policies that have rapidly and dramatically altered the foundations of ethnic minorities' social structures. In Cambodia, for example, some ethnic minority groups were resettled close to roads and rivers in the highlands. Their traditional shifting agriculture, associated with a semi-nomadic life style, is now being replaced with lowland and geographically stable agricultural systems. Large-scale development projects are being launched in their ancient homelands. Over one half of the 4.7 million hectares given in concession to trans-national companies are located in the four north-eastern provinces where ethnic minorities traditionally live. Concurrently, the migration of the lowland Khmer people to the highlands is the result of another major government initiative. The in-migration of the Khmer people is rapidly changing the density and the ethnic composition of the population in the highlands. All these factors have resulted in increased pressure on the highlands' fragile ecosystems, which used to sustain the livelihoods of ethnic minorities.[38]

3.4 Lack of participation in decision-making processes

The content and implementation methods of development interventions reflect the lack of participation of ethnic minorities in decision-making processes. In some cases, targeted interventions may distinguish ethnic diversity and the importance of respecting customary institutions and land tenure arrangements. Initiatives are more commonly driven by the wish to bring ethnic minorities in line with a lifestyle model that corresponds to that of the dominant ethnic group. Such an approach is consistent with nationhood paradigms based on the primacy of individual loyalty to the nation instead of relying on unifying symbols rooted in identities and loyalties of existing social communities.[39]

The situation is clearly exemplified by development programmes in most GMS countries. Thailand, for example, has initiated numerous development programmes for ethnic minority groups but these often exclude large numbers of people who have not been granted citizenship. Some minority group members in Thailand and Cambodia do not enjoy full citizenship or official acknowledge-ment despite the fact that their families have resided in the country for generations or even centuries.

Some ethnic minority group members become marginalized due to government policy regarding land rights and territorial ownership. This is particularly true in Cambodia where the government actively encourages ethnic Khmer (who are the majority of the population) to migrate to Ratanakiri, an area where most of the population is from ethnic minority groups. The purpose of the migration is for the Khmer to develop resources in land that has traditionally been inhabited

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[38] ILO 2005.
[39] Ibid.

by ethnic groups. Local ethnic groups are sometimes pressured to sell their land rights even when they have ownership papers. Other concerns include resettlement strategies that were implemented in Lao PDR, Cambodia and Viet Nam. In Lao PDR, entire villages have been relocated as part of development initiatives with negative consequences for the social cohesion of local ethnic groups.

3.5 Barriers to access and use health services

Multiple barriers exist throughout the GMS that prevent effective access and use of services. Many of these barriers apply equally to ethnic minorities and other populations, whereas others are more difficult for ethnic minorities to overcome. The main constraints to the access and use of social services by ethnic minorities include:

- Physical/geographic constraints
- Cost of services and high poverty levels
- Lack of coordinated multi-sectoral responses
- Budgetary constraints and inability to implement policies
- Language barriers and lack of information and understand-ing 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

3.5.1 Details of barriers to access and use health services
Physical/geographic constraints. Many ethnic minority groups live in highland and border areas that have a rough terrain. The sheer physical geography of these settings poses special challenges and increases the cost of providing and maintaining basic infrastructure (roads, communications, and utilities) and social services.[40] The strengthening of infrastructure is a major focus of current economic development plans in the GMS. Governments and development agencies should, therefore, ensure that new roads and communication facilities also serve social and economic purposes in ethnic minority areas.

Cost of services and poverty levels.
Ethnic minority groups in the GMS tend to have higher poverty levels than the general population. High poverty influences how ethnic minority group members weigh the opportunity and direct costs of accessing services against expected benefits. Such cost-benefit assessments become more significant as the private sector and fee-for-service arrangements start playing a more important role in social services. A study in Cambodia revealed that the most significant barriers that prevent patients from visiting trained health professionals include overall cost of services and treatment, travel distance and road quality. One-half of those included in the study gave birth with a traditional birth attendant, stayed at home with

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[40] ADB 2001.

family or did not seek help. The study also indicated that the principal factors that could encourage future use of trained health professionals include proximity and availability of services combined with home visits. Three fifths of women surveyed would prefer to deliver in a facility for their next birth.[41]

Lack of coordinated multi-sectoral responses.
The fact that health is not simply the absence of illness and disease is now universally well accepted. A lack of comprehensive planning to address the health issues of ethnic minorities within a more articulated vision of sustainable socio-economic development is still a challenge. Education, skills development, job creation, equal opportunities, and sound management of natural resources are not well integrated to maximise health. Ethnic minority members in the Ha Giang Province of Viet Nam, for example, identified decreased soil fertility, degraded environmental conditions, and water problems as the three principal factors that most contribute to poverty in their community.[42]

Budgetary constraints and inability to implement policies.
Some governments have financial constraints and/or inadequate planning that prevents the expansion of services to areas where ethnic minorities live. Government structures lack capacity and resources in participatory planning and governing.[43] In Sekong, one of the most remote provinces in Lao PDR for example, some districts are

virtually inaccessible during some parts of the year.

Language barriers and lack of information and understanding about available services. Ethnic minority groups often have limited access to information due to language barriers. They may also have misconceptions about health problems and the nature of services available. Misconceptions lead community members to doubt the usefulness and quality of specific health services or health promotion interventions. A UNFPA-sponsored assessment of training interventions in mountainous areas of Viet Nam, for example, found that Community Health Centres were displaying posters on clients' reproductive health rights but with limited results.[44] The information was in Vietnamese, a language that most ethnic minority people in the area could not read.

Lack of knowledge and understanding about the population to be served.
Health services frequently do not take local cultural norms and customs into account. A lack of understanding of the language, cultural, religious, and socio-economic profile of the population frequently impedes the provision of effective health services. Centrally designed or standardized interventions and service delivery programmes frequently fail to acknowledge and validate the use of local knowledge systems.

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[41] UNFPA 2006a.
[42] University of Amsterdam/UNFPA. 2007.
[43] UNDP 2005.
[44] UNFPA Viet Nam 2007.

Quality of health referrals in my village

I am Sorn Navuth, I am 42 years old. I am Kreung ethnic minority. I live in Takab village, Ta Ang commune, Kon Mom District, Ratanakiri Province. I am married to my second husband who is the same ethnicity as I and also lives in my village.

We had two children, a son and a daughter but they both died. I am really sad because I miss both of them.

I really do not know what made them die because they died really fast. They just started having a fever and died one day later.

I used to be the health volunteer in my village. I encouraged many villagers in my village to go and get health services from the Health Centre and Referral Hospital.

The first time I helped to refer a man in my village who had asthma to the Referral Hospital. I helped to negotiate with the health staff for him to stay there for one week. After one week, the man was not yet cured but he was forced to leave. The second time, I helped to refer a woman with a lot of pain and numbness all over her body. She paid 40,000 riel for the health service. After one week's stay, she was still not cured but was nonetheless forced out of the hospital.

Right now, no one believes me, whatever I do to encourage him or her, no one goes to the referral hospital. They say, "why do we need to go, they do not treat us all the way until we are well." I do not know what to do. Before I came to join this meeting, I tried to complete a fee exemption letter for a patient but he refused to go.

When I asked and received help from one NGO for two women to get treatment in Phnom Penh things were different. After diagnosis and operation and treatment at the hospital in Phnom Penh both women are now back in the village, one is already cured, the other is on medication and is getting better.

I think health is very important for people in my village and I will do my best to encourage them to go get health services at the referral hospital.

Interview and photograph by Nuon Sopheak, HU Advocacy Officer
Source: Health Unlimited 2007.

Members of ethnic minorities can also be sceptical of services that challenge traditional knowledge and practices and are resistant to accessing such services. Most importantly, service providers' lack of understanding the population to be served may compound existing stigmatizing and discriminatory attitudes and reinforce inadequacies in policy and programme development.

