Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

Ministry of Health
Department of Planning and Finance
Simeuang Road, Vientiane Capital
Telephone: 856 21 214059
Email: hsipmoh@etllao.com

Ethnic Group Development Plan

For
Health Governance and Nutrition Development Project

Based on
Health Services Improvement Project
Ethnic Group Development Plan

March 2015

Ethnic Group Development Plan

1. Overview

1. The Ethnic Group Development Plan (EGDP) provides a strategy and a programmatic approach to enhance the inclusion of different ethnic groups in the Health Services Improvement Project. It furthermore aims to ensure compliance with policies of the Lao People's Democratic Republic concerning ethnic groups, as well as the World Bank's Operational Directive 4.20 on Indigenous Peoples.[1]

[1] The Bank usually applies the policy to ethnic minorities belonging to the Austro-Asiatic (e.g. Mon-Khmer ethnic groups), Hmong-Mien, and Sino-Tibetan (also referred to as 'Chine-Tibet') ethno-linguistic groups (there are no Sino-Tibetan ethnic minorities in the project areas). The policy does not apply to Lao-Tai ethnic groups which make up the majority and dominant population in Laos. In the Lao PDR the term 'indigenous' is not used by the Government, rather 'ethnic minorities' is the preferred expression. But in fact, the Government considers that all citizens belong to 'ethnic groups' (*xon phau*), including the ethnic Lao who comprise approximately 30% of the population. (ADB. 2001. Participatory Poverty Assessment. Manila: Asian Development Bank. ; Chamberlain, James R., and Phomsombath, Panh. 2000. *Policy Study on Ethnic Minority Issues in Rural Deveopment [Lao PDR]*. Geneva: International Labor Organization (ILO).)

2. By most standards, the Lao People's Democratic Republic (Lao PDR) is one of the poorest and least developed countries in East Asia. Poverty, especially rural poverty is found primarily among upland ethnic minorities (NSC and ADB, 2001), and is of major concern. Health constitutes a key social sector for the socioeconomic development of the country. The proposed Project has been designed as a program of investments and institutional capacity building needed to improve access to health care and to contribute towards reduction of rural poverty. A strong emphasis on the involvement and participation of villagers living the Project target districts is an integral feature of the proposed project.

3. The Health Services Improvement Project (HSIP) is designed to have positive impacts for local villagers, especially ethnic minorities. The villagers will participate in the development of their own health systems. Villagers will also benefit from improved access to district and provincial health services. Each village in the Project will also become involved in a community-based system that will reflect the needs and wishes of each village and de facto of the various ethnic groups.

4. The Health Services Improvement Project's negative social impacts will be minimal. Participation in the Project activities will require some commitment of time which could be problematical especially in upland villages or villages where cultivation activities require long periods away from the village. And since the project will assist villagers with health system development, there is a risk that some villagers may benefit more than others depending on the location of fields.

5. There are no adverse impacts expected from the Project on non-Lao ethnic groups. The least developed villages belong to ethnic groups in the more remote upland sites which are not readily accessible to the formal health system. These non-Lao ethnic groups already are disadvantaged in terms of greater poverty, less access to development (such as roads, schools, and health clinics), and have a lower literacy in the Lao language than do Lao and related Lao-Tai ethnic groups. The Health Services Improvement Project has been designed, however, to take these differences into account in its capacity building and training strategies. Furthermore, the present Ethnic Group Development Plan provides additional measures and activities that support the participation of ethnic groups in ways that are appropriate within the respective cultural systems.

The Health Services Improvement Project

Objectives

6. The Project goal is to contribute to the enhanced health status of the population by:

(i) expanding coverage and improving the quality of health service delivery;
(ii) strengthening institutional capacity to plan, deliver, and evaluate health services at central, provincial, and district levels; and

(iii) strengthening health financing to improve access to affordable health care for the poor.

7. Specifically, in line with the Government's priority health development policies as set forth in the "2020 Health Strategy," the Project would: Increase access to and utilization of basic health services by all vulnerable/underserved groups by

- Expanding the outreach, health center and first-referral network; Prioritize disease prevention and health promotion activities to control communicable diseases;
- Improve the quality of health personnel at all levels with a particular emphasis on technical,
- Administrative and behavioral skills; and
- Promote measures to ensure increased and sustainable health financing, improve the administration of sector resources and protect the poor.

Description

8. Within the framework of the Government's policy to reduce poverty by decentralizing the delivery and improving the quality of services, the project will support the development of district health services in 8 central and southern provinces. Specifically, the project will enable districts to: (a) respond more effectively to the needs of the population (and particularly underserved groups); (b) deliver an improved package of curative and preventive services at village, health center and district hospital levels (including the integrated delivery of activities for controlling infectious diseases, such as malaria, TB, dengue, STIs, diarrhea, acute respiratory infections, and for reducing mal-nutrition); and (c) to strengthen the institutional and financial mechanisms for sustainable health services financing.

9. The project will focus on 30 districts ranked as "poor" and "poorest", all located in remote areas, with large numbers of minority populations and with little access to either public or private health facilities. The project will support district health teams to better plan, manage and monitor health care delivery in their respective geographical areas. The annual planning process in districts will be strengthened and used for allocating project funds and monitoring implementation. The project will also build capacity at provincial level to enable provincial teams to support and supervise the district health teams. Besides improvements in quality and utilization of services, the project will improve resource utilization and will render health services more affordable. The project will also strengthen health financing including cost recovery and sustainable drug revolving funds with a renewed focus on maintaining the affordability of the services for the poor. The project is being prepared in collaboration with other partners and with due attention to the requirement of complementarity with other Bank funded operations and the Poverty Reduction Strategy.

Key findings from the Social Impact Assessment

10. The findings of the SIA are essentially that while the project has no particular negative impacts, positive impacts will depend upon the degree to which an increased effort to include ethnic group participation in the health care system can be successful. To accomplish this, additional focus and financing will have to be directed at programs aimed at the ethnic minorities in the form of (1) language and culture, and (2) the integration of traditional and conventional medical systems.

Under the componential structure of the project, the SIA finds that:

11. With respect to Component 1 (Improving Quality and Utilization of HCS), it is difficult for the current health services to compete with local solutions to health-related problems that involve (a) trusted local unofficial practitioners; (b) psychologically and culturally satisfying integrations of religious, herbal, and conventional medical approaches; (c) lower costs and lower debt burden of the local system.

12. With respect to Component 2 (Strengthening Institutional Capacity), education and training currently lack (a) social science inputs in three areas: medical anthropology, cross-cultural psychiatry, and integrated approaches to health service delivery; (b) special waivers to allow increased ethnic minority participation as health care staff; and (c) ethnic sensitivity training. District planning, despite the Decentralization Decree (PM Decree No. 01), is still basically top down and needs to be based upon participatory or qualitative data collection. HRD related to this methodology is still lacking at the District level.

13. With respect to Component 3 (Health Financing) it was found that (a) the staff salary issue continues to loom large and remains an impediment to morale in health centers; and (b) exemption systems for the poor which are restricted to medical costs only will probably not increase service utilization except in villages which are already located in close proximity to health centers because other costs associated with treatment are prohibitive (transportation, costs for accompanying persons, food provision for everyone, social debts incurred, loss of savings in form of livestock, etc.).

2. Ethnic Group Development Plan

14. The Project is anticipated to have a positive impact on ethnic groups living in the target districts. In most cases, the upland ethnic groups in the project areas are culturally, socially and economically distinct from the lowland groups, and they are vulnerable to becoming disadvantaged in the development process. Government is thus required to prepare an Ethnic Group Development Plan (EGDP) to ensure that vulnerable ethnic groups do not suffer adverse impacts of the Project and that they receive benefits in a

manner that is culturally appropriate to their particular circumstances as required by the Bank's safeguards policy on Indigenous Peoples (OD 4.20).

