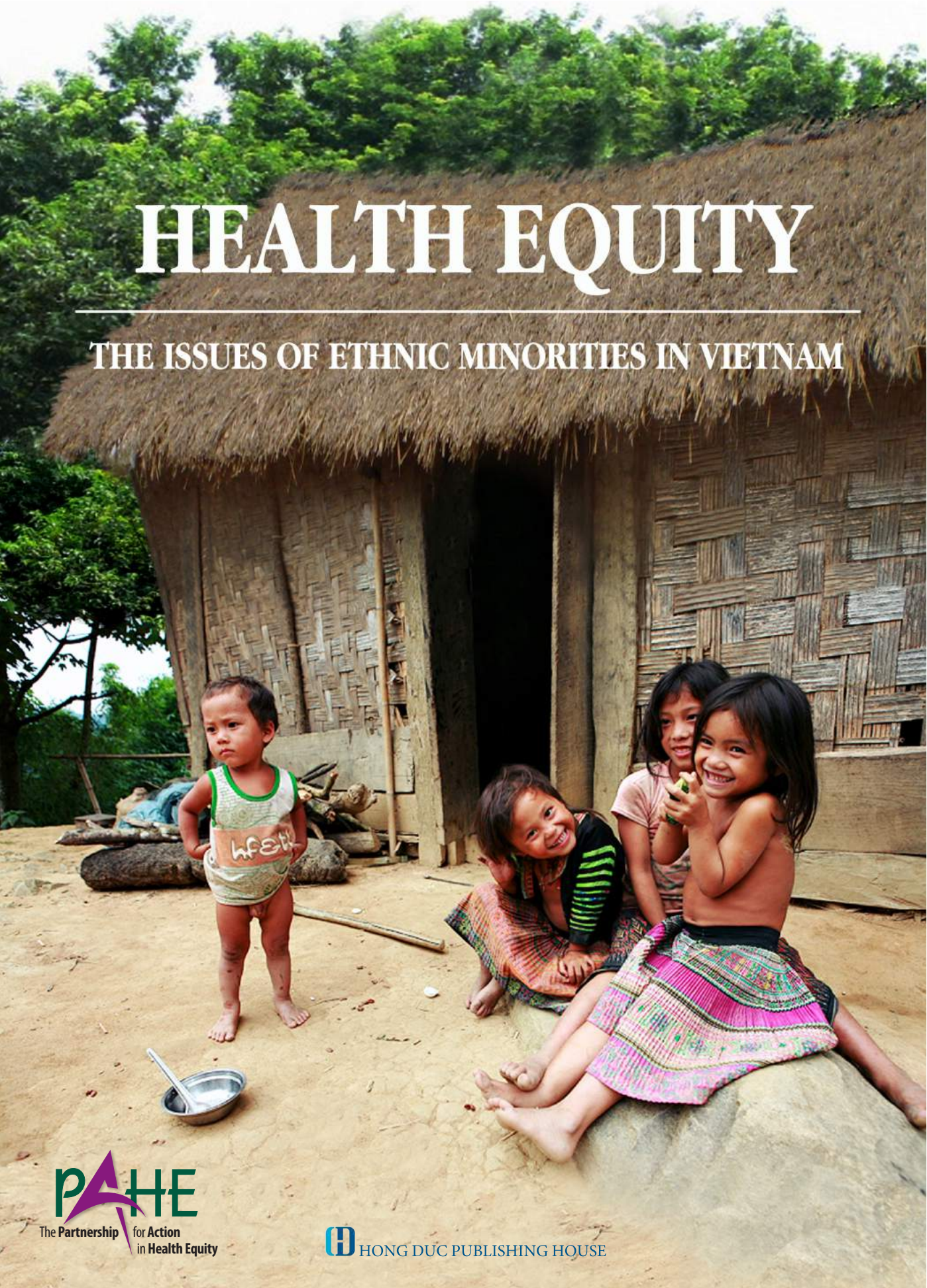
HEALTH EQUITY

THE ISSUES OF ETHNIC MINORITIES IN VIETNAM



PAHE
The Partnership for Action in Health Equity

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"All men are created equal."

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HEALTH EQUITY

The issues of ethnic minorities in Vietnam

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LIST OF ABBREVIATIONS

ARV	Antiretroviral
CCRD	Center for Community Health Research and Development
GSO	General Statistics Office of Vietnam
CHC	Commune Health Center
HIV/AIDS	Human immunodeficiency virus infection/acquired immunodeficiency syndrome
MDGs	Millenium Development Goals
MIC	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
OOP	Out-of-pocket
PAHE	The Partnership for Action in Health Equity
SARS	Severe Acute Respiratory Syndrome
SAVY	Survey Assessment of Vietnamese Youth
SDOH	Social Determinants of Health
UNICEF	United Nations Children's Fund
VHLSS	Vietnam Household Living Standard Survey
VNAS	Vietnam National Survey on Aging Population
WHO	World Health Organization

CHAPTER I

I. INTRODUCTION

Social justice and equality are among the top interests of human beings, and therefore the center of development strategies of most countries in the world. Although there has not been an absolute agreement over the concept of social justice and equality, many theorists have distinguished the concepts of social justice and social equality: Social equality refers to the equality between individuals in (one or more) economic, political or cultural terms while social justice is a historical concept that differs in its implications within different social systems.

Each society has its own criteria in terms of social equity which is decided by that society's specific historical situation[1,2]. As such, although improvements in economy and political institutions have positively influenced social equality, the progress in social equality needs to be made in parallel with social development in general, especially with facilitating each individual in utilizing and bringing into full their potential in order to accelerate development and foster social advancement.

1.1. Health equity – an important aspect in social justice

According to WHO definition, "health" is not merely the absence of disease but the healthiness in both physical and psychological status.

Although health equity is an important element in social equality and has been among the most attention drawing issues in the world over the past decades, there have existed certain differences in the definition of health equity among different schools of thoughts. In our opinion, there is a need for a clear distinction between two definitions in this study. They are equity in health and equity in health care.

1 Nguyễn Duy Quý 2008. Social justice in the socialism oriented market economy.

2 Central Institute for Economic Management (VNEP). Theme 09 – Implementation of social justice and progress in development policies.
Website: http://www.vnep.org.vn/Modules/CMS/Upload/6/Chuyen%20de%209%20_06%20format%20VNEP.pdf

Health equity is denoted as a systematic social justice and equality in allocating health[3] for people belonging to different social status. Previously, health equity was related to two main components:

(1) Equity in health care including such health system related elements as the distribution of health care resources, health care quality, and access to health care.

(2) Equity in human health or health status including such elements as mortality rate, life expectancy, nutrition status, disease patterns, etc. Nowadays, the view and concept of health equity have been broaden so that the social factors affecting health condition are also taken into consideration[4]. One of the most popular approaches is to use *"the framework of social factors in health equity"*, which will be presented in the later section of this report.

As such, equity in health care is only a component of health equity[5], and only includes the equity in allocating resources, accessing and utilizing health care service that meet individual needs. On the other hand, the difference between "health inequalities/health disparities" and "health equity" should be clearly distinguished. From today's perspectives, the health inequalities or health disparities are the differences in the specific health condition between various population groups and are often reflected by the indexes of specific health condition while health inequity does not refer generically to just *any* inequalities between *any* population groups, but very specifically to disparities between groups of people categorized *a priori* according to some important features of their underlying social position.[6] Some other concepts and definitions also indicated that inequity is resulted from systematic disparities among groups.

3 PAHE. 2011. Health equity in Việt Nam – The perspective of civil society, p. 7.

4 PAHE. 2011. Health equity in Việt Nam – The perspective of civil society, p. 29

5 PAHE. 2011. Health equity in Việt Nam – The perspective of civil society, p.27

6 Braveman P.A 2003. Monitoring equity in heatlh and health care: A conceptualframework. Jounal of Health Population nutrition, 21(3): 181-192

PAHE is undertaking this report in order to contribute to the current understanding and knowledge concerning health care equality and health equity of the ethnic minorities in Vietnam. Within the scope of a small research report with considerable limitations in data and information source, we can only focus on examining in a more systematic way the trend in equity and inequity between the two groups of people: the ethnic minority groups and the majority (Kinh) group in Vietnam, and the extent the health care and social determinants can affect these trends. At the same time, we will also raise further research questions that aim to contribute to the development of a more comprehensive, reliable and systematic information system that can be of effective service to policy making and monitoring of health equity in Vietnam in the near future.

1.2. Perspectives and strategies on social justice and health equity in Vietnam

It is made clear in the Vietnam's socio-economic development strategies period 2011-2010 that: rapid development must parallel with sustainable development; economic growth must be in harmony with cultural promotion, social progress and equality and continuous improvements in citizens' quality of life. Socio-economic development is defined as "the comprehensive social and cultural development in harmony with economic development"[7].

Health equity is one of the prioritized issues for ensuring social equity that has been institutionalized by Vietnamese Government through various laws and legal documents. Thus ensuring health equity is among the primary goals of the health care system[8] and is one of the five guiding principles of the country's Government and ruling Party for innovating and perfecting the health care system in Vietnam.[9] Yet up to now, it can be said that the existing health statistics system has yet standards and adequate data base for evaluation and monitoring of health equality and equity among different population groups in Vietnam, especially the ethnic minorities who are more socially and economically disadvantaged than the Kinh people. Reports from national surveys such as Population and Housing Census, Household Living Standards Survey, or the Monitoring the Situation of Children and Women conducted by the General Statistics Office of Vietnam (GSO) have provided certain data and information about health and nutritional conditions, health care and other social welfare of ethnic minorities and the Kinh population. However, statistical information from these surveys is rather limited

7 Vietnam Communist Party. Strategy for socio-economic development 2011 – 2020

8 Vietnam Communist Party. General Assembly Documents IX – 2001

9 Vietnam Communist Party -Resolution No 46 by Poliburo, dated 23/02/2005. Resolution No 46/NQ-TW

due to their differences in purpose, scope, or time and thus is not systematic in terms of types and amount of information, respondents and coverage of the study. That is why at present in Vietnam there has not been any national or local data set that adequately meets the information needs for regular monitoring the improvement in health inequality of the disadvantages populations especially the ethnic minorities over the years. Also it is difficult to accurately identifying the existing problems, particularly the main causes of health inequalities in a systematic and scientific way. This is a major shortcoming of the information system of Vietnam in general and, particularly, in the health system to support socio-economic development policies as well as hunger eradication and poverty reduction toward enhancing social justice.

1.3. Policies ensuring the equity for Vietnamese ethnic minorities

At present, Vietnamese population is composed of people from 54 ethnicities, each of which has its own language and cultural identity.

According to Article 4 of Government's Decree 05/2011/NĐ-CP dated 14 January 2011 on ethnic affairs, the majority group is denoted as the group whose population accounts for over 50% of the total national population according to the census and the minority groups are defined as those whose population is smaller than that of the majority within Vietnamese territory. By this definition, the **Kinh people are the majority, and the remaining 15% population of other ethnic groups is the minority.**

The ethnic minorities often live in the mountainous areas where the infrastructure is poorly developed. Another disadvantage is the language barrier. That is why over past years they have had quite limited access to information channels, basic health care, education and social service as compared to the Kinh people who is the majority group. The poverty and restricted access to essential social and health care services make the minority people among the most vulnerable and disadvantaged groups in Vietnam. Their indices of development are also lower than the average of the general population. And thus the rate of people who are poor and illiterate of national language among ethnic minorities are far higher than that of Kinh people. According to the report from Vietnam's General Statistics Office, 59.2% of minority people were poor while this rate of Kinh/Hoa people is only 9.9%.[10]

10 GSO. Statistics of poverty and migration in 2012

Ethnic affairs and ethnic development have always been the Government's focus of attention. Numerous policies have been made, and lots of resources have been invested through several ethnic minorities support programs and projects to facilitate socio-economic development and construction of infrastructure. First and foremost, the Strategy for Ethnic Affairs until 2020 was approved by the Prime Minister under Decree No.449/QĐ-TTg dated March 12, 2013 setting the common goals of developing the economy and society in a comprehensive and sustainable way, promoting poverty reduction, narrowing the gap between population groups, reducing the highly disadvantaged zones and strengthening human resources of the minority population.[11]

To quickly deploy the implementation of this strategy, the Prime Minister issued Decision No. 2356/QD-TTg dated 04/12/2013 on the "Action Program to implement the Ethnic Affairs Strategy up to 2020". Besides the National Targeted Program on poverty reduction, the Government has formulated policies, plans and economic development projects for every disadvantaged area[12] such as:

- Resolution No. 30a/2008/NQ-CP of the Government on the Program supporting rapid and sustainable poverty reduction for 62 poor districts[13].
- Decision No. 07/2006/QD-TTg of the Prime Minister dated 10/01/2006 approving the Program of 2006-2010 Socio-Economic Development for extremely disadvantaged communes in ethnic minorities and mountainous areas (hereinafter referred to as Programme 135 - Phase II).
- Government also approved to scale up the project supporting extremely disadvantaged ethnic minority groups to become the Policy to Support the Extremely Disadvantaged Ethnic Minorities under Decision No. 138/2000/QD-TTg dated 29/11/2000 issued by the Prime Minister[14].