Poor quality and relevance of services provided.
Services, which are not responsive to locally felt needs, may not only be perceived as irrelevant but can also be unpopular. Attracting and retaining qualified personnel to work in areas with a high proportion of ethnic minority people has an impact on the low quality of services. Existing low quality services further exacerbate the perceptions of neglect of the needs of ethnic minorities. In remote mountainous areas in Viet Nam, for example, the turnover of Village Health Workers and Population Communicators is as high as 30-40 per cent per year, due to factor including low remuneration and marriage of single female VHWs.[45] Health Unlimited's experiences from Ratanakiri Province in north-eastern Cambodia suggests that low utilization of services is the result of low public confidence in the quality of services offered in health centres.[46] Other reasons for not using formal health services include distance and informal fees. Many reports and other sources describe negative relationships between health staff and patients in the GMS because staff discriminate against patients from ethnic minority groups

Lack of attention to gender dimensions of health issues. Cultural attitudes and values regarding acceptable sexual and reproductive roles and behaviours are almost universally influenced by power distinctions. These power distinctions, in turn, create gender-specific patterns in potential clients' attitude towards health services. Power distinctions influence real and perceived utility and opportunity costs of the services offered. The effectiveness of methods used by service providers to reach populations, foster learning, or encourage health-seeking behaviours are influenced by gender issues. Policy makers and programme managers need to consider whether gender issues within minority populations differ from those of the majority population. Adjustments to address potential barriers to access to and use of services need to be made if gender issues influence health seeking.[47]

[45] UNFPA Viet Nam 2007.
[46] Health Unlimited 2003.
[47] ADB 2001.

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Women's health:
Domestic violence in my village

My name is Tukla. I am Kreung-Khmer. I am 18 years old and have 4 younger sisters and 2 younger brothers. I live in Tahoey village, Toen commune in Kon Mom District.

I have seen a lot of violence happen in my village, especially between youth and by married men; when they are drunk they fight each other.

There was a family in my village in which the husband always hit his wife when he was drunk. I have seen it happen many times in that family. I can still picture it and remember very clearly that one day when the wife's face was swollen and she had a black eye. The wife tried to escape to her neighbour's house that time. Unfortunately, people did not get involved as they are scared of the husband.

I understand what you mean by domestic violence. It means bad, conflict, threats, and fighting like animals without sympathy. People in my village fight each other because most of them are not educated. No one (*from outside the community*) has come to talk to us about domestic violence in the past.

The education in my village is very poor. The school in our village only has grade 1 and 2 and the classes do not operate regularly. In my case, I can read and write thanks to my father who always spent time to teach me so I am now able to read and write Khmer.

I wish the school in my village would have more grades in the future so that the people in my village can learn. I also hope that someone will come and provide training to people in the village to know about domestic violence because I think that can reduce it.

Interview by Nuon Sopheak, HU Advocacy Officer
Source: Health Unlimited 2007.

4. Socio-cultural issues influencing health-seeking behaviours

Certain cultural beliefs and practices influence health-seeking behaviour including those related to reproductive health. Comprehensive research is needed to understand the relationship between beliefs and practices so our analysis is limited to key examples.

Policy makers and programme managers need to develop approaches that address misconceptions and harmful practices while recognizing the usefulness of customs and practices that positively influence health. Approaches need to seek solutions within common local methods to transmit knowledge so that self-confidence and cultural identity are not undermined. Security in identity helps to ensure self-confidence and decrease alienation. Cultural alienation needs to be avoided since it can result in negative long-term impact on social stability.

4.1 Perceptions of illness, health care, and health-seeking behaviour

Perceptions of health differ among and between ethnic groups and other dominant populations. Unlike many Western models of health, ethnic minority groups' notion of health is often not individual but encompasses the health of the whole community and that of their ecosystem. [48]

Attitudes to health and well-being are also influenced by perceptions of the relative importance of good health within a hierarchy of competing needs. In China, reproductive health customs differ according to local culture and traditions. These differences in customs also influence the types of health conditions found in communities and health indicator results. Lack of access to safe water also limits the ability of people to put hygienic health practices into action.

Beliefs about the connection between the spirit world, magic, sorcery and illness, disease and healing are widespread among ethnic minorities in the GMS. The Hmong in Ha Giang province in Viet Nam have strong beliefs that poor health is influenced by imbalances in the spiritual make-up of an individual and the interconnection of different elements of spiritual "networks". For a person to be in good health all twelve souls residing in the body must be intact. [49]

The connection between people and their environment is also an important element in the Hmong's health cosmology. These complex belief systems find expression in a series of health seeking behaviours and health care practices. Many Hmong people still rely on spiritual practices whenever a person is

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[48] Stephens et al. 2005.
[49] Lee and Pfeifer 2007.

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identified with a health problem. Herbs are often used to treat infertility, menstruation, delivery complications and as nutritional supplements after delivery.[50]

A recurrent theme in the literature on poverty in Viet Nam is the relationship between illness and poverty. The 2001/2002 Viet Nam National Health Survey indicated that ethnic minority groups in the *Central Highlands* were more likely to have been ill in the previous four weeks than the population as a whole. More than 20 per cent of the ethnic minority members who were ill failed to seek medical treatment. The ethnic minority population of the *northern mountains* had similar levels of illness as compared to the general Kinh population but were considerably less likely to seek medical advice when they were ill.[51]

Across the region, with some exceptions, most women from ethnic minority groups prefer to give birth at home with the support of a traditional birth attendant. Many ethnic groups are familiar with their own ways of giving birth and unfamiliar with the formal health care system.

Studies in Yunnan Province in China suggest that women rarely seek reproductive health care services, primarily due to poverty and lack of knowledge. Some women also have misperceptions about services offered. They believe, for example, that a prenatal exam will disturb the foetus.[52] There is no specific data about the health seeking behaviour of minority ethnic groups in Yunnan. A WHO supported project, for instance,

stated that most ethnic minority groups visit health centres. Anecdotal information suggests that ethnic groups deliver children either in health centres, at home alone or with a traditional birth attendant and some prefer to give birth at home. Hmong (Miew in Mandarin) and Yee are examples of ethnic groups who prefer to deliver at home. Reasons for delivering at home are similar to those found among other ethnic minorities in the GMS: poverty, lack of access, and lack of transportation. Some women also do not like or understand birthing methods used in health centres. Some prefer to give birth standing or crouching and do not feel comfortable lying down. The health system needs to adapt to accommodate women's choices.

In China, as ethnic groups are allowed more than one child—some choose to visit health centres when having their first child and then deliver their second child at home. Responding to the needs of ethnic groups is a priority for the Yunnan provincial government and thus health care provision and policy is of a higher standard then in other GMS countries.

Research in Viet Nam suggests that ethnic minority group members do not visit health centres mostly due to financial constraints.[53] Health centre visits are usually only made for difficult cases of abortion or IUD insertion. The health care delivery

[50] University of Amsterdam/UNFPA 2007.
[51] Swinkels and Turk 2004.
[52] Yunnan Reproductive Health Research Association (YRHRA) Kunming, Yunnan Province
[53] UNIADS and UNICEF 2000.

Childbirth in Viet Nam

According to at least one source, many groups, such as the Hmong, deliver babies unassisted even by traditional birth attendant or family members[54.] Other groups, such as the Thai, deliver at home, with assistance of family members or of the father-to-be. The Khome group deliver children in health centres.[55] Other sources suggest a high access to antenatal care, even among ethnic groups. In some provinces, especially in the mountainous areas of Ha Giang only 37 percent made three or more antenatal visits.[56] In Hoa Binh, a province where over 80 percent of the population is from minority ethnic groups, the Provincial Health Department reported that over 95 percent use public health services. Some districts within the same province reported only 40 percent use of public health services.

system operates under financial, technical and programmatic constraints resulting in a lack of basic health service provision to a large segment of the population. Such problems are especially relevant in the North Mountain and Midland Region and Central Highlands where the geographic terrain and cultural constraints compound the problems. Studies reveal that a majority of women from ethnic groups have never received health education nor have they visited health centres. At the commune level, health workers are not trained to provide services in all major health subjects and may not have the knowledge and skills to provide antenatal care. A majority of ethnic minority group deliveries take place at home as a result of these constraints.

In Lao PDR, awareness of contraception among some ethnic minorities is inconsistent at best. Women and men lack basic information about pregnancy and safe motherhood, including nutrition and exposure to heavy work during pregnancy. Women continue to work during pregnancy including fetching firewood and water and doing agricultural work. Pregnant women usually do not access health centres for antenatal care, instead they wait for the 'health day campaign', which is held once every 3 months. The Katang and the Ta' Oy ethnic groups hold strong beliefs about needing a newly built bed for delivery. Such a bed must never have been used before and the health centre's beds are not acceptable. Deliveries can only be assisted by family members. Poor Katang women have to return to their work in the fields soon after delivery.[57]

4.2 Gender dimensions of vulnerability and social exclusion
Women from ethnic minorities in the GMS appear to have limited decision-making autonomy in general, including in matters of sexual and reproductive health

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[54] Zankel 1996.
[55] Zankel 1996.
[56] UNFPA 2003.
[57] National University of Laos/UNFPA 2007.

