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**The social inclusion in public services of ethnic minority and religious groups in Vietnam: A scoping review**

**The social inclusion in public services of ethnic minority and religious groups in Vietnam: A scoping review**

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# EXECUTIVE SUMMARY

**Background:** Ethnic minority and religious groups are marginalized groups in Vietnam. Members of these groups face particular challenges in accessing public services, including health care and education. The overarching objective of this research was to achieve a better understanding of strategies for improving the accessibility and utilization of public services for ethnic minority or religious groups in Vietnam

**Method:** We conducted a scoping review between January and April 2017 focused on ethnic minority and religious groups and public services (health, education, local government, and police services) with four themes: key drivers of social exclusion; strategies to address exclusion; and vulnerable groups within these populations (concerning gender, age and migration status) and gaps in existing knowledge that could inform an agenda for future research. We triangulated our findings on these four themes with experts from public service institutions, policymakers, research institutes, and non-government organizations that were working with ethnic minority groups in four national workshops in Vietnam. Research findings were then discussed and enriched through four international workshops involving partners from the Socially Inclusive Societies Network from the UK, Nigeria, Kenya, and India.

**Results:** Very few research studies were found on religious groups and local government and police services in Vietnam. More research in these areas is greatly needed. The Vietnamese government has developed and implemented an enormous number of long-term policies and strategies for the inclusion of ethnic minority groups in Vietnam. These policies and strategies are comprehensive in content at the central level, covering all socio-economic aspects. Ethnic minority groups, however, face many challenges in accessing public services and their health and education outcomes are much worse than the ethnic majority group. Our evidence reviews highlighted multi-layered and interconnected factors affecting the social exclusion of minority ethnic groups. To improve the accessibility and utilization of public services more evidence is needed at macro, or policy, level on the development processes relating to social inclusion policies for ethnic minority groups. At most, or institution, level research is needed on factors affecting policy implementation, including support systems for implementation (human resource, financial resource, data management). Rigorous impact evaluations are also needed on the efficacy and effectiveness of social inclusion policies. At the micro-level, research on cultures, and traditions of targeted groups and their understanding of services is needed. At all stages of intervention or research design, planning, implementation, and evaluation there is a need to empower and involve ethnic minority groups.

**Conclusion:** Ethnic minority groups in Vietnam have been recognized and prioritized in inclusion policies by the Vietnamese government. To the successful implementation of these policies, more rigorous evidence on policy process and evaluation is needed.

**Keywords:** ethnicity, religion, exclusion, inclusion, public service, Vietnam

# Introduction

There are 54 ethnic groups in Vietnam, with Kinh constituting the majority of the population (84.7%)[[1](#_ENREF_1)]. Most of Vietnam’s ethnic minorities live in remote, lightly populated mountain regions in northern, central and western Vietnam. Some are assimilated; others are not. The largest minorities in the north are the Tay (1.6 percent of the Vietnamese population), Muong (1.4 percent), Tai (1.2 percent), Nung (1 percent) and others (2.3) percent). The main minorities in the south are Chinese, Montagnard (1.5 percent), Khmer (1.2 percent) and Cham (0.1 percent). The smallest ethnic minority groups are only of hundreds of residents each group (Brau, Ro Mam, O Du, for example).

The non-Chinese minority peoples of Vietnam are for the most part highlanders who live in relative independence and follow their traditional customs and culture. They are classified as either sedentary or nomadic. The sedentary groups, the more numerous of the two kinds, are engaged mainly in the cultivation of wet rice and industrial crops; the nomadic groups, in slash-and-burn farming where forested land is cleared for a brief period of cultivation and then abandoned. These groups are notable for their diverse cultural characteristics. They are distinguished from one another not only by language but also by such other cultural features as architectural styles, colors, and shapes of dress and personal ornaments, shapes of agricultural implements, religious practices, and systems of social organization.

Ethnic minority groups, however, are one of three marginalized groups in Vietnam together with people with disabilities and urban migrants. Members of this group had faced particular challenges, lower life expectancy, lower social mobility, the high proportion of being poor, for example, despite strong government commitments to their full inclusion in society. There is thus a need to explore evidence and evidence gaps in the complex and intersectional nature of inequality faced by members of minority ethnic in Vietnam and how public institutions can contribute to reducing such exclusion.

This report produces from activities of Socially Inclusive Network which joint India, Kenya, Nigeria, Vietnam, as well as in the UK under the sponsor of ESRC. Network activity stimulates local, national and international collaborations and facilitates the development of common research goals that can be agreed between key stakeholders across disciplinary and national boundaries. Network membership is multidisciplinary with academic, policy/practice and voluntary sector input on key themes of economics/finance, health, social diversity, education, media and communication and policing.

This literature review report focuses on inequality of opportunity in public services, which include health, education, and local government services among ethnic minorities. The work aims to answer the following questions:

1. Which ethnic minorities experience inequalities and what impact does this have upon them?
2. What are the key drivers of ethnic exclusion and what concepts and theories are used to explain such exclusion?
3. What strategies would improve the social inclusion of ethnic minorities in Vietnam?
4. What further evidence is needed to inform future policy and practice in these contexts?

# Method

The report synthesizes evidence from the literature review and three national workshops in Vietnam, involving key stakeholders from public service institutions. Parallel evidence reviews and workshops were held in India, Kenya, Nigeria, and the UK to explore the same issues from a national perspective.

## Literature review

The review was guided by 13 specific research questions, structured around four themes that aimed to improve understanding of:

1. Key drivers of ethnic and religious exclusion internationally and which populations were identified with the evidence available
2. Strategies available to address causes of social exclusion in four public service sectors (education, health, police, and local government services), including evidence of their effectiveness in different contexts
3. Strategies would improve the social inclusion of ethnic minorities in Vietnam
4. Gaps in existing knowledge and agenda for future research, to inform future policy and practice to combat social inequalities

Searching was conducted by both the Leeds team and the Vietnam team between January and April 2017. Leeds team searching for published evidence about Vietnam that covered literature available in English from 19 key academic databases covering publications in social science, criminal justice, economics, education, and health (see Appendix). Vietnam team searching for published evidence from the National database on science and technology (NASATI) and other websites of non-government organizations (both national and international one) which works on the ethnic minority in Vietnam such as World Bank, UNDP Vietnam, ISEE or database on Vietnamese Policy online. Legal documents on policy/program for inclusion of ethnic minority was also searched on an online system of legal normative documents of Vietnam.

**Title and abstract screening**

**Full-text screening**

Searching from Leeds: 139

Searching from **NASATI**: 256

88

35

Other sources: 38

7

18

24

**Review management**: Endnote.

**Title and abstract screening**: A single reviewer manually examined titles and abstracts of records identified through the searches of electronic databases to assess eligibility. Eligible publications describe strategies for the social inclusion of minority ethnic or religious populations in public services within the relevant country (globally for the UK team).

**Full-text screening:** The full-length reports of all studies promoted from the first level of screening was obtained. Detailed manual examination of the full-length reports undertaken independently by pairs of reviewers to assess inclusion. Reviewers met to compare and discuss their assessments. Any disagreements between the reviewers’ decisions were resolved by discussion and re-reading of the text.

**Excluded studies**

We excluded 104 studies from Leeds after screening for title and abstract. The most frequent reason because of Vietnamese ethnicity in other countries, particularly in Us not in Vietnam.

After screening full-text, we excluded 28 studies from Leeds because strategies for the social inclusion of minority ethnic or religious populations in public services were not describing clearly.

Legal documents: 267 legal normative documents from 1946 – 2016 were searched. After excluding the documents categorized as ineffective at the time of searching; duplicated documents and years of promulgated after 2000, 151 documents are remaining. Screening for policy level of resolution, directive, decree, decision; exclude circular and joint circular, after screening the title, remaining 48 legal documents.

We first try to do a systematic review but due to the broad work, we then do a narrative literature review to be able to answer all research questions. A total of 88 references has been used in this report.

## Workshop

Three national workshops were held in May, August, and November in Hanoi, Vietnam. The first one was on social exclusion to identify which groups are experience inequalities, drives of inequalities and research gap. The second one was on strategies for social inclusion and research gaps. The third one focused on age, migrant, and gender equality among ethnic minority groups. Each workshop involved about 25 – 30 participants from multidisciplinary with academic, policy/practice and NGOs sector input on key themes of health, social diversity, education. In each workshop, the draft of the review was circulated beforehand, then presented key points for discussion. The World Café, an interaction method focused on conversations were used for discussion in three small groups at the workshops. This is a creative process for leading collaborative dialogue, sharing knowledge and creating possibilities for action for all participants from different backgrounds.

The following parts are to answers the four questions mentioned above.

# PART 1: SOCIAL EXCLUSION

# The exclusion by social services among ethnic minorities

## Health sector

The exclusion in health among ethnic minority magnitude by (1) health care seeking and utilization, particularly in maternal and child health; (2) environment hygiene; and (3) its impacts, which included malnutrition, communicable disease, and maternal and child mortality.

### Healthcare seeking and utilization

Ethnic minority people used public health services less frequently than the majority group (24% vs. 43%)[[2](#_ENREF_2)]. They are more likely to seek care at a lower level (commune and district level) and rate their health as poor and very poor at these levels [[3](#_ENREF_3)]. They spent less on health, received less expensive treatments when referred to hospital, get less blood, fewer lab exams and less surgery (minor and major) compared to the non-poor [[4](#_ENREF_4)].

