



## CROSSCUTTING THEMES

Applied research on ethnic minorities in the GMS suggests that ethnic minorities (1) often receive low-quality services in health and education as compared to the national norm, (2) encounter numerous barriers to using health and education services, and (3) have significantly lower health and education status than the national average. The elements that cause and sustain these conditions are complex. Learning about them requires identifying measures to change or reverse these conditions, grounded in an understanding of factors specific to the provision of health and education services. It also requires attention to trends affecting the course of development in the region, along with knowledge about the institutional, political, economic, and geographical conditions for each country. The following section outlines key constraints in brief, then later subsections elaborate on each of these constraints in more detail.

### 3.1 Constraints to Access

Unfortunately, throughout the region there are multiple barriers preventing the effective use of services. Many of these barriers apply equally to ethnic minority and other populations, whereas others are likely to be more severe for ethnic minorities. Table 3.1 presents some of the key constraints that are likely to impede or prevent ethnic minorities from using health and education services.





















People often face physical barriers to access. Quite simply, required services may not exist or may be too far for people to take advantage of them realistically. For example, schools may simply be too far away for children to attend. Physical barriers are relative: A child with a bicycle may be able to attend a school that













other children find too distant. Solving problems such as these requires supply-side investments.

The utilization of social services can be described as part of a household decision process. The decision to use a social service is influenced by the cost of the service, the income available, and the expected benefit from the service. This approach also recognizes ethnic minorities as active participants in the health and education system and as people who constantly must make decisions at the household level.

Factors such as distance, monetary cost, waiting time, and subsidies affect the cost of services. Many families simply are unwilling to send their children to a school that is several hours away, effectively reducing the children's capacity to work at home and creating a serious opportunity cost. Of course, monetary costs—e.g., cost of travel to school or to a clinic, or the cost of books—also can obstruct access, especially considering the universally low incomes that ethnic minorities earn in the highlands.

In addition to considering the cost of services, households also must consider the value of the services that they are using. If services are of poor quality, they will not be used regardless of the cost. Ethnic minorities may be especially sensitive to considerations of quality or appropriateness. Language barriers make it difficult for their children to take full advantage of the school system, lowering its perceived value. Likewise, the health system is aimed at the majority and is not sensitive to the beliefs of ethnic minority patients. In the worst cases, health providers do not have the training to deal with health problems that are common in the highlands.

 <b>Table 3.1: Constraints to Access and Use of Social Services by Ethnic Minorities</b>					
Constraint	Description	Nature of the effect		Locus of possible solution	
		Can impede physical access to services	Can impede use of existing services	With service provider ("supply" side)	With community to be served ("demand" side)
Physical-geographical constraints	The ethnic minority groups considered in this study tend to live in rough-terrain highland and border areas of the Greater Mekong Subregion (GMS). The sheer physical geography of these settings poses special challenges, as well as costs, in the provision and maintenance of basic infrastructure (roads, communications, utilities) and social services.				
Economic constraints	Even where services are available, ethnic minority groups of the GMS shoulder severe economic constraints. Due to their isolation from markets and low productivity (mainly agricultural), many ethnic minorities have very low incomes. People with limited economic means must carefully weigh the opportunity costs and direct costs of accessing services, against the expected benefits. This is especially the case as the private sector and fee-for-service arrangements begin playing a more important role in social services.				
Fiscal constraints	On the supply side, competing demands on limited funds may result in entire communities that are simply lacking in basic services. The high cost of providing services in highland areas may reduce the availability of services. Likewise, the government might not have sufficient resources to target subsidies for the ethnic minority population. Decentralization (both de facto and de jure) may exacerbate the situation.				
Legal and policy constraints	The legal status of ethnic minority groups may impede them from taking legal advantage of existing services. The effectiveness of existing policy and the technical competence of policymakers to address the needs of minorities may also be limited at the local and national level. There may not be political will to enact and support policies that favor minorities' access to and use of services.				
Lack of understanding and information about available services	Ethnic minorities may have limited knowledge and understanding of the health and education services that are available in their area. Incomplete or erroneous information on how to access services, what they might cost, or the nature of a given service or procedure, can discourage potential clients and even lead to distrust of service providers. Lack of understanding about the methods or intended outcomes of education or particular health procedures can lead to doubts about their quality, effectiveness, or relevance.				
Lack of understanding and knowledge about the population to be served	Service providers, for their part, may lack sufficient understanding or knowledge about their potential clients' needs and behaviors to engage their attention, recognize or appreciate their concerns, or show proper respect. These shortcomings will impede the providers from offering adequate and appropriate assistance or instruction. Differences in language, educational level, class, and ethnicity can create barriers to real communication and effective services. They can lower the "interpersonal" aspect of the quality of the services and make the services less attractive for members of ethnic minority groups. They also can weaken the social services' ties to the community.				

