

Ethnic Groups Plan

Project Number: 46490-001
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Myanmar: Greater Mekong Subregion (GMS)
Capacity Building for HIV/AIDS Prevention

ETHNIC GROUPS PLAN

1. The Greater Mekong Subregion (GMS) Capacity Building for HIV/AIDS Prevention Project in Myanmar includes a significant proportion of minority ethnic groups within its target groups in the targeted states. The Ethnic Groups' Plan (EGP) ensures analyses of ethnic peoples' needs and their participation and access to benefits of the project.
2. The project is classified as Category B for indigenous peoples.

A. Background

3. Myanmar is one of the most ethnically diverse countries in the world. The country is geographically and administratively divided into seven Regions, which are largely inhabited by the majority Burman population and seven ethnic minority States named after the largest population group in them—the Chin, Kachin, Kayin, Kayah, Mon, Rakhine and Shan. These States are not ethnically homogenous and there are many smaller groups and sub-groups with over 100 different dialects, based on which the Myanmar Government has officially classified '135 national races'.¹ In general, the different ethnic groups in Myanmar have been loosely classified into four main language families: the Tibeto-Burmese, Mon-Khmer, Shan (or Tai), and Karen. Amongst the overall population, the majority Burman constitute 69%.² The largest minorities are Shan, Karen, Mon, Rakhine, Chin, Kachin, Karenni, Danu, Akha, Kokang, Lahu, Naga, Palaung, Pao, Tavoyan, and Wa peoples.

4. Ethnic minority groups likely to benefit or be affected by the project in the proposed sites include Shan, Karen, and Mon peoples. These ethnic groups make up the majority populations in the project sites. A baseline survey which would include gathering and analysis of relevant and appropriate ethnic data/profile will be conducted to strengthen ethnic community mapping in the project areas.

5. Most ethnic Shan live in the lowland valleys of Shan State but large numbers are also found in Kachin State. A majority are Theravada Buddhists, with some elements of animist practices. Shan language is part of the Tai-Kadai language family, and is closely related to Thai and Lao which makes migration to Thailand particularly easy. Karen peoples comprise a number of sub-groups who speak a number of distinct but related languages. A majority of Karen are Buddhists, although a significant number have converted to Christianity. Karen sub-groups are also found in Thailand. Mon language is from the Mon-Khmer group of Austro-Asiatic languages. The vast majority of Mon are Theravada Buddhists.³

6. Consultations will be conducted with representatives of ethnic minority groups who make up key affected populations in target areas during different stages of project implementation. This will initially take place during participatory needs assessment and demographic analysis of provision of health services for STI/HIV and other infectious diseases including malaria reaching ethnic minority populations in target townships. Further consultations will be made during the design and delivery of culturally-sensitive outreach strategies and the development and use of linguistically and culturally appropriate information, education, and communication (IEC) material. Wherever appropriate, implementation of activities will be done in coordination with local ethnic-staffed community-based organizations (CBOs).

¹ Health in Myanmar Report 2009 p.7.

² UN Office for the Coordination of Humanitarian Affairs. Available: <http://www.irinnews.org/report/95462/>

³ Ekeh, Chizom, 2007. *Minorities in Burma*, Minority Rights Group International. London UK.

B. Ethnicity and Disease Vulnerability

7. Ethnicity is directly related to HIV vulnerability for a number of reasons. Remoteness and language differences constrain effective HIV programs in areas populated by minority ethnic groups.⁴ In addition, periods of internal and ethnic-based conflict have led to health threats due to resource constraints,⁵ displacement, and migration. Surveys show a disproportionate disease burden in some minority and border areas stemming from multi-drug resistant tuberculosis and drug-resistant malaria (*P.falciparum*). In the past, civil conflict and lack of opportunity have fostered large-scale migration into neighboring Thailand, in particular ethnic minorities from Shan, Mon, and Kayin States. It is estimated there are more than 3 million registered and unregistered migrants from Myanmar working or (temporarily) residing in Thailand.⁶ Amongst these, migrant women (and men) enter voluntarily and involuntarily into the sex industry, where they often have higher levels of HIV infection than their Thai counterparts.⁷ At the same time, mobile and migrant men also visit sex workers. Due to ongoing movement back and forth across the border, border zones show heightened levels of HIV prevalence. According to Kayin State medical data, surveys in Myawaddy at the Myanmar-Thai border show high levels of HIV prevalence: voluntary confidential counseling and testing done by UNFPA showed a 24.4% HIV prevalence and prevention of mother-to-child transmission testing done by UNICEF and Global Fund showed 1.1% HIV prevalence amongst pregnant women.

8. Subsequent ceasefires have created the opportunity for the development of more effective health service delivery and allowed dialogues to begin with civil society groups and CBOs in previous conflict zones. An ongoing restraint, however, is the limited number of CBOs that have an official status. The recent rapprochement in many areas has also allowed a greater tolerance for use of minority languages in unofficial forms of education and can be potentially used in IEC developed by the project.