Women and children were the most vulnerable groups and need more health care seeking and treatment. Among maternal and child health care services, family planning, exclusive breastfeeding, and immunizations were more equitably distributed. Health care services, which required multiple service contacts, such as four or more antenatal care visits, and required significant support from the health system, such as skilled birth attendance, were the most inequitable (Axelson et al., 2012). For example, ethnic minority mothers had much lower 4+ Antenatal visits compared to the major group (32.7 vs 82.1%); lesser blood pressure measures, urine tests and blood tests (22.5 vs. 63.1%) during antenatal; ([Viet Nam General Statistics Office, 2014](#_ENREF_67)). The risk of not giving birth in health facilities among ethnic minority mothers was 20 times higher than Kinh/Hoa major groups in 2010 – 2011 (OR: 18.8; 95% CI: 8.96-39.2)[[5](#_ENREF_5)]. Inequalities within ethnic minority groups existed. Some ethnic minority groups had very low maternal health care services utilization such as La Hu, Ha Nhi, Si La, La Ha, Mang, Hmong, Cong, Co Lao, Lu. The institutional delivery was less than 20% and ANC at the health facility was about 20% - 40% [[6](#_ENREF_6)].

Regarding child health, in general, the ethnic people did not frequently identify the children to be sick as a major group. When the child was sick, the parents were less likely to seek care (professional consultation or self- prescribed treatment) and this tends to increase in the last years. For example, the percentage of ethnic minority children aged between 2 and 4 years old who have not been taken to formal health facilities increased from 40.5% in 2007 to 54% in 2012 [[7](#_ENREF_7)]. Although immunization was the most equitably distributed(Axelson et al., 2012), children from minority ethnic groups were still less likely to receive timely immunization completion compared with children of Kinh ethnicity (IRR=0.77 (*p*<0.05)[[8](#_ENREF_8)].

### Water and sanitation

The access to clean water and sanitation among ethnic minorities was lower compared to the majority groups. The proportion of ethnic minority groups using “bottled” drinking water was 75.1% compared to 94.8% of major groups. The ethnic minority people often use unimproved sanitation facilities (48.5%), while the rate was lower among a major group (12.1%). Ethnic minorities have much higher rates of open defecation than Kinh/Hoa (26.8 percent versus 2.4 percent) [[9](#_ENREF_9)].

### Health outcomes

#### Communicable diseases

The researches were shown ethnic minorities have a higher risk of diarrhea but less likely to had care-seeking, and less likely to receive treatment[[1](#_ENREF_1)] (Table 4). Children of Kinh ethnicity demonstrated lower odds of suffering from diarrhea (OR = 0.70, CI: 0.56-0.87) but higher odds of suffering from cough (OR=1.29, CI: 1.10 - 1.51)) compared with their counterparts[[10](#_ENREF_10)].

The risk of having communicable diseases i.e., HIV/TB, Malaria, and Neglected disease among ethnic minority was not different between ethnic minority and majority groups[[11](#_ENREF_11)]. Some higher risk of malaria infection among Rag Lai people [[12](#_ENREF_12)], Stieng people ([Le Hung et al., 2005](#_ENREF_30)), however, has been reported. Table 4 presented some figures about prevalence, care-seeking, and treatment for children with diarrhea and ARI symptoms of Kinh and other ethnic groups.

#### Malnutrition

Malnutrition is two times higher among ethnic children than the other major groups in 2014 [[13](#_ENREF_13)]. The minorities were more likely to have underweight and stunted than those from Kinh/Hoa groups (OR= 1.56., 95%CI: 1.25 - 1.95 and OR = 1.71 (1.44 - 2.03)[[14](#_ENREF_14)]. Children from Thai people and Muong people have a 2.7 times increase for underweight (OR = 2.7, 95% CI = 1.1 – 6.5) than the Kinh group[[15](#_ENREF_15)].

The malnutrition rate is different among ethnic minority groups. The rate is lowest among Muong (16.4%) and followed by Tay (21.3%), Nung (27%), Khome (27.2%), Dao (27.3%), Thai (28.4%), Ede (28.6%), and Bana (28.9%) and H’mong group (33.9%) (Figure 2). However, it should be noted that in minority groups with small populations, the sample size was not representative enough for the prevalence to be presented[[13](#_ENREF_13)].

The data on stunting also was shown similar patterns among the ethnic groups. The lowest prevalence was found in the Kho me, Kinh and Muong children, with the highest prevalence, noted in H’mong, Dao, and Bana children (Figure 3)[[13](#_ENREF_13)]. Complementary feeding practices were less optimal among ethnic minorities compared to Kinh. Compared with Kinh (75 %), fewer ethnic minority children received minimum acceptable diets (33 % in Thai-Muong, 46 % in E De-Mnong, and 52 % in Tay-Nung; P < 0.05)[[16](#_ENREF_16)].

#### Maternal and child mortality

A global analysis data from 1990 to 2015 proved that maternal mortality reduction is related to coverage of specific maternal care services, which included one visit of antenatal care, four antenatal care visits, in-facility delivery, and skilled birth attendance[[17](#_ENREF_17)]. Low utilization of maternal and child health services impacted poor maternal and health outcomes among ethnic minorities in Vietnam.

The MMR is much higher among ethnic women living in the ethnic region than the major groups living in the main region. The data was shown that during 2001-2002, MMR in the Northern Midlands and Mountains and the Central Highlands was approximately 10 times higher than the mainland region (Red River Delta and Southeast regions) [[18](#_ENREF_18), [19](#_ENREF_19)]. In 2006–2007, the MMR was 3 times higher in the ethnic region (108/100,000 vs 36–40/100,000). The MMR among ethnic minorities (H’Mong, Thai, Ba Na, Tay, Dao, and Nung) is 4 times higher than that for the Kinh group [[18](#_ENREF_18), [19](#_ENREF_19)]. Ethnic minorities had higher risk of stillbirth (OR= 6.34, 95%CI:1.33 - 30.29)[[20](#_ENREF_20)], neonatal mortality [[21](#_ENREF_21)]. Ethnic minority child is three times more likely to die in the first five years of life than a Kinh/Hoa majority child. After adjusted for other factors, the odds of experiencing a child's death were higher for women in minority ethnic groups compared with Kinh women (OR:1.57, 95%CI: 1.15 - 2.14)[[22](#_ENREF_22)].

## Education

Vietnam has little inequality with gaps slightly favoring females, urban, higher wealth in reading and math proficiency in upper-secondary school overall compared to other nations. However, Vietnam has moderate levels of inequality in mean years of schooling by wealth due to differences in transition and completion rates to upper-secondary school[[23](#_ENREF_23)].

The education of ethnic minorities was worse than the major groups. For example, the proportion of ethnic minority children who completed the first 5 years of primary education was just over 60%, compared with 86% of ethnic majority children[[24](#_ENREF_24)]. Besides, the school dropout rate was higher among ethnic minority households, compared with households from ethnic majority groups (50% vs. 16%) due to school fees, language barriers, and travel constraints [[25](#_ENREF_25)]

Ethnic minority children are still less likely to be enrolled in school, particularly at the upper secondary level, and educational attainment is low among ethnic minority adults. By 2012 nearly all-ethnic minority children ages 7–9 were enrolled in primary school, a large majority attended lower secondary, and roughly one-third enrolled in upper secondary. From age 14 (the last year of lower secondary) a steep fall-off in ethnic minority enrolment begins, and relatively few children from ethnic minorities make the jump to upper secondary[[26](#_ENREF_26)]. By 2012, around one-fifth of children in the ethnic minority areas are poor in education[[7](#_ENREF_7)].

Enrolled ethnic minority children perform worse than majority children, scoring lower on mathematics and reading tests than Kinh children. The disparities are very large before children start primary school. Language appears to be an important factor in poorer performance. Despite their lower starting point, ethnic minority students show substantial learning gains—particularly in the Vietnamese language[[26](#_ENREF_26)].

## Local government services

There are under-researched in this area. Ethnic minorities are less well covered by social programs aimed at the poor, like the health care fund for the poor, than their majority counterparts, for example [[25](#_ENREF_25)]. Ethnic minorities, have very limited access to tax and budget information, including their entitlements from public services, and tend to be unaware of their rights to access tax and budget information, as stipulated in the Constitution and the Law on State Budget[[27](#_ENREF_27)]. They were also less utilized for legal services, particularly among women[[28](#_ENREF_28)].

# The exclusion in some sub-group of ethnic minorities

## Migration among ethnic minority

Most migration studies in Vietnam provide information on general migration or the ethnic majority group. There are very few studies providing information on the migration of ethnic minorities. One of the reasons for this is the lack of data, in part because these groups have not given much attention. Strategies for including those groups in accessing public services are also lack of information.

### Ethnic minority group lack of mobility and it driver to poverty

Migration programs have favored Kinh investment, moving lowland Kinh into the highlands with financial sponsorship or set up services and work opportunities with the states rather than vice versa[[25](#_ENREF_25)] Kinh migrants have benefited from their mobility and use social networks to access information, finances, and power, which led to high economic outcomes. Meanwhile, ethnic minorities were experienced increasing restrictions in use or losses of land, less mobility outside their home village which affects their ability to see and learn new ideas and technologies.

In terms of migration level, 2.2% of minorities made a move during the 5 years before the census in 2009 with the haft of those move within short- distant and half move within long – distant, more female moved than male, self-employed migrants account for the largest proportion, the figures are much higher among minority migrants than among those of the Kinh majority, i.e. 71 and 64 percent comparing to 45 and 48 %. A high percentage of self-employment among minority migrants may be due to their low education. The percentage of minority migrants working in the public or private sector is also lower than that for Kinh migrants[[29](#_ENREF_29)]. Ethnic minorities made up low proportions of internal and interprovincial migrants, mostly engaging in rural-to-rural migration. Only 4.8% of total migrants in Vietnam were minorities who migrated from rural to urban area and 15.7% migrated from rural to rural areas and. Most of them moved with organized migration or delocalization programs (for hydropower plants, for example)[[30](#_ENREF_30)].

