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Reproductive Health of H'mong People in Ha Giang Province

Medical Anthropology Perspective

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Acronyms

BCC	Behaviour Change Communication
CHC	Commune Health Centre
CP6	Sixth UNFPA Country Programme
CP7	Seventh UNFPA Country Programme
EM	Ethnic minority
FP	Family Planning
GBV	Gender Based Violence
HH	Household
HW	Health worker
HIV/AIDS	Human Immuno-Deficiency Virus; Acquired Immune Deficiency Syndrome
IEC	Information-Education-Communication
IMR	Infant Mortality Rate
IUD	Intra-Uterine Device
M&E	Monitoring and Evaluation
MCH/FP	Maternal and Child Health/ Family Planning
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NMR	Northern Mountain Region
OB-GYN	Obstetrics and Gynecology
RH	Reproductive Health
RHIYA	Reproductive Health Initiative for Youth in Asia
RTIs	Reproductive Tract Infections
RH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TOT	Training of Trainers
UNFPA	United Nations Population Fund; and UN: United Nations

Acknowledgements

This report documents the findings of a qualitative study conducted during April and May, 2007 by medical anthropologist, Dr. Nguyen Tran Lam, on reproductive health in Ha Giang province.

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On behalf of UNFPA, I uphold the view that the findings in this report will be particularly useful to policy makers, programme managers, health professionals and donors in designing and implementing more appropriate reproductive health programmes for ethnic minorities in general and H'mong people in particular; in alignment with Millennium Development Goals and commitments of the International Conference on Population and Development.

Ian Howie

Representative

UNFPA in Viet Nam

1. Introduction

This report presents the findings of a qualitative research study, conducted in Ha Giang province between April and May 2007, on the ethnic minority H'mong people living in Meo Vac district. Primarily, this report examines the methodology applied for delivery of reproductive health (RH) to ethnic minorities and makes appropriate recommendations for improvement within the framework of the UNFPA Seventh Country Programme (CP7). The data analysis situates reproductive health issues in Ha Giang within a broader Vietnamese socio-political context.

A sketch of Ha Giang

Ha Giang province, located in the northernmost part of Viet Nam, is characterized by precipitous, limestone mountains with elevations exceeding 1100 metres above sea level. The climate is sub-temperate and the soils, laterite due to weathering.

The land area of the province is 7.884 sq.km with a population of 632.500 (50,4% female). The five major ethnic minority groups are H'mong (30,75% of total population), Tay (24,94%), Dzao (15,16%), Kinh (12,13%) and Nung (9,69%). Administratively, Ha Giang is divided into 10 districts, one town and 195 communes of which 145 are classified by the government as poor. The poverty rate of the province in 2004 was 29,3% of households (IFAD 2006).

The H'mong ethnic minority people are classified as the poorest in Ha Giang province. The livelihoods of the White H'Mong inhabiting the high mountain zone, depend on the unique rock pocket agriculture whereby most fields are rain-fed and rock-covered. Other than a very small area of wet rice fields in the valleys, crops are cultivated only in the rainy season. Almost all land is devoted to raising maize, their staple food.

The health system in the province is inadequate and challenged by significant shortages of essential drugs, equipment and human resources. According to the UNFPA baseline survey conducted in 2006, Ha Giang province has 175 commune health centres, 21 inter-commune clinics, 10 district hospitals, three provincial Hospitals and one provincial Maternal and Child Health/ Family Planning (MCH/FP) centre.

Rationale for the research

Within the framework of CP7 (2006-2010) UNFPA and the Government of Viet Nam signed a Country Programme Action Plan. This Progamme is designed to assist implementation of the national reproductive health (RH) and population development (PD) strategies. The Programme provides a blueprint for strengthening capacity of central ministries and associated agencies in seven selected provinces: Ha Giang, Hoa Binh, Phu Tho, Kon Tum, Ninh Thuan, Ben Tre and Tien Giang. The two major components of RH and PD, also focus on the integration of gender related issues.

Since 1997, UNFPA has supported Ha Giang initially through CP5 and CP6 and currently as one of the seven specifically selected provinces in CP7. However, despite programme objectives, there is still very little known about RH issues and their effect on ethnic minority groups particularly those living in remote and mountainous regions. To date, very few qualitative studies on RH have been conducted in Ha Giang, hindering programme capacity to design sensitive and effective RH projects. The aim of this report is to provide in-depth qualitative data resulting from the recent field research to assist the development of appropriate projects that in turn will lead to improvement in RH services and delivery to the ethnic minority people of this region.

2. Methodology

Conceptual framework

The research consultant studied folk concepts of ethno-physiology, particularly how they relate to reproductive, therapeutic and ritual practices. He was able to gain insight both to the structure of decision-making and to considerations that inform reproductive choices (Browner and Sargent 1990). The study also researched the theory of livelihood in reference to capabilities, assets (i.e., capital, including human, natural, physical, financial, social, informational, cultural) and activities (De Haan 2000; Ellis 2000). In-depth qualitative analysis of the changing nature of livelihoods typical of the northern mountainous region, will lead to improvements to the current level of RH activity.

Study questions

1. What are the common traditional fertility regulating practices?
2. How does the social and cultural context influence RH activities among the H'mong?
3. What do the H'mong see as the advantages and disadvantages of contraceptive technologies?
4. How do users respond to the RH care provided by FP services
5. How do people perceive the services that are provided?
6. How can services be improved to better meet consumer needs?
7. Identify policy factors that affect RH programming in Ha Giang?

Study site

Meo Vac is located in the northeast of Ha Giang province with a population of 53,915 (1999). The district is home to 14 ethnic minority groups of which the largest is the H'mong (41,428). The White H'Mong inhabiting the high limestone mountains are challenged not only by scarcity of agricultural land and water but also a very harsh climate. Due to low literacy rates, the main mode of communication is by word of mouth.

Well known H'mong families in the region include: the Vuong, Giang, Sung, Mua, Ly, Lau, The, Vu, Va, Ha, Chu, Sinh, Cu, Cha, Lu. These family groups can be distinguished by the colour of their clothes, the style of embroidery and the tone of language. However, traditional customs and rituals are gradually being fractured due to faster transportation (motor bikes), heightening interaction among groups. Specific demographic features are presented in Table 1.

Table 1 : Meo Vac demographic figures

Area	574 km2
Number of villages	18 (17 villages and 01 township)
Population	53,915 inhabitants
Male	49%
Female	51%
Number of households	11,505
- Urban households	797
- Rural households	10,708
Number of 15-49 year old women	14,583
Number of 15-49 year old married women	11,191
Ethnic groups	Dzao, Tay, Giay, H'mong, Nung, Xuong, Lolo, Clao, Pubeo, Cao Lan, Muong, Hoa, Kinh, Bo Y

Source: UBND Meo Vac, 2007

Data collection

Data collection was completed in two phases. During the first phase (March-April 2007), the consultant studied relevant literature available in Hanoi and held desk interviews with various experts involved in RH issues. In the second phase (April-May 2007), the consultant paid a 10-day visit to Ha Giang province, to conduct fieldwork.

In Ha Giang town the consultant worked initially with UNFPA project staff to become familiar with the provincial health system and RH issues specific to the province. The consultant then held discussions with a number of health personnel, provincial policy makers and pensioners to obtain further information about the lives, customs and health practices of the H'mong.

In Meo Vac, the consultant collected data through ethnographic interviews, Focus Group Discussion (FGDs), observations and case studies. Interviews took place with health personnel, shaman, healers, private pharmacists, adults and youth at mutually convenient times. Thematic manual data analysis was applied. However, it should be noted that during his field work, the local authorities attended in most interviews, a practice that effectively limited opportunities to obtain rich information from the H'mong interviewees.