In the health sector, improving the quality of health services for ethnic minorities is one of the main tasks of the Ethnic Affairs Strategy until 2020 approved by the

11 http://thuvienphapluat.vn/archive/Quyet-dinh-449-QD-TTg-nam-2013-phe-duyet-Chien-luoc-cong-tac-dan-toc-den-2020-vb175923.aspx

12 http://www.tapchicongsan.org.vn/Home/Viet-nam-tren-duong-doi-moi/2013/24707/Chinh-sach-xoa-doi-giam-ngheo-doi-voi-dong-bao-dan-toc.aspx

13 http://www.moj.gov.vn/vbpq/Lists/Vn%20bn%20php%20lut/View_Detail.aspx?ItemID=12476

14 http://www.moj.gov.vn/vbpq/Lists/Vn%20bn%20php%20lut/View_Detail.aspx?ItemID=22707

Prime Minister which aims to comprehensively developed culture and society of ethnic minorities. In addition, policies of health care and health insurance for the poor and ethnic minorities are also integrated into social policies and poverty reduction programs. In general, health care for ethnic minorities has been receiving due attention, institutionalized into many policies, legislation and widely implemented up to the grassroots level, especially in remote and mountainous areas. Therefore, a number of important health care policies for ethnic minorities have been enacted and implemented:

- The *"2011-2020 National Strategy for People's Health Protection and Improvement with a vision to 2030"* was approved by the Prime Minister under Decision No. 122/QD-TTg dated 20/01/2013. The Strategy highlights some standpoints of renovating and completing Vietnam's health system in accordance with justice, effectiveness and development, ensuring full access to good basic health care services for the poor, ethnic minorities and people in remote areas.[15]
- Circular No.07/2013/TT-BYT prescribed standards, functions and duties of village health workers to help ethnic minorities and people in remote or mountainous areas have better access to health care services[16].
- Health Insurance Law enacted on 01/07/2009 prescribed that poor, ethnic minorities living in disadvantaged areas are eligible to receive subsidizes health insurance from the State.
- Decision 139/2002/QD-TTg dated 15/10/2002 and Decision 14/2012/QD-TTg dated 01/03/2012 regarding medical care for the poor designed so that poor and ethnic minority households are offered free health insurance and entitled to healthcare support regulation[17].
- Decision 153/2006/QD-TTg approved the master plan on developing Vietnam's health system up to 2010 with a vision to 2020. It aims to improve health infrastructure and enhancing health workers' basis, focusing on the provision of health services at communal level[18].

15 2011-2020 National Strategy for people's health care, protection and improvement with a vision to 2030

16 Circular No. 07/2013/TT-BYT

17 Decision139/2002/QĐ-TTg by the Prime Minister dated 15/10/2002: Medical examination and treatment for the poor and Decision 14/2012/QĐ-TTg by the Prime Minister dated 01/03/2012: Amendment of some Articles in Decision 139/2002/QĐ-TTg dated 15/10/2002 on 39/2002/QĐ-TTg

18 DecisionNo. 153/2006/QĐ-TTg by the Prime Minister dated 30/06/2006: Approval of the Health System Development Master Plan in Viet Nam to 2010 and vision until 2020

1.4. The Partnership for Action in Health Equity group (PAHE) studies on health equity

The Partnership for Action in Health Equity (PAHE) is one of the pioneering groups in Vietnam using social determinants of health as an approach for research in health equity in Vietnam[19]. With this approach, the PAHE group has conducted three independent research reports on health equity in Vietnam:

- The first **Vietnam Health Watch Report** with the theme: *"Health equity in Vietnam – Civil society perspective"* was completed in 2011. The report presented the basic concepts on health equity and over view of health equity in Vietnam using the social determinants of health as an approach to research health equity in Vietnam.
- The second **Vietnam Health Watch Report** with the theme: *"Health System in Vietnam: Toward targets with equity"* was released in 2013. This report updated the assessment of patterns and levels of health equity in Vietnam among different population groups stratified by: 1) Gender; 2) Age; 3) Education; 4) Ethnicity; 5) Economic status; and 6) Place of residence (urban and rural). On the issue of health equity disparities among population groups, primarily between ethnic minorities and the Kinh population, the report mentioned issues related to the proportion of infant mortality, child nutritional status, accessibility to reproductive health care services and child health care, and catastrophic health care expenditures. The report findings show the low level of inequity in ethnic minority groups in most of these issues. However, there remains in the report some unclear issues and research questions that need further explorations, for example: the report mainly focused on analyzing disparities in health status but gives little reference to factors affecting health equity, especially the social factors affecting inequality in the health status among population in general and ethnic minority groups in particular. Moreover, the report also more concentrated on the coverage of health services rather than analyzing their quality.
- The third **Vietnam Health Watch Report** this time with the theme: *"Health Equity – The issues of ethnic minorities in Vietnam"* continues focusing on in-depth analysis of issues related to ethnic minorities. This report will continue updating, adding, and enhancing the analysis of differences in critical health status indicators of ethnic minority groups following the Millennium Development Goals. This

19 The Partnership for Health Equity in Vietnam (PAHE). 2011. Health Watch Report , page 11 the Vietnam Health System - Toward targets and Equity, page 11

report will adapt the World Health Organization (WHO) conceptual framework on social determinants of health equity for guiding the data analysis and report writing process, especially for the in depth analysis of intermediary factors including health and non-health system factors that may affect the equality and inequality between ethnic minorities and Kinh people.

II. RESEARCH METHOD

2.1. Research questions and hypotheses

To obtain more comprehensive and systemic understanding of the health equity between the Kinh and the minority groups, the main research questions include: whether or not there exist health inequities between the two groups? If yes, what aspects of health the inequity exists most? To what extent? What are the underlying factors affecting these inequities? Based on the theoretical framework and previous studies on this subject, this research will focus on the two main hypotheses:

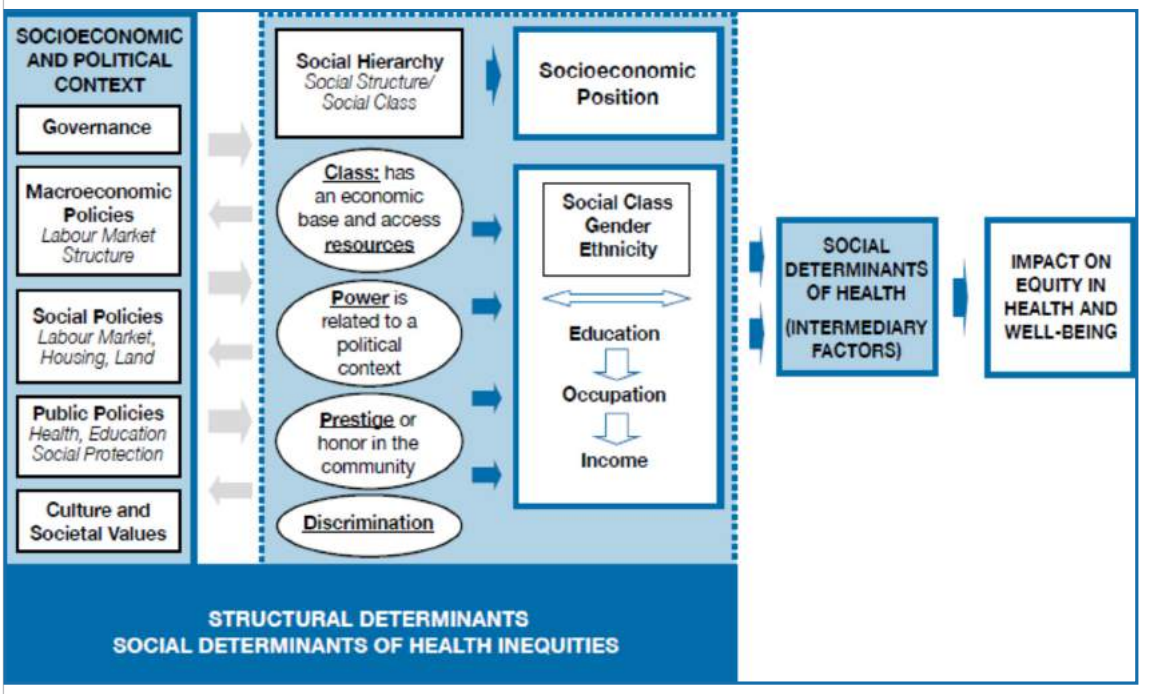
- The systemic differences between the ethnic minorities and Kinh people in essential health indicators like mother and child mortality, illness and disease situation and child nutrition are the primary attributes to health disparities and inequities between the two population groups in Vietnam.
- Health inequities among the ethnic minority groups exist because they are more disadvantaged in the social determinants of health and health care such as limited access to health care facilities and to quality health service; the poorer living and working conditions; difficult access to information channels especially mass media; limited health care knowledge and behavior of individuals as well as of community.

It should be noted that although the above hypothesis seems to be logic and strongly associated in theory, it may not be true in reality that any difference in the determinants will definitely lead to the differences in the health status of population groups. They may depend on the extent to which the determinants are combined together at a certain time and in a certain situation. This issue has not yet been addressed in the previous studies and thus will need to be explored in the future research.

2.2. Theoretical framework

In order to ensure the continuity and consistency in the theoretical framework we continue to use the WHO's conceptual framework on social determinant of health and the definitions of health equity and equality in the two previous reports on health equity in Vietnam published by PAHE group. Thereby, health equity is more broadly defined, closely related to the WHO's Social Determinant of Health (Fig. 1). According to Braveman, equity in health is operationally defined by the 1995–1998 WHO Initiative on Equity in Health and its Determinants as "minimizing avoidable disparities in health and its determinants including but not limited to health care - between groups of people who have different levels of underlying social advantages or privilege....", noting that (in) virtually every society in the world, differences in social advantages are reflected by socioeconomic, geographic, gender, ethnic, and age differences (Paula Braveman, Annu. Rev. Public Health 2006. 27:167–94).

FIGURE 1: Model of social determinants of health



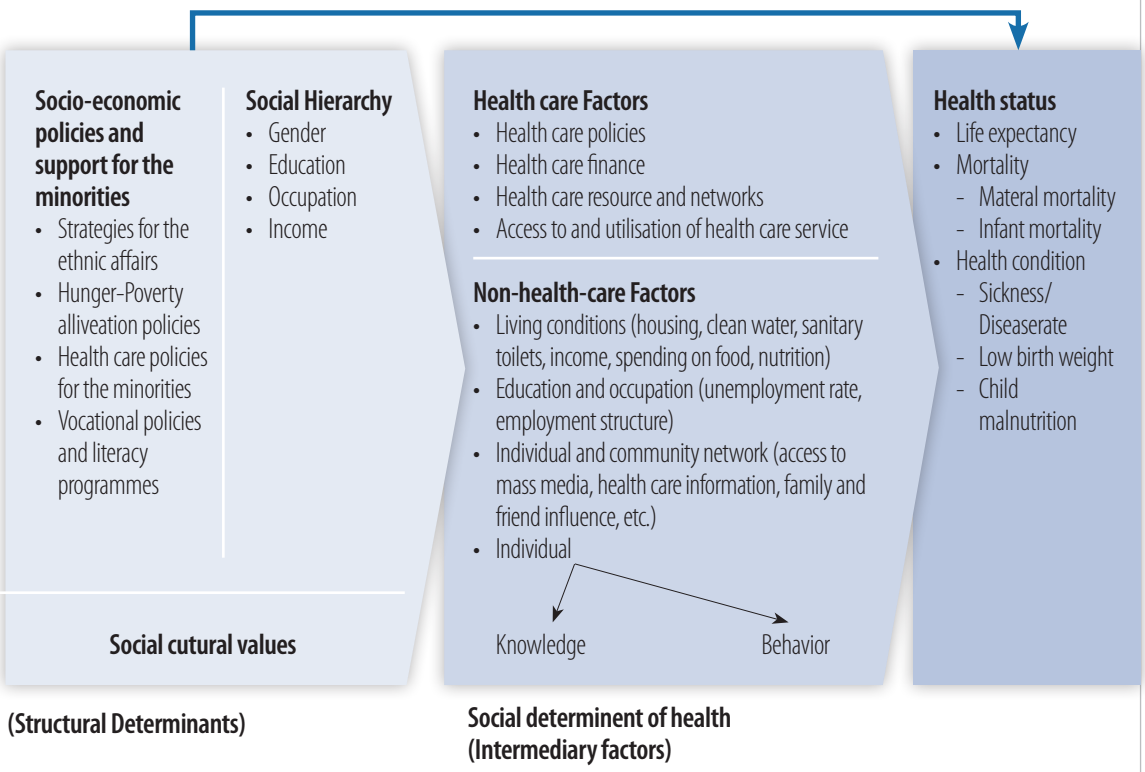
Source: WHO 2010. A conceptual framework for action on the social determinants of health

The theoretical framework of this report was developed based on the above WHO model, with necessary adaptations to meet the specific purposes of this study and the country's situation (Fig. 2). Specifically this report will focus on analysis of factors related to the health equity issues of ethnic minorities in Vietnam, especially in the two following areas:

(1) Equity in Health is presented in the theoretical model as the final outcomes reflecting the overall impacts of the "affecting factors" including the "structural determinants" and other "social determinants" of health.
(2) Differences in social determinants of health which is the intermediary factors. In the theoretical framework, these factors are regarded as intermediate results from structural determinants that directly impact the status of health equity.

