

# Situation Analysis of Migrant Health in Viet Nam



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## LIST OF ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
ASEAN	Association of Southeast Asian Nations
CSO	Civil Society Organization
FGD	Focus Group Discussion
FSW	Female Sex Worker
GSO	General Statistics Office
HCAB	Health Care Access Barriers
HIV	Human Immunodeficiency Virus
IHR	International Health Regulation
ILO	International Labour Organization
IOM	International Organization for Migration
IUD	Intrauterine Device
JEE	Joint External Evaluation
MBDS	Mekong Basin Disease Surveillance
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
NGO	Non-Governmental Organization
NTP	National Tuberculosis Control Programme
OECD	Organisation for Economic Co-operation and Development
OHS	Occupation Health Standards
SDGs	Sustainable Development Goals
STD	Sexually Transmitted Disease
STIs	Sexual Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHA	World Health Assembly
WHO	World Health Organization

# EXECUTIVE SUMMARY

## Context

Viet Nam is home to dynamic and multi-dimensional population movements. While the country is witnessing an increasing number of internal migrants according to recent census data with an estimated 35 per cent of the country's population located in urban areas by 2017, Viet Nam is also a high-profile migrant-sending nation. This is underlined by the more than 126,000 Vietnamese migrants working under fixed-term contracts in 28 overseas countries/territories in 2016.

Harnessing the full benefits of the migration process can unlock opportunities and deliver much needed income and prosperity to families and communities, yet migrants themselves have been identified as vulnerable populations facing disadvantages in health-care access in Viet Nam and destination countries. The relationship between health and migration is complex and influenced by the socioeconomic and cultural backgrounds of migrants, their previous health history as well as the nature, quality and access to health-care systems prior to moving.

At regional and global levels, ensuring the health of migrants is a human rights quest and a common responsibility with public health impacts that transcend national boundaries. This is recognized as a key Global Health Goal by the World Health Assembly (WHA) and a tenet of the Sustainable Development Goals (SDGs), as evidenced by *SDG 3. Good Health and Well-Being and Target 3.8: achieve universal health coverage*.

Viet Nam's Ministry of Health (MOH) has realized the importance of migrant health and is committed to implementing Resolution 70.15 "Promoting the health of refugees and migrants" endorsed by WHA in May 2017. However, this determination to better safeguard migrants is impeded by a dearth of data on Vietnamese internal and cross-border migrants' health and access to health-care, with limited information on stakeholders' roles in responding to migration-related health challenges domestically and in destination countries. In particular, little is known about health-care access among undocumented migrants.

Cognizant of this intensifying need, the MOH in partnership with the International Organization for Migration (IOM) and World Health Organization (WHO) jointly undertook a situation analysis of migrant health. Its findings are articulated in this ***Situation Analysis of Migrant Health in Viet Nam*** report, which outlines the key needs and steps forward for development of a national action plan to promote the health of migrants in Viet Nam.

## Methodology

To achieve these objectives, the study team used a qualitative research approach to assess the situation of migration and health-care access for migrants, including challenges and other health dimensions of migrants in Viet Nam.

Four key questions underpin this research: 1) what is the current situation of migration in Viet Nam, 2) what challenges do migrants, especially undocumented ones, face in accessing health care, 3) what are stakeholders' perceived barriers to migrant health-care services and 4) which challenges have stakeholders encountered in implementing strategies, policies and programmes related to migrant health. To help answer these questions, the study team firstly assessed migration flows (internal, outbound and inbound) and determined migrant categories with stakeholders involved in migrant health mapped at national and sub-national levels. Secondly, a literature review explored the key themes of migration and migrant health in accordance with the Madrid Operational Framework, SDGs and migrant health in Viet Nam, health status of migrants in Viet Nam and health impacts of migration on families left behind.

Complementing this work were in-depth interviews with migrants and stakeholders as well as focus group discussions (FGDs) with stakeholders in Viet Nam's two largest cities (the capital Ha Noi and Ho Chi Minh City) and three border provinces (Ha Giang, Ha Tinh and Kon Tum). Data were collected from February 2019 to August 2019 and encompassed in-depth interviews with cross-border migrants in the three border provinces, interviews with internal migrants in the two cities and 11 FGDs with health-care providers, public health officers and policymakers engaged in migrant health. Key themes were derived from interview data with migrants, while four thematic areas of the Madrid Framework were used as key themes for the stakeholder analysis.

## **Results**

In setting out to explore barriers to migrant health care in Viet Nam, this study discovered a broad spectrum of gaps and opportunities that characterize the policy environment and the country's response in realizing its international commitments to achieving optimal health outcomes for migrants.

### ***WHA Resolution 61.17***

Viewed through the lens of WHA Resolution 61.17 on the Health of Migrants Global Operational Framework, Viet Nam has developed a range of national laws and policies that impact on health-care access for migrants and endorsed several international and regional frameworks that support migration and health. Despite these steps forward, two key laws (on Residence and Health Insurance) can impact on health-care access for internal and outbound migrants on residency grounds, while further International Labour Organization (ILO) conventions await ratification in the wake of earlier approvals.

While some policies and national strategies ensure equitable access to health promotion, disease prevention and care for any type of migrant in Viet Nam, laws tend to be more restrictive than protective in health-care services for internal migrants. Short-term and irregular migrants without residence registry are particularly vulnerable. In terms of monitoring migrants' health, there is no mechanism in national surveillance systems to collect migrant-specific health data. As internal migrants not residing in registered localities may be excluded from national surveys, this results in an acute lack of information about health-care needs, access and trends among migrants in Viet Nam.

### ***SDGs 3 and 5***

In parallel, the SDGs also spotlight the gaps and opportunities for Viet Nam to enhance migrant health outcomes. With respect to *SDG 3 Good Health and Well-Being, specifically Target 3.8: Achieve universal health coverage*, Viet Nam is committed to achieving universal health insurance coverage for at least 90 per cent of its population by the end of 2020. However, regional disparities in the uptake of health insurance among migrants and non-migrants have emerged, with migrants facing perceived high costs and burdensome documentation requests. Short-term and irregular migrants without residence registry are not adequately covered by law and incur high out-of-pocket payments. While the government recognizes this vulnerability, a legislative remedy to promote equal access to quality basic services for migrants needs to be strengthened.

The acute vulnerability of migrant women and girls is captured by *SDG 5 Gender Equality, Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights*. Despite the majority of female migrant workers in Viet Nam operating in the informal sector without employment contracts and limited access to social protection services, there is still an unmet need for sexual reproductive health care among migrants. While migrants are a focus population of a national strategy for population and reproductive health during 2011–2020, current reproductive health services have been found to not meet the needs of vulnerable groups including migrants, ethnic minorities and people-living-with-HIV. Migrant women and girls, especially those trafficked or in an irregular situations, often face challenges to access appropriate specialist health care, information and education. Migrant sex workers are also at risk of not accessing reproductive health care, with stigma and no legislative protection major hurdles.

While migrants are recognized as a vulnerable population, with WHA Resolution 70.15 having called for action from member states, Viet Nam's MOH faces a shortage of human resources for provision of migrant-friendly health-care services and limited information about health of migrants due to their mobility and residential status. This compounds the vulnerability of migration populations at risk from common threats such as HIV, malaria, tuberculosis as well as alcohol abuse and cigarette smoking.

Migration may not only disrupt traditional family structures, but also protection mechanisms for left-behind families with intergenerational co-residence playing an important role in supporting the elderly. The physical and emotional health of children left behind is also affected by migration of parents or guardians of children. Although migration can financially improve the living conditions of migrants' left-behind families, it might not be beneficial for their health and social support mechanisms for left-behind families of migrants are needed in Viet Nam.

### *Key Barriers*

Overall, these gaps and opportunities to enhance migrant health outcomes when viewed through the dual lens of WHA Resolution 61.17 and the SDGs can also be seen as barriers as reflected by in-depth interviews with internal and cross-border migrants at the study sites. In total, the research team identified 22 barriers among cross-border migrants and 16 among internal migrants and grouped them into four key sets (structural, financial, cognitive and social support).

A key **structural barrier** highlighted by study respondents was complex administrative procedures for use of health insurance at health-care facilities. With the current patient referral system developed under the resident registration system, internal migrants face significant barriers to obtain health insurance and access public health-care services as they must register in a new area. This leaves migrants with out-of-pocket expenses for health care, to self-medicate.

The need for gender-sensitive health services was also highlighted by respondents to overcome a reluctance by many female migrants to seek reproductive or gynecological-related health care. Ethnic minorities tended to receive insufficient information on reproductive health care, underlining the shortage of bilingual health-care providers in ethnic minority and border areas. Moreover, migrant groups in general rarely received health-care information in their communities, with cross-border and internal migrants missing out due to prolonged absences abroad and work schedules, respectively. Excessive hospital waiting times were also pinpointed as a significant barrier, with many migrants reluctant to incur lost income while away from work places unless the health condition was serious. Cross-border migrants, who mostly work in the informal sector without employment contracts and health insurance, were also found to encounter specific barriers. Portable health insurance and cross-border referral systems would help reduce their health and financial burdens.

With the cost of care and health insurance status categorized under **financial barriers**, key obstacles were identified by the study team across the two migrant groups. Unaffordability of health-care costs were spotlighted by low-income migrants who, even with health insurance, still faced higher hospital fees without a referral document. Cross-border migrants also encountered high costs for even basic medicines when abroad. These reported cost burdens are compounded by migrants' limited financial capacity, with insufficient disposable income for health-care needs. Self-medication was commonly practiced by migrants, many of whom claimed to be in good physical health.

The research team also explored **cognitive barriers** to migrants accessing health care, including aspects related to knowledge and communication. The perceived unprofessional attitudes of health-care professionals and administrative officers was reported by migrants as a deterrent to seek care. Limited understanding and knowledge of how access to health-care services also exposed migrants, many of whom have limited education, to greater health risks due to insufficient knowledge and misinformation. Such knowledge gaps were also evident with respect to the benefits of health insurance, including the right to transfer registration status to other facilities at destination locations. Cross-border migrants were also at risk of being knowledge deficient on destination country health-care facilities, living costs and emerging diseases in neighbouring countries.