3. Findings

3.1 The H'mong people and their culture: findings from literature and the field

The H'mong came to Viet Nam from Yunnan, China about 200-300 years ago. On the way south, some H'mong clans settled in the northern mountainous regions while others traveled to Laos, passing through Lai Chau and Son La into Xiengkhouang and Sam Neua (Luong, 2000; Son, 996). This movement of population is described by Christian Culas as a "flight from uprisings and wars and associated massacres, lootings and famine" (2000: 31). After living in Laos for three or four generations, many H'mong settled in Nghe An, Viet Nam (Luong, 2000). Today, households of different H'mong clans intermingle with other ethnic groups, a practice reflected in the names given to newly-settled families. This trend of intermingling differs significantly from the past isolation of separate ethnic minority groups.

Worldwide, there are about seven million H'mong people living in parts of Thailand, Laos, China, the US and other countries. In Viet Nam, approximately 800.000 H'mong inhabit three regions, North, Central, and Southern, making up one percent of the total national population. H'mong history, culture, and rituals are preserved orally from generation to generation. It was not until the early 1950s when the Western missionaries came to South East Asia to preach Christianity that the H'mong acquired a written language.

Historically, the H'mong form a clan-based society worshiping a common ancestor. The society is patrilineal and the family unit highly regarded. Most H'mong people practice animism believing that well-being equates with harmony, creating a balance between the inner life soul and the spirits outside the body. For centuries, the H'mong practiced slash-and-burn cultivation *(đốt nương làm rẫy)*, an agricultural technique that relates closely to their mobile lifestyle, even today.

The H'mong *(Meo)* in Viet Nam are divided into five principal branches, distinguished by variation in female costume, dialect, traditions and customs: *Meo trang (H'mong dau,* in the *Meo* language*)* or white *Meo*; *Meo hoa (H'mong lenh)*, or motley *Meo*; *Meo den (H'mong du)*, or black *Meo*; *Meo xanh (H'mong sua)*, or green *Meo*; and *Meo do (H'mong pe)*, or red *Meo*. Of all the *Meo*, the most numerous are *Meo trang* or white *Meo*. The H'mong writing system, developed since 1956, is based on the latin alphabet.

H'mong religion is influenced by the Chinese philosophies of Confucianism and Taoism. These religions impact strongly on the order of daily life in local communities. While on one hand women are expected to perform demanding duties and to uphold their responsibilities, on the other, they are denied both personal and RH rights. When the H'mong talk about religion, they are usually referring to the rituals and ceremonies that take place in the home. They believe that human existence is closely linked to an earth inhabited by spirits and religious cosmologies. They pray to many supernatural powers (to rain, land, tree, animal, home and ancestor spirits), believed to control the success or otherwise of their livelihoods. Most activities, whether house building, hunting, weddings, cultivating a new field, happiness, unhappiness and disease are shaped by a complex cosmology. For example, selection of the right piece of land

for cultivation involves many taboos and may require the conducting of spiritual ceremonies. It is important to identify the right day and even the hour to finalise the transaction.

The cult of ancestor worship is widespread. An altar, dedicated to the ancestors, is placed against the back wall facing the principal door, made simply of a rectangle of local bark paper (cay zo), about one handspan wide and one and a half long, usually coloured red. The paper, bought from the cult master, is stuck vertically on the back wall opposite the principal entrance on the day of the house inauguration. The bark paper bears some Chinese ideograms and is adorned with a few cock feathers sacrificed for the occasion. As the ceremony proceeds more feathers and incense sticks are added.

The H'mong abide by numerous rules of conduct and behaviour. Social and economic organization is mostly determined by kinship networks that reflect clan or lineage membership. The Chief of the H'mong lineage (hopau) is very influential. His responsibilities include, "reporting" to the ancestor about marriage and birth, organizing funerals, solving disputes between families within the lineage and between his and other lineages, mobilising resources to help families in difficulty, ensuring safe transfer of lineage rules and practices to the next generation, and making decisions on migration. All lineage members are obliged to listen and comply with the lineage chief's advice although older members may also be consulted.

Illness and Health care[1]

The H'mong beliefs in spirits, magic and sorcery are intense and popular. They claim that if any of the dozen souls residing in the human body are missing, sickness and disease will result. For example, if the belly soul exits the body, it might take with it the head and breast souls, meaning that death is approaching. Illness can result from an imbalance between a person's physical state with the environment or from internal physical imbalance. Another symptom that may bring illness or misfortunate is disrespectful behaviour, or perhaps taboo violation. The seriousness of the disease depends on the vital spirits and how close or far away they stray from the patient, or perhaps caught by a ghost. A series of deaths are interpreted as a manifestation of local spirits, wanting to expel human beings from their territories.

Illness classification

Illness is classified by the location of the pain. For example, stomach ache is classified as diarrhea, dysentery, constipation, appendicitis, etc. The cause of the illness is sorted into 2 categories. The first refers to social natural illnesses such as bleeding, eye pain, toothache, backache, fever, heart disease, or mental disorder and the second, to supernatural illnesses such as separation of soul and spirit punishment. However these classifications can be altered, depending on the severity of disease (Lam 2006).

Illness prevention and treatment

The H'mong apply a variety of methods either singly or in combination, for prevention and treatment of diseases. They may prescribe herbal, animal or mineral medicines, magic, food and health taboos. Generally, for curing diseases in young babies, the H'mong resort initially

[1] This session is heavily based on works by Tap (1989), Thang, Lam (2006)

to magic. If this proves ineffective, they progress to other treatment. Religious rituals also play an important role. Herbs are used to treat infertility, menstruation and gynecological complications, and also as vitamin supplements administered after birth delivery.

3.2 Implications of social change on the livelihood and RH of H'mong people

Some studies show that household size has decreased significantly over the last two decades as land availability, soil fertility and rice yields become insufficient to support a large extended family (Zankel 1996, Lam 2006). According to officials in Meo Vac, 72% of the district population live in poor households that comply with Government definition.[2] In fact people are much poorer than official statistics suggest. The H'mong in Meo Vac talk about their poverty with phrases such as *"dưới đáy nghèo"* [below the bottom of poverty]; *"mở mắt ra là nhìn thấy đá"* [open your eyes in the morning and you see only stone]; or *"sống trên đá chết chôn trong đá"* [we live on the stone and we die in stone]. Indeed, the level of hunger and malnutrition among adults and children, is alarming even to the extent that many children aged 9-10 have never tasted milk.

Data extracted from literature and interview analysis identify a number of contextual factors that shape livelihoods and determine RH conditions among the poor H'mong living in this region. These include:

Decrease of soil fertility and chemicals: Poor soil fertility is due mainly to external factors such as rain, erosion, self-decomposition of humus and nitrogen levels. Nutrient loss is largely the consequence of reduced density of the forest ecosystem. Decreased land fertility has led H'mong farmers to increase investment in chemical pesticides to encourage crop production. In Ha Giang and in some other provinces safe pest management practices are declining relatively fast in favour of chemical pesticides. Some studies show that skin problems commonly diagnosed in rice farmers are due to intense exposure to chemical pesticides (Pingali et al 1995; Sprince et al 2000). The consultant was unable to explore this issue further due to the short time available for field research. However, evidence suggests that chemical poisoning could also contribute to gynecological problems experienced by some Meo Vac women.

Degraded environment: Meo Vac people confirm that, 30 years ago, there existed in their area 20 rare animal species, such as leopard, tiger, black gibbon, black bear. However, because so much of the forest has now been destroyed, these animals are not seen any more. Forest products previously a source of livelihood for the H'mong are becoming increasingly scarce. Of course this has impacted on incomes making it even harder for local people to meet escalating market costs. Most households are no longer in a position to produce sufficient maize to meet both their own needs and to sell or exchange for necessities such as education and clothing, salt, kerosene, fish sauce, fertilisers and antibiotics. In addition farmers have to cope with costly animal epidemics and natural disasters such as landslides and droughts.

