

IPP99  
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**Socialist Republic of Vietnam  
Ministry of Health**

**Vietnam HIV/AIDS Prevention Project**

**Ethnic Minority Policy Framework  
(Draft)**

**Hanoi, November 2004**

## Table of Contents

1. Introduction	4
2. Socio-economic Information	5
3. Socio-cultural Conditions	6
4. Health Situation of Ethnic Minorities	7
5. Health Seeking Behaviors and Utilization of Services	7
6. Vulnerability and HIV/AIDS	8
7. Drug Use and Harm Environment	9
8. Sex Work and Harm Environment	10
9. Risk Reduction and HIV/AIDS	10
10. Policy Framework	11
11. Guidelines for Ethnic Minority Development Plan	13
12. Data Gathering	13
13. Guidelines for Provincial/City Action Plan Preparation	14
14. Monitoring and Evaluation	15
15. Institutional Arrangements	15

### Annexes

Annex 1	Vietnam: Composition and Distribution of Ethnic Minorities
Annex 2	Ethnic Minority Population in Participating Provinces/Cities
Annex 3	Summary of FGD Findings
Annex 4	References

## Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CEMMA	Committee for Ethnic Minorities and Mountainous Areas
CPRGS	Comprehensive Poverty Reduction and Growth Strategy
CPMU	Central Project Management Unit
CSW	Commercial Sex Worker
FGD	Focus Group Discussion
HDI	Human Development Indicator
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MOH	Ministry of Health
NGO	Non-government Organization
PF	Policy Framework
PPC	Provincial People Committee
PPMC	Provincial Preventive Medicine Center
PPMU	Provincial Project Management Unit
STD	Sexually Transmitted Diseases
UNODC	United Nation Office on Drugs and Crime
VHAPP	Vietnam HIV/AIDS Prevention Project
VLSS	Vietnam Living Standard Survey
VNHS	Vietnam National Health Survey
WB	World Bank

## 1. Introduction

1. Vietnam is facing an HIV/AIDS epidemic that is accelerating while at the same time, changing its character. The prevalence rate in the adult population (15-49) is approximately 0.4 percent. Most HIV infected persons are men (85 percent), with nearly half of them and a clear majority of new HIV positive cases falling in the 20-29 age range. This epidemic displays a distinctly geographic pattern, e.g. Quang Ninh, Hai Phong and Ho Chi Minh City, with prevalence rates considerably above the mean across provinces.

2. The Vietnam HIV/AIDS Prevention Project (VHAPP) aims to strengthen the HIV/AIDS program in the country in order to slow the spread of the epidemic by ensuring that national, provincial and local authorities in Viet Nam have the policies and capacity to design, implement and evaluate information and service delivery programs designed to halt transmission of HIV/AIDS among vulnerable populations and between vulnerable populations and the general population.

3. The project will be implemented in eighteen provinces and two cities (An Giang, Bac Giang, Ben Tre, Cao Bang, Dong Nai, Hai Phong, Hau Giang, Ho Chi Minh City, Khanh Hoa, Kien Giang, Lai Chau, Nam Dinh, Nghe An, Son La, Thai Binh, Thai Nguyen, Thanh Hoa, Tien Giang, Vinh Long, and Yen Bai).

4. In line with the World Bank's Operational Directives on Indigenous People (OP 4.20) this policy framework (PF) is developed to guide the preparation and implementation of provincial/city action plans, taking into account its ethnic minority population. The PF sets out policy objectives and guidelines for the design and implementation of the provincial/city action plan provisions regarding ethnic minorities. The PF will also provide guidance in the overall implementation and monitoring and evaluation of the Vietnam HIV/AIDS Prevention Project.

5. Vietnam has 53<sup>1</sup> ethnic minority groups<sup>2</sup> from different family and language sets. They comprise about 14 percent of the total population or about 10.5 million people. The Kinh group is the majority in the country.

6. In a review of data on ethnic minorities, it was found that the 20 provinces and cities participating in the VHAPP have 32 ethnic minority groups, with a total population of 3,250,000.<sup>3</sup> Almost 70 percent of them are located in 8 northern provinces. Each participating province/city is home to not one but several ethnic minority groups.

7. In order to gather ethnic minority group insights on the development of the PF, and to get initial information from them on paramount issues and concerns related to HIV/AIDS prevention control, Focus Group Discussions (FGD) were conducted in 2 northern provinces. In Thai Nguyen, the FGD was held in the village of Pham Ko, Hau Teung commune among female and male members of the Tay, Nung and San Dui ethnic minority groups. In Bac Giang, it was at Nghia Phuong commune among female and male members of the Cao lan ethnic minority group.

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<sup>1</sup> See Annex 1 for the composition and distribution of ethnic minority groups.

<sup>2</sup> Ethnic minority is the term used in this Policy Framework for Ethnic Minority Groups for which the World Bank's policy OD 4.20 on Indigenous Peoples applies.

<sup>3</sup> See Annex 2 for the list of participating provinces and their ethnic minority population.



## 2. Socio – Economic Information

8. The ethnic minority groups can be found in 45 provinces and cities. Most of them live in the uplands. The only ethnic minority groups who live mainly in the lowlands are Hoa (Chinese), Cham and Kh'me. There are 42 provinces located in mountainous areas occupying three quarters of the total land area. Here, 19 million people reside, of which about 10 million are ethnic minority groups. Within provinces and lower administration levels (district and commune) the concentration of ethnic minorities varies from location to location.

9. Ethnic minority groups are concentrated mainly in two mountainous geographical regions. They can be found in the 11 Northern Highland provinces (Northern East and North West) that encompass 31 ethnic groups. They are also in the Central Coastal and Central Highlands, covering 19 provinces with 19 ethnic groups. The Central Highlands also host many newly settled ethnic minority groups. The Hoa, Khme, and Cham, who reside in the coastal and lowland areas, mix with the Kinh group in the South Coastal and Mekong River Delta provinces.

10. Population growth in the mountainous regions is higher than the national population growth rate, which is 2.1 percent. In the Northern region, the population growth rate is 2.3 percent and in the Central Highlands it is 3 percent. For several ethnic groups, the population growth rate is much higher than the national average.

11. There is great diversity among the ethnic minority groups in terms of their size, language, lifestyle, customs and beliefs, social organization, and means of livelihood that generalization is not possible. However, there are some characteristics that are commonly shared by ethnic minority groups:

- Attachment with community land, natural resources, social organization and lifestyle;
- Their customs, beliefs and rituals, lifestyles, community organization, the role of family, respect for elders and village authorities reflect the differences in their language and cultural traditions; and
- Level of social integration can be characterized and measured by the Human Development Indicator (HDI) poverty, education, health care, infrastructure, etc.