**Social support barriers** encapsulate employers' compliance with regulations and local community support to enable migrants to access health-care services. With 91 per cent of interviewees reporting not having employment contracts due to informal sector work, this lack of employment safeguards and support from employers can leave migrants locked out of the health-care system. The legal status of migrants can still prove a key determinant to accessing health insurance, developed under the household registration book, meaning those without residential status are unable to purchase voluntary health insurance nor change registered hospital on the health insurance card. In addition, migrants reported a lack of health and social welfare support at destinations. This is compounded by a potential lack of legal status, employment contracts or remote destinations which lead to migrants' exclusion from host communities.

### *Stakeholders*

FGDs with government and health sector stakeholders at central, provincial, district and commune levels also delivered insights into the challenges and barriers in provision of health-care services for migrants.

Within the arena of coordination and partnerships among stakeholders, insufficient networking and collaboration across ministries were highlighted. This is compounded by migration and migrant-related health issues not specifically assigned to one government agency. Limited collaboration between public and private health sectors, information sharing between management levels that oversee migrants' health and the need for cross-border referral systems and collaboration were also identified.

Exploring policy and legal framework development, FGD participants pointed to inconsistent implementation of local level policies as a barrier to migrants accessing social welfare services, a finding also reflected in interviews with migrants. Monitoring migrant health remains challenging, with difficulties in identifying and reaching mobile and migrant populations. A comprehensive migrant monitoring system is essential to meet this need, however, FGDs and in-depth interviews revealed shortcomings in the current system and State information collection. The lack of a national migrant tracking database was reported as the root cause of ineffective monitoring of migrants. Barriers to achieving a migrant-friendly health-care system were identified by FGDs, including a lack of community health-care communication programmes, a need for gender-sensitive health services, limited funding for quality health care, migrant stigma, a lack of interpreters and time constraints on migrants.

Stakeholders also shed light on migrant challenges from their perspectives, with complex administrative procedures – particularly household or temporary registration for internal migrants – highlighted as a major barrier to policy implementation. A range of further highlighted factors also dovetailed with findings from interviews with migrants themselves. They included the perceived prohibitively high fees for health insurance, affordability of health-care costs, unprofessional attitudes of health workers and administrative staff towards migrants, limited knowledge about access to health-care services, low awareness of health insurance benefits, lack of destination knowledge and support from employers.

### *Summary*

In exploring migrant barriers to health care, strikingly almost all self-reported obstacles that prevented migrants from accessing social services were underlined by expert participants in the research. Such barriers ranged from unsuitable policies, to a lack of migrant-sensitive health services.

Importantly, the study pinpointed the residency book (*ho khai*) system as a hidden obstacle that prevented migrants from accessing social services at destinations as access to such services is limited to the registered residency location. Inconsistent and burdensome administrative procedures to register new housing residency were documented by participants. As a result of not registering in a new location and insufficient knowledge of health insurance rights, internal migrants are forced to pay out-of-pocket expenses or practice self-medication. The abolishment of the book system and introduction of electronic management, with the new ID card in 2020, are expected to mitigate the problems of migrants' residence registration and access to social welfare services.

This report analysed barriers from various dimensions “Policy-Legal Frameworks”, “Monitoring Migrants’ Health”, “Migrant-Sensitive Health Services”, “Partnerships, Networks, and Multi-Country Frameworks”, SDGs 3 and 5 and “Social support, understanding, and cooperation for migrant health”.

*Policy-Legal Frameworks:* Despite enhancements to migrant health-focussed frameworks, their effectiveness has been blunted by inconsistent implementation at local level and a lack of resources, communication between central and local governments and monitoring at border areas. The reality on the ground requires the government to build a comprehensive action plan to maximize potential improvements to migrants’ health and access to health care.

*Monitoring Migrants’ Health:* An effective migrant-focused monitoring system was identified as a key step towards enhanced migrant health, yet local governments underlined difficulties in identifying and reaching geographically mobile and migrant populations. This impedes migrants’ ability to obtain health-care knowledge and health authorities to deliver follow-up treatment.

*Migrant-Sensitive Health Services:* Through migrant interviews and FGDs with experts, the study identified several health-care barriers related to the lack of migrant-sensitive health services. These obstacles range from a lack of ethnic minority interpreters in the health system, to unprofessional attitudes of health-care professionals and administrative officers, stigma and a general reluctance from migrants and ethnic minority groups to discuss reproductive health. Stakeholder interviewees expressed concern about the limited coverage of health communication programmes due to funding constraints.

*Partnerships, Networks, and Multi-Country Frameworks:* Greater cohesiveness between various migrant health actors is essential to address an apparent lack of synergy between private health-care providers and public health entities. The role of private health-care facilities in migrant care was found to be more significant than previously estimated. Hence, private facilities have access to significant information on migrants’ health, yet regulations requiring the recording and submission of such reports to local authorities remain ineffective. Within central government, the lack of a formal inter-ministry cooperation mechanism to focus on migrants’ issues resulted in inefficiencies from a lack of communication, coordination and partnerships between related actors.

*SDG 3 - Good Health and Well-Being (Target 3.8 Achieve Universal Health Coverage):* Viet Nam has made great efforts to ensure its population benefits from financial risk protection through health insurance, with broad health insurance coverage across the population reported by the end of 2018. However, previous research illustrates the gap in health insurance coverage between migrants and the general population. In addition, many migrants stated health insurance did not shield them from significant costs for health services. For outbound migrants, there is a scarcity of data on health insurance coverage in destination countries.

*SDG 5 - Gender Equality (Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights):* The necessity for gender-sensitive health services was underlined by migrants and stakeholders. Numerous women reported a reluctance to see health professionals due to unease when discussing reproductive health issues. This could be a result of a lack of common languages, gender-sensitivity of health-care professionals or ethnic minority-related cultural differences.

*Social support, understanding, and cooperation for migrant health:* Migrants face various cultural differences in destination areas or countries. In such situations, all relevant entities surrounding migrants should be supportive for their health and broader inclusion. The study’s findings draw a complex web of inter-linked factors impacting on migrants’ access to health care. To address these barriers, an integrated approach from central government and all stakeholders is essential. Establishment of a data collection system on migrants’ health status, detailed migrant-focused policies developed and implemented at local level and a synergized approach by all stakeholders in migrant health are essential steps forward.

## *Recommendations*

This research “Situation Analysis of Migrant Health in Viet Nam” identified key factors that impact on the health of migrants and their ability to access health care: fragmented policy implementation at local level, insufficient migrant health monitoring systems, lack of effective partnerships and networks between stakeholders, limited migrant and gender sensitivity among health-care professionals, administrative officers and broader society. To address these interconnected issues comprehensively, the research team proposes multiple action points in each key theme in line with recommendations of Resolution WHA 70.15, and six priorities of the Draft global action plan, 2019-2023 presented at the WHA in May 2019.

To realize these action points, as presented in Chapter 5. Conclusion and Recommendations page 57, this report’s overarching recommendation is the establishment of an inter-ministerial working group or committee at national level to enable the Government of Viet Nam to manage migrant-related health issues and coordinate with relevant governmental entities to foster the design and implementation of more migrant-friendly policies.

In conclusion, given the acute lack of information about migrant health in Viet Nam, this report is an important milestone in providing the government with a baseline situational assessment to guide action in addressing migrants’ needs, gaps and priorities for future planning. Collaboration across the departments of MOH and other ministries through taking inter-sectoral action is crucial for advancing the migrant health agenda in Viet Nam.

# CHAPTER 1. INTRODUCTION

## Background

Viet Nam has a long history of population movements. An estimated 35 per cent of the country's population lived in urban areas in 2017. Recent census data have indicated an increasing proportion of internal migrants (1). Viet Nam is also a migrant-sending country. Approximately 126,000 Vietnamese migrants were working under fixed-term contracts in 28 overseas countries/territories as destinations in 2016 (2). Migrants have been identified as vulnerable populations facing disadvantages in health-care access in Viet Nam and destination countries (3).

The health of migrants has a significant impact on a wide range of areas, including health and non-health sectors, in Viet Nam. Healthy migrants are an important workforce that contribute to the productivity and growth of host communities and their communities of origin. At regional and global levels, ensuring the health of migrants is a human rights quest and a common responsibility with public health impacts that extend beyond national boundaries. This is recognized as a key Global Health Goal by the World Health Assembly (WHA). Global health security requires collective efforts across countries as emerging infectious diseases, such as Ebola, SARS and the Zika virus, threaten the international community.

The relationship between health and migration is complex, dynamic and influenced by the socioeconomic and cultural backgrounds of migrants, their previous health history as well as the nature, quality and access to health-care systems prior to moving. It is also affected by the circumstances surrounding the migration process including travel and transit conditions, social and health characteristics, such as working and housing conditions, as well as access to health-care services in the country of destination. Language skills and familiarity with a host community's culture, policy and legal frameworks, attitudes of host communities and health workers and epidemiological factors also play important roles in determining health outcomes.

There is an acute lack of data on Vietnamese internal and cross-border migrants' health and access to health care, with limited information on stakeholders' roles in responding to migration-related health challenges in Viet Nam and destination countries. In particular, little is known about health-care access among undocumented migrants, especially internal migrants without a household registration (*ho khau*) at their place of residence. Undocumented migrants are often excluded from national health surveys and censuses due to a lack of a sampling for studies of undocumented migrant populations. There is also a dearth of studies on health-care access among cross-border migrants. The ASEAN Economic Community, which took effect in 2015, allows for free movement of goods, services, skilled labour and capital. This regional transformation has inevitably led to increased movements of people across borders in ASEAN countries, making control of communicable diseases (such as TB, HIV and Malaria) regional issues. Thus, more communicable disease control efforts targeted at cross-border migrants are needed in the ASEAN region, including Viet Nam.