 <b>Table 3.1 (continued)</b> <b>Constraints to Access and Use of Social Services by Ethnic Minorities</b>					
Constraint	Description	Nature of the effect		Locus of possible solution	
		Can impede physical access to services	Can impede use of existing services	With service provider ("supply" side)	With community to be served ("demand" side)
Competing knowledge systems, practices, and values	It has been shown that centrally designed or standardized interventions and service delivery programs often fail to acknowledge and validate the use of traditional indigenous knowledge systems. In turn, minority peoples can be skeptical of services that challenge traditional knowledge and practices, and resistant to participating in such services. They may view schools that discourage children from using their native tongue, or health care procedures that directly oppose traditional beliefs, as threats to their ethnic identification and welfare.				
Poor quality and relevance of services provided	Services that are of low quality or have little relevance for the client population are likely to be not only ineffective but also unpopular. Unfortunately, many services that operate in remote areas fit this description. Schools in remote areas tend to have difficulty attracting and retaining qualified teachers, which are the key to learning. Likewise, curricula presenting dominant culture models and skills suited to urban, mainstream lifestyles may have, or be perceived to have, little to offer to rural highlanders. Health care posts may have few trained staff and medical supplies and may not be able to offer services of sufficient technical quality.				
Lack of attention to gender-specific considerations, especially those of girls and women	Cultural values and distinctions regarding acceptable behavior, activities, and relations with others are almost universally colored by gender. These values and distinctions, in turn, create gender-specific patterns in potential clients' demand for or resistance to services, in the real and perceived utility and opportunity costs of the services offered, and in the effectiveness of methods used by service providers to reach populations, foster learning, or encourage good health behaviors. These values within minority populations may differ from those of the majority, and social services may have to adjust to these differences to develop services that are demanded by ethnic minority girls and women.				
Language	In the GMS, national policy generally requires the national language as the language of instruction and discourages use of ethnic languages in schools. It is often the de facto language in many health services since it is the language that the providers know. Young children who speak only a local language in their homes and communities are likely to have serious difficulty adjusting to school, and often leave school before they do, having learned little in any language. And where teachers and health care providers do not even speak the language of the community they work in, outreach, communication, and ultimately effective assistance to parents and other potential seekers of services surely are seriously curtailed.				

### 3.1.1 Physical-Geographical Constraints

This study explicitly focused on ethnic minorities living in highlands, in areas that are isolated from rest of the economy. It is not surprising that ethnic minorities are largely located in the least accessible areas: Although these areas are poorer, they afford a certain amount of cultural protection. In the past, isolation limited the contact between the majority culture and ethnic minorities, which played an important role in cultural survival. For example, in Viet Nam, 50 out of 54 of the ethnic groups are located primarily in highland areas. In Cambodia, the only two provinces where the non-Khmer population is a majority are also the most mountainous and isolated provinces of the country.

Geographic isolation and the lack of transportation, however, have serious consequences for access to health and education services. Formal education requires continuous contact with the school system over a number of years. Clearly if schools are too distant, it is not possible for children to attend on a regular basis. Possible solutions include the construction of more schools, improvements in transportation, and the construction of boarding schools and hostels.

Evidence from all four of the countries shows that distance is indeed a barrier to the



*Dak Lak Province, Viet Nam. These sixth-grade ethnic minority students (Ede) from the Central Highlands share a dormitory room at their boarding school for minority students. These students spend months away from their villages in order to attend school past the primary grades. Only the select students are eligible for post-primary education at such boarding schools, located in larger towns or provincial centers. (Photo by Myles Elledge)*

education of children. For example, in Viet Nam, despite great advances in terms of the universalization of education, some villages still have no schools and many have incomplete schools. In Cambodia and Lao PDR, a large number of isolated villages have no schools or incomplete schools. For example, in Lao PDR, in five mountainous provinces, fewer than 45 percent of villages have any sort of school. In lowland provinces, this proportion is substantially lower and access to schools in other villages is much more feasible given the closer distances and better roads.

A serious constraint in the education sector in all four of the countries is the difficulty in recruiting teachers who are willing to work in isolated areas. Although numerous factors make it difficult to attract qualified teachers, the isolation and poverty of the highlands surely play a big role. Interviews in Cambodia and Lao PDR confirm that it is difficult to convince teachers to move to highland areas and to convince them to stay. Staff turnover rates are high across the four countries.

Viet Nam and Thailand have networks of boarding schools and hostels to help children who want to increase their education level and do not have the opportunity to do so at a local school. Lao PDR also operates a limited system of boarding schools, and Cambodia is considering reopening boarding schools, which have not functioned in the northeast for some time. Thailand also has a program of sending mobile teachers (teachers on horseback or motorbike) to isolated villages to ensure some continuity in education. This approach is common in a number of countries beyond the region, such as Mexico, which has sophisticated networks of mobile teachers who supervise education in isolated communities.

Physical-geographical constraints on health are more complicated. Individuals often are willing to travel great distances to relieve health problems. However, preventive services require more continuous contact with the health system and followup by health providers. In general, distance is cited as a major factor that limits the utilization of all forms of health services.

In all of the countries in the study, health care is largely organized following geographic boundaries, with hospitals operating at the provincial and district levels, and primary health care units centered at a lower level (communes in Cambodia and Viet Nam and villages in Lao PDR). This arrangement is not a problem for lowland areas, which have a dense population and good transport networks, but it is inappropriate for low-density, remote areas.

Cambodia has been developing a reformed health system that follows natural boundaries rather than political boundaries. Nevertheless, one of the major reasons cited that ethnic minorities in Cambodia avoid health centers is the distance from communities.

As in the education sector, it is difficult to attract health professionals to live and work in isolated areas. Field work and interviews in Son La and Dak Lak Provinces in Viet Nam showed that health workers are reluctant to relocate to the highlands and generally try to leave after a few years. A strategy aiming to improve health of highland populations must seek solutions to the lack of trained personnel. Viet Nam, as in parts of northern Thailand, has started an innovative program to train some members of the local population to provide limited primary health care services.