(SRH). Hmong women in Viet Nam are considered to be non-permanent members of the family as they are expected to marry early and become wives and mothers in other households. A Hmong daughter does not customarily have a right to inherit property. A Hmong widow is also not entitled to inherit her husband's property. A married Hmong woman does not have the right to return to her parents' house without permission from her in-laws and unless she is accompanied by her husband. Early marriage is a major contributing factor to high fertility rates among Hmong adolescent girls and young women. It is still common to find a history of at least 8-10 pregnancies among Hmong women aged 40-50. Not surprisingly, discussing sexual and reproductive health issues is not easy for most Hmong people. Women appear to have very limited knowledge about important issues for their SRH including menstruation, the prenatal process,

delivery, post-natal care and safe sex.[58]

Traditional attitudes and practices concerning pre-marital sexual activity vary between different ethnic groups. Pre-marital sexual activity has also been influenced by the recent GMS socio-economic development trends. Young people face a situation of rapid change with limited skills to manage it. There are very strong rules against pre-martial sex among both the Katang and Ta' Oy people in Lao PDR. Some villages are situated near new or improved roads junctions, which has brought an increased influx of men coming from other areas. The new infrastructure has also contributed to an exodus of unmarried young men leaving the villages to seek better work opportunities. Katang girls, often encouraged by parents, serve whiskey to male visitors for a fee and many fear that this situation will lead to increased and unsafe pre-

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Cultural resilience: marriage in times of rapid change
Despite the existence of regulations on the age of marriage in many countries, including China and Viet Nam, many ethnic groups choose to maintain their custom of marriage at a young age. People of the Hmong group in Viet Nam get married at the age of 10 to 15 years. Key factors for early marriage include the need for household labour and low school attendance. The Thai Den people marry and start having children at the age of 14 to 16. These customs are perpetuated despite knowledge of the Law on Marriage and Family, which sets the minimum age of marriage at 18 for women and at 20 for men. Among the Hmong group in Thailand, a person who is unmarried and has no children at the age of 18 to 20 is already considered very old. Many people from these ethnic groups circumvent these laws by first marrying according to their customs and traditions and only officially registering their marriage when they reach the minimum age established by the law.[59]

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[58] University of Amsterdam/UNFPA 2007.
[59] UNAIDS and UNICEF 2000.

marital sex. This situation may result in increased transmission of infections as very few people in the area report knowledge about STIs, HIV and AIDS.[60]

Changes to legal and policy frameworks may sometimes have unexpected effects and can increase social vulnerability if they are introduced without a sound understanding of the cultural and social context. Viet Nam's Law on Marriage and Family (2000), for example, includes stipulations on monogamy and marital age (18 for women and 20 for men). Polygamy is prohibited and early marriage is discouraged. As a consequence, many ethnic minority couples do not register at Commune Peoples Committees as required by the legislation. Many ethnic minority boys and girls continue to marry early but their unions are not reflected in official statistics.[61]

The negative effects of poverty and gender inequality continue to affect the lives of many women from ethnic minority groups. Katang families in Lao PDR do not want to limit the number of their children because of high child mortality rates. They fear that if there are not enough children there will be no one to take care of older people. Despite the role of women as mothers and wives, all decision-

[60] University of Laos/UNFPA 2007
[61] University of Amsterdam/UNFPA 2007.

making during delivery is made by Katang parents or husbands. Women have no autonomy. Even in groups which appear to have a matrilineal kinship pattern, such as the Museu Dam in Lao PDR, a preference for a girl-child is based on the concept of women as caregivers for the family. Boys usually have more opportunities to go to school than girls do.[62]

Lack of human rights protection compounds gender inequality and increases social exclusion, risk and vulnerability for thousands of girls and women from ethnic minorities. In Thailand, for example, although many hill tribe women are Thai-born they are not Thai citizens and their children are stateless. The lack of fundamental citizenship rights impedes the legal registration of births and marriages; denies opportunities for education and employment in the formal economy; create restrictions in the freedom of movement; and establishes serious barriers to access of health services.[63]

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[62] National University of Laos/UNFPA 2007.
[63] Leiter et al. 2004.

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5. Reproductive health status of ethnic minority groups

The reproductive health situation of ethnic groups in the GMS including family planning coverage, maternal health and neonatal health is cause for concern. Data is scarce so estimates cited are based on a variety of types of sources.

5.1 Family Planning Coverage

Available data indicates that ethnic minority group members tend to have more children, are generally less aware of modern contraceptives and have much lower rates of modern contraceptive use than the general population.

Women also have high fertility levels to compensate for high infant mortality rates. Families perceive a need for many children to care for the household and parents. These factors contribute to high total fertility levels. Many cultural and traditional beliefs related to family and ancestry require that women bear boys and/or girls. Women tend to continue to produce children until they bear the desired sex. This is especially common among Hmong and Akha groups across the region.

Table 1- Awareness and Use of Contraceptive Methods

	National Total Fertility Rate	Total Fertility Rate Regions with Minority Groups	National Awareness of Modern Contraceptive Methods	Regions with ethnic minorities* Awareness of Modern Contraceptive Methods	National Use of Modern Contraceptives	Regions with ethnic minorities* Use of Modern Contraceptives
Lao PDR[64]	4.1	4.8	88.5%	84.0%*	35%	22.8%*
Viet Nam [65]	1.9	2.9**	99.5%	NA	56.7%	41.6%**
Thailand	1.95	NA	NA	NA	70%	NA
Cambodia[66]	3.4	NA	99.3%	75.3%****	27.2%	19.3%***
Myanmar	2.4	3.5****	96.1%	90.4%****	32.8%	23.4%***
China (Yunnan)	1.4	NA	NA	NA	83%	NA

Locations are estimates based on assessment of various sources and should be interpreted with caution
NA: not available

*Southern region of Lao PDR
**Central Highlands.
*** For Mondol Kiri and Rattanak Kiri Provinces
****Rakhine

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[64] National Statistics Centre, Lao PDR 2007.
[65] General Statistical Office 2003.
[66] National Institute of Public Health and National Institute of Statistics 2006.

Concerns and misconceptions about contraceptives and modern medicines are widespread. Family planning initiatives in Lao PDR have used information and materials that have resulted in many misconceptions. Villagers have significant concerns regarding the side effects of various forms of available contraceptives. These issues have been addressed by strengthening regular monitoring as well as promoting basic advisory skills of district health trainers and health workers.[67]

Many ethnic groups tend to have more than 4 children (especially the Hmong) and practice no birth spacing or use contraceptives. Some women use temporary methods (pills or injectables). If their villages are located in remote locations they have difficulty going to health centres during the rainy season and their access to contraception is interrupted. In some villages women do not have access to family planning information at all. If they have had exposure to information and do want to use a modern method they frequently cannot find family planning commodities in their villages.[68]

In Lao PDR, approximately 88.5 per cent of all women included in the 2005 Reproductive Health Survey reported awareness of at least one modern contraceptive method, predominantly the condom and contraceptive pill (79 per cent).[69] Such knowledge differs slightly across areas with figures of 85.6 per cent in the North, 84.0 per cent in the South, and 93.8 per cent in the Central Provinces. While nationally 35 per cent of married women are using modern methods of contraception, it is much lower in the southern region at 22.8 per cent and as low as 11.9 per cent in Sekong province where 97 per cent of the population are from minority ethnic groups.

5.2 Maternal Mortality

Reliable data on maternal mortality is lacking throughout the region. Existing data suggests that maternal mortality is generally higher among ethnic minority group women across the GMS than in the general population. Low levels of health seeking behaviour and lack of access to antenatal care are just two of the causes of higher maternal mortality. Other causes include higher levels of malaria, diarrhoeal diseases, acute respiratory infections, measles, prenatal conditions, and complications of pregnancy and childbirth.[70] Additional factors include pregnancies early and late in life, short birth intervals and high fertility rates overall among women from ethnic groups.[71] Cambodia and Myanmar have high maternal mortality rates due to complications related to abortion, eclampsia, and hemorrhage. Sources suggest that in Myanmar approximately 50 percent of maternal deaths result from unsafe abortions.[72]

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[67] Lao Women's Union and Family Planning Australia 2004.
[68] Health Unlimited, ICOMP and UNFPA 2003.
[69] National Statistics Centre, Lao PDR 2007.
[70] WHO 2006.
[71] Ministry of Public Health, Lao PDR 2000.
[72] Smith 2002.