12. With the rugged conditions and slow development in the mountain areas, its population is more disadvantaged in terms of living conditions. Its people also lag behind in economic and social progress. A 1998 study by Phan Thanh Xuan presented the three categories of the mountainous areas in terms of socio-economic development.

- The 1<sup>st</sup> category covers 931 communes (21.4 percent) with 6 million people and various ethnic minority groups. The minority groups typically reside along the main roads, industrial centers, and agricultural enterprises close to basic infrastructure services (health stations, communications, schools, and markets). Many ethnic minority groups grow rice, develop animal husbandry or cultivate commercial products. Most of the ethnic minority population are settled and have developed a household based economy with an income per capita approaching the national average.
- The 2<sup>nd</sup> category includes 1854 communes (42.5 percent) with about 8.5 million people, where most of the ethnic minority groups have settled but have not achieved a stable life. Many ethnic minority households exist on a subsistence based economy and have access to limited basic services. They are often at risk of living in poverty and need support to develop a sustainable lifestyle.
- The 3<sup>rd</sup> category, consists of the poorest and most difficult conditions with 1568 communes (36 percent), with about 4.5 million people including 90 percent ethnic

minorities who live in high and remote areas. Some of these ethnic minority groups include the very small population base groups. In these areas the natural resources are often depleted, there is a high risk of natural calamities and inaccessible roads. Most ethnic minority households practice a subsistence type of living. They are nomadic “slash and burn” farmers or are primary hunters and gatherers. The rate of poverty among these groups is quite high compared to other social groups.

13. There are twice more ethnic minorities (75 percent) who fall below the poverty line compared to Kinh (31 percent). The gap in income and living standards between ethnic minorities and the Kinh population is seen to be widening.

14. In general, ethnic minority women suffer more from the effect of poverty than ethnic minority men. The women’s situation is also influenced by many socio-cultural practices that are related to gender issues. This limits their access to social and health services.

### **3. Socio-Cultural Conditions**

#### *Literacy*

15. Literacy is lower among ethnic minorities. The literacy ratio for ethnic minorities is estimated to be 73 percent compared to 90 percent for the total population. Primary education is available for 90 percent of the total population while for ethnic and poor it is much more limited. At secondary and higher education levels, gender disparities still exist due to cost, fees, and socio-cultural barriers.

16. Illiteracy among women is double that for men. The adult female rate of illiteracy is 13.1 percent and 6 percent for men. In the mountainous ethnic minority areas (Northern East and Northern West provinces), the adult illiteracy is much higher (female –35.3 percent, male - 17.8 percent) and in the Central highland (22.2 percent and 11.8 percent).

17. In two national household surveys (VLSS 1992-1993 and 1997-1998), the gender gap in education between boys and girls remained the same for ethnic minorities, while it decreased nationwide. The gap is more prevalent for groups in the Central Highlands and Northern mountainous area. Girls in rural and ethnic minority areas often drop out of school earlier than boys and stay at home to help with household work.

18. The high illiteracy rate, low level of education among adults and the pervasiveness of socio-cultural barriers, language and cultural differences influence many aspects of health care, particularly preventive care. The specific factors that limit the use of preventive services include parents’ child bearing and nurturing abilities, access to and understanding health care knowledge and information, and general involvement in public health services.

19. In order to fill the human resources needs of the ethnic minority groups, the National Education Target Program for Mountainous Areas established boarding schools in 47 lower and secondary provincial schools. Notably, 200 elementary and lower secondary schools at district level and 10 pre-university institutions have been developed and improved. Every year, about 4000 high school graduates are eligible to enroll in universities and colleges. These students are expected to provide the manpower for ethnic minority mountainous area development.

## *Gender*

20. There are strict division of labor between men and women, although variations are common among ethnic minority communities. Women are assigned the traditional “women’s work” such as taking care of domestic chores, reproductive and family care and activities related to hygiene and sanitation. In preventive and health care practices at household level, women play a specific role in the care of common diseases based on local experience and traditional knowledge; in food preparation and cooking, diet as well as household living arrangements. They also work as traditional healers, and drug sellers. However, among some ethnic minority groups, the availability of limited preventive and treatment practices, misuse of self-medication and lack of trust in modern medicine impede their health and child care.

21. Ethnic minority women often lack the knowledge about their rights. This is exacerbated by the prevalence of traditional custom law and practices that has a negative impact on women’s health and development; for example early or enforced marriage, multi-child family, limited decision-making on fertility matters and other old beliefs and practices.

22. Gender gaps are more marked and complex among certain ethnic minority groups. Some ethnic minority groups maintain strong matrilineal traditions where women’s status is higher than men’s. This is found among the Ede and Hmong groups. Men are still considered the representative head and main decision maker in the household and community. Generally, women have a limited role and representation in the public community sphere. This situation is accentuated by the language barrier which is typically more pronounced for women than for men. In ethnic minority communities the role and power of village elders is strong.

## **4. Health Situation**

23. The overall health situation among ethnic minority groups is strongly influenced by their less favorable socio-economic conditions under which they live. Characteristically, mothers and children suffer the most. Girl mortality is higher than for boys.

24. Ethnic minority women often face significant health risks associated with childbearing and reproductive health in general.

25. Among ethnic minority groups, women of reproductive age use traditional birth control methods and are reluctant to use modern methods. The use of modern methods is low among the illiterate women in many ethnic minority groups in the mountainous regions. The number of children and family size of ethnic minorities are higher than the national average.

## **5. Health Seeking Behavior and Utilization of Service**

26. To ensure better access to health facilities, the government provided an extensive network of commune health stations, district and provincial hospitals in provinces where there are large concentration of ethnic minorities. Generally, the rate of people contacting and using the health service, especially among ethnic minority groups, has increased over time. The commune health station is the preferred service point for most ethnic minority groups. There is still a group of people, especially the rural poor and ethnic minority women, who tend not to use public health services for common illnesses. The ethnic minority groups’ utilization of health service depends on various factors.

27. For some ethnic groups, access to health care services provided at the district hospitals and commune health stations seems difficult. In some mountainous areas, the chief barrier is the distance between their homes and the public health service points. It can be a day's travel for an ethnic minority family to reach the nearest public health facility.

28. Socio-cultural factors such as educational level, language and low living standards are additional barriers to an active health seeking behavior among ethnic minority groups. They have more health needs but are often reluctant to seek health services. This behavior is changing more slowly than it is for other rural social groups. Many come too late to the health service and consequently bear a higher cost for treatment.