The Ministry of Health (MOH) of Viet Nam has recognized the importance of migrant health and committed to implementing Resolution 70.15 'Promoting the health of refugees and migrants' endorsed by WHA in May 2017. To achieve the vision of the 2030 Agenda for Sustainable Development based on the principle of "leave no one behind", it is also imperative that migrants' health needs are adequately addressed. In response, the MOH of Viet Nam, International Organization for Migration (IOM) and World Health Organization (WHO) jointly undertook a situation analysis of migrant health to identify needs, gaps and priorities for future planning. Its findings underpin this report *Situation Analysis of Migrant Health in Viet Nam*, which outlines the key needs and steps forward for development of a national action plan to promote the health of migrants in Viet Nam.

Research questions of this study are as follows:

## Research questions

1. What is the current situation of migration in Viet Nam?
2. What challenges do migrants, especially undocumented ones, face in accessing health care?
3. What are stakeholders' perceived barriers to migrant health-care services?
4. Which challenges have stakeholders encountered in implementing strategies, policies and programmes related to migrant health?

## Methodology

### Study design

The project team used a qualitative research approach to assess the situation of migration and health-care access for migrants, including challenges and other health dimensions of migrants in Viet Nam. The study was conducted from January 2019 to August 2019.

First, the study team assessed migration flows (internal, outbound and inbound) and determined migrant categories. A mapping of stakeholders involved in migrant health at national and subnational levels relevant to migrant categories was conducted. Second, a literature review was undertaken on the following key themes:

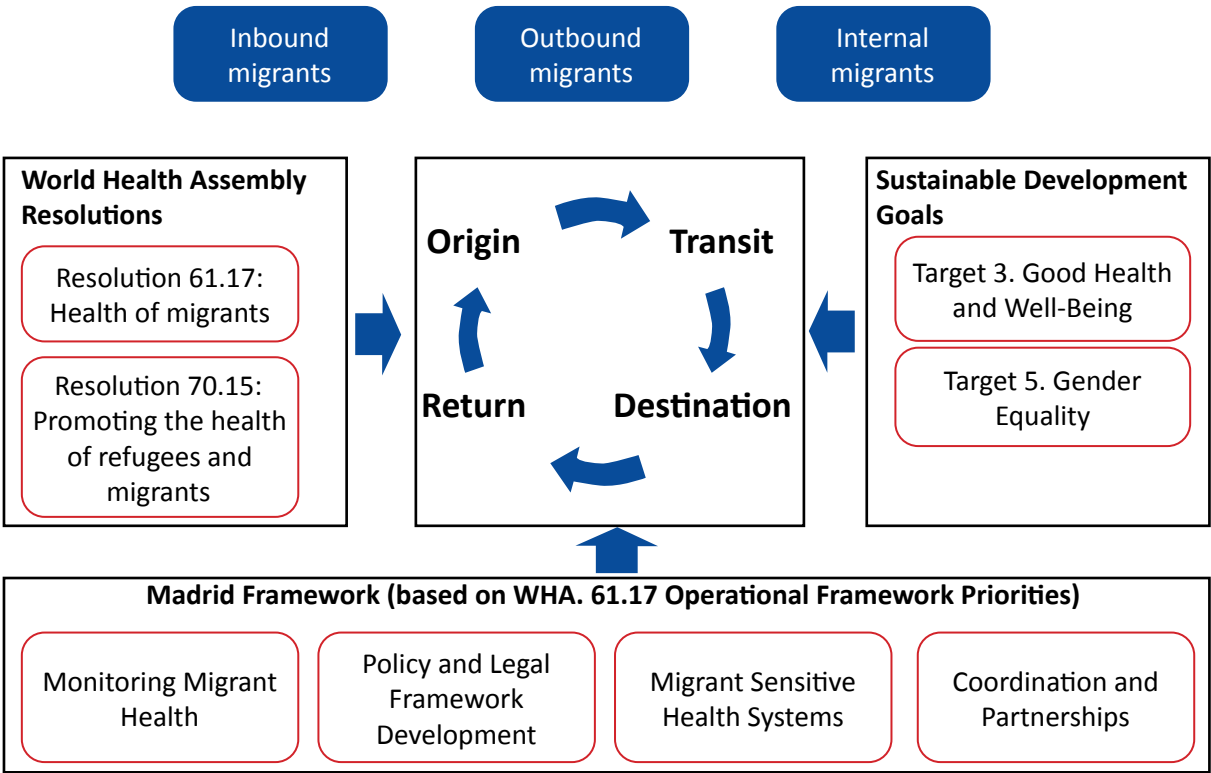
**Table 1. Key themes undertaken for the literature review**

No.	Key theme	Content
1	Migration and Viet Nam	<ul style="list-style-type: none"><li>• Socioeconomic context</li><li>• Internal migration</li><li>• Outbound migration</li><li>• Inbound migration</li></ul>
2	World Health Assembly Resolution 61.17 on the Health of Migrants Global Operational Framework	<ul style="list-style-type: none"><li>• Policy-legal frameworks</li><li>• Monitoring migrants' health</li><li>• Migrant-sensitive health services</li><li>• Partnerships, networks and multi-country frameworks</li></ul>
3	Sustainable Development Goals (SDGs) and migration health in Viet Nam	<ul style="list-style-type: none"><li>• SDG 3. Good Health and Well-Being<ul style="list-style-type: none"><li>- Target 3.8: Achieve universal health coverage</li></ul></li><li>• SDG 5. Gender Equality<ul style="list-style-type: none"><li>- Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights</li></ul></li></ul>
4	Health status of migrants	
5	Health impacts of migration on families left behind	<ul style="list-style-type: none"><li>• Health of children left behind</li><li>• Health of caregivers of children left behind</li></ul>

Electronic databases on key themes were searched, with results restricted to English and Vietnamese language publications from 2009 to 2019. The study team not only included peer-reviewed literature, but also unpublished migration and health-related information from the Vietnamese Government, international agencies and non-governmental organizations (NGOs). The study team gathered baseline information to identify laws, policies and legal frameworks in health and non-health sectors (such as immigration and labour) that impact on migration flows, migrant categories and health of migrants in Viet Nam. The health of migrants, including enabling and vulnerability factors, was explored through the literature reviews and key informant interviews. As recent census data have revealed the proportion

of female internal migrants was growing, the project also assessed gender equality and issues faced by female Vietnamese migrants (4). A conceptual model for the situation analysis of migrant health in Viet Nam is illustrated in Figure 1. The desk review used four pillars of the Madrid Framework, offered in the 2010 Global Consultation on Migrant Health, and recommendations of WHA Resolutions 61.17 and 70.15 as a guiding framework. The study team also examined the situation and gaps to achieve relevant SDGs in migrant health by analyzing the situation through the literature review and interviews with migrants and stakeholders as well as focus group discussions (FGDs) with stakeholders.

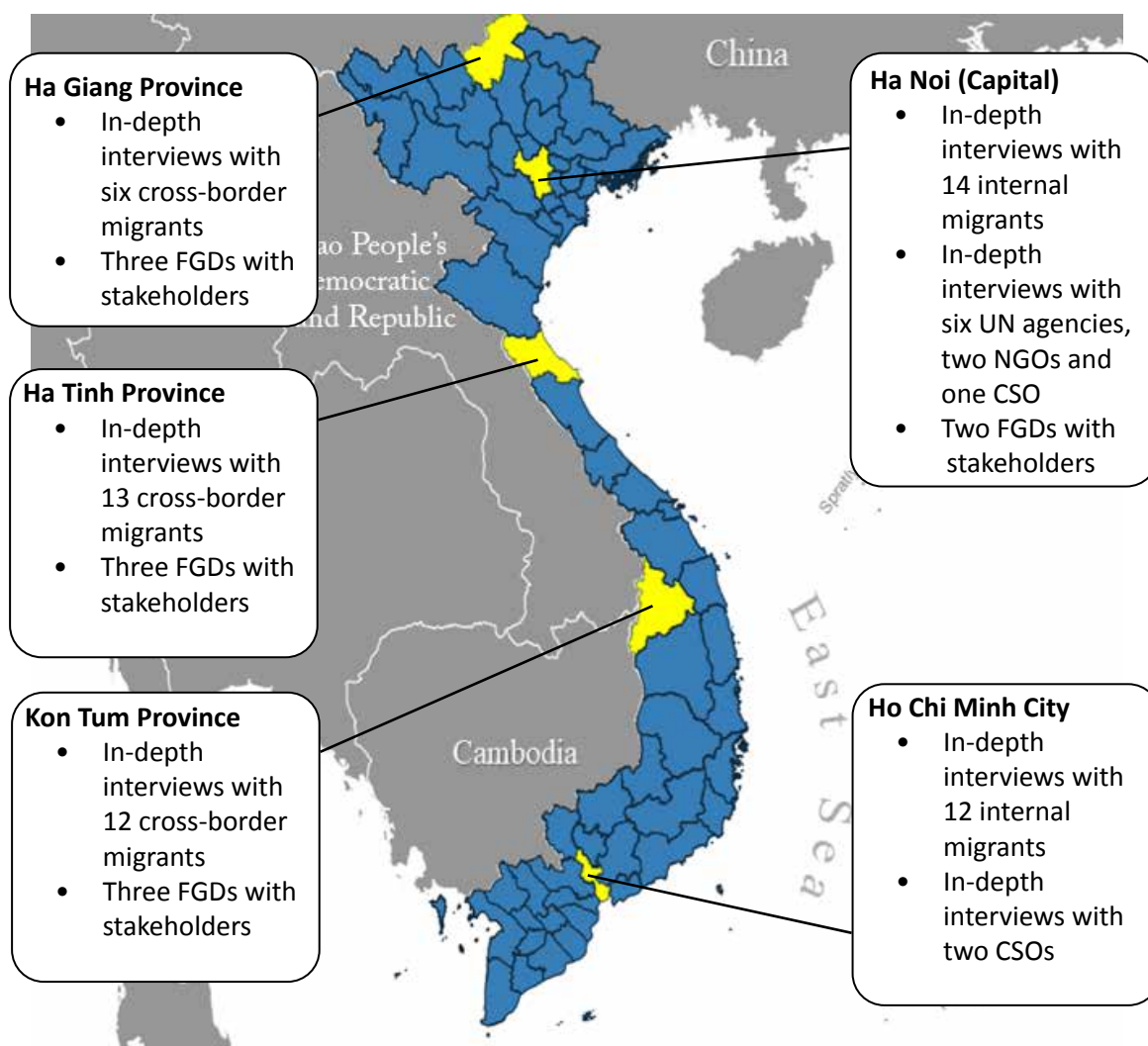
**Figure 1. Conceptual model for the Situation Analysis of Migrant Health in Viet Nam**



Source: *Health of Migrants: Resetting the Agenda*, Report of the 2nd Global Consultation, IOM and WHO, 2017.