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### 3.1.2 Economic Constraints

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In the past decade, Cambodia, Lao PDR, and Viet Nam have all undertaken significant market-oriented reforms, and all three have largely abandoned central planning as the primary means to allocate resources. The decade of the 1990's has also seen an unprecedented growth rate in all four of the countries in this study. Although the Asian financial crisis of 1997–98 affected the entire region, there is no doubt that average per capita income rose and poverty fell at unprecedented rate in all of the countries.

This change has happened at the same time that the social sectors in all countries, except Thailand, have introduced cost sharing. Although the government continues to

subsidize health and education services, to some degree users are expected to pay the cost of the services.

In Cambodia, it appears that user fees largely finance social services at all levels; evidence suggests that users pay more than 90 percent of the total cost of services out of pocket. In Viet Nam and Lao PDR, user fees are also widespread, but the governments have been able to maintain some subsidies for primary education and for basic health care. Thailand, with its larger economy, maintains a system of widespread subsidies for basic services.

Whereas this growth has undoubtedly benefited a large percentage of the population in each of the countries, ethnic minority populations have not benefited much from growth in recent years and suffer from the increasing emphasis on cost sharing for social services. Although the lowland populations have benefited from increasing income and the possibility of obtaining better-quality social services with their income, ethnic minorities have been excluded from the benefits of economic growth and face higher costs for the same low-quality services that they have always received.

In all of the countries, there is clear evidence that ethnic minorities have higher rates of poverty than the average for the rural population. Surveys in Lao PDR confirm that the poor largely consist of ethnic minorities in remote areas (Chamberlain, 2000). Viet Nam probably has the most detailed studies of poverty and ethnic minorities; results there show that even taking into account other factors such as family size, education, and distance from urban centers, ethnic minority households are poorer than Kinh households. There is no reason to think that the results would be any different in the other countries in the study.

The cost of education was cited during field observations as a major impediment for ethnic minority children. Education costs include both formal and informal tuition charges, in addition to expenditures on other goods such as uniforms and textbooks. In Viet Nam, the government has tried to focus scholarship and

### ❖ Case Study: Hoping for a Better Life for Her Children

Dao, a Muong ethnic woman from Dak Lak Province, Viet Nam, is married with five children, ages 2, 4, 5, 8, and 10. It takes 2.5 hours to reach the nearest road, telephone, school, or health clinic. A rough motorcycle ride through the forest is the quickest way to such services; a trip by bicycle takes all day.

Her family grows rice and maintains livestock and chickens. In most years, the family is able to sell a cow and excess rice to make a modest amount of money.

Her oldest child goes to school on most days, although household demands often require her son to miss school. He has one textbook that has been provided by the teacher, but it must be shared among two other students in the village.

She notes that they are lucky to have a teacher in the village. She knows there really is no chance for schooling after the fifth grade, as distance and cost make it impossible for her children to plan for more schooling. She values education, and speaks with emotion of her desire to see her daughters and her sons go to elementary school. She hopes these few years of schooling for each of her children—more than she ever had—will open up chances for the children to become teachers or nurses for their village.

fee exemptions on poor areas, targeting ethnic minorities in particular. Viet Nam also offers stipends for some ethnic minority children to attend school.

Another consideration is the importance of child labor to the household enterprises (usually farms). As most ethnic minority households are living in a state of poverty, the labor that children provide is essential for the household's survival. Schooling tends to be very time consuming and many households simply cannot afford to keep their children away from the field for long periods of time.

Evidence from the Cambodia field work clearly confirmed this fact; ethnic minority households felt that the school calendar definitely did not match well with the agricultural calendar. There, the highland agricultural calendar also differed from the

lowland agricultural calendar. During the peak agricultural period, schools serving ethnic minorities are generally closed as both students and teachers are fully occupied with the harvest. Education projects should take into account the labor needs of households and adjust the school schedule to reflect the agricultural calendar.

As noted above, the increased cost of health care has had a similar effect on health-seeking behavior. In Viet Nam, as user fees play a larger role in financing health care, many consumers are turning to less formal health solutions, such as self-medication and consultations with pharmacists. The lack of money for health services may reduce the access that ethnic minorities have to health care. This pattern is also seen in Cambodia and Lao PDR as the health services have to rely increasingly on user fees. Users often seek alternatives such as self-medication or simply no care.

Interviews in Cambodia showed concerns about the cost of health care among ethnic minorities, often leading to households “cutting corners” when it came to health care. This situation calls for the introduction of targeted subsidies that provide exemptions or “discounts” for vulnerable populations, such as ethnic minorities.

Viet Nam has a number of programs focusing on ethnic minorities, including health insurance for hospitalization, through the provision of a “health card.” Thailand has also introduced health insurance cards for the poor, which allow access to hospitals.

### 3.1.3 Fiscal Constraints

In all societies, the demand for public resources always exceeds their availability. This point is especially true in low-income countries like Cambodia, Lao PDR, and Viet Nam, where poverty rates are relatively high and the government has a limited tax base.

In the specific case of health and education services for ethnic minorities, it is clear that resources are not being targeted to ethnic minority communities in the study countries.

In most countries, it is common to see governments dedicate a significant portion of their health and education budgets to services that largely do not benefit poor populations.

In the case of education, a disproportionate amount of the budget is often spent on universities. Although higher education is important for development, investments in universities tend to be highly regressive, for a number of reasons. For example, university students need to have a high initial level of education. Studies cited in this report show that in all cases, children from ethnic minority groups have numerous problems attending and completing school. Moreover, universities are generally located in urban areas and most of their students live nearby, which excludes ethnic minorities who live some distance away. Without significant scholarships and fellowships, it is difficult for ethnic minority students to attend university, due to the associated costs. Finally, individuals with higher education generally have higher income than people who don't attend college, so they are in a better position to pay for their education (through loans or higher tuition fees).