29. Financial constraints are significant factors on the health care seeking behavior among many ethnic minorities. In 1998, the government enacted Decision 135 focused specifically on poverty alleviation for ethnic minorities. Under this policy, health cards were distributed to the ethnic minorities, entitling them to specific free health services. In spite of this, ethnic minorities continued to suffer inequity in health care. To correct this and to provide cover for the other poor citizens, the government implemented the Decision 139 (Health Care for the Poor Initiative) in 2002, where the poor and disadvantaged, including the ethnic minority groups, received a more extensive health coverage through a fund created from contributions from the central government (75%) and the provincial government (25%). Beneficiaries are either provided with a health insurance card or a health card that entitles them to free health services at all levels. Since its introduction, there has been an increase in health service utilization by ethnic minorities. This could be higher if more ethnic minority groups fully understand the benefits accruing to them under these 2 policies.

30. Access to basic healthcare among ethnic minority women in isolated areas is more difficult than men. Women's traditional roles take precedence over their own health. They are expected to care for all members of the family as well as perform routine household duties, leaving them little or no time to seek basic care. Social isolation for some remote ethnic minority groups is a difficult issue to break down. Social customs structure the way a community is organized and interacts with different health service levels.

31. There is a dearth of health care workers in some ethnic minority regions like North uplands, Red River Delta and Central Highlands, where the need is for well trained staff who speaks ethnic minority languages or knows local culture and customs. The government policy, embodied in Directive N 06-CT/TW of the Central Party Executive Committee from 2002 to the MOH, is clearly to increase the ratio of ethnic minority staff in the health workforce. However, it will take some time to realize the benefits of this policy due to the low education base for many ethnic minority communities.

32. In some remote ethnic minority areas it is difficult to attract highly qualified health personnel or even trained local ethnic minority people to work at district or commune levels. This situation results in a significantly higher turn-over of staff in remote areas of the country.

## **6. Vulnerabilities to HIV/AIDS**

33. The HIV/AIDS rate among ethnic minority is lower than for other social groups. However, in some ethnic minority communities, especially near border areas, HIV is prevalent and spreading quickly among drug addicts and prostitutes. Awareness of these health risks is still limited among some ethnic minority communities.

34. Gynecological diseases make ethnic minority women more vulnerable to HIV/AIDS infection. They suffer frequently from a number of reproductive tract infections such as sexually transmitted diseases (STDs). The percentage of women reported suffering from gynecological diseases is high (70 to 80 percent) in rural and ethnic minority areas. These conditions make women feel weak; their health status aggravated by bad working conditions, lack of clean water and sanitation, improper care and treatment. The national average for gynecological check ups at health clinics is a high 80.0 percent. However, the rate for ethnic minority women in mountainous areas is much lower than for the Kinh women. The lowest rate of health check ups was for ethnic minority women in the southern area (56 percent) and in the Central Highlands (63 percent). Most poor women indicated that they had never had a gynecological check up.

35. Increasingly, males from ethnic minority groups engage in circular migration, traveling to other provinces and cities for seasonal work and returning to their villages after the season is over. Because they usually leave their families at home, many men take up with casual sex partners, who may either be CSWs or not. Although no studies have been done specifically on ethnic minority migrant workers and condom use, other studies have shown that majority of male migrant workers are errant in their use of condoms during sex with a casual partner.

## **7. Drug Use and Harm Environment.**

36. Several ethnic minority groups in the Northern provinces have had a long history of opium poppy cultivation, many since the second half of the 19th century. Members of the Hmong and Dao ethnic groups were at one time the only groups under the Indochinese Union authorized to grow opium for domestic use. And because the Vietnamese authorities did not succeed in imposing its policy against poppy cultivation in the northerly provinces until the mid-90's, there grew a sense of tolerance, more unavoidable than deliberate, that allowed opium to become integrated into the economic and social life of these two ethnic groups.

37. The growth in drug use in the early 1990's that prompted the continuing massive campaign against poppy cultivation, is fed not only by the existence of illegal poppy farms but mostly by significant drug trafficking.

38. A UNODC study on drug use among ethnic minorities in the provinces of Son La, Lai Chau and Lao Cai reveals that "the traditional means of consumption of the mountainous regions are gradually being transformed and replaced by a drugs scene closer to the urban realities of Vietnam. Drug users tend to be younger; heroin and, to a lesser degree, amphetamines are fast supplanting opium."

39. The study confirms that a) older drug users tend to use opium as their exclusive drug of choice, though, consumption of heroin and amphetamine has been reported b) the centuries old uses of opium among the ethnic minorities as a therapeutic drug and a social tool appear to have become more and more marginal c) the presence of IDUs has been confirmed; so are high-risk behaviors by IDUs, even though information on the means of transmitting HIV appears to be available d) services for HIV detection among IDUs and their spouses, and the distribution of injection equipment and condoms, are not apparent.

40. The same study points to the preference by drug users to access treatment and rehabilitation within the community. However, there are several obstacles to this: primarily, cost (investment in terms of infrastructure), the availability of skills (training of local medical staff and availability of outside expertise) and the effectiveness itself of on-site treatment regimen.

41. Although the preference for community based treatment and rehabilitation remains high among drug users from ethnic minority groups, many of them enter 05/06 rehabilitation centers. In Thai Nguyen province, officials estimate that about one fifth of the residents in its 05/06 center are ethnic minorities.

42. Drug users have expectations of the support and understanding of their community. These expectations concern job creation and credit schemes. In the case of jobs, it is not easy to determine the nature of locally available and relevant employment that drug users could obtain, given the current economic situations in the communes concerned.

43. Even though drug users from ethnic minority communities are not exactly thought of as ordinary inhabitants by the others in the commune, they generally remain integrated into the community and do not appear to undergo the same degree of marginalization and exclusion experienced by their urban counterparts.

## **8. Sex Work and Harm Environment**

44. There is a dearth of data related to ethnic minority groups and sex work. There are a few studies that point to the increasing participation of young ethnic girls in the sex trade. They usually work as commercial sex workers (CSW) in their home province, especially in the tourist areas. In the northern mountain resort of Sapa, two studies claim that girls below 16 years old are engaging in sex work. Most are from the Hmong ethnic group.

45. The UNODC study points to the absence of ethnic CSWs in its subject communes. However, it verifies their presence in the bigger communes and the capital towns. It reports that they receive business from the subject communes. This mirrors the situation in the village and commune in Thai Nguyen and Bac Giang.

46. Women and minors from ethnic minority groups residing in border provinces are subject to cross-border trafficking. While some do it voluntarily, many are forced into it. They usually end up in foreign countries as sex workers while others are exploited as work slaves in factories and sweat shops.