15. The present Ethnic Group Development Plan describes the legal, cultural and socio-economic context surrounding ethnic groups in Lao PDR, particularly pertaining to the receipt of health service benefits. The Plan describes measures, institutional arrangements and budgetary needs that addresses the particular needs and circumstances of ethnic groups that are vulnerable to the development process as defined below.

16. Finally, the Plan prescribes a process during project implementation that provides for:

- collection of more site specific information on ethnic groups through participatory methods;
- the informed participation of all members of ethnic groups covered by this Plan;
- identification, in close cooperation with the given ethnic groups, of their specific needs and priorities to be incorporated into site specific health system development activities;
- training of VHVs in the pilot studies, training relevant officials at the Central, Provincial and District levels in ethnic sensitivity, especially the relevant project staff;
- procedures for participatory monitoring and evaluation of project activities and their benefits and impacts on ethnic groups; and
- complaint mechanisms.

3. Background Information

Ethnic Groups in the Lao PDR

17. One of the main characteristics of the Lao PDR is its cultural diversity. Although there have been differing numbers given for the groups, specialists mostly agree on the ethnolinguistic classification of the ethnic groups.[2] For the purposes of the 1995 census,

[2] In the late 1950s, the former government had categorized the population into three major groups, the *Lao Loum* (lowlanders), *Lao Theung* (midlanders), and *Lao Soung* (highlanders). This classification was adopted for political purposes, to stress how all ethnic groups were part of the Lao nation and also to simplify a complex situation. Following the adoption of the 1991 constitution this system was officially discontinued even though it is still used by some provincial authorities. Chamberlain (1996) lists 236 ethnic groups that have tentatively been identified.

GOL recognized 47 main ethnic groups or categories and 149 sub-groups, and the last revision of this list by the LFNC contained 49 categories, and over 160 subgroups (the forthcoming National Assembly will be asked to ratify this list in the near future).[3]

18. Thus, the official terminology for describing the diverse population of the Lao People's Democratic Republic is 'ethnic groups.' This terminology was introduced with the 1991 Constitution. The previous terminology is, however, still used by many Lao people. The term 'ethnic minorities' is used by some to classify the non-Lao ethnic groups while the term 'indigenous peoples' is not used by people in Lao PDR. The official terminology of the Lao Constitution is used in this Plan.

19. The ethnic groups of Lao PDR can be categorized in terms of four ethno-linguistic groups:

- the Lao-Tai (also referred to as 'Tai-Kadai'), which includes the 'ethnic Lao' group (about 30 percent of the total population of Lao PDR) and lowland Tai/Thay speaking groups (about 36 percent);
- Mon-Khmer ethnic groups (about 23.5 percent);
- Hmong-Mien, including the Miao-Yao (about 7.5 percent);
- Sino-Tibetan (also referred to as 'Chine-Tibet'), which includes Chinese Ho and Tibeto-Burman ethnic groups (about 3 percent).

20. Although in previous EGDPs carried out in Laos it has been the practice to define as "indigenous" with respect to OD 4.20 only the non-Lao-Tai groups, for purposes of the HSIP only the Lao, as defined by the official classification will not be included as "ethnic minorities". The category "Lao" officially includes Lao, Kaleung, Phouan, Nyo, Yooy, and Bo. (See Appendix)

21. These groupings indeed meet the Bank's definition of indigenous people, that is they have,

- a close attachment to their ancestral territories and the natural resources in these areas;
- self-identification and identification by others as members of a distinct cultural group;
- an indigenous language, often different from the national language;
- presence of customary social and political institutions; and,
- primarily subsistence-oriented production.

In addition, while it is true that the Lao-Tai groups show up as comparatively better off by outside economic measurements, they are more vulnerable in other respects. For

[3] The important change in the new list is the classification by ethnolinguistic families (Lao-Tai, Mon-Khmer, Hmong-Mien, and Chinese-Tibetan) which agrees with the classifications of international specialists in each of these ethnolinguistic families. This is a major break with the Vietnamese influenced system used in the past.

example, in a recent comprehensive study on human trafficking in Laos done by UNICEF, Tai-Thay (non-Lao) groups are the most affected segment of the population.[4]

22. Ethnic groups vary in their attitudes towards social services, gender issues, and other cultural practices that shape their overall worldview. Unfortunately, relatively few full ethnographies or monographs exist to document this cultural diversity.[5] It should also be remembered that these different ethnic groups are not all practicing traditional lifestyles or necessarily living in isolation. But the study of what changes and what does not is a complex issue. We are as yet incapable of adequately describing the patterns of changes and non-changes in any comprehensive way, or of discerning the sets of rules that govern and explain such patterns. The Project will work with minority villagers to define the parameters of changes, and to provide them the opportunities to influence decision-making with respect to their involvement in health related activities, and in the use of village drug funds according to village priorities.

Government Policy and Legislative Framework Regarding Ethnic Groups

23. According to the 1991 Constitution, Lao PDR is defined as a multi-ethnic state, with "equality among all ethnic groups." Article 8 of the Constitution reads:

> *The State pursues the policy of promoting unity and equality among all ethnic groups. All ethnic groups have the rights to protect, preserve and promote the fine customs and cultures of their own tribes and of the nation. All acts of creating division and discrimination among ethnic groups are forbidden. The State implements every measure to gradually develop and upgrade the economic and social level of all ethnic groups.*

It is assumed here that the intention of the Constitution is therefore to grant equal status to all ethnic groups, and to this end no reference is made to distinctions between highlanders (*Lao Soung*) and lowlanders (*Lao Loum*) and midlanders (*Lao Theung*).[6] The constitution defines the Lao PDR as a multi-ethnic state, as well as guaranteeing a

[4] Chamberlain, James R. 2004. *Innocence and Modernism: A Study of Child Trafficking in the Lao PDR*. Vientiane: UNICEF. (Draft, official version not yet available)

[5] Notable exceptions are the ethnographic study of the Kmhmu ethnic group, *Kmhmu Livelihood – Farming the Forest* (S. Simana and E. Presig, Ministry of Information and Culture, Institute of Cultural Research, Vientiane, 1997); Izikowitz, Karl Gustav. 1951. *Lamet: Hill Peasants in French Indochina*. Göteborg: Ethnografiska Musset. [Reprinted in 2001 Bangkok, White Lotus]; Lemoine, Jacques. 1972. *Un Village Hmong Vert du Haut Laos: Milieu Technique et Organisation Sociale*. Paris: Centre National de la Recherche Scientifique; Lemoine, Jacques. 2002. *Wealth and Poverty: A Study of the Kim Di Moun (Lantène) of Meuang Long District, Louang Namtha*. Vientiane:NSC/ADB; Vargyas, Gabor. 2001. *A La Recherche Des Brous Perdus: Population Montagnarde Du Centre Indochinois*. Paris: Scripta Editions; and Wall, Babara. 1975. *Les Nya Hön: Etude ethnographioque d'une population du Plateau des Bolovens (Sud-Laos)*. Vientiane: Vitagna.

[6] That is, from this point on, the terms *Lao Loum, Lao Theung, Lao Soung* are no longer recognized as official terminology.

number of fundamental rights, including the right to work (Article 26), and the freedom of assembly and association (Article 31).

24. The 1992 ethnic minority policy, *Resolution of the Party Central Organization Concerning Ethnic Minority Affairs in the New Era*, focuses on gradually improving the lives of ethnic minorities, while promoting their ethnic identity and cultural heritage. It is the cornerstone of current national ethnic minority policy. The general policy of the Party concerning ethnic minorities can be summarized as follows:

- Build national sentiment (national identity).
- Realize equality between ethnic minorities.
- Increase the level of solidarity among ethnic minorities as members of the greater Lao family.
- Resolve problems of inflexible and vengeful thinking, as well as economic and cultural inequality.
- Improve the living conditions of the ethnic minorities step by step.
- Expand, to the greatest extent possible, the good and beautiful heritage and ethnic identity of each group as well as their capacity to participate in the affairs of the nation.