[2] Poverty criteria: average income VND 80,000 per person per month according to the Decision 1143/2000/QD-LDTBXH dated 01 January 2000; new criteria (effective 2006-2010): : average income VND 200,000 per person per month

Water shortage: this challenge was the most cited by the Meo Vac people. Water shortage is a serious problem throughout the region. The cost of a can of water is subject to seasonal fluctuation that can vary between 5.000 -15.000 VND (100.000 VND for 1 cubic metre of water). There are no household bathrooms and few latrines. Drinking water is seriously insufficient to meet demand, not helped by the fact that water sources are located far away. It can take several hours to traverse the mountainside on foot to fill containers. Children often miss school because of the need to fetch water, especially in the winter. The consultant located some water tanks (funded by UNICEF) but the quality of the contents was poor. Water shortage causes difficulties for women who are unable to bathe properly and maintain hygiene during menstruation. Lack of hygiene contributes to the prevalence of gynaecological infections in the region.

Housing conditions: People in Ha Giang say that if you want to know who is rich and who is poor, just look at their houses. Indeed, most houses in Meo Vac are makeshift, old, dilapidated and lack sanitation. People live in narrow and cramped spaces with no windows. The house also functions as a storage facility for maize and other starch food, compromising the occupants even further. H'mong people are accustomed to breeding animals (goat, cows, ducks, chicken, pigs) next to their house, making the immediate environment very dirty, damp and polluted.

Another negative aspect found in this style of housing is the air pollution. Long term indoor exposure to smoke from cooking with wood fires, living with waste, animal dung and other biomass fuels contribute to illnesses. Women do most of the cooking and are therefore more intensively exposed to indoor air pollution than men.

Manpower and children: The demand for extra labour is met in part by the low average marriage age and the increasing birth rate among H'mong ethnic groups. Cultivation of maize, planted on the side of a mountain, is extremely labour intensive. Harvesting is made more difficult because the only means of transporting the maize is in a basket on a human back. H'mong children start working at a young age. Girls are given housework tasks at 6 years of age; boys start labouring jobs between 10-12 years old. A girl of 9 or 10 years old is often expected to weed the maize crop, collect firewood, spin fibre and weave cloth.

Long hours typify the working day of H'mong women and girls. They must take responsibility for all domestic tasks including child care in addition to helping in the fields and weaving clothes for the family. Women work from dawn to dark, especially during crop season. They are left with no time to care for themselves or to deal with RH issues, many women carry small children on their backs while working on the mountainside. Women work harder than men, yet men are always viewed as the decision makers. H'mong men rarely help women with housework.

Youth and sexuality

H'mong youth follow the ethnic custom of marrying and engaging in sexual relations at a relatively young age. One H'mong man commented “Nowadays the H'mong have a small build…this is due to early marriage. In the old days H'mong were of a bigger build”. Indeed, it is common for boys of 16 and girls 14 years old to get married. While divorce is rare, pre-marital and extra-marital sex is widespread. Despite the traditional importance of virginity, pre-marital sex is not uncommon in the H'mong community today. Many women accept the

fact that their spouse may have engaged in sexual relations with other partners. Indeed, many interviewees maintained that pre-marital sex is condoned by H'mong customs. In Meo Vac, young people often engage in sexual relations on Saturday or Sunday, or at the "love market" where they can hide their behaviour from their parents.

It is common for a husband to have multiple wives. Today, many young H'mong men prefer to marry women from other ethnic groups. Talking to young people over a glass of wine in a relaxed atmosphere, they explained to the consultant that "white H'mong in Ha Giang can get married with any Kinh, Tay, or Dao…my friend has just got married with a Tay girl". Indeed, rapid changes occurring in the infrastructure and socio-economic environment have significantly altered the balance of relationships between the H'mong and other ethnic groups in the region and among the H'mong communities themselves. (Truong 2001, Lam 2006)

3.3 Barriers to accessing sexual reproductive health services

There are a number of factors that impact on the level of ethnic minority access to RH services, including:

- Socio-cultural factors of education, religion, traditions, gender dynamics and IEC networks.
- Service related factors such as distance/transportation, language difficulties, stigmatization, shortage of equipment and drugs, diagnostic and prescription problems.

a) Socio-cultural factors

Education. The H'mong in Meo Vac do not view education as a priority for their children. As one man said:

> *"Going to school? What for? In the old days, those who are 5th grade graduates can become cadres. Nowadays, some people, after 10 years attending school, return to the commune and continue the farm work"*

Religion. Since 2000, many H'mong in Ha Giang have converted from animism to Roman Catholicism. Studies show that family planning activities are less practiced among Roman Catholics due to church orders that forbid contraceptive use (other than natural methods) and abortion. (Thang 2005, Lam 2005).

Customs. Large families are normal. H'mong people use the term 'delivery' or 'tuv nhua' meaning 'arrest'. Thus, those with few children often complain that they can not 'tuv nhua' or 'deliver' many children. The expectation of producing at least 4-5 children remains widespread. One elderly H'mong man pointed out that:

> *'Our lineage is becoming extinct…many people died…so now we have to have many offspring…no need to adopt children…there is nothing else in the mountains so children are our only source of happiness'.*

Indeed, the H'mong believe that large families not only guarantee a labour force and income but also command more community respect. Women bearing few children are stigmatized by

neighbours. A well-off family is defined by a large house, plenty of rice, cattle, and 8-10 immediate family members. While there is practical necessity for both male and female children, sons are preferred. Boys are destined to provide economic support to the family, while girls are viewed as the care givers. Another H'mong custom is to construct a very narrow bed for the newly-wed couple to stimulate contact thus enhancing the prospect of early pregnancy.

Gender dynamics

H'mong women perform 5 key roles: cook, housekeeper, sexual partner, income earner and bearer of children. Despite their hard work and multiple roles, women's work is under-valued. From the moment she is born, a girl assumes an inferior position that remains with her to the day she dies. As an adult, she must show respect towards her husband and elders and during adolescence, remain relatively secluded to ensure sexual purity before marriage at the appropriate time as endorsed by local tradition.

A woman assumes a lower position in the family hierarchy, relative to her in-laws from the outset of her marriage. She must oblige her husband sexually on demand and provide manual labour as required by her in-laws. Pregnancy, labour, birth delivery and baby feeding are her responsibility. Any inadequacies or resistance may be met with beatings or expulsion from her home. A woman's capacity to bear sons is vital not only in perpetuating her husband's lineage but also for maintaining the traditions associated with ancestor worship. From this perspective, failure to bear a male child has serious implications for maintaining her married status. She is not empowered to plan either the timing of birth or number of children in the family. Like many H'mong women, she lacks information on how to care for her personal needs and hygiene during menstruation. Indeed, all matters relating to sexual and gynaecological functions are viewed with shame and embarrassment.

H'mong women, whether living in Ha Giang or in other provinces in Viet Nam, share the same fate. Community attitudes are influenced by strong beliefs in patriarchy and Confucianism that have existed for thousands of years, and that undermines policy and guidelines on RH.

A further problem identified in ethnic minority communities relates to gender based violence (GBV). This problem is widespread among patriarchal ethnic groups in the northern mountainous region including the Tay and Dzao, but particularly prevalent among the White H'mong in Ha Giang. Some H'mong husbands are known to beat their wives regularly and/or force them into sexual submission. This alarming situation is due first and foremost to the embedded nature of patriarchy and Confucianism that depicts women in the role of servant/wife. If, after some years of marriage, the wife does not become pregnant, the family grows concerned. She is urged to visit the shaman healer or witchdoctor and may be accused by her husband or parents-in-law of being 'defective' or 'unproductive'. Two of the women interviewed commented that they never use contraceptives for fear of being beaten by their husbands or scolded by their parents-in-law.

A second cause of GBV is related to the fact that H'mong women often look older than their husbands who may show them little or no respect by complaining about their ugly, old wives. This point of view, heightens the incidence of violence by husbands against their wives and encourages H'mong men to commit adultery.

Thirdly, alcohol drinking and opium smoking, are two 'traditional habits' of Hmong men, that can potentially result in aggressive action against their wives. In-depth interviews during the field study with Meo Vac women and a representative from the local bureaucracy confirmed that this kind of behaviour occurs frequently.