## **9. Risk Reduction and HIV/AIDS**

47. IDUs from ethnic minority groups who participated in the UNODC study practice risk behaviors. Majority admit to sharing needles and syringes. An even bigger number said that they commonly engage in unprotected sex with either their regular or casual partners.

48. Their knowledge of HIV and its modes of transmission vary. While many IDUs are aware of HIV, more non-drug users know about modes of transmission. But both IDUs and non-drug users have a wide knowledge gap between modes of transmission and concrete actions to prevent HIV. Non-drug user respondents in Thai Nguyen have the same knowledge gap.

49. There are 3 problems identified by the UNODC study that could be important barriers to harm reduction activities among ethnic minority groups: 1) there is a lack of or limited discreet access to clean injection paraphernalia in the village or commune 2) condoms are solely for family planning purposes exclusively distributed by family planning workers and 3) distributing injection equipment is tied to the “social evils” context. In any case, there is little indication that commune residents will agree to such a distribution.

50. In Thai Nguyen, there is an on-going pilot program on the distribution of clean needles and syringes to IDUs in a few communes where ethnic minority groups reside. Initial findings point to difficulties in reaching out to the IDUs because the clean injection paraphernalia are being provided in the commune health station. According to a commune health station provider, IDUs are hesitant to go there because they are afraid that people they know would find out about their drug use and would discriminate against them. This was confirmed by the provincial health officials.

51. Stigma is a growing problem. In spite of the fact that drug users from ethnic minority groups are usually not overtly discriminated against when they are in their communes, majority of non-drug users sees “being separated from infected persons” as a method of preventing HIV. This is again a very similar situation found during the FGDs.

52. The UNODC and the FGDs also have similar findings when it comes to sources of information about HIV, its modes of transmission and prevention. The primary source was television, followed in order by radio, newspapers, commune officials, family, friends, and commune broadcasting. The UNODC study notes that Vietnamese is the language of national and local mass media (TV, radio, newspaper); that many commune households own a television set, a radio or both; that almost all communes have a communal television set; that newspapers, all owned and published by government agencies, are circulated within the commune. It further stated that while ethnic minority groups can understand Vietnamese, majority have limited fluency, leading to information breakdown and distortion.

## **10. Policy Framework**

53. The ethnic minority policy framework aims to ensure that the development process foster full respect for their dignity, human rights and cultural uniqueness, and that they will receive culturally-compatible social benefits. The World Bank’s OD 4.20 on Indigenous People underscores that the strategy for addressing the issues pertaining to indigenous people must be based on informed participation of indigenous people themselves. Thus identifying local preferences through direct consultation and incorporation of indigenous knowledge into project approaches are core activities for any project that affect indigenous people.

54. The Vietnam Law upholds the equality of ethnic minority groups, as stipulated in Article 5 in the Vietnam Constitution (1992):

*“The Socialist Republic of Vietnam is a united nation having many nationalities. The State implements a policy of equality and unity and supports the cultures of all nationalities and prohibits discrimination and separation. Each nationality has the right to use its own language and characters to preserve their culture and to improve its own traditions and customs. The State carries out a policy to develop thoroughly and gradually improve the quality of life of ethnic minorities in Vietnam physically and culturally.”*

55. Policies for ethnic minority groups have been promulgated to reduce migration trends among the ethnic groups. A landmark policy is Government Guidance No.525/TTG on 2/11/1993 that called for the implementation of development in the highland and ethnic areas. Its main points were

- Develop infrastructure especially transportation road system and fresh water supply;
- Increase food security;

- Consolidate the education system, adjust education program based on the characteristics of provinces, create favorable conditions, and support the non-formal education programs; and
- Develop the internal economy.

56. Under these government policies, ethnic minority groups have been receiving critical benefits, such as preferential treatment in college admission and provision of basic necessities such as cooking oil, kerosene, and iodized salt at highly subsidized rates. The government, foreign donor agencies, and many NGOs have organized numerous development and special assistance programs that targeted ethnic minorities. Substantial funds have been invested with the intention of helping the uplands in general and ethnic minorities in particular to “catch up” with lowland areas.

57. In 1994, the Committee for Ethnic Minorities and Mountainous Areas (CEMMA), an agency directly under the office of the Prime Minister, was assigned as coordinator for Instruction 525, which significantly increased the role of CEMMA in the development of ethnic minorities.

58. In November 1995, the Framework for External Assistance to Ethnic Minority Development was enacted. Based on previous experience, the Framework suggested a new strategy for ethnic minority development within the government policy objectives of stability, sustainable growth and equity, and poverty alleviation. Among the operational implications of this new strategy were: (i) a need for an integrated policy and planning framework, which is participatory; (ii) a concern to strengthen the management capacities of CEMMA and existing agents; (iii) a recognition of cultural, linguistic and social differences; (iv) an emphasis on balancing investments in human resources and physical infrastructure; (v) a participatory approach which employs consultation with ethnic minorities; and (vi) a need to improve the flow of resources to identify poverty groups.

59. Decision 135 from 1998 put the framework into policy and focused specifically on poverty alleviation for ethnic minority groups. The general objectives were: (i) rapidly improving the life of ethnic minority groups in extremely poor villages in mountainous and remote areas; (ii) creating better conditions for these rural areas in order to surmount poverty and backward and slow development, (iii) integrating ethnic minority groups in the general development of the whole country; and (iii) contributing to security, safety, and natural defense. Among the goals from 1998-2005 were: eliminating hunger and reducing poverty by 4-5% annually (and 25% by 2005), supporting infrastructure (domestic water supply, building vehicle roads to commune centers, and promoting rural market development), encouraging children to go to school in right age, providing training to the majority of ethnic minority groups, enriching them with knowledge and skills of production, and controlling dangerous diseases. Under this policy, health cards were distributed to ethnic minority groups in 1999.

60. Decision 139 or the Health Care for the Poor from 2002 enabled the poor and disadvantaged, including ethnic minority groups, to receive more extensive health coverage through a fund created from contributions from the central government (75%) and the provincial government (25%). Beneficiaries are either provided with a health insurance card or a health card that entitles them to free health services at all levels.

61. The Comprehensive Poverty Reduction and Growth Strategy (CPRGS) for 2001-2010 integrates a set of guidelines on ethnic minority health care, equity, and gender equality. It also set goals and targets for ethnic minority groups.

- Achieve better education;
- Reach gender equality and empower women;
- Reduce infant and child mortality;
- Improve maternal health;

- Combat HIV/AIDS, malaria, and other communicable diseases;
- Reduce vulnerabilities; and
- Eradicate poverty and preserve the culture.