The study team conducted FGDs with government stakeholders, such as the ministries of Labour, Invalids and Social Affairs (MOLISA), Foreign Affairs and Public Security involved in migration and health. UN agencies, international NGOs and civil society organizations (CSOs) were also interviewed. FGDs among government stakeholders and in-depth interviews with other agencies provided an opportunity to explore migrant health with stakeholders. This situation analysis included field visits to provinces of Ha Giang, Ha Tinh and Kon Tum where cross-border movements by Vietnamese migrants to work in neighbouring countries are most common. The study also included in-depth interviews with cross-border migrants in these three border provinces of Viet Nam and interviews with internal migrants in Ha Noi and Ho Chi Minh City (Figure 2). Site selection for the study was carried out by experts from the Ethics Council of the Department of Medical Service Administration, MOH, Viet Nam who have an awareness of migration issues in respective provinces/localities. The sites were also selected to ensure a practical schedule for the study team.

**Figure 2. Map of study sites in Viet Nam**



Source: Map produced by IOM. This map is for illustration purposes only. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the International Organization for Migration.

## Study sites

### Ha Tinh province

Ha Tinh province is located in central Viet Nam. According to the General Statistics Office (GSO) of Viet Nam, Ha Tinh's population in 2017 was 1,272,200 people. With an underdeveloped local economy and limited job opportunities, Ha Tinh residents tend to migrate in search of employment within industrial zones located in and around Ha Noi, Ho Chi Minh City, Binh Duong and Dong Nai. According to data from Ha Tinh's Department of Health, the province had the highest number of residents nationally who migrated to other provinces or countries in recent years, particularly internal migrants. In 2019, approximately 53,000 people from Ha Tinh were reportedly working overseas. Of those, only 50.47 per cent reportedly had employment contracts. A sizeable number of migrants were solicited by brokers to work abroad without proper documents. The most common destinations were China, Japan, Malaysia, and the Republic of Korea. Ha Tinh authorities struggle to monitor the mobility of local people who migrate abroad due to increased irregular migration without proper documentation and through illegal channels.

A high number of cross-border migrants originate from Son Kim I commune in Huong Son district due to its proximity to Cau Treo Border Gate to Lao People's Democratic Republic. All interviewees were of Kinh ethnicity, and the average age was 48 years. The longest period of stay in Lao People's Democratic

Republic among interviewees was one year, while the shortest was one month. Most (78%) were small traders, while only a small number reported working in the agricultural sector. Others were domestic helpers. The majority of participants completed at least secondary school education.

### Ha Giang province

Ha Giang is one of the poorest mountainous provinces in northern Viet Nam, sharing a border with China. Ha Giang's population, according to the census on 1 April 2019, amounted to 854,679 people - of which H'mong made up 32.9 per cent, followed by Tay (23.2%), Dao (14.9%), Viet (12.8%) and Nung (9.7%).

The province is prone to natural disasters, including harsh weather particularly during winter that makes life for ethnic minorities in the highland area challenging. From 2014–2018, internal migration was common and unreported to local authorities. During that period, the majority of migrants were ethnic minorities and usually coincided with the end of the Tet New Year and dry season. Common internal destinations for Ha Giang migrants were Dak Lak and Lam Dong in the Central Highlands, which attracts a large number of manual workers during the coffee, rubber and pepper harvest season. In recent years, Ha Giang authorities have implemented several policies to enhance agricultural development, reformed health insurance fees and resettlement programmes for ethnic minorities.

Interviews with migrants were conducted in Then Chu Phin commune in Hoang Su Phi district, which shares a border with China. Due to challenges in accessing remote areas and a tight research schedule, the research team was only able to interview five cross-border migrants to China. They were from the H'mong ethnicity group, and their average age was 36.5 years. The length of stay in China varied between eight to 12 months. Most migrants found work in farming and other manual jobs. Average education was only 1.8 years. Even though two-in-five interviewees reported they completed Grades 4 and 5 of primary education, their Vietnamese language reading and listening skills were limited.

### Kon Tum province

Kon Tum is located in the Central Highlands and shares a border with Cambodia and Lao People's Democratic Republic. According to the General Statistics Office of Viet Nam, Kon Tum's population in 2018 was 535,000 people. Agriculture is the backbone of its economy. The economic reform period 1986–1990s saw the settlement of people in Kon Tum, especially from northern provinces, which rejuvenated it. Today, migrants have assimilated themselves in Kon Tum as residents. The province's Department of Health reported that internal immigration within Kon Tum was dynamic, with 22,040 internal migrants in 2017 and 12,986 in 2018.

Due to the Bo Y Border Gate, Ngoc Hoi district was the most popular destination for migrants. Many seasonal workers stayed in Kon Tum to earn incomes during the coffee, pepper and rubber harvest season. Construction work also attracts manual workers from other provinces to Kon Tum. The study team conducted in-depth interviews with cross-border migrants at Bo Y commune. After assessments of interview transcripts, five interviewees were chosen for analysis. Two were Kinh, two Brau and one a Muong. While male cross-border migrants were forest-goers, female cross-border migrants were often farmers or picked seeds in the forest. One interviewee had 11 years' education, while the others dropped out of school at an early age. The duration of stays in Cambodia or Lao People's Democratic Republic varied between two months and two years. However, monthly incomes of migrants were lower than those of the Ha Giang and Ha Tinh interviewees.

### Ha Noi and Ho Chi Minh City

Based on the "2015 National Internal Migration Survey: Major findings", the fast pace of economic reform from the 1980s paved the way for industrialization and urbanization, especially in Ha Noi and Ho Chi Minh City (5). These cities offer significant working opportunities for rural residents able to move after the harvesting season. The report also emphasized the dominant rural-to-urban migration trend in search of employment and study. Nearly one-third of migrants had an employment contract under

three months validity or informal agreements, which could lead to a higher risk of unemployment, economic losses and increased vulnerability to abuse and exploitation compared to permanent residents.

This report's research team conducted in-depth interviews with internal migrants in Ha Noi and Ho Chi Minh City and targeted migrants working in informal sectors who might be marginalized from mainstream society. In Ha Noi, there were 12 interviews, with an even gender split. The average age was 41.6 years. The majority (10 out of 12) of interviewed migrants were Kinh ethnicity, while only two were ethnic minorities (Thai and H'mong). Migrants' occupations were sex worker (SW) (four), construction worker (two), street vendor (two), baby sitter (one), manual worker (one), driver (one) and farmer (one). Interviewed migrants' incomes fluctuated from VND 4-10 million (USD 172–430) per month. Two migrants had employment contracts in the past year worth VND 9 million (USD 387) and VND 20 million (USD 861) per month, separately. One interviewee reported her income was only VND 1.5 million (USD 64.5) per month. In Ho Chi Minh City, the same quantity of migrants was selected, and their occupations were student (four), shoe polisher (three), construction worker (three) and street vendor (two). Their income varied from VND 1.5-8 million (USD 64.5-344) per month, with one interviewee reporting VND 20 million (USD 861) per month. The lowest level of educational attainment was primary school education, while the highest was university.

### Study participants and sampling

Purposive sampling was used for FGDs and interviews with stakeholders. The sample size for the research followed the saturation concept as there is no precise way to determine a sample size in qualitative research (6). After data analysis, the researchers found repetitions in responses from study participants as highlighted in Chapter 3. Due to time and resource constraints, the study team did not recruit further participants than those set at the beginning of data collection.

FGD participants were divided into three main groups: health-care providers, public health officers and policymakers involved in migrant health. The study team conducted 11 FGDs. Each FGD was formed based on the relevance of its role in migrant health in Viet Nam. Participants were informed by an introductory email or phone call. A participant information sheet and consent form were provided on site and all consenting interviewees were included in the study.

During field visits, interviews with Vietnamese cross-border migrants were conducted individually at their homes or health-care facilities. Participants were: 1) aged 18 and above, 2) born in Viet Nam and 3) who reported crossing a border for work and working in a neighbouring country (Cambodia, China and Lao People's Democratic Republic) for more than one month in the 12 months prior to the interview. In addition to interviews with 31 cross-border migrants in the three provinces, the study team interviewed 26 internal migrants in Ha Noi and Ho Chi Minh City. The inclusion criteria of internal migrants was: 1) a migrant who moved from one district to another in the five years prior to the interview, 2) who resided in a current place of residence in Ha Noi or Ho Chi Minh City for one month or more, 3) aged 18 and above and 4) was born in Viet Nam. After reviewing interview transcripts, 14 participants were excluded as they did not meet selection criteria, such as length of stay at current residence and nationality. Cross-border and internal migrants were recruited using a convenience sampling method. Local authorities and CSOs assisted the research team in recruiting migrants for the study.

### Data collection

Data were collected from February 2019 to August 2019. Data collection was three-fold: 1) desk reviews, 2) in-depth interviews and FGDs and 3) field observations during field visits to the provinces of Ha Giang, Ha Tinh and Kon Tum.