Information-Education-Communication (IEC)

The field study confirmed that lack of knowledge on RH issues is aggravated by poor communication and transport facilities throughout the region. Many households have no access to the national electricity grid and even those with power, prefer to turn on the light for just one or two hours necessary for preparation and eating of the evening meal. Few families have radios and only the heads of the village People's Committee and People's Council own televisions. Some radios are rarely used due to lack of operational understanding and/or limited broadcasting hours. According to staff at the district health centre, population issues were broadcast over the radio only 7 times throughout 2006, totalling 65 minutes. The infrequent and inadequate quality of RH messages compounded by lack of leisure time provide little incentive for farmers to turn on the radio.

Attempts by public health workers to deliver RH services to the Meo Vac district are severely impeded by challenging road conditions. Driving on bumpy roads also consumes more petrol and both district and village population workers have requested motorbikes and petrol subsidies to facilitate IEC work in remote and mountainous regions.

At the District Health Centre, the consultant noticed large quantities of IEC print materials (provided under the UNFPA project). However, health staff reported that the RH officers rarely consult these documents and booklets due to the density of information. Even though transcribed in the H'mong language, almost no notice was taken of a poster on tuberculosis pinned on the wall, most likely due to a pervasive inability to understand the concept of the message.

The field interviews confirmed that IEC delivery by mass organisations such as the Women's Union, is significantly weak. Some H'mong interviewees complained that officials put pressure rather than advise them about following FP activities. The majority of the hamlet population collaborators are young and lack experience in IEC work, and this adds to the difficulties of persuading local people, particularly those older than themselves to change their behaviour. It is clear that in this region, delivery of IEC information and services cannot succeed without the support of the community it is supposed to serve.

FGD data suggests that the H'mong people might be more receptive to RH and other information if presented audio-visually. Television is a relative novelty in the region and therefore offers an appealing option. Informants in the FGDs recommended that IEC delivery should take place during social events during New Year, Gau Tao- a H'mong traditional festival-, at the open air market, or *"chợ tình"* (love market). In keeping with traditional taboos of the H'mong culture, IEC on RH issues might be more usefully encorporated in the oral telling of local legends.

Networks

The most efficient IEC channel in this region continues to be word of mouth. Interviews with health workers and H'mong people in Meo Vac show that women tend not to talk with parents about RH issues, but they do discuss contraceptive methods and IUD side effects in the field and among themselves. If H'mong women are encouraged to recognize examples set by other

ethnic minority women of the Kinh, Tay, or other Hmong groups, that having fewer children improves the quality of family life, they too will become more interested in learning more about the benefits of FP.

A second communication opportunity can be found in the marketplace. H'mong people consider going to market an economic, cultural and social activity. The market provides an ideal opportunity to exchange information. H'mong women and their families can meet women from other ethnic groups and discuss health care topics and information otherwise inaccessible.

The third source is the hamlet population collaborator, well known in the community. However, the relative youth and limited ability of the population collaborator to reach a large number of women impede efficient communication of RH information.

The fourth, and possibly weakest channel, is through health workers and local bureaucrats. While in theory there is a well established official network (People's Committee, population and mass organisations, village/hamlet heads, population collaborators) in practice, coordination and implementation of activities are inadequate. Recruitment of village health workers also poses problems. According to focus group discussions, the hamlet population collaborator is usually selected from a privileged "village management family", i.e. families of the Committee chairman, population bureaucrats, and health workers. While this might be good for networking, selective recruitment undermines accountability and encourages mal-practice.

b) Service factors

Distance/transportation: The commune health centre (CHC) provides basic services for local people such as essential drugs, vaccination for children and patient referral to the district health centre (DHC). However, for many H'mong people, travel to the DHC or CHC can take up to half a day, or more. The majority of clients must walk along rocky and steep, dirt roads. For emergencies, motorbikes provide an alternative, but expensive means of transportation. Further, the CHC premises shares common ground with the Commune People's Committee and the primary school, thus denying ethnic minority women confidential access to sensitive RH and condom services.

Language barrier: The majority of health workers at district and commune levels are ethnic Kinh or Tay and speak a different language/dialect than the H'mong. Difficulties with language also lead Kinh health workers to adopt a negative attitude towards clients from other ethnic minority groups. Language difficulties are proving a major obstacle to effective communication between patients and health providers and between CHC staff and H'mong people working in the WU and YU.

Stigma: Interviewed respondents agreed that negative health care worker attitudes undermine the quality of care provided to clients. The need for health care workers to improve their attitude was cited by several clients as more important than reducing costs. Higher level health workers in particular are viewed as more impersonal and rude than local health workers who tend to be more considerate and polite.

There is a lack of motivation among health workers to provide important information to patients or carers concerning their illnesses. Local health workers often do not have the qualifications nor capacity to cope and fear taking responsibility for their actions frequently opting to refer

clients to a higher level health care service. In some cases, patients with relatively minor illnesses are referred to district or provincial health care services. However, these services are usually provided only to Kinh clients. One H'mong woman who experienced referral to the district hospital said:

> *"We are treated rudely and the Kinh laugh at us asking if we have tried killing any buffaloes for our illness"*

Shortage of equipment and drugs: The government provides medicines free of charge to ethnic minority groups. However these are limited to cheaper drugs for treatment of minor diseases such as diarrhoea, simple colds and influenza. In reality, medicines are not always given to the designated patient. A previous study of H'mong health care found that medicines are sometimes sold for cash (Lam 2006). Health workers at the Meo Vac DHC also reported that some equipment provided by UNFPA projects had broken down (e.g. delivery and episiotomy sets) and lack funding and/or expertise for maintenance.

Diagnosis and prescriptions: The consultant observed health staff at work in the CHC and noted that client symptoms are rarely recorded in the consultation book. Further, he found evidence to suggest over-prescribing of antibiotics, a practice that is rampant not only in Ha Giang, but throughout Viet Nam. Excessive prescribing of antibiotics provides CHC workers with a difficult-to-resist temptation to sell the drugs and increase their income.

Indirect care costs

Poor patients are eligible to receive some medicines free of charge. However, if they require referral to higher level care (e.g., district and provincial hospitals) they then become liable for a number of costs that include transportation, accommodation and food (for both themselves and the accompanying carer). These costs effectively negate the benefits of the free medicines. In addition, these patients must deal with the anxieties of leaving fields uncultivated, cattle unattended and their children to fend for themselves. Some people are compelled to discontinue higher level treatment before completion because of unaffordable incidental costs. Meal expenses for one patient and two carers during hospital treatment average 3 US$ per day, a burden for many.

In general, the cheapest health care option outside the home is provided by the CHC. Both district and provincial hospital services are significantly more expensive, even for outpatient consultation. This means that clients from poorer households often have to refuse hospital care for financial reasons. Private practitioners such as shamans or district pharmacists are usually more flexible about payment deadlines than public providers. In general, it is easier for a client to defer payment to a commune health provider than to district or provincial hospital administrators.

3.4 Ethnic minority response to RH services

Contraceptive methods and user statistics in Meo Vac and Can Chu Phin communes are shown in Table 2 and Table 3 below (based on reports from Meo Vac District health and Can Chu Phin health centre).

Table 2 : Contraceptive use in Meo Vac district and Can Chu Phin commune in 2006

	Number of users (Meo Vac)	*Number of users (Can Chu Phin)*
IUD users	2153 (in which 385 cases have to change IUD)	75
Pill users	640	15
Condom users	588	25
Abortion cases	156	-
Sterilisation	26	02
Others	-	30

Note:

- Can Chu Phin population: 4.725 (805 households)
- Number of women aged 15-49: 886 of which 807 are married
- Number of pregnancies in 2006: 91

As the tables above show, IUD is the most commonly used contraceptive in Meo Vac due to its durability and convenience. IUD insertion not only provides longer term contraception, but is preferred to sterilisation. However, some women complain of becoming pregnant while using an IUD for reasons they don't understand.