The implementation of the Party's policy on ethnic minorities is tasked to the Lao Front for National Construction (known colloquially as *Neo Hom*).

25. The Resolution calls for a focus on the expansion of education, culture, health, and other social benefits. The network of formal primary education should be expanded to guarantee that all children of school age attend school. In addition, the policy calls for a revival of the "ethnic youth" schools in mountainous areas, which were in place in liberated zones during the war, with the condition that quality should be emphasized. It is also emphasized that minority children have the same rights to education as other children in the lowlands and cities. A detailed plan for teacher training is called for, directed at the ethnic minorities in remote areas, together with a policy and the personnel for its realization. Here, most importantly, the mandate is given for the relevant organization to urgently research the writing systems of the Hmong and the Khmou using the Lao alphabet as was formerly used in the old liberated zones for use in areas occupied by these ethnic minorities, to be studied together with the Lao language and alphabet.

> *To achieve [education for all], teacher development must be carefully planned in order to provide enough teachers for ethnic minorities in remote areas ... Relevant organizations must urgently re-study the Hmong and Khmou alphabets used during the period of the revolution in order to apply when teaching those ethnic groups along with instruction in the Lao language and alphabet. (Politbureau, 1992)*

Also reiterated in this section is the promotion and expansion of the traditional cultural heritage of each ethnic minority, "to allow the mental lives of each ethnic minority to blossom and contribute to the rich multi-formed and multi-colored culture(s) of our Lao nation."

26. The policy calls for protection against and eradication of dangerous diseases and to allow minority peoples to enjoy good health and long life. The Government, it states, should provide appropriate investments to enlarge the health care network by integrating modern and traditional medicine.

27. Collection of data on the ethnicity of government employees, retired ethnic officials, the handicapped, and families of those killed in action is another activity called for in the policy.

28. The task of dissemination of information in the remote areas is mandated, through many methods, especially, radio broadcasting in minority languages. The plan calls for engagement of specialist officials who speak minority languages and who possess a knowledge of science, production, and socio-economic problems. The issue of where these persons are to found is not addressed.

29. The Ethnic Minorities Committee under the National Assembly is charged with the responsibility to draft and evaluate proposed legislation concerning ethnic minorities, lobby for its implementation as well as implementation of socioeconomic development plans. Ethnic minority research is the responsibility of the Institute for Cultural Research under the Ministry of Information and Culture. The lead institution for ethnic affairs is the mass (political) organization, the Lao National Front for Construction (LNFC), which has an Ethnic Affairs Department.

30. The mandate of the Institute for Linguistic Research includes:

- research the Lao national language and writing system and on the languages and writing systems of ethnic minorities;
- surveying and collecting data on the languages spoken in the Lao PDR for use in linguistic research;
- dissemination of information in the form of books, journals, photographs, and video tapes, and exhibitions;
- coordination with schools and other academic institutions on matters of curriculum and research;
- coordination with the National University in the training of linguists;
- improvement of the quality of the institute through increasing general awareness of the heritage of the Lao language and the languages of the ethnic minorities; and,
- coordination with universities and academic institutions abroad.

With respect to issues concerning the EGDP, linguistic inputs are essential to the investigation of ethnomedicine, ethnophychiatry, and medical ethnobotany, as well as in dissemination of health information in minority languages.

31. All of these agencies have a potential role in the improvement of health care services: (1) the LFNC as the lead agency in charge of implementing the Ethnic Groups

Policy; (2) the National Assembly Committee that oversees legislation related to ethnic minorities; (3) the Institute for Cultural Research who may carry out requisite health-related research in ethnic communities; and (4) the Institute for Linguistic Research that may assist in the dissemination of health information in minority languages.

32. In spite of this considerable foundation, most non-Lao-Tai ethnic groups rank low in virtually all measures of development, such as poverty, literacy, and health. Many ethnic groups are unable to speak the Lao language, and thus unable to effectively make use of schools and health clinics, whose staff, in most cases, are not able to communicate in minority languages.

Ethnic Groups in the Project Area

33. The areas selected for the project contain an estimated 76 ethnolinguistic groups. These groups comprise a large portion of the selected project provinces as can be seen in the first Table below:

Table 1 – Percentage of Minority Populations in Project Provinces

Prov	Pop (1997)	Share 1	%	Share 2	%	Share 3	%	Total 3 Grps	Total Minority %
XSPZ	57.3	Hmong	53.7	Lao	19.4	Khmou	16.7	89.8	80.6
BKXY	173.3	Tai-Neua-Phouan	41.0	Lao	40.2	Hmong	9.2	90.4	59.8
KMME	288.6	Lao	59.4	Phou Thay	14.0	Brou	13.4	94.5	46.6
SVKT	711.5	Lao	57.5	Phou Thay	18.9	Katang	8.7	85.1	42.5
SRVN	271.4	Lao	60.0	Katang	13.3	Souay	8.1	81.4	40.0
CPSK	531.1	Lao	84.8	Laven	4.9	Souay	2.4	92.1	15.2
XEKG	68.0	Katu	24.3	Talieng	21.8	Alak	15.5	61.6	91.4
ATTP	92.4	Lao	36.9	Brao (Lavè)	17.4	Oy	16.4	70.7	63.1

Source: (Chamberlain, 2000)

34. The target provinces are thus highly diverse in ethnic composition. There may in fact, be others that have not been documented in any given province.

Table 1 - Ethnic Groups in Project Provinces

Province	Ethnolinguistic Family	Ethnic Groups
Xaysomboun	Lao-Tai	Phouan, Neua, Tai Dam, Tai Deng, Xin
	Hmong-Mien	Hmong Ntsoua, Hmong Daw
	Mon-Khmer	Khmou, Phong, Phouak
Borikhamxay	Lao-Tai	Lao, Phou Thay, Thay Bo, Nyo, Mène, Pao, Phouan, Sek, Kaloep, Khang, Kouan, Moey, Theng, Vang, Yeuang, È, Ô
	Hmong-Mien	Hmong Ntsoua, Hmong Daw
	Mon-Khmer	Brou (Sô), Ahoe, Ahao, Ahlao, To'e, Makang, Liha, Toum, Phong (Cham)
Khammouane	Lao-Tai	Lao, Phou Thay, Yooy, Kaleung, Xam

	Hmong-Mien	Hmong Ntsoua, Hmong Daw (one village only)
	Mon-Khmer	Brou (Sô, Makong), Tri, Chalouy, Chouy, Arao, Ahoe, Malang, Maleng, Thémarou, Phóng, Kri, Mlengbrou, Cheut
Savannakhet	Lao-Tai	Lao, Phou Thay, Angkham
	Mon-Khmer	Brou (Makong, Mangkong), Tri, Chali, Katang, Pacoh, Ta Oi, Souay
Saravanh	Lao-Tai	Lao, Phou Thay
	Mon-Khmer	Alak, Jru (Loven), Kado, Kanay, Kaseng, Katang, Katu, Ngkriang (Ngè'), Souay, Ta Oy,
Champasak	Lao-Tai	Lao
	Mon-Khmer	Khmer, Brao (Lavè), Katè, Nya Hoeñ, Jru (Loven), Souay
Xékong	Lao-Tai	Lao
	Mon-Khmer	Katu, Ngkriang (Ngè'), Cha Tong, Triw, Dak Kang, Cheung, Tariang, Hrlak (Alak), Jouk, Jeh, Jru, Lavi, Kaseng, Chatong, Ngung Bo, Ta Oy
Attapeu	Lao-Tai	Lao
	Mon-Khmer	Sedang, Kayong, Yè (Jeh?), Kaseng, Brao, Sou, Souk, Hrlak, Cheng, Oy, Jru, Sapouan, Todrah (Sedang), Sok, Sou'

35. The groups speak distinct languages and identify themselves as distinct ethnic groups. Xaysomboun and Borikhamxay have three ethnolinguistic families represented, and the rest have two. The Mon-Khmer family, it should be noted, is the oldest and most internally diverse. Many of its branches are of a time depth equal to that of other families. There are considerable differences between the Khmouic, Vietic, Katuic, Bahnaric and Khmeric branches (not shown in the tables). The degree of variation within Mon-Khmer (or Austroasiatic) is indeed similar to that of Indo-European.[7] Romanized and Lao writing systems have been developed for Khmou and Katu, and for several others although these have not been universally disseminated.