In the case of Lao PDR, estimates show that indeed ethnic minorities do not receive a particularly large share of the total education budget. On average, university students receive a state subsidy that is approximately 20 times that of primary students. Viet Nam has taken steps to remove similar inequalities in its education funding. National-level evidence suggests that Viet Nam's allocation of its resources is somewhat more equitable than in the past and there is a real effort to target funding to poor and mountainous provinces. On the demand side, the government of Viet Nam has set up a number of programs to encourage ethnic minorities to continue their schooling, ranging from school fee exemptions to university scholarships.

Fiscal constraints in the area of health are similar. The highest returns to health care investments are for preventive and primary-level curative care. Government expenditure on hospitals is generally a much worse investment, as the care is expensive and the

beneficiary population is much smaller. Ethnic minorities live in remote areas, which complicates access to hospitals. With the exception of Thailand, hospitalization tends to be expensive and may be out of the reach of much of the ethnic minority population.

In most countries, the government only contributes a small part of total spending for health care. In Viet Nam, it is estimated that the government pays for around 20 percent of total health costs, while in Cambodia and Lao PDR, it is likely that government subsidies account for an even smaller proportion of total spending. In Thailand, the government pays for half of health expenditures while households and employers pay the other half. Given the small role of the government in most of the countries, the government needs to ensure that its health spending benefits the poor and the vulnerable.

The four country studies reveal a tendency to reserve a large portion of the public health budget for hospital care. Even with good primary care, countries do require a hospital system. However, it appears that these countries overinvest in hospital care, with hospital patients generally receiving a larger subsidy (as a proportion of the total cost of care and in absolute terms). Thailand has made an effort to boost primary health care and improve access to health care in rural and isolated areas.

Both Thailand and Viet Nam have introduced insurance programs that give subsidized health cards to the poor. Viet Nam should accelerate the implementation of this program and continue to target ethnic minorities as priority recipients of health cards.

In both the education and health sectors, there are complaints about delays and nonpayment of salaries. This problem is most serious in Cambodia and Lao PDR, although Viet Nam has had problems in the past paying its employees in the social sectors, especially in rural areas. The government of Viet Nam has taken over the payment of commune health workers at many commune health centers in poorer regions (including areas with high ethnic minority populations).

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### 3.1.4 Legal and Policy Constraints

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Access to health and education services has a significant legal aspect. In many countries throughout the world (including the four in this study), the Constitution states that, at least at some level, education and health are inalienable rights of the population. Although there are many ways that the government can facilitate this right, it is clear that only people that have full status as citizens can fully exercise these rights.

Among the four countries studied, the biggest problems with granting citizenship were found in Thailand. Indeed, the evidence suggests that many hill-tribe members do not have citizenship (estimates range from 40 to 80 percent), despite laws dating back more than two decades. As part of the discussion associated with the 1997 Constitution, Thailand is currently in the process of clarifying the citizenship of many of its hill-tribe groups. As the country is one of the richest in the region, it serves as a magnet for illegal immigrants. Thus, it is not surprising that the process of identifying legitimate applicants for citizenship is a long one. However, the government should make every effort to ensure that ethnic minorities that have been long-term residents in Thailand (in some case, for a longer period than the Thai-speaking population) receive full citizenship.

The lack of citizenship in Thailand has several important, immediate effects on ethnic minorities' access to social services. In the education sector, many children find their studies increasingly difficult as they advance through school, and children without citizenship cannot avail themselves of many special tutoring programs. In the health sector, the situation is similar. Whereas ethnic minorities without citizenship can get basic and emergency care, they are not eligible to receive the subsidized health cards or to participate in other programs.

However, beyond access to education and health services, citizenship has other important effects. In Thailand, ethnic minorities without citizenship may have a

difficult time finding a job and are often hassled by the authorities. The message these persons receive from society is that they do not belong to the country.

The Constitutions of Cambodia, Lao PDR, and Viet Nam all recognize highland ethnic minorities as citizens of their countries. Viet Nam has a long tradition of granting equal rights to ethnic minorities. Lao PDR has been increasing its recognition of the ethnic diversity within its borders; the 1995 population census included detailed questions on diversity for the first time in the history of the country. Lao PDR is negotiating with the International Labour Organisation (ILO) to sign ILO Convention 169, an international agreement that gives rights to ethnic minorities and tribal peoples.

Despite these advances, in all countries there is a tendency for some officials and citizens to see ethnic minorities as somehow not being part of the nation. Social exclusion of minority groups is all too common. Key stakeholders, such as the government and concerned NGOs, need to take action to educate the majority population about the rights and responsibilities of citizens. This effort would help to improve the actual status of ethnic minorities, above and beyond what the law declares.

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### 3.1.5 Lack of Understanding and Information about Available Services

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Social services have traditionally focused on access and utilization as being a supply-side problem. However, many service providers now realize that increased utilization does not simply happen through increased availability of services. The public also has to understand the importance of the services and be willing to take advantage of them.

For many people who live in remote areas, these services are essentially new. Thus, the clients need education not just on the availability of the services but also on how using the services will improve their standard of living in a tangible way.

In all countries, field studies confirmed that the ethnic minority population often did not feel that understanding of services was a problem. For example, in Lao PDR the field team reported that in many villages with a large ethnic minority population, it is common to see social services simply not being used. Information campaigns should be informed by the current knowledge and beliefs of the local population.