A large proportion of ethnic minorities live in mountainous and remote areas and have limited information on migration opportunities. Migration costs may also be higher due to long distances to cities. However, even after controlling for household and commune level, the association between ethnic minority status and migration for work remains significantly negative. Whether these are supply-side (the pull of localized cultural and kinship ties, for example) or demand side (discrimination on the part of potential employers), or a mix of the two, remains to be discovered[[31](#_ENREF_31)]. This lack of mobility is a possible driven of poverty among Vietnam’s ethnic minority populations[[31](#_ENREF_31)].

### Ethnic minority migrate to more marginal areas and not being supported by government

Some ethnic minorities practice shifting cultivation, they secure their livelihoods often by moving into more marginal areas, where they are more exposed to climatic variations and poorer soils[[32](#_ENREF_32)]. It was also isolated and hard to reach the area, often in sensitive border areas. These have been not encouraged by the government due to environmental degradation and out of control[[33](#_ENREF_33)]. Minorities also were not being able to take advantage of new labor export policies by the government to work overseas, as language barriers and a lack of confidence kept them out of these programs[[25](#_ENREF_25)].

### Ethnic minority migrant to urban areas facing multi-layers of exclusion

Migrant workers are excluded from planning processes in the areas where they live and work, thus making it more difficult for them to access basic services and social protection. Migrant workers and their family members are not included in local planning for socio-economic development at their destination/working areas, thus the local public services systems are not designed or budgeted to meet their needs and demands. Migrants to urban areas also face stereotyping from local authorities and local people. Many authorities blame migrants for overcrowding, overloaded infrastructure, dirtiness and social problems like theft, drug use, and prostitution. Migrants often find it hard to integrate into society at their destinations. Residential registration requirements prevent them from accessing public services. Labour law violations by employers are common, but migrant workers dare not raise their voices out of fear of losing their jobs. Many workers do not have contracts and so are unprotected from employment and health and safety risks. They are not able to organize collective negotiation for better payment or compensation in cases of unemployment, sickness or accident[[34](#_ENREF_34)].

Temporary and unregistered migrants face job insecurity; and jobs rarely provide health insurance, unemployment benefits, sick leave, or maternity leave. Migrants tend to be less skilled than residents, which is a likely reason for the slightly lower average incomes of migrants compared with residents, especially women migrants and migrants from ethnic minority groups. And language can be a barrier for ethnic minority migrants in urban areas[[32](#_ENREF_32)]. Limited access to markets and business opportunities, lack of credit and less developed technical skills also disadvantaged the ethnic minority migrants compared to Kinh migrants. Furthermore, tensions arose between in-migrating groups, because of diverse ethnic, cultural and economic backgrounds[[32](#_ENREF_32)].

The minority were also lacking networks and connections, particularly in agriculture and trading[[25](#_ENREF_25)]. Cultural differences between minorities and Kinh that play out in market interactions, schooling, and other activities. For example, minorities report being unwilling to divide families up for economic gains, such as leaving one’s family behind to engage in migrant labor. Minorities also reported cultural barriers to economic transactions, such as norms against charging interest on loans from kin and neighbors. For the minority communities studied, the ability to make money was looked upon as a socially unfavorable trait[[25](#_ENREF_25)].

## Ethnic minority women are more vulnerable than men

The ethnic minorities people are belonging to 53 different ethnic groups, and in each ethnic group, there exist many sub-groups with diverse languages, cultural practices, customs, religions, livelihood activities in association with the different contexts of natural environment and culture. All ethnic groups are divided into the patriarchy group (e.g., Tay, Nung, Thai, Dao, H’Mong, etc.), matriarchy group (E de, Bana, M’nong, Cham Ninh Thuan, etc.) and duarchy group (e.g., Xo-dang, Brau, Xtieng, etc.) with diverse gender relations. With this diversity, we simply cannot make generalized conclusions about gender issues within the ethnic minority communities in Vietnam[[28](#_ENREF_28)].

However, in general, ethnic minority women are in much lower status than ethnic minority men. Ethnic minority women have less access to resources, little possession of production tools and lower access to social services [[25](#_ENREF_25)]. There are often cultural or economic barriers to women’s capacity and decision-making ability in minority communities, as cultural norms may place ethnic minority women in a subordinate position[[25](#_ENREF_25)]. The Mong value highly a social system with “father-right” as the norm. Here, the male head of the family and male relatives who are assigned to represent him in his absence or after his death, have the authority to make decisions affecting the household and the lineage. Even when they (men and women) are equal in family decision-making, however only the men participate in the community activities[[35](#_ENREF_35)].

Pham Quynh Phuong suggested that gender inequality is tightly associated with underdevelopment: “in parallel with the underdevelopment of economic situation comes to the underdevelopment of society including gender inequality,” which exhibits through “the unreasonable division of labor between men and women,” “women rarely get to attend festivals or weddings and funerals in their mountain villages” (while the men “do nothing for the whole month but attending weddings and funerals”), “the women are not allowed to join guests for a meal but have to eat in the kitchen,” “victims of many forms of domestic violence…, are beaten and abused,” “women are those who get more access to resources than men, but own less control over these resources,” etc.[[36](#_ENREF_36)].

Women not allowed to travel themselves and need to accompany by husbands [[37](#_ENREF_37)]. Women felt ashamed to go to commune health centers because the skilled birth attendant was men only[[38](#_ENREF_38)]. The opinion of the husband and parent – in – law play an important on birthplaces too [[39-42](#_ENREF_39)]. 40% of women have home delivery as their husband’s decision, 23% as their parent – in – law’s decision [[39](#_ENREF_39)].

Son preference is quite prevalent among ethnic minority groups. This could affect the decision of using contraception[[38](#_ENREF_38)]. Furthermore, the Thai, Hmong, and Dao groups have a significantly low rate of girls going to school compare to boys. In a financially difficult situation, even though there are tuition fee reduction policies, other costs for education are also burdened for many ethnic minority families, and girls are likely to stop schooling first[[25](#_ENREF_25)]. Children who were male (OR =1.61, CI: 1.09 - 2.38) were more likely to receive oral rehydration therapy than children who were female[[10](#_ENREF_10)].

Current legal services are not appropriate for EM people, particularly for women: a lack of services in rural and mountainous areas, the lack of officials who can understand EM culture or speak their languages, and ineffective supports for EM people, high cost. There are barriers from EM women themselves limiting their access to legal services such as poverty, limited awareness of legal issues, their psychology of acceptance and sufferance, the limited capability of speaking Vietnamese[[28](#_ENREF_28)]. The perspective of ethnic minority people, however, are not share the same concept of “equality” as the media and current law. Instead, the concept of inequality does not exist, their perspective of an ideal family is “being together”, caring for each other, and sharing the workload in association with the livelihood needs to co-exist. They accept to behave following rules of traditional culture, that does not mean justice for women[[28](#_ENREF_28)]

## Young people are facing underage marriage and consanguineous marriages

### Underage marriage and consanguineous marriages

Underage and consanguineous marriages are issued highlighted and prioritized by the government. By law, age at first marriage in Vietnam is above 18 for women and 20 for men. Prevalence of underage marriage and consanguineous marriages among ethnic minority groups are presented in Figures 1 and 2.



Figure 1. Ethnic minorities with highest underage marriages prevalence in Vietnam (2015) (%o)

Figure 2. Ethnic minorities with highest consanguineous marriages prevalence in Vietnam (2015) (%o)

Overall, early marriage directly affects socio-economic development, resulting in a vicious cycle of poverty among ethnic minority groups, reduced quality of human resources among ethnic minority areas. Early marriage has constrained girls’ opportunities for education, training and finding decent work in the future. Early marriage also leads to early pregnancy when the body hasn’t yet reached full maturity, significantly affecting girls’ psychological and physical development, while contributing to the risk of domestic violence and other forms of gender-based violence, as well as violating child rights. An in-depth analysis of the data from the Census 2009 showed that adolescent birth rate was up to 10 times higher among ethnic women, especially Hmong (129/1,000) and Thai (68/1,000), compared to Kinh women (12/1,000)[[1](#_ENREF_1)].

Adolescent pregnancy and early marriage have severe consequences for ethnic girls such as drop out of schooling, increasing the risks on morbidity and mortality, increasing the risks of having dangerous therapeutic complication: fecal contamination*,* gestational hypertension, anemia, preterm birth, amniotic infection [[25](#_ENREF_25), [43](#_ENREF_43)]

For some ethnic minority people, as the ‘Hmong believe that a person should be industrious, contribute to the family in the form of labor, and fulfill their role in society as soon as they are able’, the community has no concept of adolescence. Historically they have had no concept of even childhood. While relations are governed by a strict hierarchy of age, a child’s world is not seen as fundamentally different from an adult’s and children are treated ‘with the same respect given a living adult individual’, in part because of beliefs that ‘he is but the reincarnation of a passed away adult’. Adolescence, on the other hand, remains a tenuous concept, even for adolescents. While it might be argued that the space between school-leaving and marriage is serving as functional adolescence, as children are still seen as children, this period in many ways is more infantilizing than maturing. Adolescents, and particularly girls, are expected to shoulder an adult workload, but have no voice in family decision-making and are almost completely prevented from investing in their futures[[44](#_ENREF_44)]

# PART 2: KEY DRIVERS FOR SOCIAL EXCLUSION

Inequalities become inequitable when such differences are unevenly affected or mediated by social circumstances that are avoidable, such as income or ethnicity, e.g. when access to care is differentiated between people based on social constructs. The Commission on Social Determinants of Health (CSDH) that was set up by the World Health Organization (WHO) has proposed a conceptual framework to orient its work (Figure 2). This framework departs from previous research and aims to aid researchers, policymakers and health planners in their work to reduce health inequity[[45](#_ENREF_45)].