36. The Hmong-Mien family, formerly known as Miao-Yao, are represented by five languages, White Hmong (Hmong Daw), Green Hmong (Hmong Ntsoua, Mong), Black Hmong (Hmu ?), Iu Mien (Yao) and Kim Moun (Lantène, Lao Houay). Of these only the first two are found in the project area. There is a Romanized writing system for White Hmong known as the Barney-Smalley alphabet which dates from the 1940s. This is very widespread and is taught informally to Hmong children throughout the country. There are Hmong alphabets using Lao characters for both White and Green Hmong, and there are two Hmong alphabets that were created from scratch by pantheistic religious sects emanating from Nong Het and from Xaygnaboury. These latter are not widely known. The Hmong, though, whether in China or in Vietnam, have always used the available writing systems in their environment to write their own language (Lemoine, 1972).

37. The Lao-Tai (or Tai-Kadai) family is comprised of three branches: Northern, Central and Southwestern. Lao, Phou Thay, Tai Dam, and the majority of the groups in Laos belong to the Southwestern branch. The exceptions to this are the Yay (Nhang), the Sek, and the Mène which are all Northern Branch languages whose closest relatives are the Chuang and Pu-Yi in Guangxi and Guizhou of southern China. Most of the Southwestern Tai languages had or still have their own writing systems. Although literacy for the majority of the Lao-Tai groups is less of a problem than for the other families, overall rates for the country are still low. For ages 15-59, the secured functional rate for the country is 30.8 percent, but when this is disaggregated by ethnolinguistic family the Lao-Tai rate is 40.3 percent; Mon-Khmer 22.7 percent; and the Hmong-Mien 18.1 percent. Thus health related written media will still be largely inaccessible. The following table is illustrative:

Groupings	**Secured Functional Literacy**		
	Male	**Female**	**Total**
Lao PDR (15-59)	37.4%	24.5%	30.8%
Urban	59.7%	45.6%	52.4%
Rural	32.2%	19.5%	25.7%
Lao-Tai (Tai-Kadai)	47.6%	33.5%	40.3%
Mon-Khmer	28.6%	17.2%	22.7%

[7] Gérard Diffloth (p.c.)

Sino-Tibetan	22.1%	14.6%	18.3%
Hmong-Mien	28.7%	6.8%	18.1%
North	28.9%	17.7%	23.2%
Central	48.8%	34.6%	41.5%
South	32.1%	18.4%	25.2%
Champasak	56.4%	42.0%	49.2%
Khammouane	40.6%	25.5%	32.8%
Savannakhet	40.2%	32.0%	35.5%
Xaysomboun SR	38.6%	20.4%	29.3%
Borikhamxay	37.1%	25.4%	31.1%
Attapeu	26.2%	12.7%	19.5%
Saravanh	23.1%	12.1%	17.5%
Xékong	25.2%	7.2%	16.3%

38. With respect to multilingualism, among the lowland Lao-Tai speaking groups, there is a high degree of bilingualism and bi-dialectalism. Regional conventions have evolved as well, such that Lue predominates as the lowland norm in most of Phongsaly, Oudomxay, Louang Namtha, Bokeo and northern Xaygnaboury; Neua-Phouan serves the same function in most of Houa Phanh, Xieng Khoang, northern Vientiane, and Borikhamxay; Phou Thay predominates in the interior portions of Khammouane and Savannakhet; and Lao is the main language along the river from Vientiane north to Louang Prabang, and from Thakhek south to Champasak including the capitals of Saravanh, Attapeu, and Xékong, as well as Rattanakiri and northern Stung Treng in Cambodia. The result then, is a highly diverse Lao-Tai population, with considerable linguistic flexibility. (Chamberlain, 2002)

39. When we begin to discuss the socio-linguistic situation among the upland minorities, we immediately find ourselves in need of additional information. With respect to the national language, it is mostly those groups who have had access to education or who have lived adjacent to Lao villages who are competent in Lao. Otherwise, if the uplander speaks a Lao-Tai language, it is predictably the regional dialect norm, one of those cited above. In Xieng Khoang and Xaysomboun, Hmong predominates and many of the Khmou speakers in these provinces speak Hmong as well. In eastern Borikhamxay, apart from Hmong, most of the population in Vieng Thong District speak Vietic languages (Phong, Liha, Toum) and can understand Vietnamese well. The same is true for the Vietic speakers in Nakai and northern Boualapha districts of Khammouane, those these groups are fluent in Brou as well, that is they are solidly trilingual. Thus from Hin Boun and Nakai south through much of Khammouane and interior Savannakhet, Brou-type languages are spoken and are mutually intelligible to some degree (Brou, Tri, Chalouy, Makong etc.) Often these speakers, especially the men, know the Phou Thay language as well.

40. Further South the situation seems to become more complex. Ta Oy and Katang dominate in Saravanh, though the nature of the relationship is unknown. Likewise in Xékong, Katu and Ngkriang (Ngè') appears to be the dominant language of Kaleum District, while Tarieng, a Bahnaric language, has been described as the lingua franca of Dak Cheung (Thongphet p.c.). Jru (Laven – also a Bahnaric language) prevails on the Bolovens, but historically their relationship with other Bahnaric speakers has been problematic, as with the Nha Heun. Alak likewise is ambiguous as to its role. In Attapeu, Brao (Lavè) along the southern border are widely spoken and appears to be the lingua franca here. But the sociolinguistic position of Oy and Cheng are less clear.

41. The *Participatory Poverty Assessment* (NSC and ADB, 2001) has shown that poverty in Lao PDR is a condition of rural non-Lao ethnic groups, who comprise 93 percent of the country's poor. 80 percent are uplanders. They face problems of access to land, food security and limited access to public services, infrastructure such as all-season roads, education, clean potable water and health services as well. Even where ethnic groups have a school or health clinic in their village, often they do not make use of such services where the government staff are unable to speak the local languages.

42. Traditionally, villages are organized along ethnic lines with all village members belonging to a single ethnic group and speaking their own language. In many cases today, following relocation or village consolidation, larger villages may be comprised of two or more ethnic groups. However, they usually remain segregated, living in separate quarters or *khoum* of the village. Consideration may have to be given to treating these *khoums* as separate communities for purposes of the project, as it is almost always the case that one group will tend to dominate in some way the others. Considerable thought will have to be given to how to address this problem in the project. The strategy for new or resettled communities may ultimately differ considerably from that in the old villages.