Thus with the "structural determinants" component this report will merely provide an overview of the State policies on the health care and social welfares but not comprehensively address all the factors because in our view the Government of Vietnam has made significant efforts to develop a fairly adequate policy and strategic framework couples with priority programs for ensuring health equity and socio-economic advancement of the ethnic minorities. These efforts have been institutionalized through a system of legal documents issued by Government in the past years. In addition, other fundamental factors that constitute social positions like age, gender, employment and income that constitute social groups and social class will be analyzed together with the intermediary factors related to health equity.

FIGURE 2: Theoretical framework of the research
(adapted from the WHO conceptual frame work)



It should be noted that, social determinants which play the role of intermediately factors to the health disparities and equity especially those of the health care system and living conditions can have impacts on health equities in both quantitative and qualitative aspects. That means the questions are not merely of "how much?" but more importantly is "in what way and to what extent?". Also, the structural determinants and intermediary factors do not only have direct effects on population's health status but also have dynamic interactions with each other. In the health equity theoretical frameworks or models, health care always belongs to the social determinants as it is greatly influenced by socio-economic policies. The concept of "health care" used here does not simply refer to the health care provision and access, but also the distribution of health facilities and resources, finance and service quality.

2.3. Method of evaluation and comparison

This report looks at the differences in health status between the minority and majority people with the most essential indicators of inequity. It also examines how the differences of intermediary factors are related to the health status between these two groups of people.

a. Evaluating health equities

The theoretical background points out that the human health status is a final outcome that reflects the effectiveness of all the structural determinants and other social determinants. Hence, the measurement of differences in the health status should be of great importance in observing the health disparities between different groups of people for which in this case, between the ethnic minorities and the Kinh people in Vietnam. The commonly used health indices include indicators of life expectancy, morbidity patterns, health status improvement, the birth and death rates. Thus, these health indices are the overall and most crucial indicators reflecting the health differences between groups of people living in different conditions and social environments.

When analyzing health equities of the Kinh and the ethnic minority populations, this study choose the following health outcome indicators:

- Mortality: (1) Maternal Mortality Ratio (2) Infant Mortality Rate
- Health conditions and morbidity patterns: (1) the morbidity in the community; (2) Low Weight Birth; (3) Below 5 year olds malnutrition rate

These indicators were selected because they are the fundamental factors reflecting the health condition of people. They are also often used by international health and development organizations especially WHO and UNICEF to evaluate the human development progress of a country, particularly the developing countries. These indicators were also analyzed in the two previous reports of the PAHE group, for which this report is a continuous effort.

b. Evaluating equity in the determinants of health

In this study, the intermediary indicators selected for analyzing the disparities in social determinants of health will be divided into two groups: (1) Health care determinants and (2) non-health care determinants. Health care system is highly important but not the only factor among the determinants of health. It has a two-way interacts with other social factors on influencing health and health equities, while non-health-care factors like gender, occupation, education, income and living standards etc. are also often associated with accessibility, utilization and beneficiaries of health care services[20]. Specifically, the determinants in each group selected to be measured in this report include:

- ***Health care determinants:***
  - Health care policies on health (care) equities
  - Health care finance
  - Health care human resources
  - Network and capacity of health care facilities
  - Health care service access and utilization
- ***Non-health care determinants:***
  - Living condition, education, occupation
  - Food supplies
  - Diets and nutrition for mothers and children
  - Imtermediary factors at community level: custom, culture, language, information access
  - Imtermediary factors at individual level: Knowledge and behaviour

20 Closing the gap in generation, WHO, page 8

2.4. Data sources

Literature review and descriptive analysis are the methods used in this report to explore the relative differences in the determinants mentioned in the theoretical framework between the groups of Kinh and minorities. Data sources used to analyze and synthesize are from national surveys.

Below are the data from different national surveys selected to analyze each of the above mentioned determinants

Determinants	National Surveys				
	MICS 2011	VHLSS 2010	VNAS 2012	CENSUS 2009	SAVY 2010
Health outcome					
Self reported illness		x	x		
Life expectancy		x			
Maternal mortality				x	
Child mortality	x				
Under-5 child malnutrition	x				
Newborn weight	x				
Intermediary determinants of health					
Health financing		x			
Health human resources					
Access and use of health service	x	x			
Living condition, education, income and food intakes	x	x			
Intermediary determinants at community level	x				x
Intermediary determinants at individual level	x				x

In addition to those of the aforementioned national surveys the report also used the findings and data from some evaluation surveys on health and health care situation of the ethnic minorities conducted by a member organization of PAHE - the Center for Community Health Research and Development (CCRD). These are the regional evaluation surveys of health programs in the Mekong River Delta and in three mountainous provinces of Dien Bien, Yen Bai, and Dak Lak, where a large number of ethnic minorities reside. Although the data from these surveys could not be nationally representative, they characterize the ethnic minorities' health issues. Particularly, they provide a more realistic overview of the differences between

the Kinh and the minority peoples who share the same living environment, social services and infrastructure conditions. Moreover, qualitative information were also collected via direct interviews with local people and health workers about the factors determining their health and health care equities which are complementary to quantitative findings in a number of studies.

2.5. Major difficulties of the research

One of the major difficulties encountered while carrying out this study was the lack of data necessary for fully analyzing and comparing the indicators given in the theoretical framework. There was a particular shortage of data concerning health care finance and other intermediary determinants of health, such as health care service quality and life quality of health of Vietnamese people especially the minorities. Most data sets are also not updated therefore not accurately reflecting the up to date situation.

It is much more challenging to analyze the ethnic minority people's health care issues or health status because the official data sources as the Health Statistical Yearbook, routine reports from health care establishments or health related national surveys especially the National Health Survey, Vietnam Household Living Standard Survey and even the Population Census did not provide adequate data for measuring all health status indicators as well as allow aggregate and in-depth analysis for ethnic groups, but mainly by regions or ecological zones. In most cases the available data can only be used for some very basic information needs to understand whether there are any differences in health equities between the majority Kinh and the other ethnic minorities but not enough for determining the extents and trends of these differences among the majority and the minorities by time, or the differences in health status among at least major ethnic minority groups? More in-depth and sophisticated analysis as the causal and effects relationship between the determinants and several other important research questions critical for understanding of the magnitude and extent of the disparities in health status have not yet been tackled due to lack of good information system. This was also the biggest problem we confronted with this research. At local level, even in mountainous regions where majority of population are ethnic minorities, essential information about their health issues, health care affairs and social welfares including health insurance and social insurance are also not available.

Because of such reasons the research group was not able to undertake more systematic and higher quality study and analysis of health equities in the minority populations as expected. Especially our research has not yet been able to go further to the sub-group of the 53 ethnic groups in Vietnam.

2.6. Report Structure

This report is composed of two main chapters:

- **Chapter 1**
  - Introduction and foundation to the study of health equities in the ethnic minorities
  - Research questions and hypotheses
  - Report structure and research method
  - Theoretical framework and working definitions
- **Chapter 2**
  - Health equities and inequities in the ethnic minorities
  - Health care equalities and inequalities/disparities in the ethnic minorities
  - Non-health care determinants affecting the health status of the ethnic minorities

CHAPTER II

I. HEALTH EQUITIES OF THE ETHNIC MINORITIES IN VIETNAM

1.1. Health equity in Vietnam over the past decade

The Vietnam Health Sector Review Report 2013 stated that Vietnam has gained impressive achievements in realizing Millennium Development Goals (MDG) in the national health care. With such achievements, the country also has made big progress in improving health equity for its population. Concrete achievements of the MDGs health indicators include:

- **MDG1: Eradicate extreme poverty and hunger.** As for health care sector, **MDG1-Target 1C** is to halve the proportion of under-5-year-old children with underweight malnutrition in the period from 1990 to 2015. The outcomes were quite significant. The number of 5-year-old children who were malnourished reduced from 41% in 1990 to 16.2% in 2012, which was a reduction of over 60%, exceeding MDG1 by 10% compared to the goal set for 2015.
- **MDG4: Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate.** Vietnam has almost reached this goal for the under 5 years old children and the newborns[21]. In the period from 1990 to 2012, the under-5 child mortality rate was decreased from 58% to 23.2%. As such, on average each year Vietnam achieves a reduction 1.5% of under-5 mortality rate. With such a speed there is a high possibility that Vietnam will reach its MDG4 target of under-5 child mortality at 19.3%. Similarly the infant mortality rate was reduced from 44.4‰ in 1990 to15.4‰ in 2012, almost reaching the target of 14.8‰ set for 2015[22].
- **MDG5: Improve maternal health: Reduce by three quarters, between 1990 and 2015, the mortality ratio and achieve, by 2015, universal access to health.** In this respect, Vietnam is having fairly low maternal mortality ratio as compared to countries with similar level of socio-economic development. Especially the period 1990 - 2012 witnessed impressive improvement of maternal deaths: from 233/100,000 live births in 1990 to about 60/100,000 in 2012. Thereby it is quite possible the country will achieve the set target of reducing maternal death to 58/100,000 live births by 2015. However it is important to note that maternal mortality ratio in Vietnam is only an estimated data based on the health statistics and facility reports. Such estimate is usually lower than reality or than

21 GSO, Report on Demographic Dynamics Survey 1/4/2012: Major findings
22 Health Sector Review report period 2009 – 2013. Ministry of Health

the reported data from some maternal mortality studies conducted in Vietnam, due to difficulties in obtaining accurate number of maternal deaths that occur at home or on the way to the hospital especially in mountainous areas. This is one of the issues that requires greater efforts of the health sector in Vietnam to better monitor progress in improving maternal deaths in the country especially among the ethnic minority women.

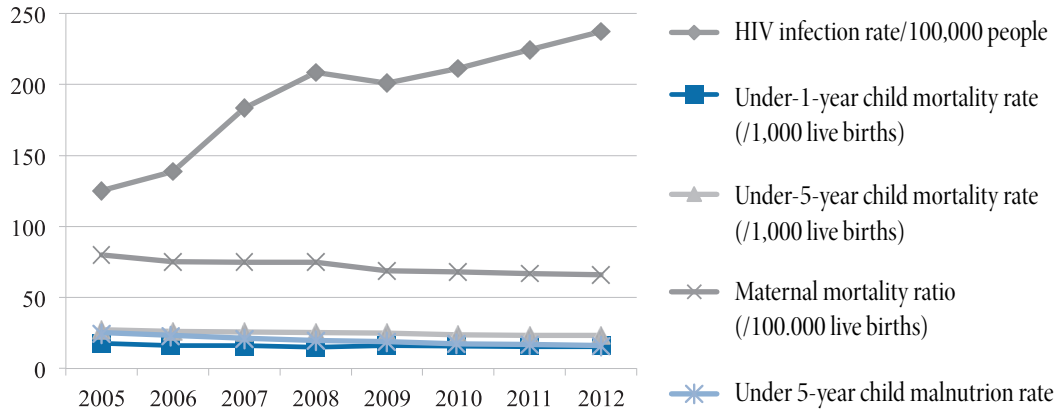
- **MDG6: Combat HIV/AIDS, malaria and other diseases. The specific targets of MGD6 are: a) to have halted by 2015 and begun to reverse the spread of HIV/AIDS; b) achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it; and c) have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.**

Vietnam has successfully controlled the HIV infection under 0.3% of the total population, the target set for 2010 by the National Strategy on HIV/AIDS Prevention and Control. However Vietnam would have difficulties cutting the number of new infections by 50%in 2015, because until 2014 the newly detected infection rate has not steadily decreased, especially in the context of more complicated epidemics due to rapid increase of sexual transmission in the recent years. Moreover, the ability of meeting the needs for HIV/AIDS treatment remain quite limited. By the end of 2014 the number of HIV positive people receiving ARV treatment only account for nearly 40%. With the decrease of financial resources, achieving the universal access to HIV/AIDS treatment for the patients and reaching the targets of HIV/AIDS prevention under the Goal number 6 would be the formidable challenges to Vietnam.[23]

The country also has mostly controlled traditional infectious diseases like malaria, tuberculosis, as well as the newly emerged dangerous epidemics like SARS, H5N1 and H1N1. Malaria prevention has achieved great successes in reducing the Malaria mortality rate. In 2012 the malaria infection rate decreased by 49% as compared to 2000, which was down to 49/100,000 people and the mortality rate declined by 68% - down to 0.01/100,000 people. With regard to the Tuberculosis control program, according to the Ministry of Health Vietnam has exceeded the global MDGs targets. However, the United Nations statistics indicated that Vietnam has not yet achieved the set target as in 2011 the Tuberculosis cases and mortality in Vietnam only decreased by 20% and 28% respectively, compared to 1990.