To protect respondents' privacy, interviews with internal migrants were conducted individually either at their home or private room of their work place. Similarly, interviews with cross-border migrants were also individually either at their home or private room of a health-care facility. Interview appointments were made based on interviewees' convenience and arranged over the telephone or in person. FGDs

among government stakeholders and interviews with United Nations agencies, NGOs and CSOs were conducted at their workplaces. In each organization, staff with experience of working on migrant health issues were selected. Stakeholders were informed by an introductory email or phone call. FGDs were initiated to explore stakeholders' collective views about responsibilities and challenges in migrant health. Interview questions were specifically developed for each FGD based on its engagement with migrant health. Annex 1 shows interview questions and FGD guide.

Interviewers and facilitators for FGDs were comprised of public health officers from MOH, IOM and WHO, and a lecturer from Ha Noi Medical University. The list of researchers can be found in the list of individuals who contributed to the study on page iv. The majority of interviewers and facilitators for FGDs were female. All interviewers had experience in conducting qualitative research. None had any relationship with migrant respondents prior to interviews. On the other hand, some government officers who participated in FGDs might have already known the facilitators of FGDs through their work with the government. Interviewers and facilitators were aware of potential interviewer and respondent bias.

A participant information sheet and consent form were given to all study participants and obtained by interviewers and facilitators before an interview or FGD. All consenting interviewees were included in the study. Among those who were given the participant information sheet and consent form, five internal migrants withdrew from participating in the study. All interviews and FGDs were recorded electronically through an audio recorder after the researcher gained a written informed consent form for participation in this study as well as consenting to be audio-recorded. Researchers took handwritten field notes to document the following information: casual observations, paraphrases of participant responses, interview backup documentation, researchers' questions, conclusions and observations discussed during debriefing sessions. Filed notes gave researchers an opportunity to include validation steps in qualitative research. Observations included field descriptions of activities, behaviours, actions, conversations, interpersonal interactions, observation tools such as having a health insurance card. After an on-site interview, the study team transcribed audio recordings and typed field notes into computer files. Each interview and FGD lasted 45 minutes to one hour. Since data were audio-recorded, transcripts were not checked with study participants for comments and/or corrections.

## Data analysis

Two researchers analysed qualitative data using Nvivo qualitative software (Version 12), which allowed the project to be inductive in coding. Thematic content analysis was used since research questions could be answered through searching for patterns and themes as well as measuring the frequency of different categories and themes in interview data.

Analysis focused on reviewing segments with similar codes and examining relationships among different codes (7). Coding developed categories which summarized raw data and led to key themes (8). The two researchers read and analysed the same set of transcripts and then compared results. If the results of data analysis reached the same answers, then the information was considered reliable and consistent (9). Chapter 3 presents results of the coding trees in Tables 6, 7 and 9. Key themes were derived from interview data with migrants. In contrast, four thematic areas of the Madrid Framework were used as key themes for stakeholder analysis. The analysis was further tested during consultative meetings with study participants who participated in FGDs and focal points from various departments of MOH who have worked on migrant health issues. The Standards for Reporting Qualitative Research Checklist, developed by O'Brien et al., was used to ensure research and reporting quality (10).

## Ethical considerations

The research proposal was approved by the Ethics Council of the Department of Medical Service Administration, MOH, Viet Nam on 6 March 2019. Participants were informed about the purpose and content of the research and their right to decline participation. A consent form was received by researchers on site and all consenting interviewees were included in the study. The study is mainly based on existing data collection with no clinical interventions and nor did it affect the habits and customs of

localities. No personally identifiable information was used or shared during the drafting of this report. Information provided by each participant was collected and stored in adherence with maintaining confidentiality, and was only used for the purposes of research. The study team was comprised of Vietnamese Government and UN agency representatives. Researchers' characteristics might influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions, potential or actual interactions between researchers and study participants.

## Operational definitions of terminology

For the purpose of this report, the following terminology is used:

**Migration:** The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification (11).

**Migrants:** At the international level, no universally accepted definition for "migrant" exists. The term migrant was usually understood to cover all cases where the decision to migrate was taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor; it therefore applied to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family (11).

**Internal migration:** A movement of people from one area of a country to another area of the same country for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (e.g. rural to urban migration) (11).

**Inbound migrants:** Foreign immigrants regardless of their immigration status (e.g. regular/documented or irregular/undocumented) and purpose (e.g. work or pleasure, temporary or permanent)(12).

**Outbound migrants:** Citizens of a country who are temporary or permanent emigrants that travel or travelled out of the country regardless of duration or residency status (11).

**Cross-border migration:** A process of movement of persons across international borders. Cross-border migrants move across a border between two countries (11).

**Undocumented migrants:** A non-national who enters or stays in a country without the appropriate documentation. This includes, among others: a person (a) who has no legal documentation to enter a country but manages to enter clandestinely, (b) who enters or stays using fraudulent documentation, (c) who, after entering using legal documentation, has stayed beyond the time authorized or otherwise violated the terms of entry and remained without authorization (11).

**Irregular migrants:** A person who moves or has moved across an international border and is not authorized to enter or stay in a State pursuant to the law of that State and to international agreements to which that State is a party (11).

## CHAPTER 2. LITERATURE REVIEW

This literature review is comprised of five major parts: (1) overview of migration and Viet Nam, (2) current situation of migrant health in accordance with the four principles of Madrid Operational Framework, (3) achievements and shortcomings in the SDGs and migrant health in Viet Nam, (4) health status of migrants in Viet Nam and (5) health impacts of migration on families left behind.<sup>1</sup>

This review was undertaken by three members of the study team. Two reviewers independently examined peer-reviewed articles and gray literature which describe key themes and content. A third reviewer checked for accuracy. For policy and legal documents, one reviewer identified laws, policies and legal frameworks in health and non-health sectors that affect migrant health. Annex 2 presents tables for data abstraction to show migrant health-related provisions of policy and legal frameworks.

### Migration and Viet Nam

#### Socioeconomic context

Economic development and intensified international integration have accelerated Viet Nam to become a source and destination country for migrants. Viet Nam has initiated economic reforms termed *Doi Moi* to facilitate private sector development, foreign investment attraction and expansion of markets since 1986. Such reforms have had significant impacts on economic development and poverty reduction, with GDP growth per capita jumping from 2.8 per cent in 1986 to 6.2 per cent in 2016. Likewise, the proportion of poor households fell from 50 per cent in the early 1990s to 14.2 per cent in 2010 (based on a poverty line of USD 2.25/person/day) (13) and to 9.8 per cent in 2016 (based on a poverty line of USD 3.34/person/day) (14). Table 2 presents the country's demographic indicators. Nearly half of ethnic minorities still live in poverty, and their share of the poor was 73 per cent in 2016, despite only comprising 15 per cent of the population (14).

**Table 2. Basic indicators on Viet Nam in 2017**

Population	93,671,600
Population growth rate	1.06%
Proportion of urban population	35.03%
Labour force aged 15 years and over	54,823,800
Proportion of workers aged 15–24	13.8%
Proportion of workers aged 25–49	59.5%
Proportion of workers aged 50 and over	26.7%
Proportion of trained workers	23.1%
Proportion of trained male workers	24.9%
Proportion of trained female workers	20.9%
Total domestic product at comparative prices, 2010	VND 3,262,548 billion
GDP per capita	USD 2,389/person
Average life expectancy	73.5
Human Development Index ranking in the world (2014)*	116th out of 188 countries

Source: GSO.

\*Viet Nam Academy of Social Sciences (VASS) and UNDP, Growth That Works for All: Viet Nam Human Development Report 2015 on Inclusive Growth (2016)

<sup>1</sup> Resolution 61.17 on the health of migrants was endorsed by WHA in 2008. The Resolution led to the first Global Consultation on Migrant Health, in Madrid in 2010. The Madrid Operational Framework was developed to guide implementation of the resolution by member states and stakeholders. The operational framework encompasses four priority areas for action: (i) developing systems and sharing good practices related to monitoring migrant health, (ii) implementing supportive policy frameworks across sectors and across countries, including financial models, (iii) creating migrant-sensitive, inclusive health systems supported by appropriate professional competencies and (iv) organizing partnerships and mainstreaming migration health within relevant multidisciplinary frameworks.

Viet Nam's open-door policies with numerous countries is also a factor influencing migration. Having restored diplomatic relations with the United States and joined ASEAN in 1995, Viet Nam participated in founding the Asia–Europe Meeting in 1996, joined the Asia–Pacific Economic Cooperation in 1998 and World Trade Organization in 2007. To date, Viet Nam has established diplomatic relations with 189 countries.

Increased internal and international migration of Vietnamese citizens is seen as an integral part of national development since the launch of Doi Moi alongside open-door policies.

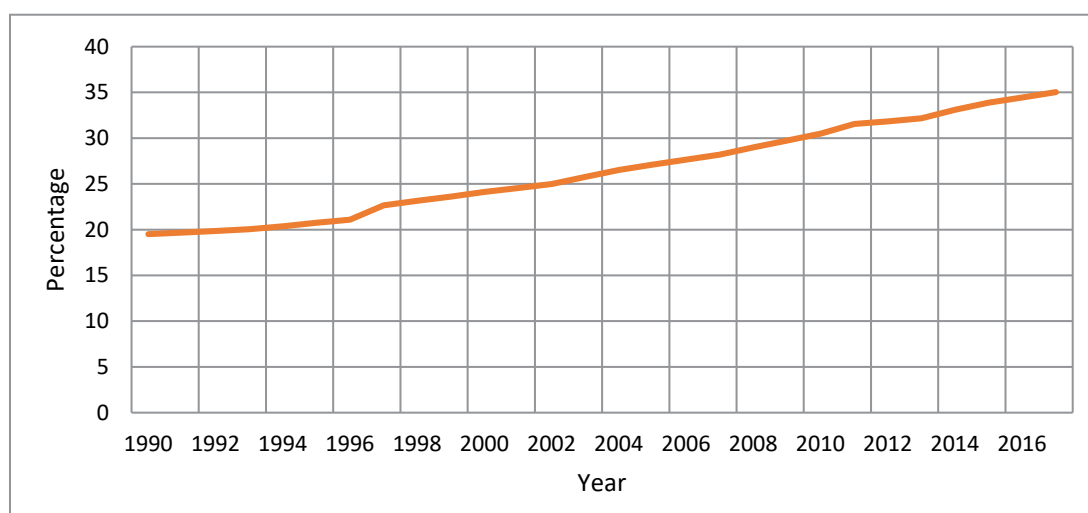
### Internal migration

Viet Nam has a long history of internal population movements. The Government of Viet Nam has controlled internal migration flows through a household registration system that restricts changes in residency (5).