Table 2- Maternal mortality

	National Maternal Mortality	Maternal Mortality in Regions with Ethnic Minorities
Lao PDR [73]	660 / 100 000[74]	700/100 000 South
Viet Nam [75]	130 / 100 000 [76]	441/ 100 000 (Cao Bang)
Thailand	44 / 100 000	NA
Cambodia [77]	472/100 000	NA
Myanmar [78]	380/100,000	NA
China (Yunnan)	63/100 000	200/100 000

Prenatal care services that help identify and manage complicated births are not readily available, especially in areas with high concentrations of ethnic groups.[79] In Lao PDR, for example, the maternal mortality ratio is estimated at 530 per 100.000 live births nationally. The distribution is 440 per 100,000 live births in the Central regions where the dominant ethnic group lives. In the regions where more ethnic minority groups live the figures are 540 per 100,000 live births in the Northern and 700 in the Southern region.[80]

Thailand has made significant progress to improve access to health services and has improved the health status of its general population. Child and maternal death rates have decreased considerably nationally. In regions with higher proportions of ethnic minorities, such as in the north and north-eastern provinces, there has been less progress and maternal death rates are above the national average. The lack of citizenship status is one of the factors hindering health-seeking behaviour in these areas and contributes to higher levels of MMR among ethnic minority groups.

In Viet Nam, the maternal mortality rate is 110 for every 100 000 live births. Studies suggest that this figure may reach 160/ 100 000 in rural areas and is four times as high in the remote mountainous areas where ethnic minority groups reside.[81]

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[73] National Statistics Centre, Lao PDR 2007.
[74] WHO 2007.
[75] ADB 2001.
[76] National Institute of Public Health and National Institute of Statistics 2006.
[77] ADB 2001.
[78] WHO 2007.
[79] ADB 2001.
[80] National Statistics Centre, Lao PDR 2000.
[81] ADB 2001.

Samples of Traditional Beliefs and Practices Related to Reproductive Health Among Ethnic Groups in Thailand

Karen
- Most deliver at home with traditional birth attendant.
- Monogamous relationships low risk of HIV.
- Poor nutrition, anaemia common.

Hmong
- Male-preference, families prefer to have at least two sons.
- Polygamous, often to ensure more sons.
- Early age of first intercourse, between 13-14 years, "free sex" culture especially on major holidays (Hmong new year).
- Delivery at home with assistance from mother-in-law, parents of mother banned from location. If single, the pregnant women must find suitable place to give birth, she is forbidden to give birth at parents home.
- A woman who has not had children by the age of 18 is considered very old.

Lahu
- Divorce common and requested by both men and women .
- "Free sex" practice which has been abused by visitors, "free sex" is sometimes practiced after marriage, more so among men.
- Very high HIV transmission levels in this group.

Akha
- Early marriage at 15 – 16 years.
- Need many children for agricultural workforce.
- "Free sex" culture but less opportunities for women, men often practice free sex.

Yao
- Early marriage.
- Gender bias, girls expected to do most of the work.
- Animist and superstitious, usually visits traditional healers practicing "witchcraft" before visiting formal health officers.

Lesu
- Early marriage.
- Women have more decision-making powers than men do, women decide number of births.
- Preference for sons.
- Animist beliefs, belief in magical powers.

5.3 Neonatal Mortality

Neonatal mortality levels differ between countries in the region and among ethnic groups in each country. In countries with more developed health systems, such as Thailand, China and Viet Nam, neonatal mortality levels are fairly low while Lao PDR and Cambodia still report high rates. However, mountainous regions of Viet Nam have figures similar to Lao PDR and Cambodia. Contributing factors include lack of access to services and safe delivery, in particular emergency obstetric care. Low nutritional level of mothers and unhygienic living conditions also contribute to high neonatal mortality figures.

High infant mortality rates are a major concern in the highlands of Lao PDR and Cambodia, which have the highest infant mortality rates in the GMS. The infant mortality rate in Lao PDR averaged above 100 per 1000 live births, according to the 1995 census. Evidence indicates that this rate is higher in the northern provinces where ethnic minority groups are concentrated.

In Myanmar, Rakhine and Chin/ Sagaing States, which have higher percentages of Arakanese, Rohingya and Chin minority ethnic groups, have the lowest child-survival rates of 85 and 86 per cent respectively, compared to the national average of 88 per cent.[82] The neonatal mortality rate in Chin/ Sagaing states is 52.8 per 1,000, higher than the national average of 43. Similarly, the infant mortality rates in Rakhine and Chin/Sagaing are the highest in the country at 86 and 89 respectively compared to the national average of 76.

Table 3- Neonatal Mortality Rate

	National Neonatal Mortality Rate [83]	Neonatal Mortality Regions with Ethnic Minorities
Lao PDR [84]	26 / 1000	31 in the north
Viet Nam [85]	17.5/1000	32/ 1000 northern uplands
Thailand	13/1000	NA
Cambodia [86]	28 /1000	56 /1000
Myanmar	40/1000	NA
China (Yunnan)	13/1000	NA

NA: not available.

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[82] Ministry of Immigration and Population, Myanmar 2003.
[83] UNFPA 2006b.
[84] National Statistics Centre, Lao PDR 2007.
[85] General Statistical Office, Viet Nam 2003.
[86] National Institute of Public Health and National Institute of Statistics, Cambodia 2006.

In Cambodia the neonatal, infant and child mortality is very high in areas where ethnic minority groups live, especially in comparison to areas that are equally remote.[87] Neo-natal, infant and child mortality are particularly high in the Easternmost region of the country.[88] The neonatal mortality rate of Mondolkiri and Ratanakiri provinces, which have a high proportion of ethnic minorities, is 56 per 1000 live births. In Phnom Penh the neonatal mortality is 24.0 per 1000.[89] The divergence of these figures suggests that the ethnic minority groups receive or have access to less maternal and natal services.

5.4 Skilled birth attendance

The majority of births among ethnic minority populations occur without the assistance of skilled support,

which can be a significant reason for high maternal and neonatal mortality levels. Most births take place in the home with support from families and/or traditional birth attendants.[90] Some notable deviations from this pattern exist, such as in the Hoa Binh Province in Viet Nam, where approximately 90 per cent of births are delivered in health care settings. In the Northern uplands only 43 per cent of deliveries are in facilities, compared to the national average of 78.5 per cent. In the northern uplands over one third of women (37 per cent) deliver with a relative or friend at home, while nationally this figure is less than 10 per cent.[91]

In Lao PDR, approximately 60 per cent of maternal deaths occur during childbirth itself. Most births occur at home or in the village (86 per cent), with most attended by a

Table 4- Skilled birth attendance

	National Rates of Births at Home Without Skilled Attendant	Regions with Ethnic Minorities- Rates of Births at Home Without Skilled Attendant
Lao PDR [92]	81 %	85-90%
Viet Nam [93]	15%	44% (northern uplands)
Thailand	1%	12-32% [94]
Cambodia [95]	55%	86-87%
Myanmar [96]	47 %	68% (Rakhine State)
China (Yunnan)	5 %	5 per cent

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[87] DFID 2002.
[88] National Institute of Public Health and National Institute of Statistics, Cambodia 2006.
[89] DFID 2002.
[90] ADB 2001.
[91] General Statistical Office, Viet Nam 2003.
[92] National Statistics Centre, Lao PDR 2007.
[93] General Statistical Office, Viet Nam 2003.
[94] Highland Health Development Centre data – Karen (2005) 32%, Hmong (2005) 16%, Lahu (2006) 12%, Arkha (2006) 14%
[95] National Institute of Public Health and National Institute of Statistics, Cambodia 2006.
[96] Ministry of Immigration and Population, Myanmar 2003.

relative or, occasionally, with a traditional birth attendant.[97] The regional distribution of women delivering at home is 79 per cent in the Central region, 88 per cent in the Northern Region and 91 per cent in the Southern region.[98] Fifty-one per cent of urban women deliver in hospitals compared with 2 per cent of rural women in areas without roads. In remote provinces such as Phonsaly and Attapeu, with a large proportion of ethnic minorities, only 3-4 per cent of women in the province deliver in a facility. Data from 2005 confirms that areas with higher proportions of ethnic minorities have lower percentages of births attended by skilled personnel. In the Northern region, for example, 14.5 per cent of births were attended by skilled personnel, with 74 per cent delivered by a relative or friend. In the Southern region, similarly only 14.8 per cent of women had a skilled health worker at delivery, with the majority of deliveries by a relative or friend.[99] The strategic assessment reported that all women from urban as well as rural areas preferred to give birth at home even when institutional care is available. [100]