23 UNDP Vietnam, Factsheet about MDG6 http://www.unicef.org/vietnam/vi/overview_14585.html

CHART 1: Some MDG health indicators in the period 2005-2012



Source: Health Sector Review period 2009-2013, MOH

The above successes mostly benefited from Government's health care policies and investments over the past decade to help achieve social equality in general and health equities in particular for Vietnamese people.

Yet according to recent health statistics and especially health research and studies' findings, the majority of MDGs contains considerable differences in essential health indicators like maternal mortality ratio (MDG5), child mortality rate (MDG4) and child malnutrition rate (MDG1) between groups of people, especially the Kinh and the minority. Additionally, other Goals that also influence health status like MGD2 – achieve universal primary education, MGD3 – promote gender equality and empower women, and MGD7 – ensure environmental sustainability, were also seeing remarkable gaps between the two above groups of people in Vietnam.

In the next section, this report will analyze in detail the accomplishments as well as the existing gaps in MDGs between the groups of Kinh and minority people. It will also examine the social determinant of health that exerts an impact on these gaps. Data sources for this section were collected from secondary data from the national surveys.

1.2. Health equities of ethnic minority groups

As presented in Fig 2. - Theoretical framework of this report, the extent of health equities are first reflected through essential health indicators such as life expectancy, birth rate, mortality rate, and child nutrition. In such context, the below Table 1 presenting the essential health indicators that clearly indicates the differences in health status between the Kinh and ethnic minority peoples, particularly in the two most vulnerable sub- population groups of women and children.

TABLE 1: Fundamental health indicators of Kinh and minority groups

Indicators	*Kinh*	*Minorities*
General Health Indicators*		
Average life expectancy since birth (years)*	74.0	67.8
Total fertility rate in the last 12 months*	2.0	2.7
Crude birth rate in the last 12 months(‰)*	16.9	21.5
Maternal and Child Health Indicators**		
Maternal mortality ratio (MMR) (/100.000 live births)	39	107
Under-1-year child mortality rate(/1000 live births)	10	30
Under-5-year child mortality rate(/1000 live births)	12	39
Under-5-year child with underweight malnutrition	10.0%	22.0%
Under-5-year child with stunting malnutrition	19.6%	40.9%
Low birth weight	5.0%	6.0%

** Source: Population and Housing Census 2009 – * * Source: Survey Assessment of Women and Children's Targets 2011*

The existing differences are all bellowing to MDGs as the most fundamental elements of human development. Therefore there is still a long way for the Vietnamese minority people to reach the development goals of Vietnam in particular and of the developing countries in general. Evaluating the progress in each separate indicator will partly help improve the database of health status and factors determining health equities and health care equities in every group of people in Vietnam, especially those most vulnerable.

a. Indicator of Maternal Mortality (MDG 5)

Maternal Mortality Ratio (MMR) is an indicator indicating the level of maternal deaths, calculated by dividing total number of women deaths due to complications of pregnancy and childbirth to total number of live births for the same geographic area for a specified period of time, usually a calendar year. This is one of the targets put forward in the Vietnam Strategy for Population and Reproductive Health for 2011-2020. The MDG 5 also aims to improve maternal health and reduce maternal mortality ratio by 3/4 for the period of 1990-2015.

Because maternal mortality is known to be highly associated with social and human development factors including education, gender equality, nutrition and with the and capacity of the health care system to deal with pregnancy complications, this is one of the most essential indicators frequently used to assess the development level and progress of a country or a population group. Nevertheless, it is always difficult to accurately measure or even estimate maternal mortality in developing countries due to the financial and technical reasons. At present, in Vietnam there is no reliable maternal mortality data source, including the routine health reports or the national survey data. Hence, it is almost impossible to assess the trend of maternal deaths over the past years as accurately as for other health indicators. However, despite limitations different sources show a declining trend of maternal deaths over the past decades.

In the mountainous provinces (North East, North West and Highlands) maternal deaths often occur at home- up to 39.34% of all maternal deaths in this area. Notably in the North-West region, the percentage of women dying at home due to pregnancy and childbirth accounts for 56.4% of the total maternal mortality in the region. Now that the proportion of minority women giving birth at home is quite high, ranging from 15% to over 70% in more disadvantaged places, chances for reduction of maternal mortality indicator to the expected level within the minority group will remain a big challenge in the near future.

TABLE 2: Places where maternal mortalities occur in the mountainous areas (%)

Places of deaths	North East	North West	Highlands	Total
Home	27.0	56.4	34.8	39.3
Commune Heath center	5.4	5.1	4.4	4.9
Hospitals	27.0	15.4	34.8	26.2
Private clinics	0.0	2.6	0.0	0.8
In the fields or roads	2.7	0.0	2.2	1.6
Others	5.4	0.0	0.0	1.6

Source: Survey on Infant and Maternal Mortality in 14 mounainous provinces, MOH 2009

Even when women from mountainous regions, mainly ethnic minority women are able to arrive to a health facility, their chance of dying is still high due to the critical conditions on arrival. As shown in Table 2, in mountainous areas proportion of maternal deaths that occurred at district and provincial hospitals ranks second after the deaths at home due to the serious delay in reaching to a health facility capable of handling obstetric emergency. Reasons for delayed in seeking emergency obstetric assistance in mountainous areas are not only related to the distance, means of transports and the capacity of health facility but in many cases the traditions and knowledge of local people are the main attributes to maternal deaths.

According to the same study there is a large percentage of women living in the North-West and Highlands regions who died at a health facility had to travel more than 30km in their emergency obstetric conditions (44.4% and 43.5%, respectively); and on average more than 30% of them needed over 60 minutes waiting for a means of transport.

b. Indicator of child mortality

Together with maternal mortality, child mortality is also a leading indicator to evaluate the effectiveness of the health care system especially primary health care, child and maternal living conditions as well as essential social conditions for people. There are two main indicators which are often used to measure child mortality: the infant mortality and the under-5 child mortality. The infant mortality rate is the number of children dying before reaching one year of age, per 1,000 live births in a given year. Similarly, under-5 mortality rate is the number of children dying before reaching five year of age, per 1,000 live births in a given year. Compared to maternal mortality, child mortality indicators are easier to be collected and often measured through Population Censuses, Demography and Family Planning Survey, or Multiple Indicator Cluster Survey 2011.

Based on the above data sources, the second Vietnam Health Watch Report launched by PAHE in 2013 revealed that the differences in child mortality rates among ethnic groups and geographical areas was assessed as low (CI<0,2).

However this third Vietnam Health Watch Report finds more distinct differences in the child mortality between the two population groups as a result from deeper analyses of MICS 2011 data. The under-1 mortality rate and under-5 mortality rate of ethnic minorities are three times higher than that of Kinh/Hoa peoples while the ethnic minority population accounts for only 15% of Vietnam's population. It is more worrying that while the under-1 mortality rate and under-5 mortality rate of Kinh/Hoa children have remarkably dropped from 2006 to 2011, these rates are even slightly increased among ethnic minority people in the same period of time.

TABLE 3: Changes in child mortality rate from 2006 to 2011

	2006		2011	
	Kinh/Hoa	***Ethnic Minorities***	***Kinh/Hoa***	***Ethnic Minorities***
Infant mortality rate	20‰	27‰	10‰	30‰
Under-5 mortality rate	25‰	35‰	12‰	39‰

Source: MICS 2011-UNICEF

1.3. Nutrition status of the children (MDG 1 and 4)

Among the maternal and child health indicators, child malnutrition is often used in development reports and assessments in developing countries including Vietnam. Due to its long lasting impacts on physical and mental growth of future generations, improvement of child nutrition has been included among the MDGs (MDG1 and MDG4).

The second **Vietnam Health Watch Report 2** released in 2013 stated that the inequity with regard to child malnutrition according to ethnic minority groups was assessed to be at low level (CI<0.2), compared to the medium level of 0.2-0.39 and high level of >0.4).

The results of recent surveys revealed obvious differences in child malnutrition between the groups of Kinh and minority people. First, data from MICS 2011 showed that the number of children under-5 suffering from underweight and wasting-stunting malnutrition in the minority households are almost two times higher than the number of those in the Kinh households (Table 4).In addition, data trend showed that in general the under-5 malnutrition rate in the group of Kinh/Hoa people has dropped considerably compared to that in the minority group in the past years.

TABLE 4: Child malnutrion from 2006 to 2011

Under-5 with underweight malnutrition

	2006	2011
Kinh/Hoa	18.0%	10.0%
Ethnic Minorities	29.7%	22.0%
Total	20.2%	11.7%

Source: MICS 2011- UNICEF

Under-5 with wasting and stunting malnutrition

	2006	2011
Kinh/Hoa	32.0%	19.6%
Ethnic Minorities	52.5%	40.9%
Total	35.8%	22.7%

Source: MICS 2011- UNICEF

1.4. Newborn weight

Newborn weight is an indicator reflecting not only the mother's health and nutrition, but it also indicates the newborn's possibilities of survival, physical growth and social psychology. Low weight births, especially very low, will have lower chance of surviving in the lack of necessary health care condition and will also face more health risks later in life. The low weight babies often have weaker immune systems and run higher risk of getting diseases compared with children with normal birth weights. Thus, although newborn weight is not included in the MDG, this is a maternal and child health indicator that needs attention at country level.

Though recent statistics show almost inconsiderable discrepancies in the percentage of low weight births between the Kinh and the ethnic minorities, it must be noted that these figures are not reliable enough to reach a conclusion. This is because of the significant difference in the proportion of newborns weighed at birth in the two groups: while almost all the Kinh newborns were weighed (98.6%), this rate among ethnic minority babies is only nearly 66%. Statistically, the low proportion of newborns weighed at birth in minority groups may have caused bias to their low rate of under-weight given the reality that only babies delivered in the health facilities are weighed. And in the difficult mountainous conditions, the others who are able to give birth at health clinics may have more favorable socio-economic conditions and better prenatal care than those who cannot and as a result their babies are healthier. Accordingly there is a high possibility that a higher proportion of the underweight newborns are included in the 34.2% of the un-weighed babies and thus creating a bias in the overall data on the newborn weights in the ethnic minority groups.

TABLE 5: New born weight

Indicators	Kinh/Hoa	Ethnic Minorities
Percentage of infants weighed at birth	98.6%	65.8%
Percentage of low weight births	5%	6%

Source:MICS 2011- UNICEF

1.5. Self reported morbidity

Besides the fundamental health indicators included in the MDGs, the population morbidity is an important indicator for assessing health status of a community. Since the routine health care reports, only report the number of patient visits to public health facilities, self-reported illnesses is a potential and vital source of data to broadly estimate the morbidity in the community. In Vietnam this source of data has

been collected from some national surveys that provide health information like the National Health Survey or the Household Living Standard Survey.

According to the analysis of data the above surveys presented in the second **Vietnam Health Watch Report,** low CI (CI=0.1) indicated that there was not a large difference in the proportion of self-reported illnesses between the Kinh group and the minority group.

Results from the Household Living Standard Survey 2010 carried out by the General Statistic Office and from a household survey conducted by CCRD in 13 Mekong Delta provinces in 2010 also showed very consistent data with the above health watch report, indicating that the minority people may experience less health problems than the Kinh people, also with about 8% lower of self reported illness in the minority group. However, as the self-report of illness would depend on such subjective factors like individual ability to recognize or assess their own sickness, there are certain limitations in these data.