The Government sponsored people's movement from urban to rural areas, encouraging agricultural workers from one worksite to another. Despite the controls, many migrants became unregistered and continued to move to urban areas (15). Economic reforms, *Doi Moi* launched in 1986, also facilitated irregular migrants to migrate to urban areas in search of employment. Rural to urban migration has been further fuelled through social networks built by increasing numbers of populations in urban areas originally from rural areas (5).

An estimated 35 per cent of Viet Nam's population lived in urban areas in 2017 (Figure 3). According to the 2009 census, about 6.6 million people migrated internally from 2004 to 2009 (16). Previous research identified three trends during 1989–2009: (i) total population is characterized by increasing proportions of migrants, (ii) proportion of female migrants is growing and (iii) the average age of migrants is decreasing. Cities such as Da Nang, Ha Noi and Ho Chi Minh City as well as Binh Duong and Dong Nai provinces with high monthly incomes per capita are more likely to have higher rates of migration (15).

**Figure 3. Percentage of population living in urban areas in Viet Nam**



Source: IOM's calculations based on GSO.

### Household registration system

Under the household registration system, a household registration booklet (*ho khau*) is given to each household and linked to access to housing ownership and public social services, such as schooling and health care at their place of registered residence.

Before 2006, there were four *ho khau* categories:

- KT1: a person registered the permanent residence where he/she resides
- KT2: a person registered the permanent residence, but lived and worked in other city/district/province
- KT3: a person registered temporary residence at their place of destination for six months or more
- KT4: a person registered temporary residence at their place of destination for less than six months.

KT3, KT4 and individuals who do not have *ho khau* at their place of residence face limited access to social and welfare services (17). The Government of Viet Nam is aware of inequalities among people of different residential status and has taken several steps to address complexities of the household registration system since 2006.

The 2006 Law on Residence places residents into two categories: temporary and permanent. The law made registration of a new residence easier as permission from local authorities in the registrant's hometown was no longer required for registration of new residence. However, in practice the distinction between KT3 (long-term temporary) and KT4 (short-term temporary), remained as local authorities may inconsistently implement the new policy (17).

In 2017, Viet Nam decided to abolish the household registration booklet system. In 2020, all Vietnamese citizens will be provided an ID card with a national identification number ("Resolution 112/NQ-CP of Prime Minister on simplification of administrative procedures and paperwork related to management of residents," 2017). This shift to electronic management will avoid time-consuming paperwork, including obtaining a new book when moving to a new residence. Simplification of such administrative steps could mitigate the problem of migrants' residence registration and facilitate access to social welfare services (19).

### Outbound migration

Viet Nam is a migrant-sending country. On average, approximately 100,000 Vietnamese workers leave Viet Nam each year for work in other countries. Characteristics of Vietnamese migrants and the nature of migration may differ, depending on receiving countries. There are about 500,000 Vietnamese workers in more than 40 countries and territories across at least 30 different occupations that vary from low to high-skilled workers and professionals (20). The majority of labour migrants within Asia move to East Asia. Others migrate to Greater Mekong Subregion countries or Malaysia. Table 3 shows the top destinations of Vietnamese labourers in the first 10 months of 2019.

**Table 3. Top seven destinations for Vietnamese workers in January – October 2019**

	Destination	Jan – Oct 2019
1	Japan	61,937
2	Taiwan Province of the People's Republic of China	45,390
3	Republic of Korea	6,545
4	Romania	1,103
5	Saudi Arabia	878
6	Macao Special Administrative Region, China	331
7	Malaysia	318

Source: DOLAB. [www.dolab.gov.vn/New/View2.aspx?Key=4901](http://www.dolab.gov.vn/New/View2.aspx?Key=4901)

## Migration between Viet Nam and Greater Mekong Subregion countries, China and Malaysia

Table 4 shows the number of Vietnamese migrants who resided in each Greater Mekong Subregion country, China and Malaysia as well as the number of inbound migrants in Viet Nam from each Greater Mekong Subregion country in 2019. These statistics and Figure 4 indicate Viet Nam is a major labour exporter to Greater Mekong Subregion countries. The official statistics are based on governments' data and are likely to represent documented migrants only. The numbers do not reflect cross-border movements and undocumented migrants. In addition to official statistics, under-reported irregular migration might occur from Viet Nam to other Greater Mekong Subregion countries, particularly through cross-border movements to Lao People's Democratic Republic, Cambodia and China (Yunnan province and Guangxi Zhuang). They cross land borders without correct documentation into neighbouring countries along informal forest trails for work, income-generating activities or other purposes (20). Migrant populations within border areas are likely to be more vulnerable to health issues as they are less likely to be targeted by national health systems.

**Table 4. International migrant stock by origin and destination in Greater Mekong Subregion, China and Malaysia (2019)**

Country of destination	Country of origin							
	Total	Cambodia	China	Lao People's Democratic Republic	Malaysia	Myanmar	Thailand	Viet Nam
China	1,030,871				6,461		16,012	29,612
Cambodia	78,649		1,614	276	182	55	32,758	38,744
Lao People's Democratic Republic	48,275	3,634	14,205			3,005	3,490	20,076
Malaysia	3,430,380	16,166	11,864			345,947	15,580	99,875
Myanmar	75,998		34,893					
Thailand	3,635,085	689,451	77,581	934,936	1,369	1,858,735		7,350
Viet Nam	76,104	1,035	3,141	7,272	133	11,695	12,077	

Source: UN, Department of Economic and Social Affairs. Population Division (2019) [www.un.org/en/development/desa/population/migration/data/index.shtml](http://www.un.org/en/development/desa/population/migration/data/index.shtml)

**Figure 4. Migration flows and stocks in the Greater Mekong Subregion**



Source: ADB, IOM (2013) Facilitating safe labour migration in the Greater Mekong Subregion: Issues, challenges, and forward-looking interventions.

Note: The circles illustrate the migrant stocks in each country (colors indicate the origin of migrants, the surface of the circles illustrates the size of the stocks). Question marks indicate uncertain in the ratio.

In Lao People's Democratic Republic, a sizeable number of undocumented workers (up to 20,000 persons) from rural areas of central and northern Viet Nam might be working as market traders in Vientiane and engaged in the illegal logging industry on the Lao People's Democratic Republic-Viet Nam border (21). In 2009, the governments of Viet Nam and Lao People's Democratic Republic signed a bilateral agreement on labour cooperation to send Vietnamese experts to work in Lao People's Democratic Republic which could lead to further migration from Viet Nam to Lao People's Democratic Republic (21).

A large unaccounted Vietnamese migrant population might reside on the Cambodia-Viet Nam border, including Vietnamese immigrants who relocated to Cambodia from 1985–1998 and are still considered irregular migrants. Vietnamese migrants in Cambodia work in the agriculture, fishing and construction sectors (21). There are also a number of female sex workers (FSW) from Viet Nam, some of whom may be subjected to sex trafficking (22).

Improved infrastructure and road networks facilitate Vietnamese migrants to travel beyond neighbouring countries. Cambodia serves as a transit country for Vietnamese migrants before heading to Thailand's north-eastern regions to work in restaurants, local markets and garment workshops as irregular workers.

Six provinces of Viet Nam share a border with two provinces of China (Yunnan and Guangxi Zhuang). In border areas, cross-border movements are common as Vietnamese conduct business or work as labourers in China (21). Trafficking cases have also been detected in northern provinces of Viet Nam. Women and children might be subjected to trafficking for marriage, labour, sex work and adoption. Trafficking might be attributed to a female deficit in China (23).

### Inbound migration

Viet Nam is not a major destination for migrants. However, it may become a future popular destination for Greater Mekong Subregion migrants, having the one of the strongest regional economies and an annual growth rate of about 7 per cent. The United Nations Population Division reported around 76,000 inbound migrants living in Viet Nam from other countries in 2019. While more than 10,000 registered migrants from Myanmar and Thailand moved to Viet Nam, limited numbers of migrants from other Greater Mekong Subregion countries (Cambodia, China, Lao People's Democratic Republic and Malaysia) migrated to Viet Nam (24).

There might also be a considerable number of stateless persons from Cambodia. Media reports (July 2016) highlighted the plight of about 1,000 Vietnamese, who had recently returned to Viet Nam after their families settled in Cambodia's Tonle Sap area for generations. The returnees, mostly women and children, live in precarious situations in slums along the Viet Nam and Cambodia border. Many have no identification documents, connections to family villages or property. Most children were born in Cambodia without birth certificates (25).

Although the number of inbound migrants to Viet Nam was small, the country attracted more than 15 million international tourists in 2018, including 202,954 from Cambodia and 120,009 from Lao People's Democratic Republic. International tourists are not necessarily vulnerable. However, it is important to recognize international travellers might act as mediators for disease outbreaks in the country (26).

## WHA Resolution 61.17 on the Health of Migrants Global Operational Framework

### Policy-legal frameworks

The Government of Viet Nam has endorsed several international and regional frameworks that support migration and health. For rights of labourers, Viet Nam has ratified 21 conventions of the International Labour Organization (ILO), including five fundamental conventions and three governance conventions.<sup>2</sup>

<sup>2</sup> Fundamental conventions identify essential principles and rights at work that ensure the equal and safe working environments for all employees. Governance conventions play as priority instruments which pay the way for the functioning of the international labour standards system (International Labour Organization, 2015) (86).