62. Directive N 06-CT/TW of the Central Party Executive Committee from 2002 directs the MOH to formulate policies with priorities for people in remote and mountainous areas, especially the ethnic minority groups, in order to significantly improve the equity of health care and contributing to the improvement of the people's living standards.

63. According to the Government of Vietnam, ethnic minority groups have the following characteristics:

- An intimate understanding and long stay in the territory, land or area of their ancestors with a close attachment to its natural resources;
- Self-identification that is recognized by neighboring members by their distinctive culture;
- A language different from the national language;
- A long tradition of social and institutional systems; and
- A self-provided production system.

64. Vietnam's legal policy concerning ethnic minority groups is similar in content to the World Bank policy on Indigenous Peoples OD 4.20, and no supplementary policy provisions will be necessary in VHAPP. This policy framework will apply to all provincial/city action plans under the VHAPP.

## **11. Guidelines for the Development of Provincial/City Action Plans**

65. The objective of the guidelines for the development of provincial/city action plans is to ensure that under the VHAPP ethnic minority groups are informed, consulted and mobilized to participate in its project activities. Notably, the guidelines will guarantee equity in representation, reduce social disparities, and overcome any obstacles such as language and cultural sensitivity for guaranteeing equal rights for ethnic minority women, men, adolescents and children in participating and achieving benefits from the VHAPP. Their participation will enable the provinces/cities to design better delivery and provision of information and services suited to ethnic minority needs and circumstances.

66. The process of guiding provincial/city action plan preparation will consist of the following:

- Data gathering
- Guidelines for provincial/city action plan preparation workshop
- Integrated institutional arrangements
- Integrated monitoring and evaluation

67. During the process of development, continuous efforts will be made to gather feedback for better planning and execution. Consultation with and participation of the ethnic minority population, their leaders and local government officials will be an integral part of the process.

## **12. Data Gathering.**

68. Data gathering will be conducted by the PPMU. It will be a two-step process comprising desk research and fieldwork. As the first step, desk research will be conducted to verify the ethnic minority groups residing in the participating provinces. Secondary data analysis of government

statistics, historical records, available studies, and institutional reports will be employed to develop socio-demographic and vulnerability profiles of the ethnic minority groups, including names and total number of ethnic minority groups in the province, percentage of ethnic minority groups, their demographic and educational data, their social organization, their health status, and their vulnerabilities and risk factors of HIV/AIDS. These data will be updated from the results of the fieldwork.

69. The second step is fieldwork. The main objectives of the field work are to a) collect updated information about the ethnic minority groups in a city/province and b) elicit comments, views and opinions about the VHAPP from the leaders and members of ethnic minority groups. The fieldwork will be divided into parts, a consultative meeting and a series of FGDs.

70. The Provincial AIDS Bureau, through the PPMU, will organize the province-wide consultative meeting. It will be attended by leaders of ethnic minority groups, officers of the Women's Union, Farmers Union, the Fatherland Front and other mass organizations. Also attending will be representatives of the Provincial Committee for Ethnic Minorities and Mountainous Areas and the heads of the District Preventive Health Teams. Local consultants experienced in working with ethnic minority groups will be commissioned by the Provincial AIDS Bureau to facilitate the consultative meeting. Whenever available, local non-government organizations (NGO) will be invited.

71. The consultative meeting agenda will include the following sessions: a) presentation of the National Strategy and the features of the VHAPP, followed by a discussion where opinions, views, comments and suggestions will be elicited from among the participants, with special attention to the participants from ethnic minority groups and b) verification of the compiled socio-demographic and vulnerability profiles.

72. Soon after the consultative meeting, experienced FGD facilitators will conduct a series of focus group discussions. To guarantee quality data, facilitators will follow the international protocols for FGD. To ensure representation, FGDs will be conducted separately for the following: ethnic minority leaders; ethnic minority men; and ethnic minority women. Discussions will focus on

- current experiences on any HIV/AIDS activities or in its absence, any health activity;
- perception of needs and preferences related to the prevention and control of HIV/AIDS, including but not limited to language, channels of communication, access to services and commodities for harm reduction and care and support); and
- concerns, issues, and benefits of the provincial/city HIV/AIDS project on their lives, culturally and health-wise.

73. The results of the consultative meeting and the FGDs will form part of the body of findings that will be used by the Provincial/City AIDS Bureau to evaluate the extent by which ethnic minority groups are considered to be high-risk or are represented in the high prevalence numbers.

74. Prior to the workshop, the evaluation result and the findings will be presented and discussed by the Provincial/City AIDS Bureau in a meeting with ethnic minority leaders. In the same meeting, the ethnic minority leaders will recommend their representatives to the provincial/city action plan preparation workshop.

### **13. Guidelines for Provincial/City Action Plan Preparation**

75. The provincial/city action plan preparation workshop will include members of the AIDS Steering Committee, other sectoral units, representatives of the Provincial/City Committee for Ethnic Minorities and Mountainous Areas, and representatives of ethnic minority groups.

76. During the workshop, the Provincial/City AIDS Bureau will present to the participants the findings of the data gathering and the evaluation results. The presentation will be followed by a session that will address the following:

- identification of the barriers that could hinder active engagement of ethnic minority groups in HIV/AIDS prevention and control activities. These barriers would include but not be limited to language, socio-cultural practices and gender concerns, and access, affordability and quality issues pertaining to prevention, harm reduction, care and support services and commodities;
- mitigating actions addressing these barriers to enable ethnic minority groups to increase their active participation;
- strategies and programmatic approaches directed at mitigating actions to improve ethnic minority groups' participation in HIV/AIDS prevention and control activities, including targeted and needs-based BCC activities and other programs;
- strategies to ensure that the provincial action plan will contribute to gender equality; and
- types of training needed by the provincial action plan implementers, monitors, and ethnic minority groups themselves, if any.

77. The results of the discussion, the findings of the data gathering and the evaluation results will form part of the available resources during the workshop. They will be of primordial consideration during the deliberations leading to the finalization of the provincial/city action plan.

### **14. Monitoring and Evaluation**

78. The monitoring and evaluation of ethnic minority groups' participation in provincial/city HIV/AIDS prevention and control activities will form part of the MOH monitoring and evaluation plan.

### **15. Institutional Arrangements**

79. The Provincial/City AIDS Steering Committee will have as member or special adviser the Committee for Ethnic Minorities and Mountainous Areas.

80. The periodic provincial reports to be submitted to the central project management unit (CPMU) will have a section on the status of the participation of ethnic minority groups in HIV/AIDS prevention and control activities.