**Figure 2. The Commission on Social Determinants of Health Framework** [[45](#_ENREF_45)]

The key feature of the theoretical framework is the emphasis on the social position as the main determinant of inequity. Social position is defined by relations of ownership or control over productive resources and can be captured through social markers such as ethnicity, income, gender, and education. The weight and relevance of the assigned social position are influenced by the socio-economic and political context, including governmental policies, cultural values and the macroeconomic condition of a country. The impact of these structural factors on equity in health and well-being is mediated by behaviors, psychosocial factors, living conditions and access to and quality of care received when encountering the health system[[45](#_ENREF_45)].

Causes and determinants of inequity in maternal and child health in Vietnam have been reviewed by Målqvist using this framework in 2012[[46](#_ENREF_46)]. Ethnicity is one of four categories relating to the socioeconomic position following the framework. This framework is also used in the analysis of health equity among ethnic minority groups in 2016 [[47](#_ENREF_47)] and other recent studies in maternal and child health[[48](#_ENREF_48)]. We also used this framework to explain the drivers of other social services (education and government services). The following parts describe structural determinants and intermediary determinants of inequity in social services

 (2) socioeconomic position: the interaction of ethnicity with other social-economic position which included gender, education, occupation, and income. (3) social determinants of health.

## Structure determinants

Another socio-economic and political context which related to governance and policies is analyzed in the second part of the report. Gender had been reported in part 1, ethnic minority women are in much lower status than men. In this part, we focus on drivers of barriers in culture and societal values, languages, educations and household economy.

### Culture and societal value

With the perception that every object has a soul, since ancient times, the Vietnamese people have worshiped a large number of gods, especially those related to agriculture such as sun, moon, land, mountain, river, and forest, etc. Each ethnic minority in Viet Nam has its way of practicing its traditional beliefs, most noticeably those maintained by some ethnic groups such as Tay-Thai, Hmong-Dao, Hoa-San Diu-Ngai, Cham-Ede-Gia Rai, Mon-Khmer. The most popular and time-honored custom of the Vietnamese people, including some ethnic minorities, is ancestor worship and commemoration of death anniversaries. Every Vietnamese family has an altar to worship their ancestors and attaches importance to the commemoration of death anniversaries of the predecessors (79.8% of the population). Beside practicing traditional belief, Viet Nam has 13 religions, the six major religions, namely Buddhism (7.9%), Catholicism (6.1%), Caodaism (4.4%), Hoa Hao (1.6%), Protestantism (0.86%), and Muslim (0.08%)[[1](#_ENREF_1)]. The right to freedom of belief and religion of all Vietnamese citizens is provided by the Constitution and ensured in practice.

Custom and faith play an important role when deciding to go for the health care seeking behavior of ethnic minority women. The conception that birth is a natural and normal process is very popular. Having easy or difficult delivery is a hereditary factor [[49](#_ENREF_49)]. Ethnic women only come to the health center in serious cases [[49-54](#_ENREF_49)]. Some traditions that might be considered as harmful for health. For example, ethnic women often hide their pregnancy from their husband, or/and even their mother in law. In many cases, the relatives know until the fetus is five months old. The Paco and Van Kieu man, especially, often stay out of his house or avoid meeting his pregnant wife [[55](#_ENREF_55)].

The Thai, H’mong and Kho Mu/O Du consider the symptoms/problems like abdominal pain, bleeding, induced abortion, deformity baby, triplet… as the consequences when the women pass “the places with the bad ghost”, “the ghost disturb”, “the destiny”, “the ghost gets in the woman’s abdomen and eats the fetus”, “the soul of the fetus is not suit to its mother”...[[49](#_ENREF_49)]. These conceptions would delay them in seeking health care. Some serious cases, the mothers and the babies, even are let to die without any treatment because of “the god will” [[54](#_ENREF_54)].

The selection of place and visitors after delivery is influenced by the customs. The abstained custom in which do not allow strange persons enter the house with the new deliverer has a big impact on postnatal care of health provider [[41](#_ENREF_41), [42](#_ENREF_42), [51](#_ENREF_51), [54](#_ENREF_54), [56](#_ENREF_56), [57](#_ENREF_57)]. The Kho Mu/O Du people do not allow any visit after delivery, including health providers. They have the conception that delivery is an unlucky event; the mother could bring unlucky, failure in business and sickness to the attendants [[42](#_ENREF_42)]. Ba Na people, for example, just allow visits until the umbilical cord falls off. In Klongpon in Kon Tum provinces, they hang a cross-bow in front of their house and just allow visit after a month [[51](#_ENREF_51)]. The H’mong in Nghe Ang grow a green tree in the front door, the Thai knit a bamboo wattle and tie a circle made by black, red and green thread/string [[42](#_ENREF_42)], the Cham in Ninh Thuan and An Giang hang a catus in their front door for 7 days after delivery [[58](#_ENREF_58)].

The practice of contraception is also very much influenced by local customs and religions. Many places, where the village patriarch, head of the village prohibit the practice of any contraceptive method despite the availability and accessibility [[59](#_ENREF_59)]. M’nong people think the women have to deliver until they are not able to do. The Ba Na and Gia Rai consider sterilization as losing race [[60](#_ENREF_60)]

The people with Catholicism and Protestantism religions do not allow the practice of modern contraception. The H’mong people in the Northern mountainous region and some ethnic minorities in Tay Nguyen only applied traditional methods like periodic abstinence. These tenets limit the acceptance and family planning behavior, against using the contraceptive method for religion [[60](#_ENREF_60), [61](#_ENREF_61)]. The family wants to have “many babies, many children, much happiness and much virtuous”. The Ba Na and Gia Rai people do think that female sterilization would lead to losing their race [[60](#_ENREF_60)].

Cultural and language are important barriers that prevent ethnic minorities to be better integrated into society. Cultural norms among ethnic minority communities plus the fact that many ethnic minority women cannot speak Vietnamese are barriers to ethnic minority women’s access to social services and their participation in political decision-making processes [[25](#_ENREF_25)].

### Language

Language is the main barrier for ethnic minorities in participating in the educational system, which bases mainly on the Vietnamese language. Children from ethnic groups, particularly those belonging to groups with no official letters, will face more solid obstacles to attend schools, where Vietnamese is used as the official language. A study by the Ministry of Education and Training conducted in the school year of 2007-2008 shows that pupils of Grade One in 40 provinces do not use Vietnamese comfortably, among those, about 70% of ethnic minority children cannot speak or understand Vietnamese as they enter school. The absence of nursery and pre-schools for ethnic minority children to get familiar with the Vietnamese language is common. Furthermore, the lack of bilingual learning programs makes it more difficult to transfer from ethnic minority own language to the Vietnamese language in the school environment. Teachers are mainly Kinh people and many of them do not speak ethnic minority languages and there are only 8% of teachers across the country are ethnic minority people[[25](#_ENREF_25)]. Ethnic women were often reported as being reluctant to use free services due to language and cultural barriers[[25](#_ENREF_25)]. Due to the successful push to expand primary education, the language will likely be much less of a barrier for ethnic minorities in the future[[26](#_ENREF_26)]

### Education

Maternal education has long been considered an important determinant for maternal and child health. Education has an effect on health on many levels, either directly through increased knowledge about danger signs and disease patterns or indirectly through a deeper understanding of health system structures and a higher ability to adapt to change. In addition to the individual education level of the mother, it has been argued that the educational level of the whole family and even the general education level of the community has an effect on health[[46](#_ENREF_46)]. Adult educational level has been shown to have an impact on childhood nutrition in Vietnam [[62](#_ENREF_62)]. Children whose mothers attained lower secondary education and above had more than double the odds of receiving Oral rehydration therapy during an episode of diarrhea, compared with children with mothers who attained primary or lower education[[10](#_ENREF_10)]. Being uneducated was associated with an increased risk of not receiving antenatal care in the ethnic minority group, with an OR of 2.95 (95% CI 1.70– 5.12). No such relation could be established within the ethnic majority group[[48](#_ENREF_48)]. However, a recent study suggested that mothers education was the biggest contributors in 2000 on malnutrition among ethnic minority groups but the attribute of mothers education disappeared in 2011[[14](#_ENREF_14)]; the higher likelihood of child death among mothers with higher education in the Northern Midlands and Mountain areas[[22](#_ENREF_22)]

### Household economic

Members of Vietnam’s 52 ethnic minorities (except Kinh and Hoa people) have made substantial gains in welfare over time but remain much more likely to be poor than members of the Kinh and Hoa ethnic majority. Using the General Statistics Office of Vietnam – World Bank poverty line, in 2014 the poverty rate had fallen to 6.3 percent among the Kinh and Hoa while standing at 57.8 percent among ethnic minorities. Poverty rates for minority groups range from 38 percent among the San Diu to 93 percent among the Hmong. Members of ethnic minority groups make up less than 15 percent of the country’s population but account for 70 percent of the extreme poor[[26](#_ENREF_26)]

Women who belonged to an ethnic minority and were living in a poor household had an almost 10 folded risk (OR 9.69, 95% CI 5.15–18.24) of not receiving antenatal care, as compared to ethnic majority women living in a non-poor household. Poor women in the ethnic minority group ran a 6.27 (95% CI 2.37–16.6) times greater risk of not being attended by skilled personnel as compared to poor women in the ethnic majority group. An even greater disparity was found when comparing nonpoor women in the different ethnic groupings, where ethnic minority women had an OR of 7.67 (95% CI 3.54–16.6) of not receiving skilled attendance at birth. At greatest risk of not receiving skilled birth, attendance was poor women from ethnic minority groups who had an OR of 25.5 (95% CI 11.4–56.8), compared to nonpoor Kinh/Chinese women [[48](#_ENREF_48)]. Households in the highest compared with the lowest wealth quintile were over 40 times more likely to have access to both improved water and sanitation facilities (OR: 42.3; 95% CI: 29.8-60.0)[[63](#_ENREF_63)]. Household wealth status and ethnicity were the most significant predictors of childcare and education in Vietnam. The most disadvantaged groups were from ethnic minorities or poorer households, mothers with lower educational levels, or from the Mekong River Delta and Southeast Regions[[64](#_ENREF_64)].