C. Ethnic Groups' Plan (EGP)

9. A significant proportion of the population in the target provinces in Myanmar are from ethnic communities. The purpose of the EGP is to outline the potential impacts of the project on ethnic groups; specify actions to address the impacts and help improve the distribution of project benefits to the ethnic communities. Since the lands where the new health facilities will be constructed are owned by the Ministry of Health, no ethnic household will be physically and economically displaced.

10. The below actions will support integration of ethnic peoples' needs and interests into each of the project outputs, and ensure effective participation and access to the benefits of the project. Where impacts on ethnic groups are positive, measures will be identified to enhance and ensure equitable sharing of benefits. Where impacts are potentially negative, appropriate mitigation measures will be identified. The below table outlines anticipated positive and negative effects and recommendations to enhance/mitigate impacts.

⁴ Mint Thwe. 2004 'HIV/AIDS Education and Prevention in Myanmar', *AIDS Education and Prevention* 16 (Suppl. A) p.176.

⁵ National AIDS Program. *Myanmar National Strategic Plan on HIV and AIDS 2011-2015*. p.21.

⁶ Hueget, J., et al. 2012. *Thailand at Crossroads: Challenges and Opportunities in Leveraging Migration for Development*. International Organization for Migration, Bangkok.

⁷ Nigoon, J., Y. Siriporn and B. Mandhana. 2010. *Migration and HIV/AIDS in Thailand: Triangulation of Biological, Behavioural and Programmatic Response Data in Selected Provinces*. International Organization for Migration, Bangkok.

Project Output	Anticipated Positive Effect	Anticipated Negative Effect	Proposed measures to mitigate impact
<p>Output 1: Strengthened planning and management capacity at national, state/region and township level</p>	<p>Members of minority ethnic groups vulnerable to STI/HIV infection and malaria and ethnic group members living with HIV/AIDS benefitted by enhanced services</p>	<p>Possible exclusion of issues and needs of ethnic communities as a result of limited awareness amongst Government staff</p>	<ul style="list-style-type: none"> • Ensure key issues related to service delivery needs of ethnic groups are integrated into State and Township plans and appropriate budgets allocated. • Needs assessment and demographic analysis of provision of health services for STI/HIV and other infectious diseases including malaria reaching ethnic minority populations in target townships • Ensure ethnic community leaders are identified, consulted and targeted in preparation of STI/HIV and malaria response plans. • Ensure the development of guidelines that address ethnic communities' needs and behavioral factors and social contexts which can support or hinder prevention efforts.
<p>Output 2: Enhanced capacity to provide quality and accessible services at township level</p>	<p>Increased understanding and capacity of health staff to meet the needs of, and deliver appropriate services, for ethnic communities</p>	<p>No foreseen negative effects</p>	<ul style="list-style-type: none"> • Training needs assessment of health staff to include an assessment of their knowledge of minority ethnic groups' vulnerabilities. • Ensure that all training and communication materials developed/ adapted for service providers integrate needs of ethnic communities. • Ensure that 100% of township and RHC level ethnic health staff are trained through the various trainings provided by the project (relevant to their positions).
<p>Output 3: Improved access to community-outreach among target populations</p>	<p>Increased knowledge amongst the ethnic communities on STI/HIV and malaria prevention and increased ability to protect themselves</p>		<ul style="list-style-type: none"> • Training and participatory mapping of risk behaviors of at-risk members of ethnic groups by gender and age. • Integration of culturally sensitive approaches to ethnicity into all training and BCC materials, including appropriate language use, developed for service providers and target populations; • Coordination with local ethnic-staffed CBOs in implementation of activities • Ensure that IEC/BCC and peer education materials present positive images and integrate issues and information and life skills needs of ethnic groups. • Ensure materials are produced in appropriate ethnic language as needed

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			and disseminated through appropriate media and channels accessed by ethnic communities. <ul style="list-style-type: none"> • 100% of peer educators supporting an ethnic community to be from the same group. • 80% of ethnic group people reached through the project disaggregated by sex and ethnicity correctly identify HIV transmission and means of prevention.
Output 4: Monitoring and evaluation and project management	Issues and priority needs of ethnic groups integrated in regional policy dialogue and interventions.	No foreseen negative effects	<ul style="list-style-type: none"> • All joint studies include consultation with ethnic communities and report data by ethnicity and sex. • Monitor the proportion of ethnic people accessing services relative to the total population of the ethnic community and report data by sex, age and ethnicity as well as type of services accessed.

BCC = behavior change communication; CBO = community-based organizations; IEC = information, education, and communication; RHC = rural health clinics;
 Source: Asian Development Bank.

D. Implementation Arrangements

11. The overall responsibility for the implementation of the EGP will rest with the Department of Health at the national and township medical office at the subnational levels. Non-government organizations and CBOs will be consulted and engaged in the planning and implementation of activities. The EGPs will be tailored to township contexts, based on research findings during baseline assessments. These specific local level EGPs will contain timelines and responsibilities for action and monitoring during implementation periods. Implementation arrangements and estimated costs of the EGPs are part of the overall project arrangements and total budget. The monitoring of the EGPs will be part of the overall M&E Framework for the Project. Quarterly and annual reports will include a specific summary of progress toward implementing the EGPs.