81. The CPMU's periodic consolidated reports to be submitted to the World Bank Office in Hanoi will also have a section on ethnic minority groups' participation.

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## Annex 1

### Vietnam: Composition and Distribution of Ethnic Minorities (2000)

No.	Official Name	Approximate population size	Percentage	Area of distribution (province)
1	Kinh (Viet)	55,900,000	86.8730339	All over the country
2	Tay	1,190,000	1.849354389	Ha Giang, Tuyen Quang, Lao Cai, Yen Bai, Cao Bang, Lai Chau, Bac Can, Thai Nguyen, Bac Giang...
3	Thai	1,040,000	1.616242491	Son La, Lai Chau, Nghe An, Thanh Hoa, Lao Cai, Yen Bai, Hoa Binh, Lam Dong...
4	Muong	914,000	1.420428497	Hoa Binh, Thanh Hoa, Vinh Phu, Yen Bai, Son La, Ninh Binh
5	Hoa	900,000	1.398671387	Kien Giang, Hai Phong, Vinh Long, Tra Vinh, Quang Ninh, Dong Nai, Soc Trang, Can Tho, Kien Giang, Bac Lieu, Ca Mau, Ho Chi Minh City
6	Khmer	895,000	1.39090099	Soc Trang, Can Tho, Vinh Long, Tra Vinh, Kien Giang, Ca Mau, Bac Lieu, Tay Ninh, Ho Chi Minh City, Binh Phuong, An Giang
7	Nung	705,000	1.095625919	Cao Bang, Lang Son, Bac Can, Thai Nguyen, Ha Giang, Tuyen Quang, Bac Giang, Quang Ninh, Hochiminh city, Lam Dong, Dac Lac, Lao Cai
8	Hmong	558,000	0.86717626	Ha Giang, Yen Bai, Lao Cai, Lai Chau, Son La, Cao Bang, Lang Son, Nghe An, Thanh Hoa, Hoa Binh, Bac Can, Thai Nguyen
9	Dao	474,000	0.736633597	Ha Giang, Tuyen Quang, Lao Cai, Yen Bai, Cao Bang, Lang Son, Bac Can, Thai Nguyen, Lai Chau, Son La, Vinh Phuc, Phu Tho, Bac Giang, Thanh Hoa, Quang Ninh, Hoa Binh, Ha Tay
10	Gia-rai	242,000	0.376087195	Gia Lai, Kon Tum, Dac Lac
11	Ede	195,000	0.303045467	Dac Lac, Phu Yen, Khanh Hoa
12	Bana	137,000	0.212908867	Kon Tum, Binh Dinh, Phu Yen
13	San Chay	114,000	0.177165042	Bac Can, Thai Nguyen, Tuyen Quang, Quang Ninh, Bac Giang, Lang Son, Vinh Phu, Phu Tho, Yen Bai
14	Cham	99,000	0.153853853	Ninh Thuan, Binh Thuan, An Giang, Hochiminh city, Binh Dinh, Phu Yen, Khanh Hoa
15	Xo Dang	97,000	0.150745694	Kon Tum, Quang Nam, Quang Ngai
16	San Diu	94,630	0.147062526	Quang Ninh, Bac Giang, Bac Can, Thai Nguyen, Vinh Phuc, Phu Tho, Tuyen Quang
17	Hre	94,000	0.146083456	Quang Ngai, Binh Dinh

18	Co Ho	92,000	0.142975297	Lam Dong, Ninh Thuan, Binh Thuan, Khanh Hoa
19	Ra glai	72,000	0.111893711	Ninh Thuan, Binh Thuan, Khanh Hoa, Lam Dong
20	Mnong	67,000	0.104123314	Dac Lac, Lam Dong
21	Tho	51,000	0.079258045	Nghe An, Thanh Hoa
22	Xtieng	50,000	0.077703966	Binh Phuoc, Binh Duong, Tay Ninh, Lam Dong, Dac Lac
23	Kho Mu	43,000	0.066825411	Son La, Lai Chau, Nghe An, Yen Bai
24	Bru Van Kieu	40,000	0.062163173	Quang Binh, Quang Tri, Dac Lac
25	Giay	38,000	0.059055014	Lao Cai, Ha Giang, Lai Chau
26	Co tu	37,000	0.057500935	Quang Nam, Thua Thien Hue
27	Gie Trieng	27,000	0.041960142	Quang Nam, Kon Tum
28	Ta Oi	26,000	0.040406062	Quang Tri, Thua Thien Hue
29	Ma	25,000	0.038851983	Lam Dong, Dong Nai
30	Co	23,000	0.035743824	Quang Ngai, Quang Nam
31	Cho ro	15,000	0.02331119	Dong Nai
32	Ha Nhi	12,500	0.019425991	Lai Chau, Lao Cai
33	Xinh Mun	11,000	0.017094873	Son La, Lai Chau
34	Chu Ru	11,000	0.017094873	Lam Dong, Ninh Thuan, Binh Thuan
35	Lao	10,000	0.015540793	Lai Chau, Son La
36	La Chi	8,000	0.012432635	Ha Giang
37	Phu La	6,500	0.010101516	Lao Cai, Lai Chau, Son La, Ha Giang
38	La Hu	5,400	0.008392028	Lai Chau
39	Khang	4,000	0.006216317	Lai Chau, Son La
40	Lu	3,700	0.005750093	Lai Chau
41	Pa Then	3,700	0.005750093	Ha Giang, Tuyen Quang
42	Lo Lo	3,200	0.004973054	Ha Giang, Cao Bang, Lao Cai
43	Chut	2,400	0.00372979	Quang Binh
44	Mang	2,300	0.003574382	Lai Chau
45	Co Lao	1,500	0.002331119	Ha Giang
46	Bo Y	1,450	0.002253415	Ha Giang, Lao Cai
47	La Ha	1,400	0.002175711	Yen Bai, Son La
48	Cong	1,300	0.002020303	Lai Chau
49	Ngai	1,200	0.001864895	Quang Ninh, Hochiminh city, Haiphong
50	Si La	600	0.000932448	Lai Chau
51	Pu Peo	400	0.000621632	Ha Giang
52	Brau	250	0.00038852	Kon Tum
53	Ro mam	250	0.00038852	Kon Tum
54	O du	100	0.000155408	Nghe An