TABLE 6: Self reported episodes of illness in 2010

Gender	Kinh	Ethnic Minorities
Male	35.3%	26.2%
Female	40.4%	33.7%

Source:Household Living Standard Survey 2010

2. HEALTH DETERMINANTS AFFECTING HEALTH EQUITIES OF THE ETHNIC MINORITY GROUPS

2.1. Network and competency of the health care system

Overall, Vietnam has achieved equality in the distribution and coverage of health facilities especially the primary health care network among geographical areas and according to the Government's administrative system. At present up to 99% of all communes in Vietnam have a commune health center.[24]

According to Ministry of Health Circular 33/2015/TT-BYT stipulating the "Functions and responsibilities of commune health centers", commune health centre is responsible for basic health services like maternal and child health care (including normal delivery), family planning, vaccination and treatment of common illnesses. The primary health care service delivery is also strengthened with the network of

24 MOH. Health statistics year book 2011

village health workers to assist commune health centers in provision of most essential health services to people in rural and remote areas. There are also district hospitals and provincial general hospitals in all cities and provinces which are well equipped to effectively perform the medical examinations and treatment as regulated by the Ministry of Health.

While there is little evidence of the disparities concerning the distribution and availability of health care facilities between mountainous areas where more of the minority people reside with the delta where more of the Kinh people live, inequity factors do exist in the competency of the health care system including the commune health centers and district hospitals which are most used by ethnic minorities. This problem is well reflected in the following indicators:

- **The proportion of commune health centers that meet the national standards:** There is a huge gap in this indicator between the mountainous area and the delta. While percentage of commune health centers that have met the national standards in the Red River Delta, Mekong River Delta and South East regions were at 90%, 89% and 90% respectively, it is only 62% in the Highlands and Northern mountainous areas.
- **The proportion of commune health centers with doctors:** There is a relatively big difference between the delta and the mountainous areas in this indicator. For example, the proportion of doctors working in commune health centers in the Red River Delta and Mekong River Delta account to 78% and 82%, respectively, in the Northern mountainous area and Highlands it is rather low, at 64% and 67% respectively. In reality, doctors are more needed in commune health center in the mountainous areas where there is limited access to up-line health care services and a greater demand for technical support to hamlet and communal health workers.
- **Health care facilities and equipments** in the mountainous localities generally do not yet meet the technical standards. Data from the "Assessment Survey on the Program of Reducing Maternal and Infant Mortality in 14 Project Provinces" undertaken by MOH in 2010 suggests that in many commune health centers the facilities necessary for the newborn care do not meet the requirements, especially in the mountainous areas. Particularly, about 5-10% do not have equipments for prenatal care, gynecological examination, and even stethoscope or sphygmomanometer. Approximately20–30% of the commune health centers are not equipped with cutting and stitching perinea, intrauterine device insertion and removal sets and half of commune facilities do not have tools for umbilical cord care or cervical examination[25]. Ten out of 44 district hospitals (23%) do not

25 Assessment survey on the programme of reducing maternal and infant mortality in 14 project provinces 2010, MOH

have pediatricians; 61% of district hospitals do not have heaters; 40.9% do not have newborn resuscitators; 88.6% are without respirators. While same report reported that over 50% of infant deaths are due to pre-term births and nearly 20% due to neonatal asphyxiation, such serious lack of essential equipments for ensuring safe deliveries and neonatal care can be one of critical attributes to the higher number of neonatal and infant deaths.

2.2. Health care human resources

One of human resource for health indicators that is commonly used is the number of health personnel per 10.000 inhabitants in a particular country or area. Because in Vietnam it is not possible to obtain this data for each population group, we have to make comparison of health workers distribution between the mountainous areas (Northern Mountain and Highlands) with the delta areas. Data from various health statistic sources on the number of health personnel per 10.000 inhabitants indicate that there is a fairly equality between the mountainous areas and the delta with some exception in the number of auxiliary doctor specialized in obstetrics and midwives in commune health centers where these categories of health personnel are much needed for meeting the health care needs of women and children at this grassroots level, especially in mountainous areas.

However, there was a notable difference in the staff quality, especially in the expertise and competence of health workers between the areas. The "National strategy for protecting and enhancing people's health period 2011-2010 with vision to 2030" stated that: "The structure and distribution of health care human resources are witnessing an imbalance. Highly qualified health staff and experts are mainly working in the major medical centers or urban areas. The tendency of moving health care human resources from down-line to up-line hospitals in big cities is alarming, which does not ensure the required amount of health care staff for villages and hamlets in the rural and mountainous areas."

A Ministry of Health's report released in 2013 also indicated the limitation of clinical competency at communal level, even in the most essential primary health care services. According to the report data, only 17.3% of the commune health centers doctors and auxiliary doctors can correctly administer first aid in emergency cases; 17% of the interviewed doctors and auxiliary doctors at this level know all dangerous symptoms in pregnancy; 60% of commune health staff had knowledge of neonatal care; and only 54% of the commune doctors made correct diagnose and treatment of dehydration caused by diarrhea[26].

26 Health Sector Review report 2013, page 18

The weak competency of health staff in mountainous areas is an important factor constituting inequity in accessing to quality health services among different population groups, particularly when there is an association between ethnicity and use of health facilities, as presented below.

2.3. Accessibility and use of health services

The most recent viewpoint of the Ministry of Health about equity in health care services was specified as: "All people in needs of health care must receive the needed services without any discrimination and regardless of their financial affordability"[27].In this regard, existing survey data show evidence of inequality between the Kinh and ethnic minority peoples in terms of their access to, and utilization of health care services including disease diagnosis and treatment, maternal and child health care.

a. The utilisation of health care services

The utilization of health care services is resulted from interaction between healthcare service providers and their users. The indicators on use of health services help better understanding of both "the coverage and extent" of health care services among a particular population group. The fore analyses of equity in health care utilization can be used to evaluate the effectiveness of health policies on different population groups.

Following the second Vietnam Health Watch Report, which indicated that the Kinh people have higher utilization of health care services than the ethnic minorities, this report will go further by considering the differences in types of health facilities that minority and Kinh peoples received their medical services.

The present evidence reveals significant difference between the two groups in the types of health facilities they have used. Majority of the ethnic minorities use communal health centers and district hospitals, whereas the proportion of Kinh people using provincial and central health facilities is much larger. As such, Kinh people have much better access to the health care facilities that are better equipped and have a higher technical competence. This is one of the determinants of mortality and morbidity.

27 Health Sector Review report 2013, page 67

TABLE 7: Types of health care facilities used by population groups

Types of health care facilities	Kinh	Ethnic Minorities
Commune health centers	20.3%	50.7%
District hospitals	21.6%	23.8%
Private health facilities	23.1%	10.9%
Provincial hospitals	17.2%	7.5%
Central hospitals	5.4%	0.8%

Source: Household living standard survey 2010-GSO

Opinions of health managers in the poorest mountainous areas were consistent with the qualitative data selected from various national surveys with regard to the difference in access to, and utilization of quality health care services. Kinh people often get access to higher quality services at provincial hospitals or above while the ethnic minorities tend to come to district or communal health care services due to their limited knowledge and financial affordability.

> *Kinh people would know that they need to go to consult higher level health care services. On the other hand, the ethnic minority people would think to go to the local health care establishments is already a good option. District and communal health care centers are not as well equipped and skilled as provincial hospitals.*
>
> (Interview with Director of Dien Bien Dong district health center-Dien Bien)

In some delta areas where some ethnic minorities are living, although there still exist the disparity with the Kinh in the access and use of high level medical facilities such as provincial and central hospitals, the ethnic minorities are quite equal in the utilization of essential health care services, as reported by an assessment survey conducted in 13 Mekong Delta provinces by CCRD in 2011 (Table 8).

TABLE 8: Household utilization of health care services in the last 12 months among the Kinh and the ethnic minorities

	Kinh	Ethnic minorities
Medical examination (excluding Maxillofacial examination)	4.6	4.7
Regular health check-up	0.1	0.1
Vaccination	0.1	0.2
Treatment (excluding Maxillofacial treatment)	2.3	4.0
Tests	0.3	0.2
X-Ray/Ultrasonic	0.2	0.2
Buying prescribed medicine	1.0	0.8
Acupuncture/Physiotherapy	0.1	0.0

Source: Household Survey - the Mekong Regional Health Service project, CCRD 2012

b. Prenatal health care

The prenatal stage is vital for every pregnant woman to receive prenatal care services and knowledge beneficial for the mothers and their babies. The association between quality of prenatal care given to a mother throughout her pregnancy with the safe birth giving and with the child's future health has made prenatal health care has attracted more and more attention to pregnancy care. Therefore, ensuring that every woman receives the right standard health care during her pregnancy is always the first and foremost criterion to assess the maternal health care. The Ministry of Health's criteria required that pregnant women in Vietnam need to receive from four to five prenatal health checks during pregnancy.

Although in overall the proportion of Vietnamese women receiving prenatal care is quite high with nearly 94% received at least one check during their last pregnancy, there is a striking discrepancy between the Kinh and ethnic minority women in the percentage of women receiving fetal examination in general and according to the Ministry of Health's criteria in particular (Table 9).

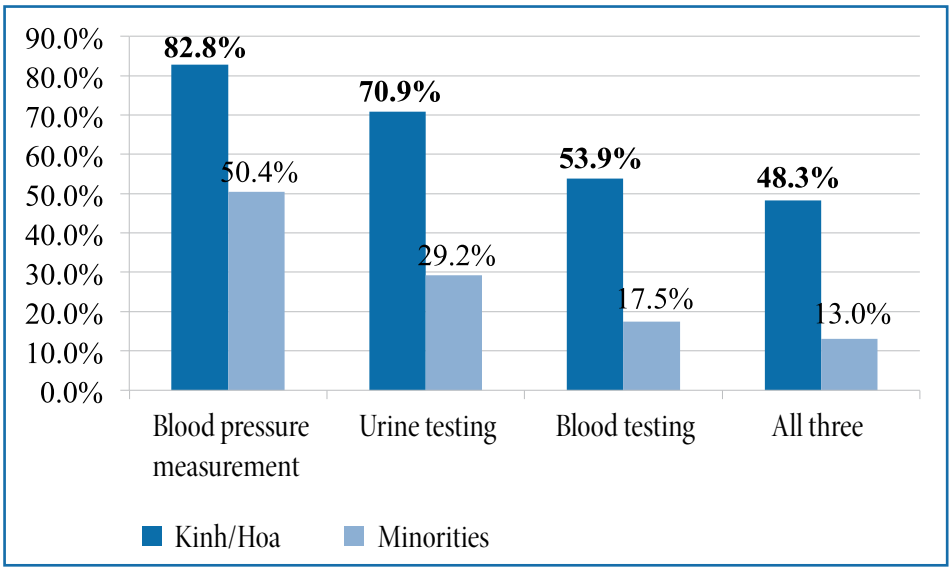
TABLE 9: Kinh and ethnic minority women receiving pregnancy examination

Frequency of fetal examination	Kinh	Ethnic Minorities
Never	1.6%	24.9%
4 times and more	69.0%	28.3%

Source: MICS 2011-UNICEF

Moreover, the quality of pregnancy care is generally not very high as not many women received the full standard package and there are wide variations among elements of services provided. The MICS 2011 also indicates that the Kinh/Hoa women who received essential prenatal health services including blood pressure measurement, urine testing, and blood testing is 3.5 times higher than that of the ethnic minority women (48.3% and 13% respectively). The wide disparities are also demonstrated across service categories (Chart 2).

CHART 2: Disparities in contents of pregnancy checks between the Kinh and ethnic minorities women



Source: MICS 2011- UNICEF

In-depth interviews with ethnic women who have experienced birth giving revealed the fact that even though these women received prenatal examinations, still they have little understanding about their pregnancy status, especially the danger signs and how to care and prevent obstetric complications.

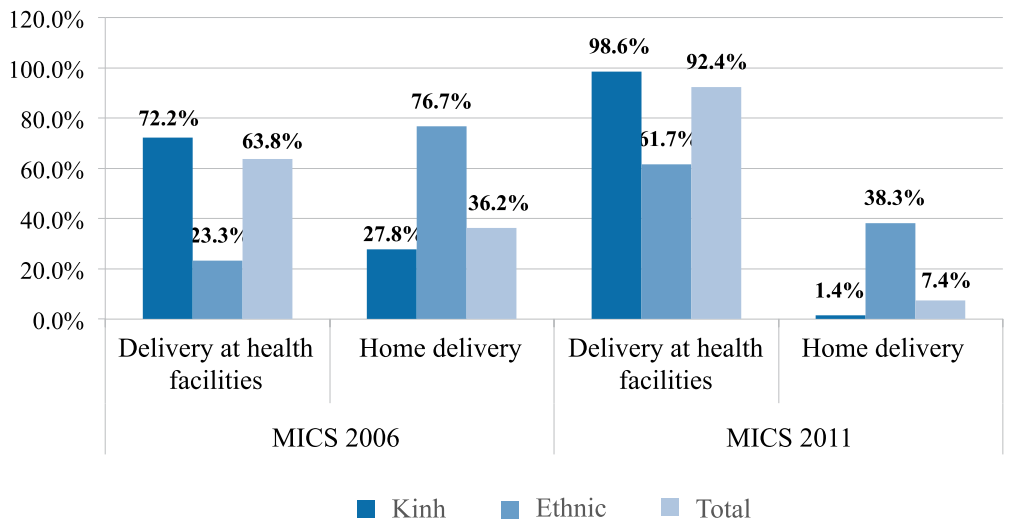
c. Safe birthgiving

Besides the prenatal check up and pregnancy care, birth giving at competent health facilities will greatly reduce the risks of dying among mothers and newborns due to obstetrics complications. In the Vietnamese situation, the leading cause of maternal deaths is post-natal hemorrhage, and of newborn deaths is premature and

suffocation, so the capacity of health staff and facilities to provide timely and correct obstetrics and newborn emergency care is the prerequisites factor for reducing maternal and infant mortality rate especially in the difficult communication and transportation of mountainous areas.