Adverse side effects that commonly lead to IUD discontinuation are cited as headaches, dizziness, weight change, weakness, depression, fatigue, nausea, vomiting and, in particular, bleeding irregularities. Menstrual irregularities can range from no evidence of bleeding, irregular bleeding or spotting to heavy/prolonged bleeding. Women feel shy about sharing menstrual information with their husbands and/or neighbours. Ex-IUD users emphasized that by discontinuing the IUD, their menstrual complaints stopped. Most women confronted with side effects ask for IUD removal, but this demand is not always satisfactorily resolved as some clinicians may recommend keeping it in longer in case the menstrual flow normalises.

Some women reject the option of IUD insertion based on fear of accommodating something strange in their bodies. Women may argue that it is 'against their custom', and therefore not suitable. A H'mong man referred to local belief that if a body part or organ is removed, the body is no longer considered whole, that the soul will be unable to find its ancestors in the spirit world after death or might be reincarnated and lead to a negative fate. This belief impacts on surgical solutions to medical problems, including IUD insertion and abortion that may not be viewed as curative, preventive or even life saving measures. Rather they are more likely to be perceived as profound forces for harm, affecting a person not only in this life, but also in many lives to come. The hamlet population collaborator said that in some cases the IUD is removed from the body of a dead woman before her burial.

The pill is favoured by H'mong women for spacing purposes at least until they achieve the desired number of children. However, due to their tight workday schedules compounded by lack of solid information, women often forget to take the pill and then, not knowing what to do, may decide to take 2 or 3 pills in one day. There is also difficulty, in same cases, of effecting

smooth transition from the old packet of pills to the new. On market days, some H'mong women sometimes buy their pills from the pharmacy[3] without prescription or counselling. The level of knowledge among local women on the implications of different contraceptives is clearly related to the availability and quality of counselling services.

Other less popular contraceptive methods to control fertility in Meo Vac include condoms or a combination of male condom use and female rhythm method. Like the pill, the condom is useful for determining the spacing of pregnancies, but this practice is often undermined by a high discontinuation rate. Some women prefer injectables as a less visible and more convenient contraceptive method with the added benefit of allowing them to 'avoid rumours and keep the secret', even from their husbands.

Sterilisation is rarely requested. Health workers confirm that, even after sterilisation, one woman in Meo Vac still got pregnant. The majority of interviewed men and women had only vague ideas about the implications of sterilisation. In general, this practice is not accepted by most H'mong people and ties in with their fears of castration, dull-wittedness or sexual impotence.

Some women said they never used contraceptives for reasons such as: (a) don't know or know very little about contraceptives; (b) fear of being beaten by husbands or scolded by parents-in-law; (c) H'mong customs do not allow this practice; (d) hearsay from other women about side effects of IUD removal that leads to infertility; (e) no time to go to the CHC. Other women were hesitant, due to their need for 'secret methods' or because their relatives (husband, in-laws, parents) forbid contraceptive use. Young women often believe they can control their fertility without contraception.

Overall, the study found that women tend to use contraceptives as a fertility limiting device rather than for birth spacing (cf. Zankel 1996). Indeed, many women said that they would consider using contraceptives only after the desired family size of 4 to 5 children had been achieved and the "offspring gender preference" met. Gender preference may vary depending on the family situation (decision of the husband, economic and land holding status), but at the very least a woman is expected to produce one or two sons.

Abortion

In Viet Nam, despite religious condemnation, abortion is legal, but has obvious implications for the H'mong Catholics in Ha Giang who are forbidden by the church in this practice. Due to time constraints, the consultant was not able to explore local abortion practices in-depth. However some observations that deserve further investigation are as follows:

Among the H'mong abortion is considered "unvirtuous" and rarely applied (see Table 2) with full term delivery the priority goal. Even in potential cases of abortion, the majority of H'mong women fear going to public health centres, reasoning that it will cost too much time and money. One woman interviewed said that she does not fear death, but does fear 'bad rumour'. Female fear also extends to becoming infertile if the abortion is performed carelessly, leading to severe punishment by the spirits.

[3] There are three pharmacies in Meo Vac

Sometimes obtaining prescription medicines can be a problem. H'mong women may resort to asking another person to go on their behalf to the outdoor market to buy abortion drugs from the healers. Women also use specific herbs or as the local people say, 'eat the herbs for abortion'. Moreover, as abortion is formally regarded as an immoral act, there are cases where healers prescribe recipes to strengthen the foetus.

The availability of counselling for women on abortion issues is almost unheard of. The 2003 baseline survey conducted in Ha Giang showed that only 5% of service providers at the district level and 6% at the commune level were knowledgeable about abortion counselling. In Meo Vac, the situation is similar, highlighting the importance of developing and improving the abortion counselling skills of public health workers.

Miscarriage/stillbirths

The results of in-depth interviews conducted in Meo Vac proved similar to those found in the study by Zankel (1996), with 5 reasons identified for the high rate of miscarriage and/or stillbirths among White H'mong as:

a) Heavy daily workload borne by women throughout their reproductive lives, conducive to accidents that trigger miscarriages.

b) Poor nutrition throughout pregnancy, increasing the incidence of premature or under-nourished infants.

c) High frequency of pregnancy and childbirth.

d) Malarial episodes suffered during pregnancy.

e) Abnormal foetal position.

Ante-natal care

The majority of H'mong women are not in the habit of seeking ante-natal check ups. Many women are not even aware of the early signs of pregnancy, not visiting the health centre until the later stages. Women tend to seek ante-natal care only if the first pregnancy or delivery was difficult. Similar trends are also evident in other studies (Zankel 1996, Futures Group 1997). There are several reasons for this situation:

- Ethnic minority women in general and H'mong women in particular do not receive routine ante-natal examination and care; the majority of ethnic minority women in Ha Giang have not received any health education on the importance of regular ante-natal checkups;
- Pregnant women living far from commune or district health centres will only visit if faced with serious problems during pregnancy (cf. Zankel 1996). In Meo Vac, women said that visiting the clinic for ante-natal checkups places them at considerable risk for miscarriage, requiring them to travel long distances across difficult terrain that requires considerable physical stamina;
- There is a commonly held view that it is easy for H'mong women to give birth and if "losing this child we will have another- this is granted by God";

- Most health workers at the CHC are not adequately trained, or as Zankel (1996) noted, they are not trained as "multipurpose health care providers". They lack both the capacity to perform procedures and adequate diagnostic equipment to conduct ante-natal check ups. Data from FGDs also point to the fact that if the health worker is male, Kinh, or Tay, the H'mong female clients feel too shy to communicate;

- The workload involved in seasonal cropping prevents H'mong women from making the arduous trip to the clinic.

Delivery

H'mong women prefer home-births. Women interviewed said that they find the home environment more congenial with their relatives in attendance despite the lack of remedies to reduce the pain and discomfort of birth related labour. Intense pain is thought necessary to ensure speedy delivery. Normally, the cord is cut with scissors (or with a bamboo splinter) and tied with jute thread. Afterwards "the cord is dried for 3 days before burying under the pillar". If the new born is a boy, his placenta will be buried under the principal pillar of the house – the main column supporting the roof near the kitchen and considered the "sacred pole" known as ma cột [pillar ghost]). If the baby is a girl, her placenta will be buried under the bed. In case of difficult delivery or complications, a 'soul calling ceremony' [lễ cúng cầu mẹ tròn con vuông] will be arranged. In general the H'mong don't worry if the newborn dies as they believe in the reincarnation of spirits. It is likely that this view also contributes to the high birth rate among the H'mong.

Old H'mong folk say that young H'mong women prefer to give birth at home rather than in unfamiliar hospital surroundings located far from supportive kin. Home birth allows the expectant mother to receive emotional and social support throughout the labour. It is also thought better to deliver at home because of the difficulties involved in transporting the woman to the CHC. In fact, many H'mong women have been known to deliver their babies in the rice field or in forests as they are walking home. In such cases, delivery takes place entirely unassisted. The mother cuts the umbilical cord with a sharpened sliver of bamboo or sickle and cleans both the infant and herself before lying down, exhausted. Meo Vac women also report that if there are no adults at home at the time of delivery the expectant mother must fend without help, for her baby and herself. A man interviewed in Can Chu Phin reported that his wife gave birth to her fifth child during the trip to the CHC, but was able to cope easily 'just like eating up a bowl of *"mèn mén"*[4].