The availability of maternal and child health services in the mountainous areas of Viet Nam is limited. Only 2 to 3 per cent of ethnic minority women go to public hospitals for delivery. The majority of deliveries occur in the home. Most health service providers had received basic training. There are large differences in the level of retraining within different provinces, however. Certain geographic areas, such as provinces in mountainous

areas, have the lowest percentage of retrained staff although this is not necessarily limited to areas with predominantly minority ethnic groups. [101]

In Myanmar, nationwide 57 per cent of births are attended by skilled personnel. However, this is much lower in Rakhine state where only 31 per cent of women have skilled personnel at delivery.[102]

In Cambodia, only 13-14 per cent of women in Ratanakiri, Mondulkiri, Stung Treng and Preah Vihear, provinces with a high percentage of ethnic minorities, are attended by skilled personnel at birth, compared to 86 percent of women in Phnom Penh.[103]

5.5 Sexually Transmitted Infections and HIV

Many ethnic groups face the danger of HIV and sexually transmitted infections (STIs) due to a lack of adequate prevention, treatment and care options.[104] These difficulties are compounded by health providers' poor understanding of the complex interplay of rapid socio-cultural change, customs, beliefs and practices. Upland ethnic communities living in exploited environments and border areas are particularly vulnerable to STIs and HIV.

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[97] ADB 2001.
[98] National Statistics Centre, Lao PDR 2007.
[99] National Statistics Centre, Lao PDR 2007.
[100] WHO 2002.
[101] UNFPA 2003.
[102] Ministry of Immigration and Population, Myanmar 2003.
[103] National Institute of Public Health and National Institute of Statistics , Cambodia 2006.
[104] ADB 2001.

Most ethnic groups in the region were geographically relatively isolated for many years and thus also isolated from many communicable diseases. Road constructions and improved infrastructure throughout the GMS has contributed to increased access to goods, services, education, social interactions, and ideas. This rapid development process has resulted in migration to commercial districts, division of families, and increased expansion of sexual networks. These changes were not accompanied by the necessary knowledge and skills to manage these changes. Migrants and refugees lack access to health information and services. It is hard collect meaningful data on migrants since they also move across borders.

UNAIDS reports that the rate of HIV infection among women in the GMS, in particular in Viet Nam, Lao PDR and Cambodia, is rising at a faster pace than among men.[105] Concerns are growing about the social impact and potential for a dramatic increase in HIV infections resulting from the Asia Highway and Asia Development Bank (ADB) project to help GMS countries develop tourism. Commercial sexual exploitation of children is already a problem in some parts of GMS countries. Internal and cross-border trafficking of women and young girls for prostitution in response to demand from truck drivers and road construction workers is a cause for alarm.

Women in many villages in Yunnan acquired HIV infection from their partners. Many of these partners had migrated in search of work opportunities and accessed sexual networks without sufficient knowledge of the possible risks and skills to protect themselves and others.

In the Luang Namtha Province in northwest Lao PDR, a region historically inhabited by 98 per cent of people from ethnic minorities groups, a World Bank-supported road upgrading increased access to and from the region. Studies indicated that road construction concurrently created high levels of vulnerability to sexual transmission of HIV.[106] The principal causes were the rapid cultural, political and economic changes that accompanied infrastructure development.

In Lao PDR, levels of knowledge about HIV transmission are low. At least one study indicates that 60 per cent of women in the North have not heard of HIV and AIDS.[107] It is quite possible that this percentage is higher among women from ethnic minorities. Men lack basic information regarding STIs, including HIV.

Studies in Lao PDR have documented behavioural risks that contribute to STI and HIV transmission such as access to commercial sex among men and young people who travel in search

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[105] TREATASIA
[106] AKHAWOOD Media Production and Distribution 2005.
[107] ADB 2001.

of work opportunities.[108]Mis-information regarding HIV also appears to be widespread. A high of 16 percent of women and 19 per cent of married men hold beliefs about "taking medicines before sex" and "not using toilets used by infected persons".[109]

Many women from ethnic minorities are involved in sex work along the different travel routes across Lao PDR. Studies have indicated that ethnic minority women from Louang Namtha and Oudomxay engaged in sex work in Louang Prabang have a near complete lack of knowledge regarding HIV and AIDS. [110] Condom use among these groups is at the discretion of the customer. HIV prevalence is still low in Lao PDR at a rate of 0.1 per cent, however, and is the lowest in the GMS. A number of factors contribute to this situation, including the remoteness of many communities; the still relatively limited but growing size of the commercial sex sector; the limited number of intravenous drug users and the less advanced market economy resulting in reduced opportunities requiring mobility. Some concerns about the under reporting of HIV infection due to low testing ratios exist so the validity of data questionable.[111]

Cambodia has been especially hard hit by HIV. It still has one of the highest prevalence rates in Asia despite some success in curbing the epidemic. There is little data on HIV infection levels among ethnic groups in Cambodia. Based on other SRH indicators, however, it is reasonable to assume that these groups are especially vulnerable as they tend to have limited access to preventive measures.[112] Cambodia is also characterized by high mobility, especially in border areas, which contributes to increased vulnerability.

In Thailand, HIV and AIDS repre-sent the gravest public health concern in the Northern highland border areas, which are inhabited by large groups of low-income ethnic minority groups. Many of the people in these areas are involved in the sex trade and are particularly vulnerable to HIV. Contraceptive use among these groups is also low.[113] Drug abuse is prevalent among some highland minorities which also increases the risk of HIV infection.[114]

The Survey Assessment of Vietna-mese Youth (SAVY) indicates that there is a marked difference in awareness rates about STIs between rural and urban young people.[115] In the case of syphilis and gonorrhoea, for example, urban respondents'

[108] WHO 2002.
[109] National Statistics Centre, Lao PDR 2000.
[110] UNOPS and UNDP 2000.
[111] AKHAWOOD Media Production and Distribution 2005.
[112] ADB 2001.
[113] Ibid.
[114] UNESCAP 2005.

awareness rates were about 20 per cent higher than those of their rural counterparts were. The SAVY survey report states that ethnic minority groups, most of which live in mountainous and rural areas, were the most disadvantaged in terms of accessing information and services. These groups were, in most cases, also among the poorest, the least healthy and the least educated. Nearly one quarter of young ethnic minority people who had not attended school had never heard of AIDS. Thirty-six per cent of ethnic youth and 20 per cent of rural females think that healthy looking people cannot be HIV positive. A noticeable trend towards a younger average age among reported HIV cases was identified.[116]Young people under 30 years old account for 60 per cent of new HIV infections. Recent studies of young people in mountainous areas indicate that only 26.3 per cent are able to answer basic questions regarding HIV transmission and/or reject major misconceptions about transmission. [117]

5.6 Adolescent reproductive health

Adolescents from ethnic minority groups are particularly vulnerable to reproductive health problems. The vulnerability of adolescents is particularly high among those with higher exposure to external lifestyles but who lack knowledge and skills to adopt and sustain healthy behaviours. The complex interplay of traditions and customs and rapid social change brings additional elements of risk and vulnerability into the lives of adolescents.

Adolescents among some ethnic minority groups are expected to marry and have children at an early age. Early sexual relations may add a risk factor for STI and HIV transmission depending on knowledge and skills to reduce associated risks. Risks among youth are heightened by the increased number of sexual partners and unprotected sex, especially in situations of high social mobility. Early childbearing also increases risks for maternal mortality.

The Lao Reproductive Health Survey 2000 indicates that Lao PDR has a relatively young population, less than one-half of the population is under 15 years of age.[118] The proportion of women between the ages of 15 and 19 years who have begun childbearing is highest in the Northern region (20 Per cent) followed by Central region (18 per cent) and the Southern region (16 per cent). Rural adolescents are over twice as likely (21 per cent) to start adolescent childbearing as their urban counterparts (9 per cent). [119]

In Lao PDR, for example, adolescents often marry at a young age and are not aware of risks related to early childbirth. The level of knowledge related to reproduce-tive health and contraceptives is very low. Most

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[115] Ministry of Health, General Statistics Office, UNICEF and WHO, Viet Nam 2005.
[116] Viet Nam Administration for AIDS Control, Ministry of Health 2005.
[117] United Nations in Viet Nam 2003.
[118] National Statistics Centre, Lao PDR 2000
[119] Ibid.

young people receive information from women in the community. There is very little access to health education so adolescents have very limited knowledge about contraceptives. Drug stores are hesitant to sell contraceptives to adolescents. Health workers do not provide services to unmarried adolescents. There is a lack of knowledge about and availability of emergency contraception.[120] It is reasonable to assume that these

issues are more severe in provinces with large numbers of ethnic minorities. Language barriers and social norms further limit adolescents from these groups to develop health-seeking behaviours.

