สำนักงานวิทยทรัพยากร
จุฬาลงกรณ์มหาวิทยาลัย

CHAPTER II

LITERATURE REVIEW

2.1 Minority

Definition

A minority or subordinate group is a sociological group that does not constitute a politically dominant plurality of the total population of a given society. In socioeconomics, the term "minority" typically refers to a socially subordinate ethnic group (understood in terms of language, nationality, religion and/or culture). (Wikimedia Foundation, 2006). Another definition given to minority was "an ethnic person who is not considered as a national by any state, mostly reside along borders" (IPSR, 2005).

Minority rights

A Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities was adopted by General Assembly resolution 47/135 of 18 December 1992 (United Nations High Commissioner for Refugees [UNHCR], 1992). In Article 5 it stated that "*national policies and programmes shall be planned and implemented with due regard for the legitimate interests of persons belonging to minorities*" and "*programmes of cooperation and assistance among*

States should be planned and implemented with due regard for the legitimate interests of persons belonging to minorities."

Minorities in Thailand

Thailand has long been providing refuge to persons fleeing conflict or political repression in nearby countries (Huguet & Punpuing, 2005). In 1949, the nationalist army soldiers (Kuomintang; KMT) and family members took refuge in Thailand following the establishment of the People's Republic of China. Several thousand of Haw ethnic group also moved from China to northern Thailand at that time. They are now currently living in the three provinces of Chiang Rai, Chiang Mai, and Mae Hong Son.

In 1959, over sixty thousand Vietnamese fled to Thailand when warfare broke out between France and Vietminh following with the establishment of the Democratic Republic of Viet-Nam after the 1954 Geneva Accords. In 1975, over one hundred thousand Vietnamese made their way to Thailand following the military rout of the Government of the Republic of Viet-Nam. During the same period, hundreds of thousands of Laotian entered Thailand. From 1975 to 1992, hundreds of thousands of native Cambodian poured across the border during the genocidal Khmer Rouge regime.

Since before 1979 a number of Burmese fled from fighting in Myanmar to Thailand. In 1984 to1988, the mass movements of persons from Myanmar

(then Burma) inflexed to Thailand when the Burmese army moved into Karen State and established bases near the Thai border. In 1988, the military in that country staged a coup and established the State Law and Order Restoration Council (SLORC). These moves caused Burmese students and other pro-democracy advocates to seek sanctuary in Thailand. The number of persons from Myanmar seeking safe haven in Thailand grew rapidly. Nowadays, still, Burmese migrate to Thailand for mainly economic reason (Huguet & Punpuing, 2005). The other minority groups were the primitive tribe living in some provinces of Northern Thailand (namely Tonghueng), the former members of Malaya communist group, Nepali immigrants, highlanders, and the people who are living in the mountains.

Present situation

Until 2004, there are 19 groups of minorities who reside in Thailand and have already been registered by and received color identity cards from the Ministry of Interior as the following table;

Table 1: Minority Groups in Thailand 2005

No	Group/Legal status followed the cabinet resolution	Color of ID Cards	Number
1.	Highlanders	Light Blue Card	180,212
2.	Former Nationalist Army Soldier (KMT)	White Card	8,703
3	Family members of former KMT soldiers	Yellow Card	4,359
4.	Chinese Refugees (Haw)	White with Orange Edge Card	12,725
5.	Burmese Displaced Persons (entered pre March 1976)	Pink Card	22,321
6.	Burmese Illegal Immigrants (with permanent residence, entered post March 1976)	Orange Card	42,879
7.	Burmese Migrant Workers (resided with employers, entered post March 1976)	Violet Card	17,902
8.	Vietnamese Refugees (entered post 1977)	White with Blue Edge Card	14,940
9.	Laotian Immigrants	Light Blue with Blue Edge Card	7,095
10.	Nepali Immigrants	Green Card	988
11.	Former members of Malaya communist group	Green Card	74
12.	Thai Lue	Orange Card	2,040
13.	Tong Lueng (a primitive tribe in Northern Thailand)	Light Blue Card	85
14.	Thai Ethnic Migrants from Koh Kong Cambodia (entered before 15 November 1977)	Green Card	4,939
15.	Thai Ethnic Migrants from Koh Kong Cambodia (entered after 15 November 1977)	Green Card	4,020
16.	Cambodian Immigrants	White with Red Edge Card	2,204
17.	Burmese Immigrants with Thai Origin (entered before 9 March 1976)	Yellow with Blue Edge Card	619
18.	Burmese Immigrants with Thai Origin (entered after 9 March 1976)	Yellow with Blue Edge Card	1,386
19	Highland Community	Green with Red Edge Card	186,929
		Total	514,420

Source: Institute for Population and Social Research 2005

Rights of minority groups in Thailand

Even though some minorities can apply for Thai Nationality according to the cabinet solutions, practically, the process is difficult and time-consuming since Thai citizenship will be considered and granted on a person-by-person basis, and will not be granted to a group of minorities. The Minister of Interior issues the final approval. Moreover, some minorities who have been issued Thai Nationality were deregistered as a result of administrative misconception. Although they could regain Thai Nationality through the hardship endeavors, during that time they lost some essential rights such as education (IPSR, 2005). Minorities who did not receive Thai Nationality faced some restrictions such as traveling, employment, education, and access to public services.

One major barrier regarding minority status is health service accessibility. Prior to the universal coverage scheme or 30 Baht scheme, some of the poorest minorities (those with 13 digits in their ID card, and with numbers that begin with 6 or 7) were given health insurance cards, and received free-of-charge health services. Since the 30 Baht scheme was launched, it has been declared that the provision is for those with Thai Nationality only. There was controversy as to whether the minorities would have access to the scheme. Finally, the royal decree committee judged that minorities are not of Thai Nationality, therefore, the insurance scheme would not cover them. Currently, these minorities continue to be faced with the difficulties of unaffordable health services (IPSR, 2005), not to mention other barriers to health services accessibility such as language barriers, and exclusion by the Thai community.