A birth attendant with skills and experience is valued more than modern instruments. The birth attendant might be a village midwife by profession or the pregnant woman's mother, mother in law, sister or sister-in-law. Indeed, delivery might be assisted by any of the older, more-experienced village women.

Few traditional birth attendants (TBAs) are literate or have any formal midwifery training. Their knowledge comes from observation and witnessing delivery performed by a relative such as mother or mother- in-law. The TBA can provide valuable help to the expectant mother at

[4] *"Mèn mén"* is a corn flour which is carefully prepared by lengthy steaming and then grinding of the kernels of corn; the dry corn is eaten with vegetable soups or soybean sauce, or mixed in soup

certain stages of delivery but, without a stethoscope or other means of detecting foetal distress, can monitor progress only by feeling the belly. The TBA lacks skills to deal with complications.

Traditional home birth practices work well if the delivery is normal. However, it is the difficult deliveries that require referral to the public health services. According to 2006 CHC records, 78 cases of complicated pregnancies were referred to DHC although details of symptoms and diagnosiswere not recorded. According to Ha Giang health workers, hospital deliveries are very rare, occurring only if the lives of the mother and her baby are at risk or in the event of serious pregnancy complications such as the likelihood of obstructed delivery or unusually difficult labour.

Diagnosis of potential difficulties requiring referral has to be made early enough to allow sufficient travel time for the mother to reach the district hospital or clinic. The district hospital has only one ambulance that may be out on another mission at the time of need. Telephone communication in remote areas is unreliable and easily disrupted, posing a further obstacle in securing emergency services. Often, H'mong people prefer to call in a shaman rather than a health worker from the CHC. A needs assessment conducted in Ha Giang by PATH showed that in all observed hospitals, health providers lacked the necessary skills and knowledge to manage obstetric complications or to resuscitate a newborn infant.

Post delivery

During pregnancy, the expectant mother and her family are more concerned about details of the baby, especially the gender, rather than focusing on providing healthy maternal nutrition. Breastfeeding is commonly practiced immediately following birth. Some women interviewed in Meo Vac explained that putting babies to the breast immediately helps to avoid 'stiff tongue'. If women are not aware of the importance of colostrum they may choose to delay the first breast feeding session.

Due to chronic poverty, milk is an expensive item and maternal breast milk an obvious alternative. Sometimes *"mèn mén"* is used instead of milk. Solid foods such as rice and minced meat are fed to the baby as early as one month old. Post-delivery food for the mother is based on a hot-cold principle with black chicken (or lean pork) and hot rice the preferred options.

Reproductive Tract Infections (RTIs)

There is a lack of accurate statistics on the incidence of RTIs among young H'mong women, one reason being that women often feel shy when discussing intimate issues with male doctors. Despite evidence that suggests a high rate of gynaecological infection, many young women prefer not to use health services for check-ups. The 2006 Can Chu Phin Health Centre report gave a figure of 3,260 case visits to the CHC for medical examination of which 650 concerned gynaecological problems.

Infertility

Serious diseases such as infertility are commonly treated with herbs or local medicines. H'mong people seek help from traditional H'mong healers or shamans for health problems (infertility, determining female pregnancy) or birth rituals (difficult delivery, son preference). The shaman, so it is believed, departs the material world for the spirit world to determine appropriate treatments for the causes of adversities. The shaman is believed to be able to retrieve the lost or captured souls of the ill person, effectively curing the disease.

3.5 Implementation of RH policies in Ha Giang: gaps and implications

a. Multilevel policies. Laws and regulations are multi-leveled and overlapping, causing confusion to local staff and ethnic minority people. According to the National Population Strategy (2001-2010) and the National Reproductive Health Strategy (2001-2010), authorities at all levels are obliged to provide RH care to people in ethnic minority areas, supported by policies, directives and programmes of action. However, existing policies are both numerous and confusing. Health workers interviewed in Meo Vac reported that often they do not know which legal document to follow.

b. Institutional structure is complicated and with frequent changes creates difficulties for effective collaboration between and within different sectors. This present system lacks coordination at all levels, resulting in missed opportunities to improve RH services and delivery.

c. Personnel policy. Government policy encourages health workers, at least in theory, to work in ethnic minority regions by offering incentives such as 35% additional salary, arranging jobs for spouses and giving priority to land issues. However, health workers are reluctant to work in remote ethnic minority regions preferring to find employment in urban areas or in the provincial hospital.

The recent changes in personnel policy have led to significant increase in personnel turnover at all levels, affecting both management and technical aspects of health care, especially for those working at the grassroots level. All health staff complain about high workloads and low salaries, two crucial factors that undermine work output and quality. Each staff member is expected to cope with a broad range of responsibilities and this means that there are no permanent, full-time staff located at the health stations in either the district or commune centres.

d. "Target syndrome" In general, both policy makers and implementers spend considerable time discussing targets in plans and reports, but less often identifying causes and solutions of problems. This pattern is clearly reflected in all reports collected during the field study in Ha Giang.

e. Financial allocation. As a rule, national funding is allocated to provinces on the basis of population count, but not geographical conditions. According to one doctor in Ha Giang, provincial trainers do not want to attend district centres for training because the allowance is very low and does not even include expenses for petrol. Indeed, riding a motorbike on the pot holed, dirt roads in Meo Vac uses double the amount of petrol required for the same distance along a lowland paved road. The same doctor also pointed out that trainers visiting the remote Ha Giang regions, receive the same financial allowance as trainers in lowland Thai Binh.

f. Red tape. Under the National Population Strategy (2001-2010) and the National Reproductive Health Strategy (2001-2010), the government has issued relevant legal documents to strengthen inspection and supervision of RH health services provided to people in ethnic minority areas. In Ha Giang, the obstetric department of the provincial hospital assigns staff to visit the DHC and selected communes twice a year for monitoring and supervision purposes.

Health staff carry a reference booklet entitled "Guideline: Monitoring, Supervising and Evaluating Reproductive Service" (MOH 2004). Reluctance of inspectors to venture into the less accessible parts of the province, severely undermines their ability to provide constructive criticism and accurate reporting on services they have neglected to observe during their "study mission".

g. Reporting system. The problems involved in reporting can be likened to a kaleidoscope. Ha Giang health administrators complain that the MOH reporting format is difficult to understand. Provincial health workers comment that the district and commune health workers are inadequately equipped to collect information, thus preventing accurate assessment of the quality of grassroots RH activities.

Indeed, in the Ha Giang district and commune reports collected by the consultant during the field study, many items lacked clarification. For example, the current year's report is used for next year's plan but without adjustments to improve activities. Numbers are frequently cited without identifying the year or month. The term percentage is used without reference to a specific item. The consultant examined hospital and CHC reports all lacking detail, a direct reflection of weak guidance and supervision of the health network.

At the study site, symptoms of illnesses were either not recorded or recorded carelessly in the CHC consultation book. Such omissions appear to be standard CHC practice, again reflecting the lack of higher level supervision and, most importantly, precluding accurate diagnostic assessment.