Studies in Viet Nam indicate that customs and practices among many groups (including Dao, Mhong, Thai Den, and Khmer) profoundly influence the sexual perceptions and behaviours of adolescents and youth. Ethnic groups expect customs and practices to be to be maintained from one generation to the next and define which activities are acceptable and which are not. Youth and adults face constraints to access accurate and current information about managing safe relationships, including safe sexual behaviours. Sexual behaviours and governed by traditional economic and cultural relations. [121]

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[120] WHO 2002.
[121] UNIADS and UNICEF 2000.

6. Case studies of good practices and lessons learned

A number of programmes have provided examples of good practices and/or lessons learned for application with ethnic minorities in the GMS. Some of the recommend-dations discussed in Section 7 are partially based on information obtained from the experiences discussed in the case studies.

Case Study 1: Maternal health as an entry point to strengthen primary health care in Lao PDR[122]

In Sayaboury Province in Northern Lao PDR, Save the Children Australia and the Provincial Health Department have conducted a primary health care initiative focused on improving maternal and child health using an integrated approach.

Maternal and child health services were used as an entry point for strengthening other primary health care services, including communicable disease control, health education and nutrition promotion. All interventions were completely integrated into the work routine of the health system. The project was coordinated by a provincial management team consisting of representatives from each participating district and the Provincial Health Office. In-service training was provided for district teams and dispensary staff. Village health volunteers and traditional birth attendants were also trained.

District mobile health teams visited each village at least twice a year, providing health education through dramatized videos in several local languages. The mobile teams also provided clinical services, antenatal care, immunization, contraception, and growth monitoring. District Teams conducted quarterly "health days" at each dispensary, spending two days monitoring the quality of services, conducting on-the-job training, and providing clinical services.

After 10 years of operation, the programme implementers were able to ensure that 92 per cent of all households were less than 5
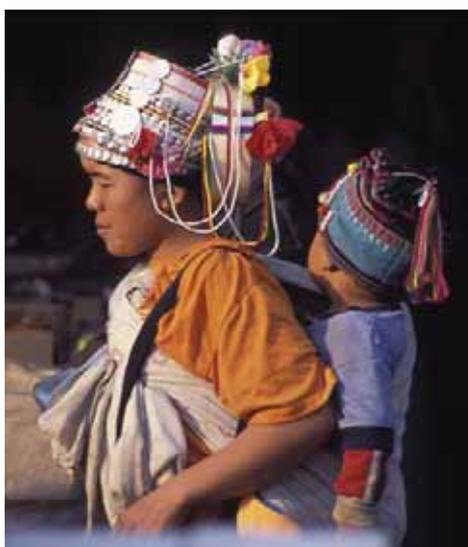
Credit: Thomas Greenwood, UNFPA Lao PDR

kilometres or less than a 60 minutes walk from a health facility. Health

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[122] WHO 2006.

volunteers were trained to provide health education, which resulted in important links between health services and the community. The improvements in access resulted in high utilization of health services and a threefold increase in the number of outpatients. Maternal mortality ratio in this programme province decreased from 218 / 100000 live births in 1998 to 111 / 100000, much lower than the national average. Other results include increasing use of modern contraceptive methods from 12 per cent in 1997 to 67 per cent in 2003. Other key success factors included retention of village health volunteers and traditional birth attendants as well as effective supervision of their operations. This approach effectively strengthened linkages between public health service provision and the community.

Case Study 2: Addressing what people want first helps build trust in Lao PDR [123]

The collaboration between Family Planning Australia and the Lao Women's Union illustrates the importance of re-orienting government structures and pro-cesses. Structures and processes need to address reproductive health within the broader context of development needs as articulated by ethnic minority groups. A key starting point and success element was the focus on developing trust with ethnic minority groups and addressing their perceived immediate needs first. The project supported the strengthening of women's capacities for income generation through a loan initiatives this was an immediate need. The Lao Women's Union capacity to

reach remote villages played a critical contribution to this process.

The project also included a concurrent focus on providing knowledge and skills to District government staff. Staff capacities were strengthened to support the target population and link women's economic empowerment to reproductive health empowerment. Women's participation in local decision-making structures was also promoted.

The project used existing structures and national resources for technical support in order to contain costs as well as to institutionalize and sustain new approaches and capacities. The approach had been replicated and adapted in other settings and countries. In Yunnan Province in China, the Centre for Biodiversity and Indigenous Knowledge is implementing an initiative that uses the management of biological diversity as the entry point. The imitative values and expands the traditional knowledge of local communities, with a focus on increasing participation in decision-making processes.

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[123] Lao Women's Union and Family Planning Australia 2004 and Center for Biodiversity and Indigenous Knowledge 2002.

Case Study 3: Linking specific issues to the broader picture in Cambodia [124]

Programming experiences from Health Unlimited among ethnic groups in North Eastern Cambodia indicate that a link between a specific issue requiring behaviour change, such as feeding practices, and the broader context needs to be established. Health communications and education about breastfeeding, for example, needs to be linked to sustainable actions that address very high malnutrition rates in remote locations. The programme, therefore, linked the provision of health education with outreach services to reach remote and marginalized populations. Health education content and messages were also revised by studying them through a cultural lens to identify inappropriate aspects and replace them with culturally relevant information. Messages that revolved around the concept of the "right age" to start weaning were, for example, meaningless to some ethnic groups that do not use "age" as a parameter for this kind of process. Messages were instead developed around other signs that had meaning in the cultures of these groups and that could be used to signal the appropriate time to start weaning.

Case Study 4: Strategic communication makes a difference in Yunnan [125]

UNESCO Bangkok's Culture Unit is developing two ethnic minority language radio soap operas in China's Yunnan province as part of a broader initiative to prevent HIV, human trafficking, and drug abuse across the Upper Mekong sub-region. The programme "Life of Tragedies" is produced in the Jingpo language and "The Weeping Jade Dragon Snow Mountain" is produced in the Naxi language. The two dramas not only address individual behaviour change but also the cultural, spiritual/religious and social context of the soap opera characters. While the primary objective is to provide education on HIV, an important additional objective is to preserve traditional culture and language, particularly for young people.

The initiative includes the capacity strengthening of community-based groups (e.g., youth or women's groups, community learning centres) in ethnic minority villages so they provide peer education support to the radio shows. The programme also helps develop the capacity of local, ethnic minority script writers, multi-media producers, and community mobilisers to develop supplementary materials in local languages that reinforce the messages contained in the soap operas.

In July 2004, UNESCO trained a team of researchers in qualitative research methodologies and the basics of HIV, drugs and human trafficking. The researchers were drawn from local Lijiang institutes and organizations. Two authors fluent in reading and writing a Naxi script wrote the radio drama,

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[124] Health Unlimited 2003.
[125] The Communication Initiative Network 2008.

drawing upon the content of the research findings. Efforts to make tapes of the music and the soap operas available for copying and distribution are in progress. With funds from UNFPA, UNESCO is supporting the Yunnan People's Broadcasting Station in Kunming to reproduce and distribute around 1,000 sets of cassettes and CDs of "Life of Tragedies" to 260 villages in Dehong Prefecture in Yunnan Province. They will be provided to the local prefecture, county and township offices, including the local CDCs (Centers for Disease Control) to use as animation materials for prevention education.

Case Study 5: Comprehensive district management health programmes yields results in Lao PDR [126]

A comprehensive district manage-ment health programme implement-ted in the remote Sayaboury province in Lao PDR has reported significant health indicator gains when compared with national results.

The reduction in Sayaboury may be attributed in part to the high prevalence of contraceptive use. The comprehensive district management health programme has increased coverage of antenatal care, training of traditional birth attendants, rate of attended deliveries and improved basic obstetric management. Moreover, the programme benefited from the long-term stability of the provincial primary health care leadership, appropriate technical assistance, and consistent donor support.