4. Key Ethnic Minority Health Issues

43. The ADB PPTA Household Survey (1999) contained variables for the main ethnolinguistic families and is useful is identifying some aspects of the health situation and health related behavior among these families. The table below is exemplary:

Table __ - Selected Health Indicators and Ethnic Groups

No	Indicators	*Ethnolinguistic Family*			
		Tai-Kadai	**Mon-Khmer**	**Hmong-Mien**	**Tibeto-Burman**
1.	Percent of villages in the sample	48	35	10	7
2.	Percent of households in the sample	48	35	10	7
3.	Percent of villages with clean water supply	54	36	47	35
4.	Percent of villages with at least one modern medical practitioner	84	60	47	39
5.	Percent of villages with a traditional healer	45	30	31	22
6.	Percent of villages with a village health volunteer	63	54	22	30
7.	Percent of villages with a traditional birth attendant	53	32	31	13
8.	Percent of villages within four hours of a hospital in dry season	90	68	53	52
9.	Percent of villages within one hour of a health center in dry season	66	33	28	18
10.	Percent of villages within one hour of a private pharmacy in dry season	82	48	34	26
11.	Percent of villages with basic drugs available	57	30	25	21
12.	Percent of villages with minimum 4 EPI visits during last year	31	24	15	4
13.	Percent of villages with minimum 1 bed net impregnation session during the last year	27	32	7	30
14.	Percent of households which impregnated at least one bed net during the last year	17	19	4	16
15.	Percent of households which know the usefulness of iodized salt	39	18	11	7
16.	Percent of households with iodized salt	33	38	42	43

ADB PPTA Household Survey 1999

44. As might be expected, Lao-Tai households all had higher positive percentages for these particular variables while the other ethnic groupings are quite low. Interestingly,

however, additional analysis carried out by Knowles (2002) on the PPTA data reveals that there is no correlation between ethnicity and the incidence of illness. This might be interpreted in several ways: (1) that traditional medicines, diets and preventative health behavior found in ethnic minority villages are as least as good as those found among Lao-Tai households with better access to public health services; (2) that those groups who reside at higher altitudes are free from certain health problems such as malaria and air pollution; and (3) that lowland Lao-Tai environments are more disease prone having additionally acquired road or city related diseases, especially cancers and water borne diseases.

45. Coincidentally, Knowles elsewhere (Knowles, 1999) has noted that promotion of latrines may in some circumstances be counterproductive as a health measure and an unnecessary expense. Latrines tend to concentrate waste and provide breeding grounds for disease as well as pollute groundwater, whereas natural treatment, as in the case of much of Laos where human feces are consumed immediately by dogs and pigs, is in fact more sanitary and environmentally sound.[8]

46. Indeed the environmental aspects of these suggestions become obvious when relocation of villages from highlands to lowlands exposes upland minorities to lowland health problems. In the case of Meuang Long District in Louang Nam Tha, one of the few locations for which data is available, mortality rates have increased by as much as 70%.[9] For an average resettled village of 200 persons, the average number of deaths over the first five years is 40, compared to an average of 23 in the original upland villages. That is the mortality rate jumps from 2.3% to 3.99% because of resettlement. The highest recorded number of deaths caused by resettlement was in the village of Tapai in Long District, Louang Namtha where 20% of the village died in the first year after resettlement in 2002. Resettlement in Long District was carried out in the name of opium eradication. Although this example is not from the project area, it is best to be aware of the possible health consequences resulting from relocation since many villages have been relocated in the project area as well. (cf. Goudineau…)

47. Knowles (2002) finds in addition that, "members of all ethnic minority groups were significantly less likely to be satisfied with the care they received from various health providers, even when the type of care obtained is held constant." It is suggested by him, and it is supported by other studies (e.g. PPA, and the present SIA), that language and cultural communication problems are often major obstacles to providing health care to ethnic minorities.

48. The SIA found that language (and by extension culture) are major obstacles. In several areas villagers reported they were not able to visit the clinic or the hospital without an interpreter. The interpreters are few, and asking them to accompany a patient

[8] Prehistorically, domestication of dogs and pigs occurred first in the East through a nurturance of the animals on human feces. In the West domestication evolved in just the opposite way, where cows and goats were first domesticated through human dependence on the animals' milk.

[9] Laurent Romagny. 2003. Key issues about resettlement and service delivery. 1st Livelihoods Forum, July 16, 2003. Action Contre la Faim.

is a major financial problem as well as a social one of incurring debt according to the norms of reciprocity in the village, usually calculated in terms of labor. The result is that villagers rarely avail themselves of public health services.

49. Where health personnel are available who are themselves members of the same ethnic group, the situation is greatly improved, as with the clinics in Xaysomboun where Hmong is spoken by health service personnel. In this particular instance, Hmong written language could be of value as well since the observed literacy rates in the Hmong language are found to be high. Other written minority languages in the project area are less well-known, but some potential exists for Khmou and Katu and perhaps others. At least it is worth experimenting with on an trial basis.

50. Other than for the Hmong in Xaysomboun, however, non-Lao-Tai ethnic minority personnel in the health service system are rare. One reason for this is the high educational qualifications that are required for admittance. For the lowest level one must have completed lower secondary school and then study medicine for 3 years. The second level requires completion of upper secondary plus 5 years of medical study. And the highest level requires completion of upper secondary and 10 years of additional medical study. Thus the majority of the ethnic minority people are unqualified due to lack of educational opportunity. This lack of opportunity then leads directly to a lack of access to health services for the respective ethnic populations.

5. Traditional Medicine

51. Traditional medical systems are pluralistic and their technical study requires and interdisciplinary approach. One author (Kleinman, 1980) critiques modern health care systems for their lack of holism, noting:

> 1. The ingrained ethnocentrism and scientism that dominates the modern medical and psychiatric professions (both in developed and in developing societies) follows the paradigm of biomedical science to emphasize in research only those variables compatible with biological reductionism and technological solutions, even if the problems are social ones. This disastrous bias has diminished the significance of all social science inputs into medicine and psychiatry, especially at the clinical level. It has strongly discouraged views of medicine in which health care is seen to include anything more than the modern medical profession and biomedical science or in which medicine is studied as a social institution from a "systems" perspective. Cultural and sociopolitical analyses of the determinants of health care delivery, for example, have not been considered appropriate venues for medical research, and the description and analysis of the total environmental context that ethnography provides has not yet been accepted as an appropriate scientific approach for medical research.
>
> 2. The bias of many health professionals in developing societies is to restructure health care delivery in their countries by copying an idealized model of *professional* care in technologically advanced societies. This fictive view of health care does not correspond to the actual situation in developed societies, where 70 to 90 percent of illness episodes are treated solely within the family context, … and is even a greater distortion of the

> more desperate situation of health care in developing societies. This interest (frequently no more than professional self-interest) militates against using the health care system model, with its crucial sociopolitical, economic, and cultural concerns. For example, it has delayed informed evaluations of self-care and treatment by indigenous practitioners, along with research on how these ubiquitous therapeutic approaches might be used in state planning for health care services.
>
> 3. The longstanding tendency of clinicians is to treat *healing* as if it were a totally independent, timeless, culture-free process to be understood either as an isolated special case or by comparisons with clinical practices in psychoanalytic therapy, hypnosis, biofeedback, and the like. Medical researchers seem embarrassed by this archaic relic in their midst and have devoted little attention to healing, the most basic of all health care processes. They do not regard healing as a core function of health care systems to be studied in its own terms within specific social and cultural contexts.

Interestingly, the Lao health professionals are not adverse to the idea of traditional medicine or research (see, for example, the report on the Dissemination Workshop in Appendix 4 of the SIA). In fact most support the inclusion of traditional medicines into the national medical system. It might be speculated that most professional medical practitioners in Laos have been exposed to a wide variety of approaches to healing and treatment and therefore have open minds on the subject.[10]

52. In other words, there is a need for health care systems to be analyzed in the same way as religious systems, kinship systems, language and other social (symbolic) systems are analyzed. The first and most important element of such analysis is the context or the cultural setting that determines the specific content of health care systems. We need to understand how cultural rules and meanings shape health care systems.