There are also a substantial amount of additional costs associated with seeking health care, both through transportation to health facilities and through informal costs to different actors in the system[[37](#_ENREF_37)]. The largest component of expenditure for inpatients with insurance was gifts, food, travel costs, and lodging[[3](#_ENREF_3)]. The unaffordability of health service expenses, including other expenses such as eating, visiting and traveling reflects the poor economic status and leads to home delivery [[42](#_ENREF_42)]. The risk of catastrophic spending for the poorest is considerable with this system, especially since a large proportion of the poor remain uninsured.

The concept of *multiple vulnerabilities* has received recent attention from both researchers and policymakers because the use of individual-level socioeconomic indicators alone may fail to capture the health impacts of contextual factors. Approaches covering multiple vulnerabilities can take into account the effects of the individual as well as the household and contextual disadvantages that impact on health. Recent research demonstrated that the receipt of antenatal care by skilled staff and birth assistance from skilled health personnel were less common among vulnerable women, especially those with multiple vulnerabilities (low education, poor, rural, and ethnic minority). The odds of receiving skilled antenatal care among women without any of the four vulnerabilities in 2000, 2006, and 2011 were 19.98, 15.13, and 23.34 times higher than the odds for women with all four vulnerabilities. The odds of receiving skilled care during deliveries for women without any of the four vulnerabilities in 2000, 2006, and 2011 were 29.92, 31.6, and 50.32 times higher than the reference group – women with all four vulnerabilities[[65](#_ENREF_65)].

## Intermediate determinants

### Psychosocial factors: stereotyping of ethnic minorities

Belonging to an ethnic minority group can be a source of psychosocial stress due to a lower social position. Social stigma against ethnic minorities is relatively common among various social groups with stereotypes that ethnic minorities are backward and should be assisted to “catch up” with the Kinh[[25](#_ENREF_25)]. Stereotypes and misconceptions on the part of teachers, local officials, and policymakers towards minority students and populations, and the negative views the latter may have of themselves directly hinder efforts to improve the quality of teaching and learning[[66](#_ENREF_66)]. An unfriendly attitude of the health providers leads to the barrier to ethnic women have been reported[[46](#_ENREF_46)]. The women with ragged, dirty and careless clothes and the strange ones are treated badly or even refuse to supply medicine for treatment [[41](#_ENREF_41)].

### Public system factors

#### Distance to public facilities

Ethnic minorities live in high mountains, causing transportation difficulty and geographical isolation. Distance to the nearest health facility was consistently reported as a barrier to use maternal and child health services in mountainous areas of Vietnam[[46](#_ENREF_46), [48](#_ENREF_48), [67](#_ENREF_67)]. The long-distance to the injecting places is the barrier for not going to tetanus vaccine injection [[68](#_ENREF_68), [69](#_ENREF_69)]. Far distance, poor transport, shortage of transportation, coming too late to a health center or fear of delivering on the way limit people give birth at a health center [[42](#_ENREF_42)]. There is a relation between reaching health center in 20 minutes and deliver at a health center [[39](#_ENREF_39)]. Travel times were substantially less for Kinh and Hoa people compared to ethnic minorities (21 vs. 36 minutes to district hospitals, and 16 vs.11 minutes to commune health station, respectively)[[3](#_ENREF_3)]. Geographical issues and distance may not be the major barriers to accessing maternal health care services, because ethnic minority people often routinely travel long distances to pursue their livelihoods [[70](#_ENREF_70)].

#### Poor public services

The unavailability of health services could be a barrier to utilization. Shortage of midwives, or male midwives, shortage of equipment or electricity, referring to other health centers are human factors relating to unwanted to have a delivery at health center [[51](#_ENREF_51)]. Commune health stations without fully-qualified doctors are highly concentrated in Dien Bien, the poorest province with a large ethnic minority population. In Dien Bien, 24% of commune health stations are staffed by at least one fully-qualified doctor and are lack a source of clean water[[3](#_ENREF_3)].

There is no law firm or law office in the northern mountainous province with ethnic minorities such as Lai Chau or Dien Bien[[28](#_ENREF_28)]

#### Services lacking culture-adaptation

Legal services for ethnic minority people in general and ethnic minority women, in particular, are not friendly with them, which shown through the lack of officials who can understand ethnic minority culture or speak their languages, and ineffective supports for ethnic minority people[[28](#_ENREF_28)].

Regarding education, one curriculum has been still applied to the whole country, regardless of urban or rural, majority or minority students. Although the Ministry of Education and Training has recently a free room of 30% of the curriculum for local initiatives so that local education offices can adjust the curriculum to be more relevant to the local conditions and students’ needs, the curriculum hasn’t been relevant to the students of many ethnic minority groups[[71](#_ENREF_71)].

# PART 3. STRATEGIES FOR INCLUSION

## Strategies exist for the social inclusion of ethnic minorities within public institutions

In general, the Government and Prime Minister’s policies for ethnic minorities were considered enormous in quantity and comprehensive in content at the central level, covering almost socio-economic aspects of ethnic minorities. Policies/strategies on socio-economy development for ethnic minority people can be divided into 7 groups (1) Policies/strategies on poverty reduction, infrastructure development, supporting production, trading, application of science and technology; (2) Policies on to support cultural preservation and health care; (3) Policies/strategies on training and education, (4) Policies/strategies on vocational training and education for authority officials/ local staffs, (5) Policies to support information, communication, advocacy, dissemination and education of law and legal aid (6) Policies on environment protection, tourism development, and sports, (7) Some other specifics policies.

The following part describes more detail about policies related to social services

### Policies/strategies on poverty reduction, infrastructure development, supporting production, trading, application of science and technology

Policies/strategies under these categories can be divided into 5 subgroups:

* Infrastructure development which includes transportation, irrigation; subside for water, electric, school, health facility, and settlement.
* Policies to support product development and poverty reduction: referential loans, tools; land allocation, forest allocation to help people escape poverty; support to improve capacity, develop production, develop traditional trades, shift labor structure from agriculture to non-agriculture; regular subsidies for poor households unable to escape poverty to ensure minimum subsistence, planning and arranging stable population following regional characteristics, especially ethnic minorities living in the uneven environment, natural resources or they are living in protected areas, special-use forests, areas frequently affected by climate change and dangerous landslides.
* Policy on trade development support: Support to trade promotion, promotion, and introduction of products in ethnic minority and mountainous areas; support to branding, geographical indications for products of ethnic minority and mountainous areas; linkage between the State, enterprises, people to produce goods, connect the market, consume products.
* Policies for application of scientific, technical and technological advances: To support enterprises, organizations, and individuals in researching and applying scientific and technical advances and technologies suitable to the natural conditions and strengths of ethnic minority and mountainous regions; Support the transfer of scientific, technical and technological advances to ethnic minority and mountainous areas.
* Policy on business support and start-up: Tax incentives, financial incentives to attract, develop businesses and start-up businesses in ethnic minority and mountainous areas.

These policies have contributed to the socio-economic development in ethnic minority regions. Some remarkable policies are:

National Target Program on Poverty Reduction under the Price Minister’s Decision 20/2007/QĐ-TTg dated 2 July 2007 helped 5 million poor households to access preferential loans with around 6-7 million Dong/time/household on average. 30 thousand training classes were opened to the handover technique. 120 thousand poor laborers received free vocational training, in which about 60% had a job after training. Poverty reduction models were expanded in 218 communes in 35 provinces and cities with 27,566 of total participated households, 77% of which were poor households. The investment was made into about 2,000 production-supporting buildings in 273 extremely difficult communes, coastal land, and islands. 53 million poor people received health insurance cards. 8 million poor pupils were reduced tuition fee and about 400 thousand poor households received houses[[25](#_ENREF_25)].

Socio-Economic Development Program in extremely difficult communes of ethnic groups and mountainous regions in the 2006 – 2010 period under the Prime Minister’s Decision 07/2006/QĐ-TTg dated 10 January 2006 used 14,025.25 billion of the State budget with annually increasing investment norms for subprojects. The investment increased from 860 million Dong/commune/year to 1,064 million Dong/commune/year in 2006 and 2007, to 1,364 million Dong/commune/year in 2010. The local budget was located over 365 billion Dong (presenting about 4.5% of the total budget)14. After 5 years of the implement, the Program was carried out in 1,958 communes, 3,274 villages and hamlets, which were extremely difficult, in 369/690 province in 50/63 districts with 4 project components, achieving important results and contributing to the socio-economic development of extremely difficult communes, villages, and hamlets in ethnic and mountainous areas[[72](#_ENREF_72)].

Policies on emigration to implement settled agriculture and fix the residence of ethnic minorities in the 2007 - 2010 period under the Prime Minister’s Decision No. 33/2007/QĐ-TTg date 5 March 2007 helped ethnic minority households to settle life, developing economy, rapidly reducing the rate of poverty and hunger, ensuring political security, protecting forestry ecosystem. At the end of July and early August of 2010, the total number of households that needed support to emigrate was 30 thousand, 6 thousand households succeeded in emigration, fulfilling 31% of the target[[72](#_ENREF_72)].