### Ethnic Minority Population in Participating Provinces and Cities

	<b>Province/City</b>	<b>Total Population</b>	<b>Total EM</b>	<b>Percent of EM</b>
1	Cao Bang	490,019	467,063	95.32
2	Lai Chau	587,542	488,488	83.13
3	Son La	882,073	728,427	82.58
4	Yen Bai	679,047	341,972	50.36
5	Thai Nguyen	1,045,884	258,981	24.76
6	Thanh Hoa	3,467,184	568,873	16.41
7	Kien Giang	1,497,281	215,689	14.41
8	Nghe An	2,858,696	381,364	13.34
9	Bac Giang	1,492,887	177,789	11.91
10	Ho Chi Minh	5,017,614	433,745	8.84
11	Dong Nai	1,984,468	164,865	8.31
12	An Giang	2,044,281	103,285	5.05
13	Khanh Hoa	1,031,363	47,773	4.63
14	Vinh Long	1,010,436	27,105	2.68
15	Ben Tre	1,298,905	5,707	0.44
16	Tien Giang	1,604,123	5,691	0.35
17	Hai Phong	1,672,098	1,967	0.12
18	Thai Binh	1,786,284	1,099	0.06
19	Nam Dinh	1,890,217	771	0.04
20	Hau Giang	No data available	No data available	No data available
	Total	32,340,402	3,249,249	

GSO, 2001

**Summary of Focus Groups Discussion Findings  
Nghia Phuong Commune, Luc Nam District, Bac Giang Province  
November 9, 2004**

**Background Information**

*Bac Giang* is about 90 km from Hanoi. Its population is approximately 1.5 million. There are 7 ethnic minority groups living in the province. They are the Muong, San Diu, Tay, Nung, Cao Lan, and Hoa.

*Nghia Phuong commune:*

The population of Nghia Phuong commune is 13,000. Of this, 5,000 are ethnic minorities. There are 7 ethnic minorities in this commune. The Cao lan group is counted as the largest among them.

The FGD was conducted in a village where 100 per cent of the residents are Cao lan. There are 92 households in this village.

The people living in this village can the Vietnamese language very well. They state that only the old generation speaks Cao lan language fluently. The younger people first learn to speak Vietnamese and then learn the Cao lan language later. Normally, those who are 40 years old and above have mastered the Cao lan language.

The people in this village benefit from Decision 139. The respondents all have health insurance cards which they use to get free services and examination at the commune health station. If someone suffers from serious illnesses, the commune health staff will refer them to the district hospital or the provincial hospitals where there are better equipment and more advanced technology for more sophisticated health care services.

The village has one volunteer health worker. She is a Cao lan. She has a first aid kit, which includes syringes and needles for the use of the villagers.

Literacy rate in the village is nearly 99%. There is a center for eliminating illiteracy right in the village.

Parents arrange the marriage of their children based on the calculation of fortune-tellers and the matching between the years of birth of the prospective bride and groom. The majority marry members of the same ethnic minority group.

From their point of view, there is no prostitution in their village. However, they admit that there is prostitution and illegal drug trading in their commune.

In the village people earn their living by cultivating rice and raising animals such as pigs, chickens, ducks. Besides, they can get extra income (5-10% of their income) from selling herbs that are ordered by outsiders. For instance, people from Hai Duong province regularly come here to buy herbs. These herbs are products from the forest in which Cao lan people live near by. About 15 tons of herbs per

year are sold to outsiders. The villagers also plant certain kinds of herbs in their garden. Income from this activity could reach one million to two million per year for each household in the village.

Thirty two out of 92 households have someone who goes to other provinces for work several months per year. They usually go to Quang Ninh to earn extra money for their family . They work for bricks manufacturers or in construction, and they go in groups in these kinds of jobs. The villagers said that it could be very difficult for members of those groups to commit any risky behavior because they usually stay together. Therefore, it is not easy to hide risky behaviors if someone may have done so. One cannot keep a secret as people gossip a lot. The people are under pressure to keep the good reputation of their family. This is also a way that villagers could help their own to get away from risky behavior. So far, no case has been reported of a villager injecting drugs or other bad behavior among the people who go to other provinces for work.

In the village, 35% of family owned TV.

According to “affirmation action” in Vietnam, there is a representative of ethnic groups in authority of the location. In the village, the head and the volunteer health worker are Cao lan people.

### **Summary of FGD Findings**

The FGD was conducted in a village where 100 per cent of the residents are Cao lan. Four women and 4 men, aged from thirty to forty participated.

- All the respondents have heard about HIV/AIDS from mass media such as TV and radio. In addition, they also get information in meetings organized by the Village Women’s Union and the Farmers’ Union. However, their knowledge on HIV/AIDS is very superficial about transmission modes of HIV infection. They said that it could be transmitted through blood, injecting drugs, and prostitution.
- The respondents have very positive experiences about HIV/AIDS activities. Village Women’s Union hold meetings every two months with different issues and they also disseminate information on topics such as nutrition, government law, TB prevention and HIV/AIDS, and marriage and family law.
- The men are members of the Farmers’ Union. They also receive different information during their monthly meeting. HIV/AIDS is sometimes mentioned in the meetings. They said that the leader of the Farmers’ Union got a leaflet and read it to the others so they could aware of HIV/AIDS. “There was very brief information on the leaflet” one man commented.
- As far as the respondents know, there is no one who in the village who is infected with HIV. However in the commune there were two cases of HIV infection due to injecting drugs. Both died already. One was from another village and the other was not a local resident. He was the son of a commune primary school teacher woman. He got infected when he was studying in a university in Hanoi.
- The respondents would like to have HIV/AIDS intervention programs in their village. They said they would like to have more knowledge to prevent HIV infection. They are interested in information like HIV/AIDS situation in the country, province, district and their commune together with more detailed information.
- They link tourism with the risk of HIV infection. They said that there is tourism spot in their area, so HIV epidemic could happen in their locality. They would like to have knowledge on HIV/AIDS, so they can prevent HIV infection.

- They would like the volunteer health worker to organize specific meetings on HIV/AIDS in the village so that all the village residents can have a chance to obtain information. Besides this, they like to receive booklets on HIV/AIDS.

**Summary of Focus Groups Discussion Findings  
Pham Co Village, Hou Teung Commune, Thai Nguyen Province  
November 10, 2004**

**Background Information**

*Thai Nguyen* is a landlocked province in the Northeast region. It has a population of about 1.1 million (GSO 2001). There are 8 ethnic minority groups living in the province. They are the Tay, San Diu, Nung, Cao Lan, Hoa, San Chay, Dao and Ho Ming. All together, they number approximately 258,918 or 24.76 per cent of the total population.

*Hou Teung commune:*

There are 4 ethnic minority groups in Hou Teung. The largest is the Nung. Both men and women are engaged in agricultural endeavors. Majority are into rice farming.