53. Traditional medical practices of the various minority groups in the Lao PDR have been poorly studied, or, in the majority of cases, not studied at all. A non-technical treatise on Katu has been published in three languages, Lao, Katu, and English (Sulavan, 1995). Otherwise, information is scarce.

54. Traditional Medicine Research Center The Traditional Medicine Research was established in 1976. It is administrated under the Department of the Food and medicine of the Ministry of Health. The original name was the "Institute of Traditional Medicine." This was changed later to the "Center for Research on Medicinal Plants," and finally to its current name.

55. Its primary role is to research traditional or indigenous knowledge of medicine, especially medicinal plants, of all ethnic groups, and to conserve the plants themselves as an important aspect of the nation's biodiversity. The Center is also responsible for pharmaceutical researching and production on an "appropriate" scale. Under the Center's definition, the various plants and herbs used are not considered as "traditional medicine"

[10] Asian medical systems generally have always supported a diversity of systems. At the Kunming Medical University in Yunnan, for example, many specialized curricula are offered all leading to advanced degrees, including acupuncture, herbal medicine, and the Chinese use of Western medicine. Often these are pursued in addition to the standard Western M.D.

until the research and production has been completed. To date the Center has produced four publications with recipes for medicines, color photographs of medicinal plants complete with botanical names and with some chemical analysis. The books, however, describe only a small portion of the more than 3,000 medicinal plants that have been so far recorded by the Center.[11]

56. The Center operates a network of research stations in 11 provinces throughout the country. They are tasked with research and promotion of traditional medicine. The center estimates that there are on the average two traditional medicine practitioners in every village. But although village practice is assumed to be on-going, there have been no government support or operations at this level, nor at the level of the district.

57. During an interview with the director of the Center, two problems were identified. The first is that of lack of adequate funding. Government financial support ended this fiscal year and the Center is expected to fund itself from revenues and assistance projects. The latter has been provided only sporadically from such sources as WHO, the University of Illinois, and from the Vietnamese. The second problem is one of patents because recipes and plant discoveries have been "leaked" to private sector pharmaceutical companies both internally and abroad with no fees or royalties paid.[12]

6. A Plan For Improving Ethnic Minority Access To Health Services

58. The Ethnic Group Development Plan has the overall objective of (1) inputing knowledge of ethnic minority language and culture into the health care system, and (2) integrating traditional and conventional medicine medical systems to derive a system that will address the social and psychological needs of beneficiaries as well as the biophysical needs.

59. If the HSIP is to truly reach the ethnic minority populations it is essential that the health care system understand who the ethnic minorities are in a deeper way than in the past. The system needs to understand how minority people live and think, it needs to begin in the villages and in the minds of the minorities themselves and proceed from here to jointly construct a system that meets real needs. Currently there is no single body that is capable of providing this very preliminary requisite information.

60. It is therefore proposed here that the information gap be addressed by Participatory Research And Extension Teams (PRETs) who will have as their mandate the investigation of traditional and current medical and psychiatric practices and who will

[11] In fact earlier work in this area by French researchers in Indochina described around 5,000 species, mostly from lowland sources. (Petelot, Alfred. 1952. *Les Plantes Médicinales du Cambodge, du Laos, et du Vietnam (4 Vols.)*. Saigon: Centre de Recherches Scientifiques et Techniques: Archives des Recherches Agronomiques au Cambodge, au Laos, et au Vietnam.)

[12] There is also of course the issue of ICPRs which is discussed in the EGDP.

participate with minority villagers to establish a health care system that meets the needs of the particular village and ethnic group. At least two teams would be formed at the beginning. The formation of these teams in terms of necessary human resources and training should be the first priority of the project. Both classroom and *in situ* training will be required.

61. The planning, establishment, and training of the PRETs will be overseen by a Working Group on EM Health Care Issues. Membership will include: Institute for Cultural Research; Traditional Medicine Research Center; Institute for Linguistic Research; Ethnic Minorities Committee of the National Assembly; Ethnic Affairs Department of the LFNC; Faculty of Social Sciences, NUOL; other relevant MoH agencies. If necessary expertise in such areas as medical anthropology or ethnopsychiatry is not available the project should provide technical assistance in these areas.

62. PRETs will begin with in-depth participatory research that focuses on indigenous knowledge systems and approaches to healing and their integration with conventional medicine. These participatory studies will provide communities with the opportunity to play a major role in the design of health care provision. Together with villagers the PRETs will generate plans for how best to implement the project in the circumstances peculiar to each location.

63. The Plans will then provide the foundation to institute a series of participatory pilot projects to follow-up with the communities in order to design and implement trial activities. This should be carried out in a wide range of ethnic groups and settings. Initially the program will begin in 10 locations with others to be decided upon at a later date.

64. The teams would be district based during their initial operations. District and health clinic personnel will also participate in the PRET exercises to learn from the teams and from the villagers how best to provide health services in minority areas.

65. Thus this program will serve as the link between research and practice, and a meeting point for the other activities considered in the plan, namely the minority health personnel inclusion, the minority media effort, and the traditional healing research.

66. To accomplish this, technical assistance will also be provided to the Traditional Medicine Research Center in the area of traditional medicine benefit maximization for integrated health care delivery systems, and on research in medical anthropology and cross-cultural psychiatry. That is, the PRET activities will go beyond simply the search for medicinal plants, to include the cultural context in which traditional forms of healing occur. The PRET exercises will also serve as the baseline survey of ethnic minority medical practices and the identification of the target sites for additional pilot projects.

67. Phase 2 of the Plan would be the institutionalization of the findings from the pilot projects into the mainstream health care system.

68. To include more ethnic minorities in the health care system overall, and on the PRETs in particular, a special program would be established to waive the difficult educational requirements and acquire more ethnic minority health personnel in the health care system. This has to be carried out with careful planning that will minimize stigma and promote on-going training and capacity building of these staff.

69. Oral and written materials will be developed in minority languages to assist communication in the delivery of services. These materials will take the form of posters, pamphlets, VCDs, radio broadcasts, or other media deem appropriate. A testing and evaluation program will be developed to assess the success of the media on a regular basis.

70. Sensitivity training for health care system personnel, including preparation of training materials will be carried out. Ethnic sensitivity training will be provided to all provincial, district, and health center staff. The primary objective here is the elimination of ethnocentrism. This can be carried out with local resources, including local consultants, the Institute for Cultural Research, and the Ethnic Affair Department of the Lao Front.

71. Higher level training will be addressed for the formal disciplines of medical anthropology and cross-cultural psychiatry. To my knowledge, there are no local resources in these fields so assistance here must take the form of (1) Technical Assistance in the form of expatriate advisors, and (2) scholarships for Lao students to obtain graduate degrees abroad. Both the TA and the scholarships would be best placed in the Center for Research on Traditional Medicine. Another related subject area would be ethnobotany since a great deal of the current research has been carried out with medicinal plants but in the absence of any social science inputs.

72. The Commonwealth Working Group (CWG) on Traditional and Complementary Health Systems established by Health Ministers from 54 countries, is currently working on systems that integrate traditional and conventional medicine, and this should be an important source of lessons to be learned and ideas that can be implemented in Laos. This will be addressed at the Ministerial level with support from the project.

73. There will need to be considerable social science inputs to this undertaking, and thus training of personnel at all levels will have to be carried out to generate the requisite human resources. The details of additional training will be established during the planning phase of the program.

74. A related area that should be addressed in light of the traditional medicine component of the project is that of Intellectual Property Rights (IPR) or Intellectual Cultural Property Rights (ICPR) for minorities who may be confronted with bioprospecting and biopiracy in the area of medicinal plants and traditional medicines. [These are sometimes discussed as Community Resource Rights (CRR) or Tribal Resource Rights (TRR).] Applications of IPRs have met with mixed results in the region and need to be strengthened to insure benefits for villagers.