Although Vietnam has achieved a very high proportion of women delivering in health facilities, up to 92.4% (MICS 2011) and made great improvements in halving the percentage of ethnic minority women delivering at home from 2006 to 2011, institutional delivery remain one of the indicators that shows biggest difference between the Kinh and ethnic minority groups. At present in Vietnam nearly 40% of ethnic minority women still deliver at home while this figure is just 1.4% in Kinh women.

CHART 3: Place of deliveries among ethnic minorities and Kinh women



Source: MICS 2011

d. Medical care for under-5 children

Equity in accessing essential child health care services like vaccination and vitamin A supplement is an effective way to accelerate health-related targets under MDGs 1, 4, 5 and 6.

The second **Vietnam Health Watch Report** indicated that the difference in the coverage of the child health care services mainly occur in the vulnerable groups of ethnic minority children or rural children. The data in MICS 2011 showed that in general ethnic minority children had lower access to vaccination than Kinh children in every compulsory vaccination and vitamin A supplement category.

In more accessible areas, almost all residents are well aware of vaccination and vitamin A supplements thank to the wide spread community education, local societies, mass media and even local newspapers. The network of village and hamlet health workers almost everywhere makes a useful contribution to the widespread coverage of vaccination and vitamin A supplements. However, as presented in Table 10 (below), certain minority groups still have not been fully immunized due to difficulty of access, and there is a need to have special strategies that target ethnic minority communities. MICS 2010 in Vietnam concluded that in spite of the great improvements made in immunization, there existed remarkable inequities in the on-schedule immunization at certain age. Differences in income, peoples, and education of parents as well as in the easy access to the CHC are the main causes of the inequities identified in vaccination.[28]

TABLE10: Vaccination and Vitamin A supplement for children

	MICS 2006			MICS 2011		
	Kinh/Hoa	*Minorties*	*Total*	*Kinh/Hoa*	*Minorities*	*Total*
Tuberculosis vaccination	95.8%	88.2%	94.4%	97.7%	82.5%	95.5%
Polio vaccination (3 times)	80.7%	48.3%	74.8%	71.6%	52.8%	68.7%
Diphtheria, pertussis and tetanus vaccination (3 times)	82.9%	56.1%	78.0%	78.2%	51.2%	74.3%
Measles vaccination	90.0%	70.5%	86.5%	93.9%	82.4%	92.2%
Vitamin A supplement	54.7%	45.6%	53.1%	79.4%	70.2%	78.2%

Source: MICS 2011-UNICEF

2.4. Health financing

Health finance is extremely crucial for every health care system as it directly impacts the health care service provision, access and utilization. In order to assess equities in the health care system components, the first one to be assessed is the health care financing. Financial resources in Vietnam include:[29]

- State budget
- Health insurance
- Fees paid by households for receiving health care services
- Foreign funding and other private financial resources

28 MICS 2010

29 Health care general report 2013, p. 106

This report focuses on analyzing the financial resources that are related to health equities in groups of people and to public health care. The relevant resources are the State budget, health insurance and fees paid by households. The analysis showed noticeable inequities in all resources of health care finance between the groups of Kinh and ethnic minority peoples.

a. State budget

According to the estimated national budget of the Ministry of Finance in 2012, the proportion of State budget for health care was 8.28% of total State budget[30]. According to the statistics of the National Health Account 2010, the State budget for health care made up 26% of the whole society's expenditure on health care[31]. Despite this, the State budget did not meet the demand for sufficient development of the health care system. In addition, gaps remained for financial potential between localities and lines.

There is also a significant inequity in the current way the State budget is allocated for health care between Kinh and minority peoples; that is, determined by quantity rather than quality or outcomes of health care services. State budget for health care is mainly allotted with the number of beds, people or health workers taken into consideration but not other factors such as ethnic status, or geographic inaccessibility in mountainous areas[32]. As such, though there are not yet official statistics, it can be inferred that the budget for health care centers in these areas where the population is mainly the ethnic minorities is small since there are fewer residents, health care centers and workers than in the delta where most of the population are Kinh people.

b. Health insurance

In its 5 year plan (2011-2015) for health care, Vietnam aimed to have 76% of its population with health insurance by 2014 and 80% by 2015. At present, health insurance for the poor and ethnic minorities is provided for free using the state budget, while health insurance can be purchased voluntarily by other people.

First of all, if the distribution of health insurance among people is taken into account, at present there is equity between Kinh and ethnic minority people. The proportion of the minorities with health insurance is even higher than that of the Kinh.According to VHLSS 2010, the proportion of the minorities with health insurance and free health care cards is 84.4% while that of the Kinh is 60%. This shows how the State and international organizations care for poor and ethnic minority households.

30 Health care general report 2013, p. 21

31 Health care general report 2013, p. 130

32 Strategy for all citizens' health care 2011 – 2020, vision 2030

TABLE 11: Use of health insurance among the Kinh and ethnic minority populations

	Kinh		Minorities	
	2008	2010	2008	2010
Using health insurance for outpatient treatment	52.4%	66.0%	75.9%	81.1%
Frequency of using health insurance for outpatient treatment (times)	1.62	-	1.62	-
Using health insurance for inpatient treatment	76.0%	79.2%	90.0%	80.8%
Frequency of using health insurance for inpatient treatment (times)	0.98	-	1.04	-

Source: Mekong Delta Household Survey, CCRD 2010

While there are equities in distributing and utilizing health care insurance between the Kinh and the ethnic minority people, the results of the Mekong Delta Household Survey 2010 revealed another aspect of the inequities in using and paying the health insurance of the ethnic minorities. Despite having health insurance, they still have more limited access to the up-line health care services than Kinh people.

TABLE 12: Percentage of Kinh and minority people using health insurance in different health care facilities

Health care establishments	Kinh	Minorities
Health care centers	48.9%	65.3%
Regional polyclinics	3.5%	1.6%
District hospitals	40.5%	32.2%
Provincial hospitals	17.8%	10.6%
Ho Chi Minh city	4.2%	1.2%
Private clinics	0.9%	0.8%

Source: Vietnam Household Living Standards Survey 2010

On the other hand, a more in-depth study of health insurance in 13 Mekong Delta provinces showed that the average health insurance payments for ethnic minority inpatients were higher than for Kinh inpatients.

TABLE 13: Health care cost paid by inpatients (Unit: 1,000 VND)

	Average cost of hospitalization		% paid by health insurance		% paid by household	
	Kinh	*Minorities*	*Kinh*	*Minorities*	*Kinh*	*Minorities*
In-patients with health insurance	3,817	4,384	37.3%	44.1%	62.6%	53.7%
Inpatient without health insurance	4,596	3,740	0.0%	0.0%	98.6%	100.0%

Source: Mekong Delta hospital survey, 2010

Therefore, the equalities in health insurance coverage do not mean the equalities in health and health care because having health insurance does not mean that ethnic minorities people can access quality health care service and have achieved good health indicators. This is one of the unproved points in the second health watch report which needs further studies and discussions.

c. Out-of-pocket expenditure on health care

The annual cost for health care is the out-of-pocket expenditure which households need to pay directly for health care services. This is also an important indicator to assess the equity in the whole health care system in general and the equity in health finance in particular. Although the household out-of-pocket expenditures out of the total costs for health care in Vietnam has tended to decrease in recent years, this rate is often higher than the level 30 - 40% recommended by World Health Organization[33]. However, the analysis shows differences in the out-of-pocket payment for health care services between Kinh people and ethnic minorities, including such indicators as (1) Out-of-pocket payment for health care; and (2) Catastrophic health care expenditures.

The analysis of the Vietnam Household Living Standards Survey made by the second Health Watch Report indicates that households of ethnic minorities pay more than their capacity for health care services compared with households of Kinh[34]. However, the analysis of out-of-pocket expenditures on health care made by the report as well as the definition of the World Health Organization did not take into account the indirect costs such as transportation and food whereas a lot of studies showed that these indirect costs also account for a large amount of household health care expenses, especially poor and near poor households.

In this report out-of-pocket expenditures for health care services also include the indirect costs in order to give a more realistic pictures of out-of-pocket payments.

33 Health sector general report, page 106

34 Vietnam health care system: Toward the targets and equity - PAHE (Vietnam Health Watch Report 2)

Therefore, the out-of-pocket expenditures for medical services and health care is defined as the sum of all direct payments made by the households for all the medical and health care services related expenses, in addition to the payments from health insurance. Such payments include both direct costs (medical examination fee, medicine, and hospital expense) and indirect costs (transportation, food, and other expenses). This report also continue the analysis of households payment capacity and catastrophic payments for health care services. The households payment capacity is calculated by the proportion of health care expenditures out of all the non-food household expenditures. The catastrophic expenditure happens when the out-of-pocket payments for medical services of a household is equal or higher than 40% the payment capacity of that household.

By using these definitions, the analysis made by this report still shows similar results with the second Heath Watch Report. The out-of-pocket care per capita expenditures for health in a year of the Kinh people is higher than ethnic minorities. However, this difference varies according to the geographic areas and the poverty situation of households. Similarly, the catastrophic payments of the Kinh households has increased from 2008 through 2010 and remains quite high as compared to that of the ethnic minorities.

TABLE 14: Household payment for health care out of non-food expenditures
(Unit: Thousand Dong)

	2008	2010
Percentage of expenditure on health care in the total non-food expenditure of households		
Kinh	23.8%	37.5%
Ethnic minorities	18.1%	18.3%

Source: Vietnam Household Living Standards Survey 2010

Still, it is noteworthy that half of the costs that the ensured ethnic minority patients need to pay for are the not covered by the health insurance. Therefore, getting treatment in the hospital is still a financial burden to the citizens in general and ethnic minorities in particular. That is also one of the main factors limiting the ability to use medical services of the poor in the necessary situations. In the situation of a Nung woman, her second child always need to go to hospital and she still has to pay a lot for indirect cost which the medical insurance does not pay.

Q: How much does it cost to take your child to hospital?
A: Millions.
Q: Do you have medical insurance?
A: Yes, I do. However, the hospital fee does not cost much. It is only few dozen to one hundred, but food costs more. Our house is so far that I cannot bring food and I have to eat in food courts.

(Nung woman, 27 years old, Yen Thang commune, Luc Yen, Yen Bai)

3. SOCIO-ECONOMIC INTERMEDIARY FACTORS AFFECTING HEALTH EQUITIES

Living conditions and social environment are ones of the most important intermediary factors which affects health equities and inequities. The WHO report "Closing the Gap in a Generation" released in2011examined the causes of health inequities and recommended that the primary goal for enhancing health equities is to focus on improving women' health, the early development of children as well as social protection and people's daily living and working conditions.[35,36.]

To provide more accurate evaluation findings and evidence, this report only assess the differences between ethnic minorities and Kinh group regarding the most fundamental living standards such as clean water, housing condition, hygienic sanitation facility, income, food expenditures, child nutrition, working condition and nutrition for pregnant women. Besides, education especially the literacy rate, gender equality, access to mass media, and some others are also factors determining health equities and inequities between Kinh people and the ethnic minorities.

3.1. Fundamental living conditions and social environment

Major studies at national or regional level consistently show that Kinh people have better socio-economic status than ethnic minorities. Specifically, not only disparities exist in essential living conditions such as clean water, housing, electricity, sanitation facilities, the Kinh people also enjoy higher living standards and facilities as compared to the ethnic minorities including food supplies, food intakes, means of transport, communication and mass media channels.