However, the Vietnamese Government has yet to ratify the following conventions related to labour migrants: (1) Maintenance of Migrants' Pension Rights Convention, 1935 (No.48), (2) Migration for Employment Convention (Revised), 1949 (No.97) and (3) Migrant Workers (Supplementary Provisions) Convention, 1975 (No.143) (27).

Viet Nam has also developed national laws and policies that impact on health-care access among migrants. While some national laws and policies facilitate health-care access for migrants, the Law on Residence (2006) and Law on Health Insurance (2009) might limit health-care access for internal and outbound migrants as access to health care is based on residence location. Migrant populations are also target groups of national strategies related to TB, malaria and HIV for prevention, detection and treatment of the three diseases. In principle, diagnosis and treatment of TB, malaria and HIV are free of charge for all citizens of Viet Nam. Short-term residents and undocumented migrants must pay for these services if not enrolled in a referral system. This report will discuss the Law on Health Insurance's influence on migrants' access to health care in more detail in the next section on SDG 3 Health and Well-Being.

The number of Vietnamese labour migrants bound for Organisation for Economic Co-operation and Development (OECD) countries skyrocketed during 1995–2012. In 2016, there were 126,296 Vietnamese labour migrants under fixed-term contracts abroad (2). In 2007, MOLISA issued decisions on the provision of pre-departure trainings and its requirements for enterprises sending employees overseas. The decisions proposed to include coverage of not only laws on labour rights, but also general health issues in training curriculums. However, such decisions do not ensure the provision and quality of pre-departure trainings.

### Monitoring migrants' health

According to GSO, the census collects information such as in-, out- and net-migration rates for provinces. The census questionnaire included a history of internal migration indicated in Decision No.1253/QĐ-TCTK on implementation of mid-term national census and households on 1 April 2014. In the census, the GSO interviewed parents/guardians of children aged 1–5 years about their migration history in the past year. Household residents aged 5 and over were also asked about their migration history in the past five years. GSO and UNFPA have also undertaken a survey on migration, the 2015 National Internal Migration Survey.

IOM Viet Nam has conducted pre-departure medical exams for migrants going overseas – such to Australia, Canada, Malaysia, New Zealand, United Kingdom and the United States – since 1996. Data on migrant health from pre-departure medical exams have also been collected on a routine basis by IOM Viet Nam. Yet, in national surveillance systems, there is no mechanism to collect migrant-specific health data. Internal migrants may not be included in national surveys if they do not reside in their registered locality. This results in a lack of information about health-care needs, access and trends among migrants in Viet Nam.

Protection of migrants' confidentiality is also an important element for monitoring migrants' health. The Civil Law protects privacy and confidentiality for citizens in Viet Nam, however, information about protection mechanisms to preserve migrant privacy and confidentiality remain scarce.

### Migrant-sensitive health services

There are some policies and national strategies to ensure equitable access to health promotion, disease prevention and care for any type of migrant in Viet Nam. In some cases, laws tend to be more restrictive than protective in health-care services for internal and outbound migrants. Registered Vietnamese citizens with permanent residence are entitled to unrestricted health-care services at commune health centres in their locality. In contrast, short-term and irregular migrants who do not have their residence registry are not adequately covered under the 2014 Law on Health Insurance that allows insured migrants to receive health care outside their residence where registered. However, the health-care service fee is higher than for permanent residents set by the 2014 Law on Health Insurance (28). Migrants without temporary residence will be able to access the same level of health-care services as permanent residents in 2021 (28).

Return migrants can access a full package of health-care services at commune health centres in their registered locality, but this implies travel costs, time and risk of losing their job. Government health-care services are often closed when migrants are able to leave work. Private hospitals, clinics and pharmacies might be convenient for migrants, but their practices may not be authorized by the government and cause delays in seeking professional health care.

Provision of health-care services is one of the requirements for labour migrants with contracts working in Viet Nam, including internal and inbound migrants. Pre-departure orientation programmes are also needed for internal and outbound migrants.

### Partnerships, networks, and multi-country frameworks

Although migration health is a cross-cutting theme that requires collaboration across departments of MOH and government ministries, there is limited collaboration on migrant health. Stakeholders' roles in migrant health-related activities and partnerships were assessed during interviews with stakeholders and are presented in Chapter 3 - Results.

Bilateral and multilateral cooperation also plays a key role in promotion of migration health. Global health security is essential amid infectious and non-infectious threats. The International Health Regulation (IHR) was initiated to prevent, protect against, control and provide public health responses to the international spread of disease in ways to restrict public health risks and avoid unnecessary interference with international traffic and trade (29).

IHR's joint external evaluation (JEE) was conducted to evaluate Viet Nam's capacities and capabilities regarding 19 IHR JEE technical areas in 2016. Although Viet Nam had made significant progress to meet IHR (2005) core capacity requirements, several gaps in implementation of IHR remained (30). For instance multisectoral collaboration, coordination and information sharing needed to be strengthened with high-level government involvement. Standardized competencies for human resources and incentives to retain public health staff are required. The evaluation team also underlined the need for sustainable investment in national health security. The country also needs to develop preparedness and standard operating procedures to respond to migrants' health needs in the context of large migration flows (30).

At a regional level, the Government of Viet Nam has committed to improving health security with other Greater Mekong Subregion countries. To implement IHR, Viet Nam in 2003 joined the Mekong Basin Disease Surveillance (MBDS) cooperation, established to strengthen surveillance systems and build capacity of staff for infectious disease prevention and control in the Mekong subregion. This collaborative initiative is a unique model for cross-border surveillance cooperation.

The mid-term review of the ADB-funded *Greater Mekong Sub-region Strategic Framework 2012–2022* called for strong health cooperation embodied in the Greater Mekong Subregion programme. Recommendations from the Ha Noi Action Plan 2018–2022 during the 22nd Ministerial Conference, led to a formation of a new Greater Mekong Subregion Working Group on Health Cooperation and development of a Greater Mekong Subregion Health Cooperation Strategy. One of the strategic pillars for Greater Mekong Subregion Health Cooperation is health security as a regional public good that consists of three major programmes: (1) core IHR capacities of public health systems, (2) one health response to public health threats and (3) cross-border and subregional cooperation on health security. The Government of Viet Nam will implement action plans and strategies to improve regional health security with other Greater Mekong Subregion neighbouring countries in response to the Greater Mekong Subregion Health Cooperation Strategy (31).

The Government of Viet Nam has actively participated in these regional and international networks related to migration and health. For instance, Viet Nam has been supporting the ASEAN Post-2015 Health Development Agenda, which aims to strengthen health system and access to care for migrants' health. But, it has yet to become an official member of the Joint United Nations Initiative on Migration and Health in Asia (JUNIMA) that promotes regional mechanisms to improve and advocate access to health care for migrants in Asia.

## SDGs and migrant health in Viet Nam

The SDGs empower all people, particularly the most marginalized, to ensure societies are more equitable and inclusive. The SDGs recognize migrations' integral role and immense contribution to societies. Being and staying healthy is essential for migrants to be productive and contribute to socioeconomic development of societies in origin and destination nations. This section aims to illustrate the gaps and opportunities related to health and access to health services for migrants, with a particular emphasis on SDG 3. Good Health and Well-Being and SDG 5. Gender Equality.

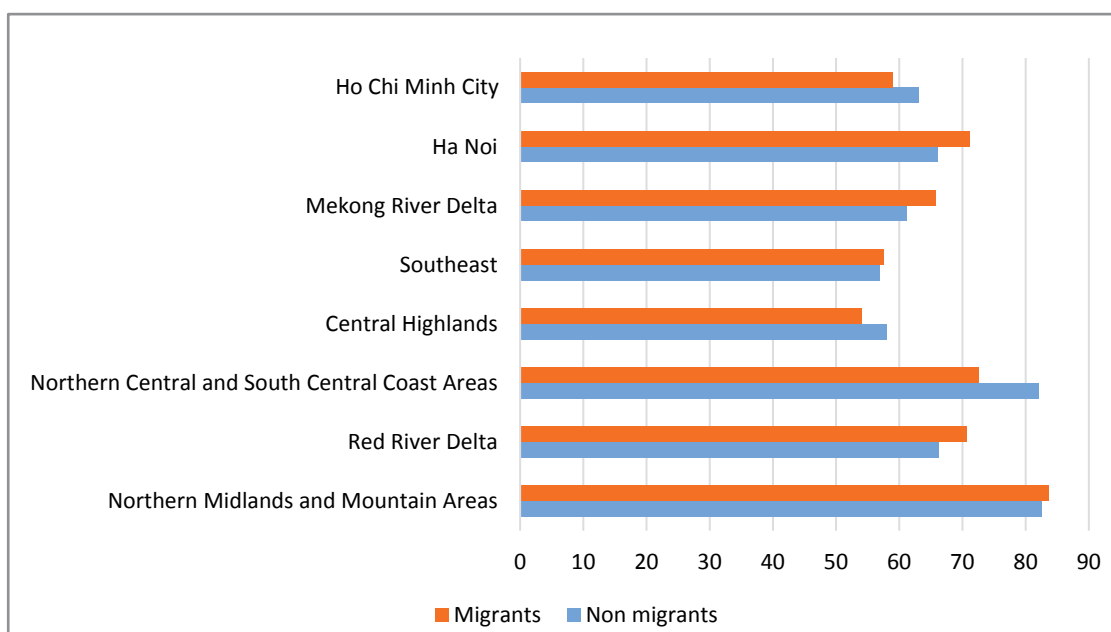
### SDG 3. Good Health and Well-Being

#### Target 3.8: Achieve universal health coverage

Universal health coverage (UHC) means that all people and communities receive the quality health services they need, without suffering financial hardship (33, 34). To monitor the process globally towards UHC, there are two indicators within the SDG framework: i) coverage of essential health services and ii) proportion of population with large household expenditures on health as a share of total household expenditure or income. The first indicator tracks countries' progress in delivering health services tailored around people's needs, with a focus on accessibility and quality of essential services and medicine. The second indicator represents the vision of granting access to health services based on health needs, rather than financial capacity to afford medical expenses. These two indicators provide information on the coverage of services and financial protection to people and communities. This section of the report aims to assess migrants' challenges associated with the second indicator, with particular emphasis on financial risk protection through universal health insurance coverage.