4. Conclusions and recommendations

Perception and use of RSH services

- Some women decline to use contraceptives due to: a) limited knowledge; b) fear of being beaten by husbands or scolded by parents-in-law; c) H'mong customs that forbid this practice; d) fear of side effects and infertility; e) lack of time to visit the CHC.
- Some women hesitate to use contraceptives due to: a) fear of being found out by husband, in-laws, parents; b) fear of becoming 'routine contraception users'.
- Some women use contraceptives to control and limit fertility rather than for birth-spacing.
- IUD insertion is the most commonly used method in Meo Vac. However, side effects often cause women to have the IUD removed. Some women fear insertion into their bodies of an alien item that may anger the spirits.
- The contraceptive pill is most often applied for spacing purposes, at least until the desired number of children is achieved. Some women purchase pills in private pharmacies without prescription or instruction.
- Less used methods include condoms or a combination of condoms and rhythm. Some women prefer injectables because the process is quick, easy, convenient and undetectable.
- Sterilisation is rarely requested due both to traditional customs and lack of knowledge.
- Abortion is considered an immoral act, although some women do use herbs to stimulate this procedure.
- The majority of H'mong women prefer not to visit the CHC for ante-natal care, unless the first pregnancy or delivery proved difficult. This reluctance is due to several factors that include lack of knowledge about the importance of ante-natal checkups, ingrained habits to delay using health services, long distances to the CHC on difficult road conditions, belief in reincarnation, shyness and language difficulties in communicating with health workers.
- Home delivery is the preferred practice, imbued with many rituals and traditions. There is a commonly held view that birthing is an easy procedure and, even if delivery occurs in the rice field or in the forest, the woman should be able to manage by herself. H'mong women prefer home births surrounded by their relatives for emotional comfort. The TBA plays an important role during delivery despite lack of training and equipment.

Barriers to access and use of RH services

- Low standards of education and inadequate IEC impact on the level of access to RH services. The mode and content of delivery of IEC messages targeting ethnic minority are inappropriate. IEC would be more effective if focused on audio and visual delivery.
- The health system faces a number of problems, including location of the health facilities, language barriers, low level of user trust in health services, negative provider attitude towards

clients, shortage of equipment and medicines, inappropriate counselling, over-prescription of antibiotics, malpractice associated with drug distribution, and inefficient referral systems.

- High costs associated with referral to the CHC or DHC such as transportation, food and accommodation.
- Pressure from peers, relatives and local community to conform to traditional values.
- Religious ideologies - Confucianism, Taoism, animism, that promote belief in reincarnation and shamanism - and customs that encourage large families.

Other related factors

- Chronic poverty and its determinants (malnutrition, bad housing conditions, intense workload of women and girls) impact on all aspects of health and on RH in particular.
- Shortage of clean water contributes to the high prevalence of gynaecological infections.
- Teenage marriage and early sexual relations practiced in the H'mong community, directly impact on birth rates, especially when FP is not well implemented.
- The rate of gender based violence among the H'mong, is alarming, encouraged by local customs of patriarchy embedded in Confucianism that treat women as servants and compounded by male alcohol and opium addiction.

Recommendations for National Policies

To improve delivery of health care services, particularly in ethnic minority regions, the government should focus on:

- Developing policies that address the real needs and interests of ethnic minority groups.
- Allocating funding levels and health care targets according to geographical and cultural conditions rather than on per capita basis;
- Adjusting RH policies to ensure they address the real needs of ethnic minorities especially adolescents.
- Raising awareness of ethnic minority related issues encorporated in laws and policies such as the Gender Equality Law (2007), the AIDS Law (2006) and the Master Plan on Safe Motherhood (2001-2005);
- Training health workers to deliver RH services and information to ethnic minorities in a culturally sensitive manner
- Adapting health personnel wages and conditions to attract lowland doctors to move to highland regions. Salary incentives should also be offered to hamlet population collaborators;
- Implementing RH projects in cooperation with other development projects to alleviate the existing chronic poverty found in ethnic minority groups.

Recommendation for IEC/BCC

Many projects that provide training for RH workers fail because they do not take account of local conditions and culture. This highlights the importance of adopting a flexible approach in training programmes to ensure local health collaborators are equipped with knowledge and IEC materials adaptable to ethnic minority needs. The value of well trained local health collaborators should not be under-estimated, as they are the initial contact for clients seeking primary health care. Not only should village health workers and population collaborators be able to provide timely and practical IEC support, but also recognize which clients should be referred to higher level care. To reduce transportation difficulties, IEC projects should budget for costs of motorbike purchase and petrol subsidies.

IEC targeting of ethnic minority people should be culturally-relevant and community-focused, and encourage active participation from local populations, including primary and secondary school pupils, in the design, development and delivery stages. Young people can then pass on information to their parents and older adults in the family.

In most ethnic minority locations, health care topics are communicated at group meetings organized by hamlet leaders, usually attended by men only, thus excluding the crucial female target group. In Ha Giang and other ethnic minority regions, local networks should cooperate in developing an alternative IEC approach with focus on information delivery by word of mouth through women's groups and neighbours.

Specifically, IEC messages should be:

- Short, simple and include material illustrated with pictures;
- Integrated with folk songs and legends performed at social events;
- Printed on the "quẩy tấu" (basket carried on the back) as a daily reminder for women;
- Pre-tested in H'mong communities;

Due to the strong influence of Confucianism[5], youth find it difficult to discuss sex matters openly. Of course this means that the current mode of IEC delivery offered in the school curriculum is largely ineffectual.

Sex education for ethnic minority groups in general and the H'mong in particular, should be based on ethno-physiology and easily adaptable to each age-bracket and social stratum. The style of delivery should respect the audience background and age group. The content of health and sex education should be flexible and age-appropriate responding to the specific needs of children, adolescents, parents, relatives or elders.

Recommendations for provincial and involved stakeholders

- All RH projects for ethnic minorities should acknowledge that changing traditional RH behaviour, will take time and require recognition of the distinct socio-economic conditions and RH values that characterize different ethnic groups. The MOH should consider these factors in developing RH programmes.

[5] According to Confucianism, sexual relations are regarded as indecent which should be avoided in talks with respectable people and in teaching Confucian dogmas

- Local people should be involved from the initial design phase through to implementation. This is often theoretically intended but not taken up in practice, yet it is crucial for successful project development. Some of the neglected stakeholders that deserve more attention are hamlet population collaborators, TBAs, village headmen, religious leaders, folk healers, shamans, private pharmacists, herbalists, elders and school children. UNFPA programme officers, project implementers and lay people should collaborate closely in implementation of all project steps.

- In many projects, but in the UNFPA project in particular, the local project team lacks clear understanding and guidance for what they are supposed to do. This impairs coordination and quality of work output. For sustainability, national and provincial project staff should meet more often to establish trust, to discuss project issues, to develop rapport and to improve understanding of their respective roles and responsibilities.

- MOH should develop training formats relevant to the specific ethnic minority environment. Medical secondary schools in all selected provinces should be networked into the UNFPA projects by providing training and re-training for RH workers. Training should cover the social aspects of RH (religion, customs, taboos, medical ethics).

- Gender based violence. Despite its widespread prevalence, GBV has not received due attention from policy makers and health personnel. An effective advocacy program should be developed for policy makers and health personnel at all levels to raise awareness of GBV issues, with emphasis on the fact that GBV is an illegal act. Training programmes should be developed that reach out to members of the district Women's Union, the Fatherland Front and village heads. Legal aid services are urgently needed and should be provided, initially at the district and commune levels, to network with health workers, population collaborators and local authorities.

Recommendations for Research Agenda

Prior to the SAVY[6] quantitative survey in 2005, no large scale study on ethnic minority youth had been conducted. Results of the current qualitative research study highlights the pressing need to conduct larger scale ethnographic studies on ethnic minority RH issues.

Quantitative studies are useful for highlighting the significance and level of contraceptive use in different socio-cultural settings. Qualitative studies are useful for describing which types of contraceptive methods women and men consider important, and why. An anthropologist of ethnic minority origin is in a strong position to understand the intrinsic values, needs and interests of his/her community, thereby contributing significantly to the development of culturally sensitive FP programs for delivery of RH care. To date, there have been no training programmes specifically designed for researchers from ethnic minority regions.

[6] The SAVY survey in 2005 made comparison between Kinh and ethnic minority youth. It found that knowledge and awareness about HIV/AIDS as well as about reproductive health were significantly lower among ethnic minority children and adolescents than under their Kinh peers. The SAVY authors hypothesize that this is due to lower IEC implementation in remote areas of Vietnam, low education levels which mitigate against understanding HIV prevention messages, a lack of appropriate targeting of HIV messages for different groups, and language barriers posed by media campaigns that are, as a matter of policy principle, only conducted in the Kinh language (SAVY 2005:58). The SAVY survey does not distinguish between different ethnic minority cultures, instead lumping all of them together in one group.