The policies on housing for the poor under the Prime Minister’s Decision 167/2008/QĐ-TTg dated 12 December 2008 gave houses to 472,635 poor households, presenting 95.3% of the total number as early approved in the proposal and counted until 31 December 2011. 79,628/ 84,572 households in 62 poor districts received housing support, gaining 94% of the total until May 2011; 22,053/22,792 households, who were Kho me people in South Central Coastal, were supported, presenting 97%[[72](#_ENREF_72)].

### Policies to include health care services for ethnic minority

Regarding cultural preservation, some policies have been developed and implemented on develop cultural infrastructure in ethnic minority and mountainous areas; preserving and promoting national cultural identity; research and popularize the written language of ethnic minorities.

Regarding Health and population support policies: Policies and strategies included building infrastructure, medical equipment for districts and communes; establishing a medical team of doctors working in hamlets of ethnic minority and mountainous areas; Improving working conditions for health care staffs; Supporting health insurance, medical examination and treatment for ethnic minorities; Development of preventive medicine; Population development and support for family planning; Improve the health, stature, and youth of ethnic minorities; Research, conservation, development of medicine, pharmacy, traditional medicine, and traditional medicine; supporting gender equality; and reduction of child marriage and consanguineous marriage.

Details of some health policies have been describing as below:

#### Developing infrastructure for improving health care services access and quality

In terms of infrastructure, to 2009, 100% of the districts in minority and mountainous areas have been equipped with the key infrastructure and facilities of health care services. There are commune health care centers in most of the disadvantaged communes. 52,86% of the communes are having health care canters in permanent condition with 41,2% of which are meeting the national standards. Along with construction and upgrading commune health care canters, priority in public investment has been also given to district and provincial hospitals in minority areas[[71](#_ENREF_71)]

In some districts of minority areas, mobile health care teams have been established to provide services to the people in remote areas[[71](#_ENREF_71)]

#### Human resource

The Government has made efforts to strengthen health care human resources to the health care services system at grassroots levels. 40% of commune health care centers are having medicine doctors. In many communes, various retired government staff, teachers and border soldiers have involved in providing preventive health care services as collaborators.[[71](#_ENREF_71)]

##### Village-based ethnic minority midwives in mountainous villages

Since 2011, Vietnam’s Ministry of Health implemented the ethnic minority midwives (EMMs) scheme to increase the utilization of maternal health services by women from ethnic minorities and those living in hard-to-reach mountainous areas. In 2016, over 2412 EMMs, which provided EMMs for 30% of 8,576 villages in poor and hard-to-reach mountainous areas where women had difficulties in accessing safe motherhood services. EMM seems to be an important mechanism to ensure assistance during home births and postnatal care for ethnic minority groups, who are often resistant to attend health facilities[[73](#_ENREF_73)]

##### Project 1816 in Viet Nam

To rectify the uneven distribution of health professionals, on 26 May 2008 the Minister of Health of Viet Nam approved Project 1816, in which qualified health staff in high-level hospitals would be assigned on rotation to low-level hospitals to help improve the quality of medical treatment. The three main objectives of Project 1816 are: (1) Enhancing quality of medical treatment in low-level hospitals, in particular in mountainous areas that are short of health staff; (2) Reducing the overload status of the central hospitals, especially national-level hospitals; (3) Transferring technology and providing training to improve the capacity of local health staff. In the 2008 – 2011 period, 72 hospitals have had staff members sent on outreach missions. 3,954 national level personnel went on outreach mission over the three years. 269 province-level hospitals sent 2,915 outreach staff members to support 360 district-level hospitals. 305 district-level general hospitals sent 4,434 health workers to support 2,116 commune health centers. 2,493 training courses were delivered to lower-level health workers by outreach personnel, with 66,403 participants. Three years into project implementation, 5,101 medical techniques across 26 specialties were transferred to the lower levels. The respective number of techniques transferred by province-level professionals is 1,702[[74](#_ENREF_74)]

#### Financial assistant

Health Care for the Poor’ and ‘Free Health Care for Children under six’ policies in ethnic minority areas

The proportion of poor people and ethnic minority people covered by health insurance is high compare to the general population nationally (75 % versus 58% in 2009), especially for the ethnic minority poor (91%). In contrast, the proportion of children under six years of age was lower than that with health insurance nationally (82.5% versus 90%), because of the late birth registration due to their poor knowledge of birth registration and policies of Free Health Care for Children under six [[75](#_ENREF_75)].

A rate of health insurance utilization among the poor ethnic minority group and children higher than the general insured population nationally (70% for HFP versus 48% nationally in 2008; and 88% for FHCU6 versus 81% nationally in 2010). Public facilities, especially commune health stations (CHSs) and district centers are important sources of health care for the poor and children under six years of age with insurance. Ethnic minority people use public facilities much more than Kinh people (90% versus 80%). Among non-poor ethnic minority people, those insured have a higher number of visits than those uninsured[[75](#_ENREF_75)]. However, for serious sicknesses, more than 50% of the respondents think that the support from health care insurance cards is not enough. The additional costs they have pay are the expenses for travel and medicines[[71](#_ENREF_71)].

#### Policies on epidemic prevention and extended immunization

##### Malaria prevention program

Since 2000, the program on malaria prevention has prescribed medicines to treat malaria, and drugs to prevent malaria or provided medicines so that patients can treat themselves as committing malaria (including high-risk groups of ethnic minorities who often work on burnt-over land and often sleep overnight in kingpins and forests, as well as people in non-malaria areas but migrate to areas where malaria is rather serious, etc.). Mass media, such as central television, the voice of Vietnam, and local media, also propagate for malaria prevention[[71](#_ENREF_71)]. Malaria reduced from 51.9/10000 inhabitants to 20.9/10000 inhabitants in 2011 – 2015 period [[76](#_ENREF_76)]

##### Thyroncus prevention program

The national target program on thyroncus prevention was launched in 1994 pursuance to Decision No.148/TTg of the Prime Minister. The number of children at the age of 8 - 10 committed to thyroncus decreased from 22.4% of the total number in the nation in 1993 to 6% in 2003, and 3.6% in 2005[[71](#_ENREF_71)]

##### Extended immunization program

Right in 1985 as the extended immunization program was included in the national target program. Vietnam has been successful to prevent polio epidemic since 2000, and maternal and infant tetanus since 2005. Additionally, the proportion of measles patients has reduced by 95% since 1990. The rate of ethnic minority children accessed to full inoculations is not lower than the national average level[[71](#_ENREF_71)]

##### Program on maternal and children healthcare

The program on reproductive health has been implemented with supports from various international sponsors, UNFPA, and UNICEF for instance. Northern mountainous, highland, and Mekong delta regions are granted special priority[[71](#_ENREF_71)]. Ethnic minority women in poor areas can receive financial subsidies from the government if they complied with population policy (Decree 39/2015/NĐ-CP) or delivery at the health facility.

### Policies/strategies on include education for ethnic minority

These strategies included:

* Policies on support for education and training development: To support the development of ethnic minority education to national standards; Support the development of the preschool system, develop the bilingual model for preschool and primary education; physical improvement for kindergarten, kindergarten, and elementary students; development of boarding education; support for students, ethnic minority students on accommodation, scholarships, tuition fee exemptions, school supplies; Assist teachers to teach in difficult and extremely difficult socio-economic regions; training of ethnic minority teachers and ethnic minority teachers; Policy to support universities, colleges, professional secondary schools to build courses exclusively for ethnic minorities; Expanding the scale of ethnic minority and ethnic minority enrolment classes at universities, colleges, intermediate and vocational schools.
* Policies to support the development of vocational training: To support the development of vocational training institutions, to support ethnic minority and mountainous ethnic minority students and mountain areas in vocational training suitable to each region, meeting the requirements of industrialization, modernization, and international integration;
* Preferential policies for job creation: Prioritize the employment of ethnic minority students after graduation; Priority, support to find jobs, change occupations, export labor for ethnic minorities and mountainous areas

Details of some health policies have been describing as below:

#### The construction of schools and improvement of school infrastructure

The Programme 135 Phase I and II were the development of infrastructure and the construction of communal centers, including public buildings such as health clinics and schools[[77](#_ENREF_77)]. Between 2005 - 2015, the number of schools increased by 37% and 44% in the Central Highlands and Northern midlands and mountain areas, respectively[[1]](#footnote-1) .

#### Enhancing learning opportunities for ethnic minority pupils in ethnic and mountainous areas via systems of boarding, semi-boarding, and school site of secondary and high schools

Since 1991, the state has invested about VND 500 million to build a boarding school system for ethnic minority people. A system of boarding secondary schools has been established at different levels, from province to district levels. Besides, semi-boarding (boarding during the weekday only) class or school also increasing opportunities for pupils. The number of pupils attending these schools increased 20-fold from 2001 to 2005[[77](#_ENREF_77)]. With the first to the third grades, to create schooling opportunities for children in isolated and remote areas, many highland provinces have developed on-the-spot school sites (village-based classes) in such villages/ wards. As of 2009, there were about 3000 on-the-spot school sites built in about 40 provinces with more than 8,000 classrooms[[71](#_ENREF_71)]

#### Scholarships and financial aid

Following the 1991 Education Law, primary school pupils do not pay tuition fees. Depending on the socio-economic status of an ethnic minority pupil’s family, she or he will receive additional financial support from various sources. In 2016, ethnic minority pupils can have received additional supports for food, housing, and rice every month with a higher number of subsidies for those in small (Degree 116/2016/NĐ-CP and Degree 57/2017/NĐ-CP). Regardless of household or village status, ethnic minority pupils receive school supplies in the form of free textbooks and notebooks. Ethnic minority pupils in state boarding schools and colleges and universities continue to receive a scholarship equivalent to 80 percent of the current minimum wage[[77](#_ENREF_77)].