A study in 2003 found that the recurrent costs of maintaining the

programme was equivalent to US$41,000, or less than US$0.13 per person per year. The costs cover mobile clinics, health days, monitoring and supervision, three-monthly inter-sectoral and project management meetings, and annual refresher training for village health volunteers and traditional birth attendants.

Case Study 6: Integrated community health helps bridge gaps in addressing maternal mortality rates in Cambodia [127]

Health Unlimited has implemented a programme to develop and expand the capacity of Traditional Birth Attendants (TBAs) in the remote North East region of Rattanakiri since 1996. The province of Rattanakiri has a large population of ethnic minority members. Maternal mortality rates are much higher in Rattanakiri than in the rest of the country. The population of Rattanakiri Province lacks sufficient income and has language and cultural barriers that limit access to health care. Continuing migration of Khmer people from the lowlands to the Rattanakiri hills threatens the land ownership of local ethnic groups.

The deforestation of the area to create space for settlements and commerce also threatens the livelihoods of local people. Local groups are gradually being pushed further away from the already poor road and transport links and from health posts. Access to health services such as emergency obstetric care is difficult.

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[126] WHO 2006.
[127] Health Unlimited 2005.

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Training TBAs is part of an integrated approach to community health that helps bridge critical gaps to achieving the goal of having a skilled attendant at every birth. TBAs are trained in disease prevention and antenatal care, safe and hygienic delivery practices, recognition and referral of maternal complications, and monitoring of deaths of mothers and infants. Ninety percent of deliveries are currently attended by a trained TBA in villages where the programme is implemented. Harmful traditional practices around delivery have been reduced and neonatal survival appears to have increased.

Case Study 7: Male involvement mobilizes resources and fosters change in Myanmar [128]

The Japanese Organization for International Cooperation in Family Planning (JOICFP), the Department of Health (DOH), and the Myanmar Medical Association (MMA) implemented a 2004-2007 UNFPA-supported pilot intervention on male involvement in reproductive health. The project was conceptualized to meet the strategic objectives of Myanmar's Five-year Strategic Plan for Reproductive Health (2004-2008) and the National Reproductive Health Policy. These strategic documents identify the reduction of maternal mortality as a major area of concern. The frameworks also recognize the need to address gender inequality as a main contributing factor to negative reproductive health outcomes.

The design of the Myanmar intervention was based on the findings of a baseline survey on men's knowledge, attitude and practices related to reproductive health, STIs/HIV, and gender issues. The survey also studied knowledge and attitudes regarding danger signs during pregnancy and post-partum. The project developed a communication strategy that included a coordinated use of advocacy, community mobilization and behaviour change communication to mobilize men. Men learn to recognize danger signs during pregnancy and post-partum and take timely action to ensure women and infants access care. Advocacy meetings were organized at township and ward/village levels to gain support of all the key partners, community groups, leaders and influential persons involved in the project. During the advocacy meetings, stakeholders provided their opinions and suggestions on intervention modalities.

Orientation sessions were organized for general practitioners from project areas who were not directly involved in the project to gain their support and provide linkages with the male volunteers. TV spots on how men could help prevent maternal mortality were developed and broadcast on national TV. Billboards with messages on male involvement and emergency obstetric care were

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[128] Source: UNFPA Country Support Team for East and South-East Asia. This project was part of a 3-year three-country pilot programme on male involvement in RH sponsored by UNFPA in Mongolia, Myanmar, and Indonesia with technical assistance from JOICFP- the Japanese Organization for International Cooperation in Family Planning.

placed in project areas. Male volunteers were recruited and trained to implement peer communication efforts. The volunteers carried out individual and group discussions in their neighbourhoods, work places, and other locations where men usually gather such as teashops and video parlours. Many male volunteers found that the project had made a positive impact on them, their families and their community. The volunteers' consistent support of activities and of timely referrals in case of maternal emergencies earned them recognition from their community. The project end line survey provided validation of useful project actions and important lessons for scaling up. As a result, the project model will be integrated into the second UNFPA Programme of Assistance (2008-2011).

Case Study 8: Incorporating HIV prevention in large infrastructure projects in the GMS [129]

The East–West Corridor (EWC) project is one of the first large infrastructure projects funded by ADB in the GMS that addresses HIV vulnerabilities specifically associated with large infrastructure projects. The project rehabilitated a road connecting the Quang Tri Province in Viet Nam and the Savannakhet Province in the Lao PDR reaching the Thai border.
The project involved local authorities in Lao PDR and in Viet Nam that were mandated to implement HIV programmes. The project provided HIV prevention actions for construction workers. The project also reached the surrounding communities and created linkages with other ADB

projects implemented in the region such as the *Community Action for Preventing HIV* project.

The project worked with the local health authorities in the Dak Rong district in Viet Nam to organize a series of musical nights in collaboration with the local youth union and other local community members. Most residents of this district are from ethnic minority groups. Construction workers living near the villages were invited to participate to improve relations between the groups. The project set a precedent for mainstreaming HIV and AIDS prevention in the transport sector.

A comprehensive approach was proposed to address health and social risks of road construction based on the recognition of risks that can emerge due to interaction between construction employees and local communities. An external evaluation highlighted key issues that can be useful for planning and implementing future programmes. Although the project design was useful implementing agencies had limited capacity to ensure compliance. Integrating the efforts of separate projects was a good concept but difficult to implement. Without a specific project budget for the HIV, STI, and trafficking-

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[129] Source: ADB 2008.

prevention activities, the project management unit had to mobilize external resources. External resources were limited which ultimately affected the quality and effectiveness of prevention efforts. HIV education efforts were limited to raising basic HIV and AIDS awareness and not specifically targeted to behaviour change outcomes. Limited efforts were taken to cross the language barriers and reach ethnic minority groups and foreign construction workers.

Increased interaction of local populations with construction workers—and eventually, road users—inevitably accompanies the development of infrastructure such as the East West Corridor with related HIV risks. Specific knowledge is needed for targeted interventions that account for these customs and address risks appropriately.

7. Recommendations

The countries in the GMS have varying degrees of success in terms of their progress towards reaching the Millennium Development Goals (MDGs). Even in countries with substantial progress on several MDGs, such as Thailand and China, national indicators mask profound sub-regional disparities.[130] Substantial disparities within GMS countries exist, particularly between areas where dominant ethnic groups live and those where ethnic minorities reside. In areas with ethnic minorities development indicators tend to be less positive, including those pertaining to reproductive health.

This reality is a stark reminder to the GMS countries that their policies, strategies, and programmes to fully achieve the MDGs should incorporate a stronger emphasis to improve development indicators and reduce social exclusion among ethnic minorities.

The importance of reducing access and equity barriers facing ethnic minorities in the GMS is evident from the literature. Case studies of effective programmes illustrate the feasibility of over-coming barriers.

Access and equity barriers constitute tangible obstacles to fully achieving the MDGs and should be addressed as a matter of priority. Many of the inequalities contributing to low development indicator results among ethnic minorities stem from lack of political representation, legal status and protection. The development goals of GMS countries can expect to be undermined by persisting disparities unless political will and wisdom is mobilized to address these issues. Continued development disparities will also continue to fuel social problems.

7.1 Recommendations for general policies and strategies

At the policy and strategy level, the following actions are recommended:

7.1.1. Increase representation of ethnic minority groups in all policy development and planning processes in government and civil society organizations at national, provincial and local levels. Institutional opportunities for the participation of ethnic minorities needs to be strengthened so that they can contribute to the formulation and implementation of plans and programmes that affect their lives. Representation will enable ethnic minorities to articulate their particular issues and needs and improve the formulation of culturally relevant solutions.

7.1.2. Ensure that key policies and strategies—such as PRSPs, MDG roadmaps and national strategies for reproductive health—are reviewed so that the frame works include references to ethnic minorities and their specific development needs.

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[130] World Bank in Thailand 2007 and UN Country Team China 2005.

7.1.3 Ensure that national frame works promote rights-based approaches, including policies supporting provision of information and social services in minority languages.

7.1.4 Ensure that national frame works should respond to priority concerns of ethnic minorities such as lack of health infrastructure and transport, particularly as related to reproductive health.

7.1.5 Ensure that national frameworks promote institutional support for the development of appropriate and adequate capacities to implement reproductive health initiatives with ethnic minority populations.

7.1.6 Strengthen participatory research and data collection, both qualitative and quantitatively disaggregated by ethnicity, to inform the development of policies and strategies and design coordinated responses.