Indeed, training programmes should be developed to instruct ethnic minority researchers in medical anthropology research techniques. Clearly, ethnic researchers can produce their best results if working among their own people.

Topics for research should include:

a. *Fertility behaviour:* to examine the motives of ethnic minority women or men in pursuing high or low fertility and the way in which they achieve their objective. For example, levels of fertility can be affected by marriage patterns, abortion and contraceptive use. The anthropology of fertility focuses on motives and the resulting behaviour patterns;

b. *The impact of social change* (changing environment, changing policies; changing livelihood, transformed sexuality) on RH among ethnic minorities;

c. *Network Study:* to improve understanding of the various dynamics that exist between ethnic minority groups in relation to RH issues. For example, institutional structures should be assessed to identify why public health IEC practiced in ethnic minority areas is proving largely ineffective;

d. *Mother-daughter interactions* and how these relate to sex education;

e. *Ethnic minority opinion* and reaction to change, useful for developing relevant RH programmes;

f. *Gate keeper perspectives:* shamans, magicians, folk healers, fortune tellers and private pharmacists;

g. *Abortion practices,* background and their connection with religion, infertility and traditional healing;

h. *Gender based violence:* study of cultural values and beliefs of ethnically diverse communities to ensure flexible, appropriate and sensitive delivery of IEC on GBV.

References

Chambers R, Conway G. 1992. Sustainable rural livelihoods: practical concepts for the 21st century. IDS Discussion Paper 296, Institute of Development Studies: Brighton.

Culas C. 2000. Migrants, runaways and opium growers: origins of the H'mong in Laos and Siam in the nineteenth and early twentieth centuries. In Turbulent Times and Enduring Peoples: The Mountain Minorities of the Southeast Asian Massif, Michaud J. (ed.); Curzon Press: London; 27-47.

De Haan A. 2002. Migration and livelihoods in historical perspective: a case study of Bihar, India. The Journal of Development Study 38: 115-142.

De Haan L, Zoomers A. 2003. Development geography at the crossroads of livelihood and globalization. Tijdschrift voor Economische en Sociale Geographie 94: 350-362.

Ellis F. 2000. Rural Livelihood Diversity in Developing Countries: Analysis, Policy, Methods. Oxford University Press: Oxford.

Hien, PTT et al 2004. Gynecological Problems among ethnic women in Huong Hoa, Quang Tri, Vietnam.

IFAD 2006. Decentralized Programme for Rural Poverty Reduction. Hanoi, Vietnam.

Khong Dien. 1995. Ethnic minorities in Vietnam. Social Science Publishing House.

Lam, N.T. 2004. Minority People in Northern Mountains Vietnam: Poverty and Infectious Diseases. Oral paper, S111, 36th IIS Congress "Social Change in the Age of Globalisation", Beijing.

Lam, N.T. 2005. The Dynamics of Sexuality among the H'mong in Vietnam. Paper presented at the Symposium at the 3rd Asia Pacific Conference on Sexual Reproductive Health, Kuala Lumpur.

Lam, N.T. 2005. Transborder Migration and Religion: The Social Context of Religious Conversion among the Hmong in Vietnam. Paper for the SEASREP 10th Anniversary Conference Nov 2005, Chiangmai, Thailand.

Lam, NT. 2006. Social Change and Infectious Diseases in the Northern Mountains Vietnam. In A.Sleigh, C.H. Leng, P.K. Hong et al. (eds.) Population Dynamics and Infectious Diseases in Asia. WorldScientific, Singapore, p.138-157.

Lam, NT. 2006. The Dynamics of Development in Vietnam: A study among the Tay and the Hmong; in "Indigenous People: Development Process or Domestication?" ed. Frederic Bourdier & Jeremy Ironside", All India Press, (accepted for publication).

Lam, NT. 2007. Development, Health, and Religion: A Case Study among The Tay and the Hmong in Vietnam. International Conference Health and Mobility in Asia and the Pacific, Melbourne 25 June 2007

Lam, NT. 2007. The Dilemma of Development in Vietnam. Paper presented at The 6th International Graduate Student Conference Feb 15-17, 2007, East West Center, Hawaii

Luong HX. 2000. Van Hoa Nguoi Hmong o Nghe An [Hmong Culture in Nghe An]. Ethnic Culture Publishing House: Hanoi, Vietnam.

Michaud J. 1997. From Southwest China into Upper Indochina: an overview of Hmong (Miao) migrations. Asia Pacific Viewpoint 38: 119-130.

Michaud J. 2000. The Montagnards and the state in Northern Vietnam from 1802 to 1975: a historical overview. Ethnohistory 47: 333-368.

MOH 2001. Current regulations on RH care. Ha Noi, Vietnam.

MOH 2001. National Strategy promulgated for RH care in the period 2001-2010, People's Army Publishing House, Ha Noi, Vietnam.

National Committee for Population, Family and Children 2002: Community Action for Preventing HIV/AIDS Project 2002. Baseline Survey Report Community Action for Preventing HIV/AIDS in: Lai Chau, Quang Tri, Dong Thap, An Giang, and Kien Giang 2002. Vietnam.

Rambo AT. 1997. Development trends in Vietnam's Northern Mountain Region. In Development Trends in Vietnam's Northern Mountain Region. Vol.1, Dorovan D, Rambo T, Fox J, Cuc LT, Vien TD (eds.); National Political Publishing House: Hanoi; 5-52.

Son TH. 1996. Van Hoa Hmong [Hmong Culture]. Ethnic Culture Publishing House: Hanoi.

Tapp N. 1989. The impact of Missionary Christianity upon marginalized ethnic minorities: the case of the Hmong. Journal of Southeast Asian Studies 20: 70-95.

The Futures Group International. 1997. Family Planning and Reproductive Health among Ethnic Groups in Vietnam.

Truong, T.T. (2001). Hmong and Vietnamese women's perception of domestic violence: An exploratory study. MA Thesis, California State University, Fresno

UNFPA 2007. Research on reproductive health in Vietnam: a review for the period 2000-2006. Hanoi, Vietnam.

UNFPA. 2006. The current status of provision and utilization of RH care in Ha Giang Province. Hanoi, Vietnam.

UBND Meo Vac 2007. Bao cao tong ket cong tac dan so-gia dinh va tre em. Ha Giang, Vietnam.

Vietnam Population Strategy 2001-2010. Medical Publishers. Hanoi, Vietnam.

Zankel S. 1996. A Health Strategy for Ethnic Minorities Living in Vietnam.

GPXB số: 33-2008/CXB/448-175/YH cấp ngày 17/11/2008 tại Nhà xuất bản Y học

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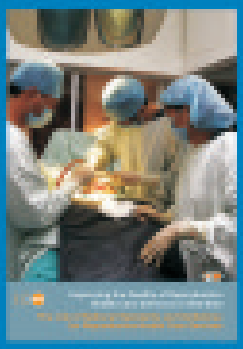



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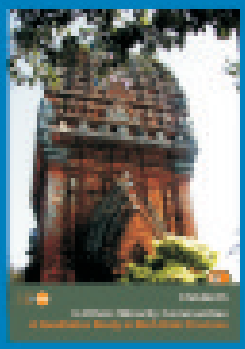
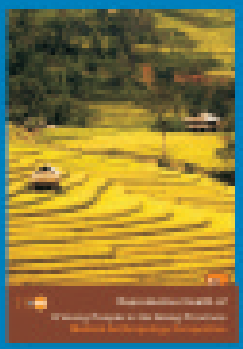

1st Floor, UN Apartment Building
2E Van Phuc Compound
Ba Dinh District, Hanoi, Vietnam
Tel: +84 4 3 823 6632
Fax: +84 4 3 823 2822
Website: http://vietnam.unfpa.org
Email: unfpa-fo@unfpa.org.vn