2.2 Reproductive health and reproductive rights

Reproductive health is fundamental to the social and economic development of communities and nations and is at the core of human development (WHO, 2003). Since The International Conference on Population and Development (ICPD) occurred in Cairo, Egypt in 1994, Programme of Action (PoA) was recommended to the international community as a set of important population and development objectives, as well as qualitative and quantitative goals that are mutually supportive and of critical importance to these objectives. Among these objectives and goals are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health (UNFPA, 1994).

Furthermore, The 58th World Health Assembly also identified specific issues requiring the immediate action on ensuring better health of the poorest people in countries, particularly those *emerging from conflict and crisis.* It stressed the importance of promoting the health of women, newborns and children, in meeting the development goals contained in the Millennium Declaration. It urged Member States of the World Health Organization to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care (WHO, 2005).

Definition of reproductive health

As defined on The International Conference on Population and Development 1994 in Cairo, Egypt "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations [UN], 1994). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are *the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant* (UNFPA, 1994).

Definition of reproductive health care

In ICPD 1994, reproductive health care was defined as "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases" (UNFPA, 1994).

Reproductive health needs

"Health Needs" is defined as "*What a person requires in terms of health care*", a pre-requisite for "needs" to exist is that an individual has the ability to benefit from receipt of a health care service at the individual level. (The European Observatory on Health Systems and Policies, 2006). Therefore, reproductive health needs can be defined as "What a person requires in terms of reproductive health care". Concerning the services recommended by organizations, the reproductive health needs are different in each group of reproductive women, for example, the adolescent might need sex education and counseling about their menstruation, while the married woman needs family planning services, also, counseling of sexual related problems, and the pregnant woman needs antenatal care and safe delivery.

Reproductive health in Thailand

Thailand launched its Family Planning Program in the 1970s. After ICPD in 1994, it was broadened to a national reproductive health program. In July 1997, Thailand released a National Reproductive Health Policy statement reinforcing that "*All Thai citizens at all ages must have good reproductive health throughout their entire lives*" (Ministry of Public Health, 2003; UNFPA, 2005a). At present, the Ministry of Public Health has included new services to cover the needs of its population. Details of the new reproductive health services that exist in Thailand are as follows (Ministry of Public Health, 2003);

(a) Pilot health care programs for adolescents

(b) Sex education

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(c) Post abortion care

(d) Premarital counseling

(e) Counseling on different aspects of women's health including breast feeding

(f) Prevention of mother-to-child transmission of HIV/AIDS

(g) Prevention and treatment of reproductive tract infections

(h) Malignancy in reproductive tract

(i) Infertility

(j) Post reproductive and old age care.

2.3 Reproductive health in minority

There is very little research of reproductive health in minorities, and most of the existing studies were conducted among hill-tribes people in Northern Thailand, who mostly hold the highlander ID cards (Light Blue Card or Green with Red Edge Card).

In 2004, Sanglek et al conducted a health survey among hill-tribes in 20 provinces of Northern Thailand. The results indicated that 65.6 percent of reproductive women used family planning services, 75.7 percent have had a complete course of antenatal care, 70.6 percent had births attended by skilled health personnel, and only 43.8 percent received post partum care. Regarding cancer in the reproductive tract, 77.7 percent never received breast examinations and only 36.3 percent have had Pap smears for cervical cancer screening (Sanglek et al., 2004).

In 2005, Jaikrajang & Sanglek conducted a health status survey in Mhong; a hill-tribe in 13 provinces of Northern Thailand. The survey results found that contraceptive rate was 66.3 percent, and Pap smear rate for cervical cancer screening was 32.8 percent among this group. This is quite low compared with the rate in Thai women. However, the antenatal care rate was 70 percent, and births attended by skilled health personnel was 79.0 percent, which is quite high compare with Thai women (Jaikrajang & Sanglek, 2005).

In 2005, Pasuwan & Sanglek also conducted health survey among Karen hill-tribes in 7 provinces of Northern Thailand. The results indicated that among this group 74.5 percent used family planning services, 60 percent received a complete course of antenatal care, only 56.3 percent had a birth attended by skilled health personnel, and 37.8 percent used post partum care. The screening rate of cancer in the reproductive tract was quite similar to other hill-tribes, as 72.3 percent never received a breast examination and 62.9 percent never had a Pap smear for cervical cancer screening (Pasuwan & Sanglek, 2005).

2.4 PRECEDE model

The PRECEDE (Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation) model developed by Green and Kreuter in 1974, is based on a theoretical foundation that addresses comprehensive assessment and program planning. It has been field tested in a variety of situations

including a guide to the development of local health department programs adopted by several state health departments (Cheney et al., 2000). In addition, the comprehensive nature of PRECEDE allows for application in a variety of settings such as school health education, patient education, community health education, and direct patient care settings (University of South Florida, 2006).

Predisposing factors include an individual's or groups' attitude, perceptions, beliefs, behavior, knowledge, attitudes, and demographic such as socioeconomic status, age gender and family size.

Reinforcing factors are the rewards or feedback a person receives from others as a result of committing an action. Reinforcing factors can serve as motivation or discouragement to repeat the behavior.

Enabling factors are those factors that can help or hinder a person commit an action such as accessibility and availability to the services, skill, and laws (Cheney, Hunt & Schulz, 2000; University of South Florida, 2006).