7.1.7 Recruit and integrate health workers and teachers from ethnic minority groups into development initiatives. Ethnic minority group staff can then become role models within their communities and become effective advocates in institutional settings. Scholarship systems for secondary education may need to be introduced to ensure that potential candidates meet the tertiary educational entry requirements.

7.1.8 Review regulations that currently prevent many ethnic minority people from being legally registered. GMS countries should particularly remove obstacles for ethnic minority groups to access full citizenship rights and entitlements. This is of particular importance for those ethnic minority or indigenous people who were born in or have been long-term residents in those countries.

7.1.9 Review definitions and categorization of ethnic minorities and or indigenous people. Definitions need to aim at the elimination of stigmatization, discrimination and exclusion that these groups currently experience in accessing essential health, education and other social services. Ethnic minorities should be meaningfully represented in these processes.

7.1.10 Increase cross border sharing of best practices to address policy and programme recommend-dations so that ethnic minority groups living in political border areas in the GMS can benefit from a regionally effective approach.

7.2 Recommendations to address specific sexual and reproductive health issues

Promising programming approaches that address key challenges to meet the sexual and reproductive health needs facing ethnic groups in the GMS can be identified by drawing conclusions from the literature research.

Key recommendations on sexual and reproductive health for minority ethnic groups:

7.2.1. Strengthen sexual and reproductive health services through increasing rights-based and

culturally appropriate approaches.

7.2.2. Ensure community participation and inclusion.

7.2.3 Integrate reproductive health and family planning in primary health care and other interventions so that they are relevant to the cultural understanding of the health and well-being of ethnic minority groups.

7.2.4 Expand strategic communication programming among ethnic minority groups, utilizing local languages.

7.2.5 Strengthen prevention of maternal morbidity and mortality through increased access to skilled birth attendants close to the community and by strengthening primary health care at district and sub-district levels.

7.2.6. Address key programming gaps in the provision of reproductive health services for ethnic minorities. Develop emergency obstetric care and male involvement in programmes.

7.2.7 Address HIV and STI issues not in isolation but linked with other development strategies.

7.3 Details of Recommendations on sexual and reproductive health needs

7.3.1 Strengthen sexual and reproductive health services through increasing rights-based and culturally appropriate approaches.
Capacity strengthening should incorporate cross-cultural communi-cation skills for health providers and managers, adapting language policies that currently limit provision of information and services in minority languages and implement-ing effective procedures to address client's grievances.

7.3.2 Ensure community participation and inclusion.
The health of ethnic minorities should be addressed within a broader paradigm of sustainable development that takes into consideration the social implications of rapid change, especially with regard to social exclusion and vulnerability. This requires a focus on empowering ethnic minorities to participate meaningfully in the identification of their development needs and representation in governmental decision-making committees. Mechanisms need to be developed to increase ethnic minority participation in the design, implementation, monitoring and evaluation of SRH programmes.

7.3.3 Integrate reproductive health and family planning in primary health care interventions and other interventions so that they are relevant to the cultural understanding of the health and well-being of ethnic minority groups.
The current approach of most health programmes is to use a vertical perspective to address health issues. Such a vertical approach does not reflect the understanding of health and well-being among most ethnic minority groups in the GMS as holistically linked to nature and the environment. The integration of reproductive health and family

planning in primary health care structures and other interventions should be informed by an understanding of the linkages that ethnic minorities identify with other challenges they face. These include improving access to education, nutrition, income generation, and sustainable use of land and forests. The entry points that these concerns provide can be used to work with ethnic minority groups in non-stigmatizing and non-discriminatory ways.

The provision of services needs to be tailored to the physical requirements of ethnic minorities. Services need to be located as close as possible to communities, with services available at hours in line with the local workday. Health campaigns need to allow for seasonal variations in weather and work occupations. The cross-cultural communication skills of health providers and managers need to be improved and services provided in minority languages.

7.3.4 Expand strategic communication programming among ethnic minority groups, utilizing local languages.

An urgent need exists to incorporate participatory communication strategies as integral components of sexual and reproductive health programmes. The strategies need to focus more on Behaviour Change Communications (BCC) as opposed to being limited to Information Education and Communications (IEC) type methods.

A review of communication activities indicates that they are mostly limited to the development and/or provision of IEC materials.

Although some efforts have been made to provide information in some ethic minority languages, these activities are not conceptualized as a strategic and comprehensive communications approach. Such an approach needs to be well oriented to help address the root causes of reproductive health problems and prevent negative outcomes. Instead, most communication interventions still tend to use a top-down "sender-to-receiver" approach. Interventions frequently focus on single issues, such as condom use to reduce risk of unplanned pregnancies and infections, which is often disjointed from the daily realities of ethnic minority group members.

Ethnic minority groups should be meaningfully involved in the design of communication strategies. They need to contribute to the identification of the most appropriate entry points into their cultural context. They should also contribute to content, translation into local languages and assist in determining modalities and channels of dissemination. Most importantly, communication strategies should aim at enabling dialogue within communities with special focus on the inclusion of the most marginalized people. Communication should be action and results-oriented and use advocacy, social mobilization, and behaviour change in a coordinated way. Communication needs to aim at the achievement of clearly identified objectives and should be linked to other programme elements such as service provision.

7.3.5 Strengthen prevention of maternal morbidity and mortality

through increased access to skilled birth attendants close to the community and by strengthening primary health care at district and sub-district levels.

Cost and accessibility are among the most significant barriers of ethnic minority groups to the utilization of trained health professionals. An urgent need exists to increase the recruitment and training of skilled birth attendants from ethnic minority groups so that access to maternal health services is improved. Skilled birth attendants cannot work in isolation but health systems in the GMS face challenges to ensure supervisory support and in-service training to maintain acquired skills. The initial provision of skilled birth attendants alone may not ensure adequate access to primary health care services for ethnic minorities. Coordinated efforts are needed to address issues such as:

- high turn over of staff in remote locations
- lack of understanding of ethnic minority health issues among
- lack of trained midwives in public health systems
- health planners and decision-makers
- poor health and communication infrastructure in remote areas

Increased recruitment and training of health staff from ethnic minority groups should take place within a policy context that prevents marginalization of these health workers. Ethnic minority group health staff are frequently only mandated to deal with "ethnic issues". Such a limited mandate

should be avoided. A rights-based approach to health care is needed so that good reproductive health care can be provided to all clients. Equal opportunities need to be provided for professional development and career advancement for all health staff.

7.3.6 Address key programming gaps in the provision of reproductive health services for ethnic minorities. Develop emergency obstetric care and male involvement in programmes.

Access to emergency obstetric care is critically important to the reduction of maternal mortality. Emergency obstetric care should form an integral element of programmes that strengthen primary health care at district and sub-district levels. The provision of emergency obstetric care remains a major challenge for many health systems in the GMS, particularly in areas where ethnic minorities reside. While governments continue to strengthen efforts to address these issues, it is also necessary to expand programmes that address gaps in the prevention of maternal morbidity and mortality at the community level and help strengthen referral systems.

An urgent need exists to coordinate existing and new programme opportunities to address the root causes of maternal morbidity and mortality with special attention to reducing gender inequality. Men still play a dominant role in decision making in many ethnic communities which affects women's sexual and reproductive health and child survival. Male involvement to ensure reproductive health has not

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expanded beyond promising small-scale projects. In most cases, projects are planned without awareness and understanding of how men's roles can be re-oriented towards equitable individual and social development goals.

7.3.7 Address HIV and STI issues not in isolation but linked with other development strategies.
The accelerated pace of economic development in the GMS in recent years and the disparities that have emerged, particularly as they affect ethnic minorities, mean that the HIV epidemic needs to be addressed within the context of overall development strategies. A good understanding of the underlying inequities and related vulnerabilities that fuel the epidemic across the GMS is necessary for the development of effective integrated strategies.

8. Conclusion

The response to the needs and challenges facing ethnic minority groups in the GMS can be more effective. All the countries of the GMS are committed to achieving important Millennium Development Goals and have made impressive progress on many of the human and social development indicators. These successes should provide the momentum to re-double efforts to eliminate inequalities and disparities that still undermine development efforts in the GMS. Renewed commitment to address the challenges of ethnic minority groups should translate into expanded and more meaningful participation of these groups in the GMS development process. Ultimately, development cannot be sustainable unless it addresses issues of social exclusion that are often associated with rapid economic growth.

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