7. Complaint monitoring and conflict resolution mechanisms

97. Complaint mechanisms should be patterned after traditional institutions for conflict resolution. These exist in varying degrees and may differ considerably among the ethnic groups in the project areas. The description of traditional decision making processes will be a part of the initial baseline studies.

98. It is possible, and indeed likely, that problems, complaints, and/or conflicts may arise with respect to the project as a whole, and health system development activities, in particular. Certain issues, such as the compliance with national laws, regulations, policies and mandates are to be addressed through legal and regulatory provisions in consultation with traditional institutions.

99. In the case of disputes at a village level, normally it will be the responsibility of Village committee to resolve conflicts, but if satisfactory resolution is not obtained, then the parties can appeal to district and/or provincial authorities for assistance. If a problem occurs between villages, such as a dispute over benefits, then normally the district authorities would mediate a resolution. In the case where a problem arises between the villagers and government, then the parties should have the right to mediation by a neutral third party, such as the provincial court or the Lao Front for National Construction.

100. With respect to health system development, the project management will develop specific sanctions to be applied in case of corruption, collusion, or other mismanagement of funds. Any existing Lao legislation or regulations concerning financial mismanagement may also enter into force.

101. Regarding the project's implementation procedures, and social safeguards (including ethnic minority issues), complaints will be handled as follows:

- As a first stage, affected or concerned persons will present, verbally or in writing, their complaints to provincial project staff or advisors, who will have to provide a documented response to the claimants within fifteen days. Reports on each complaint and subsequent measures taken must be given to the Project Consultant, with routine summaries sent to the National Project Management Office as attachment to regular/monthly reports.

- If the claimants are not satisfied with the decision, the case may be submitted to the National Project Office in Vientiane, as well as to local authorities (e.g. the Provincial Assembly or the Lao Front). Specified authorities should record receipt of complaints and reply to the claimants within fifteen days.

102. Claimants will be exempted from any administrative or legal charges associated with pursuing complaints. The national project management team must record reports on each complaint and subsequent measures taken.

8. Monitoring and Evaluation

103. The Project will have a monitoring and evaluation system. It should include participatory monitoring and evaluation (PAME), including village self monitoring of its own health system. Such participatory monitoring efforts would be linked to the overall Project's monitoring and evaluation program. Capacity will be an issue here and will need to be built up through training and experience. The system will need to get villager inputs on causation and solutions to problems, and the overall project management system will need to learn how to learn from villagers in this respect.

104. The monitoring will be at two levels: a) one at the program level; and b) the other at the village level which will be a participatory monitoring and evaluation (PAME) system by beneficiary groups. The PAME monitoring will be developed with the help of an expert who is knowledgeable with M&E in societies with low literacy where alternatives to the text and national language will be included. Monitoring of participation data will, where relevant, be disaggregated by ethnic group, gender, and socio-economic (household) status (wealth groups if available), so that the project's impacts on ethnic groups, women, and the poor can be easily monitored.

105. The Project will commission external evaluations — one at mid-term and one at the end of the Project. These evaluations will include a section on the effectiveness of the ethnic group development strategy. External monitoring of ethnic issues will also be undertaken during the periodic Supervision Missions of the Project. the Lao Front, Institute for Cultural Research or other relevant organizations may also be involved in supervision and M&E activities. Feedback from the regular monitoring and mid-term evaluation will be used to improve the program.

9. Budget

106. The budget for implementation of the EGDP is mainstreamed under the respective project components. Planned expenditures include training, equipment, technical assistance, operating costs associated with consultations and monitoring, as well as the cost of services provided to non-Lao-Tai ethnic groups. These expenditures are expected to exceed 150,000US$ over the three years of project implementation.

Item	**Number**	**Costs**
Training		
Office Equipment		
Specialized equipment		

Medical Supplies		
TA		
Transportation/vehicles		
Testing		
Village funds for activities		
Media		

10. In-country disclosure

107. The EGDP was disclosed on Minister of Health website on March 31, 2010. The text below and the EGDP plan were also sent to target provinces in the south of Lao PDR.
>>>>>>>>

To whom it may concern,

Under additional financing to the Health Services Improvement Project, financing of deliveries and child health services will be expanded in line with the new government "free maternal and child health services" policy. This support is intended to remove financial barriers to key health services and contribute to an increase in utilization. It is expected to benefit all households in the targeted communities, including groups that meet World Bank identification as indigenous persons. In order to ensure that the program is designed and implemented in a manner consistent with this goal, the MOH, in collaboration with Provincial and District Health Offices, will undertake consultation with communities and other local stakeholders prior to implementation. This process will serve to inform community members about benefits under the program, and the details of how it will work. For ethnic groups that have been assessed by the task team as indigenous persons according to OP4.10, the consultation with them will be well documented to show free, prior, and informed consultation leading to broad community support for the project at the level of ethnic communities before any program can proceed in a specific ethnic community. In addition, non-financial barriers to accessing health services for different ethnic groups in the community, as well as measures to address these barriers will be identified. Based on this process, the District Health Office will work with the Lao Women's Union, the Lao Front, and other local stakeholders towards the implementation of these measures.
In case of you need more information, please contact:

Project Management Unit
Department of Planning and Finance, Ministry of Health
Simeuang Road, Vientiane Capital
Telephone: 856 21 214059
Email: hsipmoh@etllao.com

Appendix 1 - Ethnic Groups: LFNC Classification[13]

I: The Lao-Tai Language Family (8 Groups)[14]			
No.	**General Name**	**Subgroup**	**Other local names**
1	Lao		Lao
		Phouan	Phouan
		Kaleung	Kaleung
		Bo	Bo
		Yooy	Yooy
		Nyo	Nyo
			Thay Pheung
			Isane[15]
			Thay Xam
			Thay Yeuang
			Thay Lane
			Thay Cha
			Thay Mat
			Thay O
			Thay Lang
2	Phou Thay		Phou Thay
			Thay Ang Kham
			Thay Kata'
			Thay Kapong
			Thay Sam Kau
			Thay Vang
3	Tai	Tai Dam	Tai Dam (Black Tai)
		Tai Deng	Tai Deng (Red Tai)
		Tai Khao	Tai Khao (White Tai)
		Tai Moey	Tai Mène
			Tai Theng
			Tai Et
			Tai Xom
4	Lue		Lue [16]

[13] This new classification of the Lao Front for National Construction, dating from August 2000, is based on language families generally recognized by scholars internationally.
[14] In technical literature this family is known as Tai-Kadai.
[15] Refers to the Lao of Northeastern Thailand who migrated to Laos.

		Kheun	Kheun[17]
5	Nyouan		Nyouan
		Kalom	Kalom
		Ngiau	Ngiau[18]
6	Yang (Nhang)		Yang[19]
7	Sek		Sek
			Koy
8	Tay Neua		Tay Neua[20]
II: The Mon-Khmer Language Family (32 Groups)[21]			
9	Khmou		Khmou, Kammu
		Khmou Ou	Khmou Ou
		Khmou Lue	Khmou Lue
		Khmou Nyouan	Khmou Nyouan
		Khmou Khrong	Khmou Khrong
		Khmou Rok	Khmou Rok
		Khmou Khwène	Khmou Khwène[22]
		Khmou Mè	Khmou Mè
		Khmou Kasak	Khmou Kasak
		Khmou Cheuang	Khmou Cheuang
			Mok Pray
			Mok Prang
			Mok Tang Chak
			Mok Kok
			Mok Tou
10	Pray	Thin	Thin, Lawa, Lao May[23]
11	Ksing Moul		Phouak, Lao May
12	Phong		Phong, Kaniang

[16] Conventional spelling found in the literature.
[17] Originally from Keng Tung in Burma.
[18] The Lao word for Shan.
[19] The conventional spelling is Nhang, the outsider term for the group that calls itself Yay.
[20] Recent immigrants from the Sze Mao area of Yunnan, not to be confused with the 'Neua' of Sam Neua.
[21] Mon-Khmer is the major branch of the larger Austroasiatic Family.
[22] Or 'Kwène'.
[23] More commonly referred to as 'Phay' in Laos. T'in and Lawa are names used in Thailand.