The FGD was conducted in the village of Pham Co, a 40 minute drive from the capital of the province. It was a fairly remote village, surrounded by rice fields and hills covered with tea bushes. People mostly travel by walking, although a few own bicycles and motorbikes. There are 3 ethnic minority groups in the village—Tay, Nung, and San Dui. Almost 90 per cent of the population belong to the Nung ethnic group. There are 112 households in Pham Co.

The village population can speak, write and read relatively fluent Vietnamese. They learned the language in school, from constant contact with the Kinh (Viet), and through mass media, just like many ethnic minority groups living in the low and mid-lands. The ethnic languages are usually spoken at home.

The village people earn their living from rice farming. Some cultivate tea and corn. Almost all raise animals such as pigs, chickens, and ducks.

The men earn extra income by working in other villages in nearby communes. They usually do seasonal work in the rice fields. Working in other provinces is not done at all.

The village is located 7 kilometers away from the commune health station. When a villager requires hospitalization, the health station staff, who are mostly Tays, will provide a referral to the district hospital. All the villagers have health cards which they got under Decision 135 on Poverty Alleviation, with a special focus on ethnic minority groups.

Pham Co has one volunteer health worker who is a Kinh married to a Nung, thus, the villagers has accepted her as one of their own. She has completed the requisite 9 month training for volunteer health workers. In addition, she underwent an orientation on Tuberculosis (TB) prevention and control, maternal and child care (MCH), and lately, on HIV/AIDS prevention. [She has instead focused on nutrition, EPI and MCH.](#)

About 90 per cent of the women are members of the local Women's Union. All the men are with the Farmers' Union. The young people join the Youth Union.

Almost half of village homes own a TV set. Almost all own a radio. Newspaper is not common.

### **Summary of FGD Findings**

The FGD had 15 respondents belonging to all three ethnic minority groups. Of the 15, 8 were men and 7 were women. There was also 1 adolescent who joined the group.

- All the respondents have heard about HIV/AIDS. Their main source of information is TV, followed by radio. About half of the women heard about HIV/AIDS during one meeting of the Women's Union. All the men claim that they know about HIV/AIDS from watching television and listening to the radio. Except for 1 woman who seem to know more about HIV/AIDS, such as transmission modes and preventive actions, all had superficial knowledge.
- The 1 adolescent said that she learned about HIV/AIDS from school, although she admitted that her knowledge was very limited.
- The respondents have never been involved in any HIV/AIDS activities, except for about 5 women who attended the Women's Union meeting where HIV/AIDS was mentioned.
- They have very positive experience on other health activities, such as TB. Although there are no reported TB cases in the village, the Volunteer health Worker and the village chief regularly visit households to talk about preventing TB. Their EPI program is also praised by the respondents. They also have a nutrition program for mothers.
- As far as the respondents know, there is no one who in the village who is infected with HIV. However they claim that this is not necessarily true as there has never been any testing done in the village.
- There are also no drug abusers and commercial sex workers (CSW) in the village. Although the provincial health officers mentioned that there are some ethnic minority sex workers in the bigger communes and in the capital. There are also ethnic minority injecting drug users (IDU) living in other villages in the commune.
- None of the respondents know of the symptoms of sexually transmitted diseases (STD). When asked if any of the men felt any burning sensation when they micturate, a number of the men said that it was due to kidney problems.
- Although there are no HIV cases in the village, all the respondents agree that there is still a big need for educating people about HIV/AIDS. They think that knowledge will enable them to continue to keep out the infection from the village.
- The respondents would like to have HIV/AIDS intervention programs in their village. They said they would like to have more knowledge to prevent HIV infection. They are interested in information about modes of transmission and actions to prevent transmission. They also would like to know more about STDs.
- They recommended that HIV/AIDS education be integrated in their other existing and successful programs like TB and MCH.
- Others suggested using the commune broadcasting system composed of strategically located loudspeakers. They prefer to have special audio tapes played rather than just announcements. On the language to be used, they do not mind having it in Vietnamese as they claim that all of them know the language. They felt however that more loudspeakers should be installed to ensure that majority of the resident could hear the messages.
- The respondents also recommended that the volunteer health worker, working with the Women's Union, the Farmers' Union and the Youth Union, organize specific meetings on

HIV/AIDS. The village chief should also incorporate HIV/AIDS discussions during some of the village meetings.

- They claimed that TV and radio would also be good channels to use as they are very fond of watching TV. Radio listening is their second favorite. They remember that in the past, there was a drama series on TV about HIV/AIDS, and they still remember the messages imparted during the program.
- The adolescent also asked that more information be provided on HIV/AIDS in the school and also outside, but through interesting activities that young people could participate in.

#### Comments and Suggestions from the head of the Commune Health Station

- Have more accessible VCT, not only testing sites.
- Have a better plan for distributing clean needles and syringes to IDUs in the commune. Right now, IDUs are hesitant to go to the health station because of fear of being discriminated upon. She felt that these injecting equipment should not be in the health station because the location itself is barrier to access to them.
- [She is very interested to be involved in an STD program for villagers.](#)
- IDUs who have been sent to 05/06 rehabilitation centers have relapsed just a few weeks after coming out. Although the community-based treatment program is not much better.

**References**

Community Action on Preventing HIV/AIDS, ADB, Final Report, 2003

Country Briefing Paper—Women in Vietnam, adb.org

Ethnic Minorities in Vietnam: A Country Profile, World Bank, Hanoi, Vietnam, October 1996

Ethnic Minorities Drug Use & Harm in the Highlands of Northern Vietnam: A Contextual Analysis of the Situation in Six Communes from Son La, Lai Chau, and Lao Cai, UNODC, Hanoi, Vietnam, July 2003

Ethnic Minority Development in Vietnam: A Socio-economic Perspective, Baulch, Chuyen, et al, Revised August 8, 2001

Gender Issues in Vietnam, Dr Leela Kirjavainen, Regional Environmental Technical Assistance 5771 Poverty Reduction & Environmental Management in Remote Greater in Mekong Subregion (GMS) Watersheds (Phase I), mekonginfo.org

Gender and Policy related to Ethnic Minorities Women in Southern Vietnam, Workshop Proceedings, Phan Thanh Xuan, 1998

Strengthening Preventive Health Services Feasibility Study, Ministry of Health and Asian Development Bank, Hanoi, Vietnam, August 2004

Sex Tourism and Prostitution in Vietnam, darkwing.uoregon.edu

The Tribal People of Vietnam, vwam.com/vets/tribes/tai.html

World Bank Handbook on the Indigenous Peoples in the East Asia and Pacific Region, World Bank

Vietnam Reports to Treaty Bodies, United Nations Human Rights System, 2000

Vietnam urban water supply development project, Ethnic Minority Policy Framework (Draft), 2004