#### The teaching and studying of ethnic minority languages

As early as 1961, the first sets of written characters for Tay-Nung, Hmong, and Thai languages were approved for use in education and public media, followed by those of the Jrai, Banar, and Sedang in 1981, Co Ho in 1983, Pa Co and Bru-Van Kieu in 1986. From 1955 to 1979, 10 different languages were taught in general education, mostly at the primary level, and most of the initiatives were taken up by provinces. In 1980, seven languages were taught, the selection of which was based on the availability of a written script, as well as local resources such as teachers and textbooks. Ethnic minority language teaching for officials and employees working in ethnic minority areas was also implemented at the provincial level[[77](#_ENREF_77)].

#### Policy on earmark recruitment for ethnic minority people or zone-based preferential extra marks for entrance exams

Earmark recruitment means getting admission to schools without taking entrance exams (with universities, colleges, and professional vocation schools) to train human force for areas with severely difficult socio-economic conditions, and for ethnic minority groups that have too few personnel having an educational level of the university, college, and professional vocation schools. Earmark recruitment policy has been applied since 1990, as the ministry of portfolio issued Resolution 22/NQ-TW, dated 27/11/1989, and the Ministerial Council issued Decision 72/HĐBT, dated 13/3/1990 on some major policies and guidance for mountainous area socio-economic development[[71](#_ENREF_71)].

Apart from earmark policy for ethnic minority pupils, pupils in ethnic, mountainous, isolated, and remote areas are also subjected to the policy of preferential extra mark granting for their entrance exams to universities and colleges. Accordingly, students of Vietnamese nationality, whose parent(s) is (are) ethnic minority are offered an extra mark on preferential basis for their exam results to entry universities/ colleges, and professional vocation schools[[71](#_ENREF_71)]

#### Policy on supporting teachers of ethnic minority languages, and teachers in mountainous, island, difficult, remote, and isolated areas

To attract teachers, as well as students, who graduated from universities of pedagogies to work in mountainous, island, difficult, remote, and isolated areas, some incentives have been offered, such as preferential policies on salary, housing, and non-salary direct subsidies, etc. Managers and teachers working in mountainous, island, difficult, remote, and isolated areas are offered salary allowance in addition to tutorial allowance49

#### Policy on vocational training

To encourage the vocational study, students are sent as earmarked students to study at boarding vocational schools, of which, priorities are granted to ethnic minority groups in extremely difficult areas and preferential treatment beneficiaries pursuance to the Ordinance on preferential treatment to revolution credit holders; each of them is provided with scholarship (VND 280,000/ month/ person), annual ward basing on their study records, the stipend for personal stuff, an annual lump-sum for a travel fee, book and material allowance, and stipend for a lunar new year and other ethnic festivals if they stay at schools during the festivals. In projects on vocational training and job creation for the youth during 2008 – 2015 pursuance to Decision No. 103/2008/QĐ-TTg dated 21/7/2008 and the project on vocational training for rural laborers until 2020, ethnic minority young people are also granted high priorities.

The number of medicine high education graduates who are minority or from minority areas and entered university by “nomination”, has increased, but few of them wanted to come back to work in remote areas[[71](#_ENREF_71)]

### Policies/strategies on include other government services

#### Policies/strategies on vocational training and education for authority officials/ local staffs

Policies towards ethnic minority staffs: Having separate mechanisms in planning, training, fostering, appointment and employment of ethnic minority cadres and civil servants; Support for ethnic minority cadres, civil servants and officials in training and upgrading their professional qualifications.

#### Policies on communications

Policies to support information, communication, advocacy, dissemination and education of law and legal aid included:

* Information and communication support policy: (1) Support the development of information and communication for ethnic minority and mountainous areas; Provide some essential facilities to ensure access to and enjoyment of information; Issue several newspapers and magazines for ethnic minority and mountainous areas and areas with special difficulties; (2) Increase the amount of time and improve the quality of using ethnic languages ​​on the mass media.
* Policies to support legal dissemination and education, legal aid: To support law dissemination and education activities suitable to each subject and area of ​​ethnic minority people and mountainous areas and Support through free legal aid services.

## Evidence exists about their success or effectiveness of strategies

### Well-designed impact evaluation of development projects remains very limited

The Government of Viet Nam, as well as international and domestic organizations, has implemented numerous targeted programs to include ethnic minority people in social services. Although increasing attention is paid to impact evaluation of programs, well-designed impact evaluation of development projects remains very limited [[78](#_ENREF_78)].

In Viet Nam, a quantitative impact evaluation was introduced in the early 2000s. A difficulty in the impact evaluation of development projects in Viet Nam is the complexity and overlap of projects, which have often been designed as packages of supports with many sub-components. Besides, a large number of households, communes, districts, provinces may be participating in similar projects at the same time [[78](#_ENREF_78)].

Finding a clean control group for a treatment group is not easy. Another difficulty is political involvement in the beneficiary selection, which makes the project selection process unobservable. Randomization for impact evaluation is also hard to implement. For most development projects, especially projects started before 2005, although M&E systems may have been designed, no clear design for quantitative impact evaluation was included. Impact evaluation has often been conducted after the project’s completion and without any preparation for it at the beginning. As a result, the selection process cannot be observed. Besides, there are no baseline surveys or they have not been well designed for impact evaluation [[78](#_ENREF_78)]. Most impact evaluation studies in Viet Nam, therefore rely on qualitative surveys after the project’s completion. These surveys collect data on beneficiaries’ perceptions of project impacts. The surveys may also collect current and retrospective data to examine changes in beneficiaries’ welfare. Impact evaluations also rely on qualitative assessment techniques and case studies [[78](#_ENREF_78)].

Although quantitative impact evaluations of specific interventions are not often conducted, there have been a large number of academic studies on quantitative impact evaluation of large-scale programs, such as social protection, micro-credit, and health insurance programs. Independent researchers conducted these studies using the available data sets. The most widely used are the VHLSS and household surveys, which were collected during the 1990s and 2000s.

### Limitation in policy development and implementation

The current policies still overlapped, especially in content, treatment objectives and implementation schedule in the same location[[71](#_ENREF_71), [72](#_ENREF_72)]. The content mainly focused on living support, production development while forgot technology, technique handover, environmental protection, and investment attraction. Implementation of the policies was not strong enough, especially in capital resources, or some policies were issued but not located capital to carry out. The policies were not synchronized; the implementation mechanism was weak and lacked a combination among related parties. Also, the policies were not suitable for the characteristics of ethnic minorities, characteristics of each ethnic minority and implementation context such as socio-economic development planning[[71](#_ENREF_71)]. For instance, some rural people attend vocational courses not to learn a certain profession but to get allowances. Once such allowances are not comparable to the wages paid for seasonal work, these people will not hesitate to quit the courses because it is no longer attractive to them. The policies did not ensure equality among treatment objectives in the same locality; therefore, the implementation did not bring into play the potential strength of ethnic people[[72](#_ENREF_72)].

### Example of impact strategies in Viet Nam

#### Poverty reduction and socio-economic development program

The National Targeted Programme on Hunger Eradication and Poverty Reduction (HEPR) on health and micro-credit components did not affect either healthcare use or household expenditure. However, the positive effect of education support on school attendance was statistically significant[[79](#_ENREF_79)].

The second phase of the Socio-economic Development Programme for Ethnic Minority Areas (known as Programme 135-Phase I) took place in the period 2006 – 2010 with four major components: infrastructure development, agriculture production support, socio-cultural livelihood promotion, and capacity building. The program had positive impacts on several important outcomes of the ethnic minority households, including productive asset ownership, household durables ownership, and rice productivity. Poverty among minority households in treatment communes declined significantly more than it declined in comparison communes. Finally, ethnic minority households enjoyed a reduction in travel time to health facilities, relative to households in control communes[[80](#_ENREF_80)].

The Rural Infrastructure Sector Project and Provincial Rural Road Improvement Project, which were implemented by the Ministry of Transport with loans from ADB. In the perception of beneficiaries, investment in infrastructure had made a positive impact on livelihoods and well-being for most of the people in the sub-project area[[81](#_ENREF_81)].

#### Health insurance

Several studies quantitatively evaluated the impact of health insurance. Health insurance increased health care contacts[[82](#_ENREF_82)], reduce inpatient treatment expenses[[83](#_ENREF_83)], decreased out-of-pocket expenditures[[84](#_ENREF_84), [85](#_ENREF_85)]. Voluntary health insurance helped beneficiaries increase annual outpatient contacts by 45 percent and inpatient contacts by around 70 percent [[86](#_ENREF_86)]. However, some studies found no significant impact of health insurance on health care use[[83](#_ENREF_83), [85](#_ENREF_85)].

#### Ethnic minority midwife scheme

In this scheme, young (under 35) ethnic women, nominated by their communities, participate in a 6-months training program which focuses on midwifery. Afterward, newly-trained EMMs return to their villages to provide free outreach maternal and newborn services. By 2015, 2,477 EMMs received such training, and 79,3% of them are currently working as EMMs in their villages [19]. Evidence on EMM’s performance in the community is limited. One assessment of EMM performance at the pilot phase showed that the contribution of EMM in the improvement of maternal and newborn health is promising[[87](#_ENREF_87)]. Other studies, however, suggested that EMM’s services may not always be accepted by local communities, possibly due to differences between medicalized healthcare and local birth culture and norms[[88](#_ENREF_88)]. Mothers, who use EMM services during their pregnancy, however, were more likely to deliver at home with EMM assists than those were not[[73](#_ENREF_73)].