This constraint is associated with the issue of language in many cases. Often, the information the social sector provides in the *majority* language is inadequate, to say nothing about *minority* languages. Social sector providers should make an attempt to offer “extension services” to the ethnic minority population to encourage their use. There are examples of good practice, as noted in the box opposite.

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### 3.1.6 Lack of Understanding and Knowledge about the Population to Be Served

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For service providers to be effective, they need to understand the population that they serve. This includes both the values and the organization of the population. At the same time, the social system must also be sufficiently flexible to allow for different organizations and values throughout the country.

The studies found evidence that service providers often do not understand in detail the needs of ethnic minorities. Many times the whole system is too centrally organized to adapt to local conditions. Critics of centrally designed curricula suggest that indigenous values of family, community, and close ties to natural surroundings are not well represented. This situation creates a demand for locally adapted curricula, or curriculum flexibility, of the type that may be seen in some highland areas of Thailand.

In Viet Nam, many teachers and health personnel who were working in highland areas were from the lowlands and did not plan to stay long. Clearly, temporary employees are



### Health Education — Tailoring Services

Observations from the field work in Sayaburi Province in Lao PDR tell a rewarding story of good program results and the sense of ownership fostered by programs tailored to meet the needs of the people they serve.

The Primary Health Care Project in Sayaburi, noted as a program of good practice, addresses both curative health and preventive disease issues and needs in Sayaburi. The district health department and its principal clients, Hmong and Khmu ethnic minority residents, have shown progressive support for the health care program, tackling issues of malaria, diarrhea, nutrition, immunizations, and basic health and sanitation practices.

One key factor contributing to this success has been the development and use of new health education materials to reach target groups. Pictorial story boards and other simple educational materials have helped reduce the number of cases of malaria and diarrhea, and helped communicate the value of immunizations for children. An important feature of these materials has been the use of information, education, and communication (IEC) videos in the Hmong and Khmu languages.

District officials noted with pride that all members of the population now have “equal rights” to access the health services.

unlikely to develop as solid an understanding of the population that they serve, or to deal with them as effectively, as locally recruited workers. Often outsiders view local practices as “backward,” which hinders communication and makes it difficult for providers to integrate their services with local beliefs.

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### 3.1.7 Competing Knowledge Systems, Practices, and Values

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All societies have beliefs about the best way to maintain health and the proper way to educate children and adults. In the case of health, this includes beliefs about how people become sick and what steps should be taken to maintain and improve health. Societies also have beliefs



Lampang Province, Thailand. This Hmong village elder (right) is a trusted specialist in the community for her expertise in herbal and traditional medicines. The study's literature review and field visits confirmed the importance of understanding traditional beliefs and practices among minority groups. Recognizing traditional health and education practices is critical to sound service delivery systems. (Photo by Myles Elledge)

about what should be taught to their members. It is important to point out that traditional beliefs are not necessarily fixed and unchangeable.

In education, there is evidence that the curriculum is often quite irrelevant for the local realities that ethnic minorities live through every day. In all cases, the curriculum is largely designed in the capital city with little if any local content. In Lao PDR, local content is allowed, but in practice, teachers are rarely able to teach even the full mandated curriculum, much less additional units or topics. In Cambodia, it is clear that the nationally prescribed curriculum is overly ambitious for rural students, to say nothing of ethnic minority children in the northeast. Viet Nam does have a modified curriculum that focuses on learning basic skills, and Thailand has developed the innovative Hill Areas Education (HAE) Program, which focuses on incorporating local knowledge into the curriculum.

However, modern education (for example, teaching about national history, mathematics, and science) need not clash with traditional beliefs and teaching practices.

The evidence from fieldwork in Cambodia on health beliefs of the highland population is interesting. Anthropological studies show that although ethnic minorities have no indigenous

knowledge of germs and infection, they are aware that drinking dirty water leads to illness and they also believe in isolating the sick to prevent the spread of illness. These beliefs do not follow from current medical evidence, but obviously they are not inconsistent with modern views of good health behavior. More importantly, these beliefs have evolved so that they include more modern practices.

Likewise, given evidence from the field visits and the anthropological literature in Lao PDR, it is clear that cultural beliefs have a major influence on the choices people make when they face a health problem. While traditionally, an animal sacrifice was offered to help the sick individual return to health, many individuals now express greater faith in modern treatments and often use the cost of an animal sacrifice as a guide for how much they will pay for modern treatment.



### Empowering the Community

The Hill Areas Education (HAE) Program recognized the importance of recruiting ethnic minority teachers to be among the staff administering and serving in the classroom. A conscious attempt to increase the number of ethnic minority teachers active in the village was seen as vital to inspiring villager confidence in the new curriculum and to boosting the attendance, advancement, and overall achievement of the students.

Villagers explained their reasons for preferring ethnic teachers in the community's educational system. While noting that a good teacher is a matter of individual personality, and good performance is not uniquely linked to ethnicity, villagers noted clear advantages and support for the recruitment of ethnic teachers.