35 Closing the gap in a generation, WHO, 2011
36 Viet Nam Health Watch Report No. 1, page 11

TABLE 15: Using clean water, electricity and other living conditions

Using water and electricity	**VHLSS – 2010**	
	Kinh	***Ethnic minorities***
Households using clean water for cooking	54.4%	14.3%
Households using electricity	99.0%	85.1%
Housing	**Housing and Population Census– 2009**	
	Kinh	***Ethnic Minorities***
Good housing	49.5%	27.6%
Poor housing	6.3%	14.8%
Hygienic latrines		
Septic/semi-septic indoors	37.1%	14.4%
Septic/semi-septic outdoors	20.5%	12.2%
None	5.7%	21.8%
Household equipment		
Television	95.0%	86.6%
Mopeds/Motorcycles	78.4%	77.7%
Landline	50.4%	42.6%
Refrigerator	36.1%	19.6%
Radio/Cassette player	25.2%	18.3%
Computer	15.6%	7.1%

In ecological analysis, Kinh and ethnic minorities in each region have different levels of access to clean water. Findings from the final evaluation of the Mekong Regional Health Support Project as well as the Vietnam Household Living Standards Survey (VHLSS) consistently show that the ethnic minority communities in the Mekong River Delta have almost equal proportion of households using clean water for cooking with the Kinh. The limited access and use of clean water for cooking is prevailing in all the mountainous regions - Northeast, Northwest, Central Highlands, and the coastal areas - North Central, South Central, where greater number of residents is ethnic minorities. In housing ownership, about half of Kinh people possess good housing, only 6% of them own inadequate housings while this rate among ethnic minorities is about 28% and 15%, respectively.

Regarding factors impacting the disparity in maternal and child mortality rates, the qualitative data collected through interviews of health workers in some mountainous areas where mostly ethnic minorities are living have shown the big differences between Kinh and ethnic minority groups in the causes of child mortality. The mortality rate of ethnic minority children are much higher than that of Kinh children mainly due to common infections which are related to socio-economic and intellectual underdeveloped conditions such as acute diarrhea and acute respiratory diseases.

3.2. Care and nutrition for pregnant women and mothers

Beside the above-mentioned factors in medical care such as prenatal care, midwifery, and postnatal care, etc., nutritional and caring regimens for pregnant women and postpartum mothers are the main factors, which affect maternal health as well as the early development of children, especially mortality and malnutrition of children under 5 years old.

In recent years, thanks to the progresses in gender equality in Vietnam, pregnant women and the women with small kids have enjoyed better regimens of health care and nutrition. However, ethnic minority women have still had many disadvantages, which were mainly caused by backward practices, habits, and poverty. First, ethnic minority women while pregnant or raising small kids do not have appropriate nutrition regimens because they are not only dependent on economic conditions but also dominated by the customs and the typical traditions of each ethnic group, region, or family:

Q: You have three meals a day but with rice and vegetables only?
A: Yes.

(In-depth interview with a H'Mong mother with small children, Dien Bien Dong District, Dien Bien Province)

Q: Does your ethnic tradition commands any abstinence for postpartum women?
A: Of course.
Q: What do you abstain?
A: Vegetables
Q: You can eat rice, meats but cannot eat vegetable, huh?
A: Yes.

(In-depth interview with a Dao pregnant woman, Ea Sup District, Dak Lak Province)

Q: How often do you have a bath per day?
A: Four to five times per day
Q: Is that after giving birth
……
Q: How long does that routine last in fact?
A: 1 month
Q: Is that 5 times per day on any given day?
A: Well, every day is the same. Having a bath in the morning, at noon, in the afternoon, and at night

Despite having significant and long-term influences on children's health, the working conditions during pregnancy and after giving birth of ethnic minority women have not really been improved.

Q: Do you know working like that will cause adverse effects on the baby?
A: I know. With the second kid, I did not stop working during the pregnant time until I gave birth. With this kid, I started working again, harvesting rice 4 days after delivery.
Q: Did you go to work 4 days after giving birth, did not you?
A: Yeah, I went to work 4 days after delivery because my family is too miserable. We have to work hard to make a living.
Q: How about the second kid?
A: I went to trim corns after 11 days of giving birth to the second child.
(A mother with small kids in Yang Ye village, Krong Bong District, Dak Lak Province)

Despite of impressive achievements in gender equality, there still exist the visible inequality in the nutrition and labor regimen among Vietnamese women and children living in different regions. Results from a baseline survey covering six poor mountainous districts conducted in 2010 by Center for Community Health Research and Development (CCRD) a member organization of PAHE - has provided clear evidence that the Kinh women enjoyed better care and food during pregnancy than the ethnic minority women living in the same areas.

TABLE 16: Labor and food intakes of pregnant women by ethnic group

Labour and nutrition regimes	Kinh women	Ethnic women
Working as usual	26.8%	47.6%
Avoid heavy works	63.8%	42.2%
Take usual meals	37.1%	53.0%
Take more food than usual	56.2%	44.9%

Source: Baseline survey of maternal and child health situation in 3 provinces, CCRD 2010

3.3. Care and nutrition for children at individual and household level

WHO Committee on social determinants of health has affirmed that the early development of children "has greatest potential for reducing health inequities in a generation"[37]. Besides, nutritional and dietary qualities for children quite honestly reflect living standards and social conditions among population groups.

Malnutrition in Vietnam is the result of many combined causes. The direct causes include the lack of nutritious foods, low birth weight and common childhood diseases such as helminthes and parasitic infections. It is also caused by poor living conditions and sanitation, limited access to clean water, lack of family food security, inadequate access to health services in some remote areas, and the restriction on nurturing and taking care of mothers and under one year old or small children.

Breastfeeding in the first years of life has been confirmed to be very essential to children's health. With regards to childcare, WHO and UNICEF encourage infants to be breastfed within 1 hour of birth, fully breastfed in the first six months and breastfed continuously up to 2 years old[38]. Recent statistics have shown the differences in breastfeeding between Kinh and ethnic minority people as well as between delta and mountainous areas. However, according to MICS investigation results in 2011, the differences demonstrated the superiority of ethnic minority children. The proportion of ethnic minority children that are breastfed within 1 hour and 1 day after birth were significantly higher than Kinh children were, and the proportion was the highest in the midlands and northern mountainous areas compared to other regions. Also from this investigation, children in ethnic minority households were exclusively breastfed for three times as long as Kinh children.

Apart from breastfeeding, diets for 6-month-up children have shown the clear inequity between children in ethnic minority households and in Kinh households, both in the quantity and quality of meals. In terms of meal quantity, according to MICS 2011, in the range of 6 and 23 months, the proportion of Kinh children who have minimum meals is much higher than those in the other ethnic groups. In terms of the quality, there is also a significant difference between ethnic minority children in the mountainous areas and Kinh ones in the delta. The 2009-2010 nutrition survey shows the disparity of food rations between children from 2 to 5 in the mountainous and delta areas. Animal protein which is essential to children's growth and development is used at low levels, especially in Northern Mountain and Central Highland areas. Calcium, a substance that helps to form strong bones and teeth, and

37 Closing the gap in generation, WHO, page 73

38 MICS 2011

is very important to early childhood development, is consumed at lower levels in the mountainous areas than delta areas and also lower than the recommendations of the Vietnam Nutritional Institute. Children from Northern Mountain and Central Highland areas[39] have the lowest average animal vitamin A in their rations.

3.4. Education and occupation

a. Education

Although state policy and investments has always prioritized education for ethnic minorities, it is undeniable that there is still an education gap between Kinh people and ethnic minorities. Results of a national survey show that in 2010, only 4% of Kinh people were illiterate while this figure in the ethnic minority group is about 20% (VHLSS 2010). Even in the young people aged 15 to 24 who has lower illiteracy rate than the general population, there is still a large gap between the Kinh people and ethnic minorities, with 1% and 9% of illiteracy, respectively (SAVY 2010).

b. Occupation

With regards to employment and occupational structure, although agriculture, forestry and fishery accounts for the biggest proportion of employment in Vietnam, analyzed data by ethnic groups also revealed that only a third (35%) of Kinh people are working in these sectors as compared to 74% in ethnic minorities. On the other hand, the results of VHLSS 2010 also showed another view of employment in Vietnam, that the unemployment rate among the Kinh people is double that of the ethnic minority people (4% and 2%).

3.5. Income and food intakes

Measuring and analyzing household living condition, income and expenditure, especially expenditure on basic needs, are important indicators which reflect the quality of life as well as changes in social inequality.

a. Income

Many studies and national surveys showed that economic growth is associated with economic disparities and social stratification. The result of VHLSS 2010 or Basic 135-II[40] shows that there is inequity in income between Kinh and ethnic minority people. Kinh people's per capita GDP is 2 times as high as that of ethnic minorities (VHLSS 2010). In addition, although great success in poverty reduction

39 General Nutrition Survey2009 – 2010, pages 88-89

40 Basic Investigation Report 135-II

has been achieved, the percentage of ethnic minorities and rural people who are out of poverty is very low. In 2008, nearly 50% of ethnic minorities live in poverty whereas the proportion in the Kinh and Hoa ethnic groups is less than 10%[41].

b. Food intake

Among the basic needs food is one of the most important, so this paper chose monthly food spending as the indicator to assess the equity between Kinh people and ethnic minorities.

According to the statistics given in Table 16 below, although the increase in expenditure on food of Kinh and ethnic minority people from 2008 to 2010 are nearly the same, the disparity between the two groups tends to go up. In 2008, the expenditure on food of the latter occupied about 70% of the former's. This proportion decreased nearly 10 percent, occupying 60%in 2010.The results show the inequity of monthly average expenditure on food: the expenditure per capita of Kinh people are 1.5 times as high as that of the minority people (VHLSS 2010).

TABLE 17: Annual expenditure on food in different ethnic groups (Unit: Thousand Dong)

Ethnic Group	2008	2010
Kinh	3,337	6,779
Ethnic minorities	2,331	4,131

Source: Vietnam Household Living Standards Survey 2010

3.6. Access to mass media and health care information

Beside health service access and utilization, the ability to access various communication channels is considered one of the most important factors that affects receiving health care and health protective information. In ethnic minority groups, this factor has always been considered a high priority one in health care programs since the limitation of knowledge and backward habits/ practices have greatly hindered ethnic minorities from accepting as well as accessing health care services.

41 http://www.unicef.org/vietnam/vi/overview.html#_ftn4

Overall, Kinh and ethnic minorities have almost witnessed the equities in accessing such means of mass media as television and radio (both central and local). It is the result of public investment as well as developmental programs supporting mountainous areas in recent years.

TABLE 18: Access to communication channels

	VNAS-2012		SAVY-2010	
	Kinh	*Minorities*	*Kinh*	*Minorities*
Televisions	96.8%	92.8%	99.8%	96.5%
Radios	30.9%	22.6%	79.2%	63.8%
Loudspeaker	46.9%	28.7%	-	-
Newspapers, Magazines	41.9%	31.6%	81.2%	66.6%
Internet	4.3%	2.9%	66.0%	25.7%
Tapes, discs	-	-	81.5%	73.5%

In reality, however, the similarity in mass media exposure rate has not shown equality of opportunity in access to information between Kinh people and other ethnic minorities. One major weakness of education and advocacy of health care for ethnic minorities through mass media is the official language used in transmissions of health care information, while national language illiteracy rate among ethnic groups still remains notably high. In addition, the content and design of communication products are incompatible with the ability, education level and living standard of the ethnic groups. Therefore, the equality in mass media access does not prove Kinh people and ethnic groups could understand and perceive the same information input, or in another word, the language barrier still creates differences of health care knowledge and action between Kinh and ethnic people. This results in the remarkable unbalance of health care knowledge between two groups.