		Phong Piat	
		Phong Lane	
		Phong Fène	Phong Fène
		Phong Chapouang	Phong Chapouang
13	Thène		Thène, Thay Thène
14	Oe Du		Oe Du, Thay Hat
15	Bit		Bit
16	Lamet		Lamet
17	Sam Tao		Sam Tao
		Doi	Doi
18	Katang		Brou Katang
		Pha Keo	Pha Keo
19	Makong		Brou Makong
		Trouy	Trouy
		Phoua	Phoua
		Maroy	Maroy
		Trong	Trong
20	Tri		Brou Tri
21	Jrou		Laven, Sou’
		Jrou Kong	Jrou Kong
		Jrou Dak	Jrou Dak
22	Triang		Triang
23	Ta Oy		Ta Oy
		Tong	Tong
		Yinr	In
24	Yè’		Yè’
25	Brao		Lavè, Louy Vé
		Kavèt	Kavèt
		Halang	Halang

26	Katu		Katu[24]
		Triu	Triu
		Dak Kang	Dak Kang (Panh Deng)
27	Halak		Alak
28	Oy	Sapouan	Sapouan
		Sok	Sok
		Inthi	Inthi
			Mèkrong
			Mèreuyao
29	Kriang		Ngè’
		Chatong	Chatong
		Ko’	Ko’
30	Cheng		Cheng
31	Sadang		Sedang[25]
		Kayong	Kayong
		Sadang Douan	Sadang Douan
32	Souay		Souay
33	Nya Heun		Tang Kè’, Heunh
34	Lavi		Lavi
35	Pacoh		Pacoh[26]
		Kado	Kado
		Kanay	Kanay
36	Khmer		Khom, Khmer[27]
37	Toum		Toum
		Liha	Liha
		Thay Cham	Thay Cham
			Thay Poun
		Thay Pong	Thay Pong
			Moy

[24] Conventional spelling.
[25] Conventional spelling.
[26] Conventional spelling.
[27] Conventional spelling.

38	Ngouan		Ngouan
39	Meuang		Moy
40	Kri[28]		Salang, Arem
			Tong Leuang
		Maleng	Maleng
		Mlabri[29]	Labri, Tong Leuang
III: The Chine-Tibet Language Family (7 Groups)[30]			
41	Akha		Ko, Iko
		Akha Chi Cho	Chi Cho
		Akha Pouly	Pouly
		Akha Pana	Pana
		Akha Fé	Ko Fé
		Akha Nou Kouy	Nou Kouy
		Akha Louma	Louma
		Akha Oe Pa	Oe Pa
		Akha Chi Pya	Chi Pya
		Akha Mou Chi	Mou Chi
		Akha Ya Oe	Ya Oe
		Akha Kong Sat	Kong Sat
42	Singsily[31]		Phou Nou, Pisou
		Phou Yot	Phou Yot
		Tapat	Tapat
		Ban Tang	Ban Tang
		Cha Ho	Cha Ho
		Lao Xeng	Lao Xeng
		Phay (Phong Saly)	Phay (Phong Saly)
		Lao Pane	Lao Pane
		Phong Kou	Phong Kou

[28] This is a problematic classification. The Vietic (or Viet-Meuang) subgroups of Nakai and adjacent areas consist of a number of languages, of which 'Kri' is one. Salang is a local term for this group, and Arem is the Brou term for the same group. 'Tong Leuang' (Lit. 'Yellow Leaf') is the Lao expression for hunter-gatherers that refers to the shelters constructed for short-term residence during cyclical foraging in the forest, the idea being that when the leaves turn yellow it is time to move on. (cf Chamberlain 1997)

[29] The Mlabri (also hunter-gatherers and hence the confusion) do not belong to the Kri group and are misclassified here, rather they are related to Khmou and Pray and are found in Xaygnaboury.

[30] This is the Lao term for the larger superstock known as Sino-Tibetan which consists of two main families: Sinitic (Chinese) and Tibeto-Burman. Most of the languages of this family in Laos belong to the Tibeto-Burman family, the only exception are the Chinese Ho.

[31] Also found written as 'Sengsaly'.

		Phong Set	Phong Set
43	Lahu		Mou Xoe
		Lahu Dam	Mou Xoe Dam (Black Lahu)
		Lahu Khao	Mou Xoe Khao (White Lahu)
		Kouy[32]	Kouy Soung
			Kouy Louang
44	Sila		Sida
45	Hanyi		Hanyi
46	Lolo		Lolo
47	Ho		Ho[33]
IV: The Hmong - Iu Mien Language Family (2 groups)[34]			
48	Hmong		
		Hmong Khao	Hmong Daw (White Hmong)
		Mong Lai	Mong Leng, Mong Youa (Green Mong)
		Hmong Dam	Hmong Dam (Black Hmong)
	Iu Mien		Yao
		Lantène	Lao Houay, Lènetène[35]
		Yao Phon May Deng	Yao Phon May Deng
		Yao Khao	Yao Khao

[32] Call themselves Lahu Shi 'Yellow Lahu'.
[33] Yunnanese Chinese.
[34] The recent name for this family is Hmong-Mien (Iu Mien is the name of a particular group of Yao). The former name for this family found in the literature until about 1985 is Miao-Yao.
[35] Usually refer to themselves as 'Kim Moun' or 'Mane'

References Cited

ADB. 2001. Participatory Poverty Assessment. Manila: Asian Development Bank.

Bengwayan, Michael A. 2003. Intellectual and Cultural Property Rights of Indigenous and Tribal Peoples in Asia: Minority Rights Group International.

Brown, Michael F. 2003. *Who Owns Native Culture?* Cambridge: Harvard University Press.

Chamberlain, James R. 2000. Preliminary Poverty Diagnostics: Lao PDR. Manila: Asian Development Bank.

Chamberlain, James R., and Phomsombath, Panh. 2000. *Policy Study on Ethnic Minority Issues in Rural Deveopment [Lao PDR]*. Geneva: International Labor Organization (ILO).

Chamberlain, James R. 2002. *Poverty Alleviation for All: Potentials and Options for People in the Uplands*. Vientiane: SIDA.

Kleinman, Arthur. 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Berkeley and Los Angeles: University of California Press.

Knowles, James. 1999. The Social Crisis in Asia. Paper presented at *Twelfth Workshop on Asian Economic Outlook*, Manila, ADB.

Lemoine, Jacques. 1972. Les ecritures du Hmong. *Bulletin des Amis du Laos* 7-8:123-165.

NSC, and ADB. 2001. *Participatory Poverty Assessment*. Vientiane: CPC.

Petelot, Alfred. 1952. *Les Plantes Médicinales du Cambodge, du Laos, et du Vietnam (4 Vols.)*. Saigon: Centre de Recherches Scientifiques et Techniques: Archives des Recherches Agronomiques au Cambodge, au Laos, et au Vietnam.

Politbureau. 1992. *Resolution concerning ethnic minorities in the New Era*. Vientiane: Political Bureau of the Lao People's Revolutionary Party.

Rosenthal, Joshua. 2003. Politics, culture and governance in the development of prior informed consent and negotiated agreements with indigenous communities: Forarty International Center, National Institutes of Health.

Sulavan, Khamluan, Thongpheth Kingsada and Nancy A. Costello. 1995. *Aspects of Katu Traditional Medicine*. Vientiane: Institute for Cultural Research.