*First, when a lowland teacher does something wrong, the villagers dare not report to the authority. With an ethnic teacher, the villagers feel it's easier to make comments or to give some advice. Second, a teacher with ethnic background will have a better understanding of ethnic culture and its relationship to larger society. It is believed that ... [the teacher] will be more sensitive to the villagers' problems and needs.* (Study team focus group discussion, Chiang Mai Province, Thailand)

One area of particular concern is maternal and child health. Ethnic minority women are far less likely to deliver their infants in a health provider's office or hospital than other women (Figure 3.1). Many women employ dangerous birthing practices, such as cutting the umbilical cord with an unsanitized bamboo knife. Moreover, ethnic minority women in Lao PDR have less knowledge about the importance of fluids for ill children than native Lao speakers.

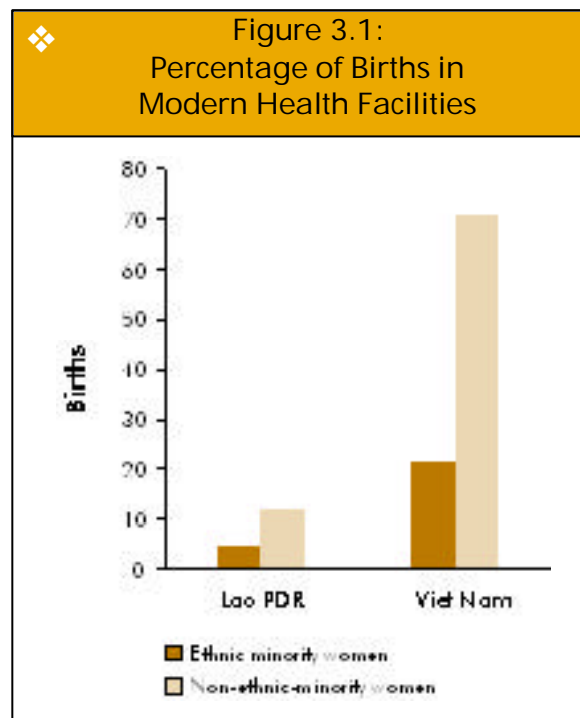
### 3.1.8 Poor Quality and Relevance of Services Provided

Providing *good-quality* services in the social sector is key to ensuring that a target population will take advantage of existing programs. Often, social service providers focus on simply ensuring that the service is offered. However, clients are also concerned about the quality of services. Quality has many dimensions; here we focus on the technical quality of the service and the quality of related amenities.

Isolated populations, such as the highland ethnic minorities of Cambodia and Lao PDR, may not live anywhere near locations where social services are being offered, and thus have no option of using them. In Thailand and Viet Nam, where ethnic minorities may have other provider options (especially in the health sector), there may be an underutilization of government-subsidized services. In both cases, scarce government subsidies are wasted.

In addition to not attracting users to social services, low technical quality will lead to poor results—for example, children not learning in school and health services not solving health problems.

Low quality was a commonly cited problem in the education sector. In the northeast of Cambodia, parents mentioned the lack of school materials as one of the principal reasons for not sending their children. The poor condition of the school building was a common complaint heard from the highland population.



Source: Lao PDR: ADB, 1999c; Viet Nam: Viet Nam Living Standards Survey (VLSS), 1997–98 (General Statistical Office [Viet Nam], 1999).

In all of the countries except Thailand, many teachers lack the required formal training. In Cambodia and Lao PDR, most teachers in ethnic minority areas are untrained. As mentioned previously, however, Lao PDR has had success in transferring basic skills in teaching to unqualified teachers through the Network Teacher Upgrading Program.

Ethnic minorities in Viet Nam had similar concerns: Schools were often overcrowded and the quality of facilities was quite low. Many schools were very poorly equipped with learning aids, such as maps, pictures, and laboratory equipment. Students often lacked the resources to buy textbooks, and highland schools were unable to lend them textbooks.

Schools must focus on education that is relevant to their community. There is a great range of livelihoods among the ethnic minority population; the perspectives and educational needs of sedentary rice-growing households differ greatly from those of mobile hunter-gatherer households, and from those of households that depend on shifting cultivation. One complaint heard in Viet Nam and in Thailand was that the textbooks, with their focus on urban life, were often irrelevant to the lives of ethnic minorities.

The situation in the health sector is quite similar, with the quality of services generally described as low. Health centers and posts often lack essential drugs and equipment and the quality of the building is often quite poor as well. In Lao PDR, for example, the study found that district hospitals (which play a key role in attending to the health needs of the rural population) generally lack equipment. The availability of equipment is often determined by what donors are willing to contribute rather than by the health needs; much of the equipment is sent to central and provincial hospitals.

Viet Nam has been more successful in ensuring that health services that serve remote populations have at least the most basic drugs and supplies. The study team found that most commune-based units had some drugs and that ethnic minorities also had a variety of private options. Clearly, for its health services to be useful to the public, the government has to ensure at least a minimal package of supplies and equipment.

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### 3.1.9 Lack of Attention to Gender-Specific Considerations, Especially Those of Girls and Women

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Attitudes and behaviors toward girls and women may differ from one ethnic minority community to another, requiring alternative strategies to ensure that the health and education needs of the entire population are addressed, regardless of ethnicity or gender. In all countries, it appears that girls and women have worse health and education outcomes than boys and men, and it is clear that special efforts must be made to include their needs in the design of social policies.

The education level of ethnic minority women is consistently lower than that of men. In the case of the highland peoples of Lao PDR, literacy rates are significantly lower for women than for men. For example, among the Hmong, the literacy rate for men is 45 percent compared to only 8 percent for women. This situation is similar in the other countries.