3.7. Knowledge on health care

Although there is no proven inequality of media channel and health care information access, more detailed analysis of the surveys from female and young people groups show a varied gap of knowledge between Kinh people and ethnic minorities depended on specific issues and types of group.

a. Maternal and child health care knowledge

The differences in maternal and child health care knowledge among the Kinh and the ethnic minority women were recorded in a survey carried out by CCRD in provinces of Dien Bien, Yen Bai and Dak Lak in 2010. Specifically:

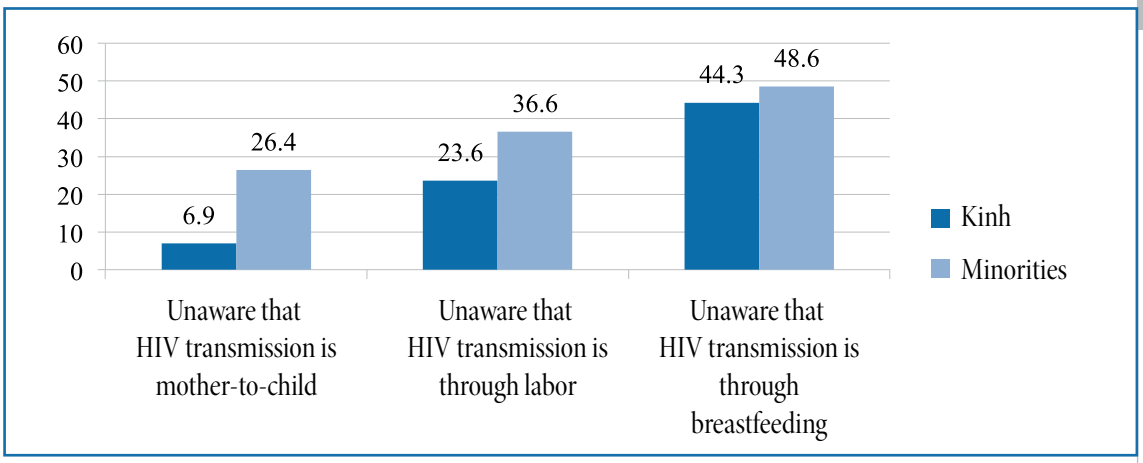
- Kinh women have more comprehensive knowledge about danger signs during pregnancy, labor or post-delivery than ethnic minority women. More than 40% of ethnic minority women could not identify dangerous signs during pregnancy compared to only 14% of Kinh women. This explains the exceptionally high maternal mortality ratio in ethnic groups is the result from the lack of crucial knowledge without which the mothers could not identify possible dangers and receive immediate medical treatment. This would endanger the mothers' life or affect their health on the long term.
- Similarly, the percentage of Kinh mothers who do not know any newborn danger was 25% while it is 42% among the ethnic minority mothers. This knowledge gap was best illustrated with the two danger signs of newborn, which are refusal to breastfeed and lethargy. Obviously ethnic minority mothers will be less able to recognize the life threatening conditions and timely seek for medical assistance for their babies, as compared to the Kinh mothers.

b. Knowledge of HIV/AIDS

Nowadays, there are a larger number of drug addicts who belong to ethnic groups, especially in the North region areas such as Dien Bien, Lao Cai, Lang Son, etc. Therefore, the HIV transmission rate between husbands or partners and ethnic women is very high. The knowledge of mother-to-child transmission of HIV-positive mothers is extremely important because these mothers could prevent their children from becoming infected with HIV by preventive methods during pregnancy, labor and child raising.

Result from MICS 2011 showed that the number of ethnic women, who know 2 methods to prevent HIV transmission, which are a) having one HIV-negative partner and b) using condoms during sex, is notably lower than that of Kinh women. Although most Kinh women and a significant number of ethnic women are aware of the danger of mother-to-child transmission of HIV during pregnancy, labor and breastfeeding, many ethnic women still have not been informed about the issue. (Chart 4)

CHART 4: Knowledge of mother-to-child HIV transmission



Source: MICS 2011

It is encouraging that ethnic youth have an equal amount of knowledge of HIV prevention compared to the Kinh youth. Analysis of Survey Assessment on Vietnamese Youth (SAVY 2010) showed there are no knowledge gaps between the two mentioned groups about HIV/AIDS. It could be concluded that with better accessibility to mass media, newspapers and books, ethnic minority people could absolutely obtain the same amount of knowledge of health care like other major groups.

TABLE 19: Knowledge of HIV/AIDS transmission of adolescents and youth

Knowledge	Kinh	Ethnic
Unprotected sex	98.3%	96.3%
Mosquito or insect bites	26.3%	34.5%
Mother-to-child transmission	-	95.8%
Sharing the same eating utensils	9.4%	15.0%
Using the same needles	99.0%	97.0%
Respiration	82.9%	75.9%
Unsafe blood transfusion	97.9%	94.3%

Source: SAVY 2010

3.8. Practices on woman and child health care

Health care behavior of each individual and each society is one of the direct factors affecting the health of human beings, especially women and children. Based on the survey assessment carried out on children and women groups, the report analyzes and compares the behavior related to women and children health care

between Kinh and ethnic people group, including: 1) Early marriage; 2) Age at which women get pregnant for the first time 3) Giving birth to more than 3 children and 4) Family planning.

Firstly, a large number of ethnic people are still in favor of early/child marriage. The percentage of children marrying under the age of 15 of ethnic people is five times higher than that of Kinh people and about one quarter of ethnic women had married under the age of 18, which is twice as high as that of Kinh people.

TABLE 20: Demographic differences between Kinh and ethnic minority women

	Kinh	Minorities
Average number of children per married women aged 15-49	1.7	1.8
Average marriage age	21.8	19.1
Average age of having first child	22.6	20.3

Source: SAVY 2010

Due to early marriage, ethnic minority women get pregnant and give birth much younger than Kinh women do. The rate of ethnic minority women aged 15-19 who ever have had children or are pregnant for the first time is much higher than that of Kinh women. Similarly, the rate of ethnic minority women aged 20-24 who have children before age 18 is 4 times higher than that of Kinh women (MICS 2011).

Other than premature birth problems, multiple births or spawning are also some of the most common problems among women in ethnic communities. For example, a woman named H'no Brap in Krong Bong, Dak Lak will soon be a mother of 3 children at the age of 28, which is not uncommon in mountainous areas. In such difficult life circumstances, malnutrition, heavy labor, premature birth and spawning will all have negative impacts on the health of minority women and children.

> *Q: Does she mean she can't talk? So can you tell me her name?*
> *A: Yes, her name is H'No Brap, born in 1982. She is raising two little boys and one of them is handicapped. And now she is 5 months pregnant.*
>
> (In-depth interview with pregnant women in Yang Ye commune, Krong Bong, Dak Lak)

However, in terms of family planning, there are almost no apparent differences between ethnic minority and Kinh women in the percentage of contraception use, including modern contraceptive methods (Table 21).

TABLE 21: Percentages of married/cohabited women aged 15–49 using contraceptive methods

Ethnic groups	Not using contraceptive methods	Using modern contraceptive methods	Using any contraceptive methods
Kinh/Hoa	21.9%	59.1%	78.1%
Ethnic Minorities	24.7%	64.8%	75.3%

Source: MICS 2011

In terms of demography, the pretty high percentage of contraceptive use among ethnic minorities is not really logical to its high fertility rates in comparison with Kinh. One of the explanations for this issue can be the low quality and availability of family planning services in remote areas that cannot ensure the effectiveness and continuity for users of modern contraceptive methods. Another possible reason for the high birth rate in ethnic minority groups which has been stated by a number of studies on family planning and reproductive health in Vietnam is because the abortions rate and frequency among the ethnic minority women are always lower than the Kinh.

Qualitative information collected by the Center for Community Health Research and Development (CCRD) in the mountainous provinces of Dien Bien, Yen Bai and Dak Lak also showed one example of how maternal mortality is affected by locals' limited perception and backward practice.

> *One example of maternal death in Hang Tau, Sa Dung. The father-in-law, husband and the birth-giving woman herself rejected medical assistance. The village health workers came to help knowing that she gave birth at home. Recognizing that she was bleeding, village health worker called for help from commune health workers who gave some first aid and called for emergency assistance from the district hospital. When the district health team arrived in an ambulance, the patient still determined not to be transported to the hospital. No health staff from different levels present there could persuade the family who were persistent in their traditional belief that women had to deliver their child at home. Finally, the woman died while there was a possibility of saving her and the baby.*
>
> (In-depth Interview with director of Dien Bien Dong district, Dien Bien)

Some in-depth interviews with local health workers point out the relation between health care service access and limited awareness of ethnic minority people as well as the propagation and campaigning role of health workers.

> *Child mortality is caused by the lack of knowledge of local people. There was a case coming to the clinic for treatment of their child. After examining, the medical staff recommended a referral as the baby was having severe pneumonia and had to be taken to hospital. The baby's father agreed. However, coming back home, he changed his mind, decided to rely on praying and kept the baby at home for one more day instead of going to hospital. Eventually, the baby died on the way to hospital.*
>
> (In-depth interview with health staff in Keo Lom, Dien Bien Dong district, Dien Bien)

CONCLUSION

The right to health care and protection is one of the most basic human rights and always affected by economic, social, environmental and political factors. In Vietnam, the issue of ensuring equality of social conditions, health care, employment and economic development for ethnic minorities has always been the focus of political documents and laws of the State of Vietnam since the last few decades.

In the field of healthcare, Vietnam has significantly narrowed the gap between Kinh and ethnic minority groups in some basic health indicators such as child malnutrition, child mortality, low birth weight, maternal mortality and the incidence of common diseases. However, data from various national statistical sources and from specific studies show that inequality is still quite evident in most of these indexes, especially the indicators of maternal and child health.

Applying the WHO *"Social determinants of health in heath equity"* model to analyze the extent of disparities in each social factor and their relationship to the health status of ethnic minority group in Vietnam, this study has brought forward some key findings below:

1. Health system factors

In terms of quantitative: There are evidences to assert that in some elements the health care system of Vietnam has achieved equality between ethnic minorities

and the Kinh group. Such equality is reflected in some of fundamental quantitative indicators: the equal distribution of essential health facilities and basic health services; the coverage and use of health insurance; the facility based allocation of State health budget and population based distribution of health personnel. For a long time, these factors have significantly improved the medical care and thereby improving the health status of ethnic minorities and narrowing inequalities with the Kinh.

In terms of qualitative: Available data indicate that ethnic minorities are receiving and using health services of poorer quality than the Kinh people. This difference is reflected in very basic criteria of the quality of the health care system that ethnic minority are utilizing such as medical staff quality; accessibility and utilization of up line health care establishments; access to higher levels and/or high-tech medical services; or budget allocation appropriate for the geographic characteristics of mountainous areas. In our view, once the quantitative aspects of health services have been equalized, then improving the quality of the health care service system for ethnic minorities will be one of the key factors that helps eliminate inequalities in their health status.

However, the theoretical framework for health equity also indicates that human health depends on not only the health care system but also on many other social factors, to the extent that a good health care system can hardly improve the health status of the population with social and living conditions far below the general level of the other groups.

2. Social factors

In contrary to the positive factors related to the health care system, the other factors outside the health care system clearly reflect differences between Kinh and ethnic minorities. Inequality and inequity between ethnic minorities and the Kinh are evident in most indicators of socio-economic and basic living conditions, such as: access to and use of electricity and clean water, education, jobs, food consumption, information accessibility and receipt, etc. Moreover, different elements of culture, habits, language, and social customs of ethnic minorities have been and will always have a decisive role in the inequality between these population groups.

Therefore, only when not only the quality of health services but also the socio-economic conditions and basic living conditions of ethnic minorities are all improved equal to the average levels of the Kinh people, then the health inequities of ethnic minority groups can be removed.

3. Policy and Strategic issues

At present, there is a lack of effective methodology and accurate indicators for measuring and assessing the levels of equity in health care among different population groups in general and between the Kinh and the ethnic minorities in Vietnam in particular. Also the limitation and fragmentation of data base in all

the areas related to the ethnic minorities in Vietnam is a major challenge to good policy making and strategic planning at all levels. In addition, there is a need for more thematic research and studies on underlying factors of health disparities and equity using the most up-to-date definitions and theoretical frameworks in order to provide accurate information for prioritization of interventions and investments in development programs for ethnic minorities. This gap should be fully addressed in the near future and the responsible Government agencies especially the Ministry of Health will have to develop a system of measurable indicators as well as a specific strategy for monitoring country's progress in achieving equity in health care for Vietnamese people. It is recommendable that indicators and strategy to be developed will less focus on quantitative measurements and on the health care system but more on improvement of health care quality as well as the effects of socio-economic factors that directly affect people's health status. In addition, there is also a need for conducting researches and studies that focus on examining the association between determinants of health equity including health and non-health factors in order to assist policy makers and program managers to clearly identify priority areas, issues as well as the levels of investments for various social equity objectives and targets.

With regard to the health system there is a critical need for reassessing the existing health system and its development strategy as well as the methods of resource allocation for designing a more effective and appropriate health system development plan in the near future. It is essential that such strategy and plan will take due account of differences between regions and population groups and not heavily based on the State's administrative units which tend to equal the resources rather than being able to ensure equity.

Although there remain certain issues to be addressed, Vietnam has had a good policy system for ensuring essential social security for ethnic minorities. In reality, by all accounts the immediate improvement of socio-economic conditions of ethnic minorities may not very much be dependent on new policy formulation or policy modification, but more on the profound understanding and true commitment of leaders of each sector and locality in effective implementation of Government policies and strategies for the development of ethnic minorities in Vietnam. **This commitment is not necessarily a matter of financial resources but should be primarily demonstrated in the leadership style and governance of the State, especially in the healthcare and in other social development programs. Perhaps it may start with the simplest but critical issues such as having a good information and reliable database system of essential social services and welfare for the ethnic minorities like social security and health care, the number of people who have access to clean water, food intakes etc., or the measures for taking better account of the voice and benefits of ethnic minority people in the formulation process of development policies and programs; or in planning and implementing major civil works where minorities are living.**

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