#### Permanent Settlement program and resettlement program

The Fixed Cultivation and Permanent Settlement Program to reduce migration for shifting cultivation, ethnic minorities are relocated to permanent settlements. The program sought to address twin goals of protecting watershed forests allegedly at risk of being destroyed by ethnic minorities while improving national defense by relocating ethnic minorities from isolated and sensitive border areas to regions under government control[[33](#_ENREF_33)]. For example, the government moved minorities back to their home provinces if they migrate elsewhere (particularly from the Northern Mountains to the Central Highlands)[[25](#_ENREF_25)].

An Oxfam/UNDP study in Quang Tri province found positive outcomes of resettlement were that in the resettlement area people felt more secure on the farm, with fewer disasters and a better economic situation. Local ethnic minority groups had gained knowledge from new arrivals, and women’s income had improved significantly. Negative effects were: lack of support and information from the resettlement program, reduction in quality of education and healthcare, much poorer living conditions. Some women reported a greatly increased workload, and there were difficulties with local transportation, limited opportunities for socialization and exchange, and the emergence of social conflict [[32](#_ENREF_32)]. Other research also suggested that around half the households thought that their living standards had improved because of the program; whereas the rest thought that their living standards had not improved or had even worsened [[82](#_ENREF_82)]

#### Gender inclusion strategies

Development programs tend to create equality for women by giving them the chance to *participate,* to *receive the opportunity to access,* and *to improve incomes.* Reports by the Committee of Ethnic Minorities, UN organizations, the World Bank all show that the issue of gender inequality has been integrated into development programs to remove and reduce poverty[[25](#_ENREF_25)]. There have been hundreds of training sessions on spreading gender knowledge; hundreds of development programs aiming for the goal of gender equality or integrating gender elements by both Vietnamese and international NGOs. Over the years, the Government has invested heavily in ethnic minority areas through a lot of poverty reduction programs, and some other programs such as 135, 30A with an integrated gender interest. Women Associations of all levels also have their programs and activities (for instance, love and shelter program, etc.) to enhance the standard of living and equality for women[[28](#_ENREF_28)].

Inclusion Gender in Development Plan, for example, in Resettlement and Ethnic Minorities Development Plan[[35](#_ENREF_35)], they plan to:

* Use at least 30% of female workers in the subproject construction, maintenance, and repair to increase the income of women, then increase women power
* Training and capacity building for women to participate in community decision making and subprojects in a most meaningful way (i.e. training on participation and negotiation skills, marketing skills, cultivation skills and eliminating illiteracy for women);
* Design and deliver the extension services targeted at women
* Advocate women to be representative of the commune women in the commune supervisory boards (accounting for about 1/3 of its members).

In reality, many studies have observed that even when the woman makes a living and provides the main source of contribution to the family’s economy (husband only makes as much as half of his wife), the women still do not achieve the “gender equality” as understood in its conventional sense. The micro-credit programs or preferential loans for women do not make them more powerful, but only increase the burden on women. The study in Sa Pa and Ky Son, Nghe indicates that for the H’Mong women, selling goods is only considered as the “extension” of doing housework. Interview at Sin Ho (Lai Chau) reveals that the Dao women, despite being the main income earners of the families, are still regarded at a more inferior position than the men, and any income increase will not change their position in the family[[28](#_ENREF_28)].

# PART 4. FUTURE RESEARCH

### Gaps in the current evidence

***Noncommunicable disease, mental health, and health patterns of older adults among ethnic minority groups.*** There is more prevalence of reports on maternal and child health care, and on using health issuances but lacking data on health pattern of ethnic minority people, particularly of older adults. Recently, Multiple Indicator Cluster Surveys (MICS) 2000, 2000, 2006, 2011, and 2014 were the most useful data source for analyzing the gap between majority/minority groups. Others database is used include household surveys conducted during the 1990s and 2000s, Viet Nam Living Standard Surveys (VHLSS) in 1993 and 1998, and Viet Nam Household Living Standard Surveys in 2002, 2004, 2006, 2008 and 2010; and Population and Housing Census Vietnam 1989, 1999, 2009. Those data also focus more on maternal and child health.

***Performance, it drives and strategies to increase the performance of ethnic minority students.*** Most founded reports were on the inequalities on enrolments and the dropout percentage of students between ethnic minorities.

***Other public services, particularly in police services and religious issues are lacking in publications.*** The research project was also looking for the exclusion of police services and religious issues. However, there was a lack of information on those issues. Data on the utilization of police services are not published in Vietnam. Social services use was not analyzed by religious or we have not yet found religion as a determinant factor in using social services in Vietnam.

***Social services used and strategies for inclusion of social services used by ethnic minority groups.*** Most of the research report analyses the inequity between majority/minority and groups all ethnic minority as one group. However, as mention above, each minority group are distinguished from one another by language, architectural styles, dress and personal ornaments, shapes of agricultural implements, religious practices, and systems of social organization. The sample size of the database mention above by each group was often quite small to compare within ethnic minority groups. To develop effective inclusion strategies and select priority, health issues by ethnic minority groups are needed.

***Background studies such as general assessment of the social-economic development by regions and by ethnic minorities and deep assessment of the living environment, customs, and practices of the ethnic minorities***.

***Impact Evaluation of Development Programmes and Policies, which Studied mutual effects between policies for social-economic development and policies for poverty reduction for ethnic minorities and ethnic minority areas*** [[72](#_ENREF_72)]

### Collaboration between researchers, communities and policymakers/practitioners

The need for collaboration between researchers, communities, and policymakers were highlighted in workshops. NGOs in Vietnam in recent years implement quite a lot of interventions to increase the utilization of social services among ethnic minority groups, however, research results were not reported or not published. Most of the national program is also lack of M&E part and being funded by international NGOs[[78](#_ENREF_78)].

Development projects in Viet Nam are the complexity and overlap of projects, which have often been designed as packages of supports with many sub-components. A multi-agency collaboration is required at all stages of intervention or research design, planning, implementation, and evaluation.

The collaboration involving ethnic minority people in research also taking into account the needs of ethnic minority people, not frame the needs of the majority to minority groups. Ethnic minority communities need to be involved in all stages of intervention or research design, planning, implementation, and evaluation. This requires the involvement of linguistically and culturally-skilled staff, understanding of cultural belief systems and utilizing social networks to identify and address potential obstacles.

Implementation research in health developed by WHO appeared to be a good model for collaboration between researchers, communities, and policymakers. The model created to boost implementation research capacity, particularly in low middle-income countries. Intended for newcomers to the field, those already conducting implementation research, and those with responsibility for designing and implementing programs and policies. WHO will provide technical support and funding for research which involved policymakers and communities. Implementation and intervention strategies need to be developed and done by communities under the support of policymakers, practitioners.

### Research designs

Some research designs that help pool together expertise from these different groups to improve social justice (consider all stages of the research cycle from developing research questions to designing studies, seeking funding, conducting research, analyzing data and dissemination) are mention in workshops, which include:

* Delphi, participatory approaches, particularly ethnic minority groups
* Mixed of qualitative and quantitative research method
* Medical Anthropology, Religious Sociology, Religious Anthropology, barrier analysis, photovoice
* Apply the theory of rationalization and secularization to explain about drivers
* Rigorous impact evaluation of development programs and policies, randomization designs for impact evaluation need to be boosted

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APPENDIX

## Appendix 1 – Databases searched by Leeds

**Healthcare**

Cochrane Database of Systematic Reviews: Issue 1 of 12, January 2017

Conference Proceedings Citation Index- Science (Thomson Reuters Web of Science) 1990-present

Database of Abstracts of Reviews of Effects (DARE): Issue 2 of 4, April 2015

Global Health (Ovid) 1910 - 2017 Week 01

HMIC Health Management Information Consortium (Ovid) 1983 - present

Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 - Present

PsycINFO (Ovid) 1806 - January Week 3 2017

Sciences Citation Index (Thomson Reuters Web of Science) 1900-present

 **Social sciences**

Applied Social Sciences Index and Abstracts (ASSIA)‎ (ProQuest) 1987- present

Conference Proceedings Citation Index- Social Science & Humanities (Thomson Reuters Web of Science) 1990-present

International Bibliography of the Social Sciences (IBSS)‎ (ProQuest) 1951 - present

Sociological Abstracts‎ (ProQuest) 1952 - present

Social Sciences Citation Index (Thomson Reuters Web of Science) 1900-present

**Arts and Humanities**

Arts & Humanities Citation Index (Thomson Reuters Web of Science) 1975-present

**Criminal justice**

Criminal Justice Abstracts (EBSCO) 1830 - present

**Economics**

E. coli (EBSCO) 1886 - present

**Education**

Education Resources Information Centre (ERIC) (EBSCO) 1966- present

## Appendix 2 – Databases search by Vietnam team

**Vietnamese Policy Online:** <http://vpo.org.vn/>

**ISEE:** <http://isee.org.vn>

**UNDP Vietnam:** <http://www.vn.undp.org/content/vietnam/en/home/library/>

**NASATI, National database on science and technology (search ‘Dân tộc” and limited research from 2000):** <http://203.191.52.10/ncpt/tkdt_advance.asp>

World Bank Open Knowledge Repository <https://openknowledge.worldbank.org/>

Google scholar

**Tracking reference from others report**

### Legal documents on policy/programme for inclusion of ethnic minority

<http://vbpl.vn/Pages/portal.aspx>

"Dân tộc" ("ethnic"), limited legal normative documents at national level

1. Calculated from statistics yearbook 2005 - 2015 [↑](#footnote-ref-1)