This low level of female education has a number of serious consequences in terms of

the welfare of women and their daughters. The shortage of educated women makes it difficult to recruit female health and education workers locally. The lack of female teachers may discourage girls from continuing in school. Families may be unwilling to keep their girls in school with only male teachers. The lack of education limits women directly in terms of their ability to interact with the larger world. Finally, numerous studies have shown that mothers' education makes an important contribution to the health and well-being of children.

In Lao PDR, statistics show that girls start out at a disadvantage in terms of enrollment. Even in the first grade, girls are less likely to enroll than boys. This situation is especially true for ethnic minority girls. Ethnic minorities are far more likely to drop out than ethnic minority boys. While few ethnic minority boys advance to the lower secondary level, even fewer girls do. These students, if the education system can reach them, will form the core of future teachers and education workers in the highlands. In Viet Nam, although the enrollment rates are substantially higher, a similar pattern exists for ethnic minority girls. Field visits confirmed that parents are worried about the safety of their daughters and whether their daughters will learn important skills at school.

In health, it appears that the situation is similar: Females are less likely to receive formal health care than males. It also appears that girls and women have a higher mortality rate, although there is little gender-specific data on the health status of the ethnic minority population.

Of particular concern is access to reproductive health services, which also appears to be quite limited for ethnic minority women (Figure 3.1). In Cambodia, Lao PDR, and Viet Nam, most births take place at home, occasionally in the presence of a traditional birth attendant. It is quite rare for the birth to be attended by a doctor or nurse. Although there is little hard evidence, anecdotal evidence indicates that the situation is likely to be somewhat better in Thailand.

Health systems require more of a focus on reproductive health, through the training of local health workers. Trained health workers should be provided with a supply of basic health inputs. Once again, the low level of female literacy may prevent the training of a significant number of workers in some communities.

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### 3.1.10 Language

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In numerous contacts with members of ethnic minority communities, the issue of language was raised as a serious constraint. For many highland ethnic minorities, the official national language is for all practical purposes a foreign language. In many cases, few members of the community have mastered the official language.

In the education sector, language is a crucial issue as the teachers and students must be able to communicate with each other and students need to be able to understand textbooks and other learning materials. Policy proposals for language in schools with ethnic minorities differ greatly. At one end, a common recommendation is to teach ethnic minorities in their native language as a way to promote both learning and cultural survival. The alternative is often total immersion in the national language. In practice, total immersion is the implicit policy chosen by many governments, largely by default.

Probably the best approach for ethnic minority children, and an approach supported by a number of policymakers in the region, is an intermediate one that emphasizes the learning of the country's official language while taking into account the fact that ethnic minority students are not native language speakers and may need additional help, perhaps through a Second Language program (e.g., Vietnamese as a Second Language).

In Cambodia, schools in the northeast have dealt with the language issue differently. Some schools use the total immersion approach, with teachers talking to students exclusively in Khmer. Others have taken the opposite

approach, using the vernacular extensively. Still others have had an intermediate approach, explaining the lessons in both Khmer and the vernacular. In all of the countries, it is quite common for parents and educators to attribute higher repetition rates, lower grades, and higher dropout rates to language problems.

Many languages spoken by ethnic minorities do not have a commonly used writing system, which also complicates teaching in many ethnic minority languages. Although scripts have been developed for many languages, speakers often do not know them, or they have not been standardized.

Many respondents also mentioned that teachers often have little or no knowledge of the native language in the area, which obviously limits the possibility of incorporating the vernacular in the school. For example, in Lao PDR, approximately 85 percent of primary teachers and 95 percent of secondary teachers are native Tai-Kadai (lowland languages) speakers. Given the low literacy rates in many ethnic minority communities, it can often be difficult to recruit ethnic minority teachers with basic education and training to serve as teachers in their communities.

Despite these challenges, Viet Nam is developing some learning material in vernacular. This activity has been limited to a few subjects, however, and is only being done in a few languages.

Language also plays an important role in the health sector. Patients and providers need to be able to communicate; this is especially true for primary care, which represents the most cost-efficient interventions for the health system. A health provider who does not speak the same language as the patient may have difficulties in diagnosing and curing a health problem, or in sharing health information. And without communication, it is difficult for patients to develop a sense of trust. This has negative effects on the health-seeking behavior of the ethnic minority population.

All the countries have some form of shortened training for village health workers; these

programs should be supported and material should be developed specifically for ethnic minority recruits. However, the low level of literacy (especially among women) may limit the ability of such health programs to recruit locally. In Lao PDR, the study team found that the vast majority of medical students were from lowland ethnic groups. Many trained medical professionals prefer to work in towns rather than working in poor rural communities.

At the local level, it appears that ethnic minorities do play a role in providing health care. In Cambodia, for example, the study found that in the health centers, most of the staff was from the area and spoke both Khmer and a local language. Viet Nam has an extensive network of health training institutes throughout the country; in many provinces, ethnic minorities constitute a significant proportion of health workers at all levels. In Viet Nam, however, mixed residence of ethnic groups is quite common and in many cases, only a few ethnic groups provide the bulk of health workers. In Thailand, evidence suggests that language can be a major barrier, as most

medical personnel do not speak the local language and few ethnic minorities are trained to provide medical services.

### 3.2 Country-Based Observations on Constraints

By way of summary of the above, Table 3.2 reviews the key constraints and links these to findings from policy dialogue and field-based observations in the four focus countries.


### 3.3 Finding Solutions

As shown in Tables 3.1 and 3.2, different constraints on access require different solutions. There are a number of policy solutions that can help reduce the barriers to access.

*Supply-side* solutions focus on changing how providers interact with the community, on training providers, and perhaps on constructing new facilities. Such solutions can improve the ability of the providers to serve the public. Positive steps may take the form of training workers at the village levels, building



*Young mother and child with village support network, Chiang Mai Province, Thailand. The majority of births occur at home, attended by family members or a village birth attendant. Traveling village health workers have improved access to vaccinations and maternal/child health education among highland populations in Thailand. (Photo by Preecha Upayokin)*

 <b>Table 3.2: Summary of Constraints and Country Observations</b>		
Constraints	Education	Health
Physical-geographical constraints	<ul style="list-style-type: none"> <li>• Serious constraints occur in Cambodia and Lao PDR, parts of Viet Nam</li> <li>• Thailand and Viet Nam have denser school networks and boarding schools</li> </ul>	<ul style="list-style-type: none"> <li>• Distance from health services is a problem in all countries</li> <li>• All countries are developing locally based health providers</li> </ul>
Economic constraints	<ul style="list-style-type: none"> <li>• Education requires some out-of-pocket expenses; exemptions are given to ethnic minorities, especially in Viet Nam</li> </ul>	<ul style="list-style-type: none"> <li>• Health care costs are a concern for ethnic minorities, due to their general poverty</li> <li>• Thailand and Viet Nam have health care schemes to insure the poor</li> </ul>
Fiscal constraints	<ul style="list-style-type: none"> <li>• Lack of public resources is a serious problem except in Thailand</li> <li>• Resources are concentrated on higher education and cities</li> <li>• Salaries are often late or unpaid</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of resources is a serious problem in all locations</li> <li>• Resources are spent on health services for urban areas, especially hospitals</li> <li>• Salaries are often late or unpaid</li> </ul>
Legal and policy constraints	<ul style="list-style-type: none"> <li>• Ethnic minority children without citizenship cannot access education in Thailand</li> </ul>	<ul style="list-style-type: none"> <li>• Access to Thailand health cards is limited, although some minorities receive basic primary care</li> </ul>
Lack of understanding and information about available services	<ul style="list-style-type: none"> <li>• This problem arises especially in some parts of Cambodia and Lao PDR</li> </ul>	<ul style="list-style-type: none"> <li>• This problem affects some ethnic minority groups, especially in Lao PDR</li> </ul>
Lack of understanding and knowledge about the population to be served	<ul style="list-style-type: none"> <li>• School calendars do not reflect the local agricultural calendar</li> <li>• Strategies to reach girls and boys may not adequately recognize different traditions across ethnic groups</li> </ul>	<ul style="list-style-type: none"> <li>• Information, education, and communication initiatives do not reflect local cultural needs and practices</li> <li>• Traditional birthing and fertility practices are not fully recognized in service design and mobilization</li> </ul>
Competing knowledge systems, practices, and values	<ul style="list-style-type: none"> <li>• Materials are often foreign or irrelevant for ethnic minority students</li> <li>• National curriculum may not build on traditional values of family, community, or forest</li> </ul>	<ul style="list-style-type: none"> <li>• Beliefs differ about the nature of illness and disease</li> <li>• Many women employ poor reproductive health practices</li> </ul>
Poor quality and relevance of services provided	<ul style="list-style-type: none"> <li>• This problem appears in all countries in remote schools</li> <li>• Schools are not well equipped and buildings are in poor state</li> </ul>	<ul style="list-style-type: none"> <li>• This problem appears in Cambodia, Lao PDR, and Viet Nam; less so in Thailand</li> </ul>
Lack of attention to gender-specific considerations	<ul style="list-style-type: none"> <li>• This problem reportedly occurs in all countries</li> <li>• Ethnic minority girls stay in school less than ethnic minority boys and majority girls</li> </ul>	<ul style="list-style-type: none"> <li>• Reproductive health services are limited</li> </ul>
Language	<ul style="list-style-type: none"> <li>• Language barriers affect primary learning and are a constraint for advancement to higher education</li> <li>• Ethnic minority students fall behind, then often drop out</li> </ul>	<ul style="list-style-type: none"> <li>• Patients lack ability to communicate a problem</li> <li>• Patients find it difficult to receive health information</li> </ul>

new schools and health centers, and improving the quality of services from existing providers. Health and education systems traditionally are experienced with these supply-side solutions; the most cost-effective solutions, however, often are *demand oriented*. That is, encouraging the participation of students and patients can ensure that resources spent on education and health services are not wasted.

Policymakers, therefore, should not ignore demand-side solutions that focus on changing demand in order to increase utilization. In addition to focusing better on the needs of potential clients, often demand-side subsidies are the most cost-efficient option. That is, it may simply be cheaper to target resources to the poor than to try to increase the supply to benefit the entire population. Demand-side solutions include targeted subsidies, discounts, and exemptions for ethnic minorities; improved transportation to reduce the cost of access; and better marketing and informational techniques aimed at ethnic minorities.

Programs that focus on just one element of the health-and-education circle are likely to be partially frustrated. For example, increasing money for education will have a limited effect if the population is sick, and increasing money for health will have a limited effect if mothers are not sufficiently educated to take advantage of services and to maintain proper hygiene at home.

Ethnic minorities often are at a particular disadvantage when it comes to escaping the vicious circle of poverty. Nationally designed programs are unlikely to take into account local knowledge and constraints. For example, a nationally designed textbook is of little use if few people speak the national language. National health programs, too, may not fully account for regional differences in fertility, disease incidence, or beliefs. Failing to recognize differences at the subnational level makes programs less effective and therefore not demanded at the local level.