The Government of Viet Nam has committed to achieving universal health insurance coverage for at least 90% of its population by the end of 2020 (Decision No.1167/QĐ-TTg on adjusting universal health insurance coverage targets). A national survey showed that approximately 70% of migrant and non-migrant participants reported having health insurance in 2015 (5). There was no significant difference between the two groups. Uptake of health insurance among migrants improved in the past 10 years, from 36.4% in 2004 to 70.2% in 2015. However, there is a regional disparity in uptake of health insurance among migrants and non-migrants. Figure 5 shows that just over a half of Central Highlands respondents had health insurance at the time of the survey (5).

**Figure 5. Percentage of distribution of migrants and non-migrants with health insurance by region**



Source: Figure produced by IOM based on the 2015 National Internal Migration Survey (GSO and UNFPA).

Migrants who did not have health insurance reported they did not see health insurance ownership as necessary (50%) or it was too costly (25%) (5). Other studies on health-care access among internal migrants in Ha Noi reported the lack of health insurance was associated with under utilization of health care. Seasonal migrants and migrants working in small private enterprises were significantly less likely to use health-care services than non-migrants (16, 37).

The 2014 Law on Health Insurance allows the insured to receive health care outside their registered residence although fees for migrants are higher than for non-migrants (37). The 2014 Law on Health Insurance states that higher fees for inpatient health-care services at provincial level will be abolished from 2021 (28).

In addition to high expenses, Vietnamese migrants face challenges obtaining health insurance and use of health-care services due to a lack of guidance on changing health insurance per location and burdensome documentation requests at social insurance offices and hospitals (38). These officials may also inconsistently implement policies on issuing and renewing health insurance cards. Short-term and irregular migrants who do not have their residence registry are not adequately covered under the law and incur high out-of-pocket payments. The MOH also issued Circular No.37/2018/TT-BYT to increase prices of a number of health-care services nationwide in 2019. This circular could negatively impact uptake of health-care services among migrants and others not insured by health insurance schemes.

Under Decree No.36/2005/ND-CP, all children aged under 6 are entitled to free health insurance regardless of residential status. However, previous research has shown that one-quarter of temporary registered children in that age group reported not having health insurance. Children of informal sector workers were less likely to obtain health insurance due to residential status (17).

The 2008 Law on Health Insurance, Article 13 assures all employees with a labour contract must be covered by obligatory health insurance. The law states employers must pay two-thirds and employees one-thirds of monthly health insurance fees not exceeding 6% of employees' monthly salaries (37). Although the law ensures migrants' rights of having health insurance, some employers do not comply and some migrants may not be aware of their rights to health insurance. According to Decree No.105/2014/ND-CP on providing details and directives on the implementation of several articles of the Law on Health Insurance on 15 December 2014, Vietnamese workers including internal migrants in the informal sector, are also eligible for voluntary health insurance. The insurance premium is 4.5 per cent of the minimum monthly wage in their city of residence.

Regarding health insurance coverage among inbound migrants, the government recently issued Decree No.143/2018/ND-CP on compulsory social insurance for foreign employees in Viet Nam. Under this decree, foreign workers with work permits, practice certificates or practice licenses granted by Vietnamese authorities for a year or more are subject to compulsory social insurance. The decree will take thorough effect in 2022, when foreign workers must start paying premiums. The following social insurance regimes will be covered: sickness, maternity, occupational accident, occupational disease, retirement and survivor benefits. However, it is unclear whether undocumented and short-term migrants with work permits would be entitled to these social insurance regimes.

There is no specific regulation on health-care coverage for outbound migrants from Viet Nam, hence coverage is highly dependent on health-care systems in destination countries. A survey showed that migrants tended to have lower health insurance coverage in the United States, with 43.6 per cent of non-US citizens uninsured compared to 14.2 per cent of the native-born population. This survey also showed that Vietnamese immigrants were highly likely to be uninsured (39). Other research indicated that some Vietnamese migrant workers in Japan were uninsured due to violations of labour standards by employers to avoid paying insurance premiums (40).

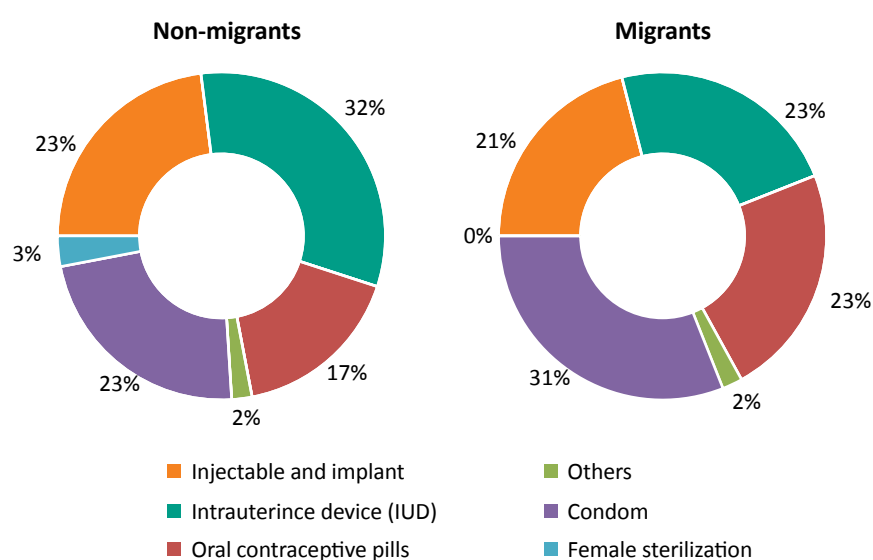
The Government of Viet Nam recognizes the vulnerability of informal workers and immigrants in accessing services based on residential registration. Yet, there remains a lack of policies and plans to address inequality and promote equal access to quality basic services for migrants in Viet Nam (41).

*Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights*

This section assesses sexual and reproductive health for migrant women and girls. In Viet Nam, the majority of female migrant workers operate in the informal sector and do not have employment contracts, with limited access to social protection services. There are no specific laws on sexual reproductive health. However, Decision No.2013/QĐ-TTg approved a national strategy for population and reproductive health during 2011–2020, with migrants one of its target populations. One of the indicators for migrants' reproductive health is to increase their proportion with access to reproductive health-care services to 20 and 50 per cent by 2015 and 2020, respectively (42). All Vietnamese, including migrants, are entitled to benefits from reproductive health programmes developed by stakeholders. Yet, the decision uses an ambiguous term for “migrants” and does not clarify if inbound migrants are included.

After five years implementation of the national strategy, a joint review was conducted with WHO to determine MOH priority missions in the next five years. It concluded that current reproductive health services did not meet the needs of vulnerable groups, including migrants, ethnic minorities and people-living-with-HIV (43). These findings are consistent with other studies that indicate the lower use of contraceptive methods among migrants (37.7%) compared to non-migrants (58.6%) (5). Figure 6 shows the difference between migrants and non-migrants in contraceptive use. Migrants were more likely to use condoms and oral contraceptive pills, while one-third of non-migrants preferred intrauterine devices (IUD) (5). In addition to the national strategy, the Law on Health Insurance ensures reproductive health-care access for migrants, such as receiving counselling services, screening tests, vaccinations, contraceptive methods and maternal care (28).

**Figure 6. Percentage of migrants and non-migrants using contraceptive methods**



Source: GSO and UNFPA, 2015 National Internal Migration Survey.

Migrant women and girls, especially those trafficked or in an irregular situation, often face challenges to access appropriate health care, information and education. In 2016, some 383 cases of human trafficking were detected nationwide with 523 traffickers and 1,128 survivors. The majority were women, child and cross-border cases. The true scale is significantly larger as most cases are undetected/unreported (2).<sup>3</sup>

<sup>3</sup> Human trafficking, sexual abuse and gender-based violence are prohibited by the Criminal Code No.100/2015/QH13 and Law on Prevention and Combatting Human Trafficking No.66/2011/QH12 in Viet Nam. To assist human trafficking survivors, Decree No.62/2012/ND-CP (13 August 2012) “provides evidence to define trafficked victims and protection for victims and their relatives” and Decree No.09/2013/ND-CP (11 January 2013) implements articles of the Law on Prevention and Combatting Human Trafficking.

It is well-documented that trafficking experiences are detrimental to the physical and mental health of survivors. While physical health can recover upon medical treatment, mental health often requires long-term and gender-sensitive psychological care (43, 44). Sexual violence, physical exploitation and mental trauma are impacts of trafficking. In particular, women and children who experience sexual violence are more vulnerable than men during reintegration into society due to stigmatization (46). In Viet Nam, sex work, HIV/AIDS and illegal drug use still remain stigmatized (46).

In general, trafficking victims can receive initial psychological counselling, health-care consultations, legal and financial assistance and vocational trainings at aid centres/local authorities (mostly from MOLISA and Women's Union) in each province. Despite government efforts, the Trafficking in Persons Report 2018 stated that government support for trafficking victims was insufficient to address the needs of human trafficking victims and data from authorities did not reflect their actual circumstances (47). For instance, human trafficking survivors do not receive sufficient allowances to support food and medical aid at just VND 30,000 and VND 50,000 per person per day, respectively. Complex administrative procedures also hinder trafficking victims from receiving allowances supported by Decree No.09/2013/ND-CP (48).

During rehabilitation and reintegration, many trafficked persons reported unmet comprehensive care needs due to limited services and occupational training. In addition, a lack of capacity and negative attitudes by health-care providers and authorities towards trafficked survivors inhibit uptake of services (49).

Migrant sex workers (SWs) are also vulnerable to not accessing reproductive health care. In Viet Nam, sex work is prohibited and there is no law to protect SWs. Although recent political debates have softened attitudes towards legitimate sex work in Viet Nam, SWs are continually targeted by police raids.

SWs are often forced to leave their home due to stigma and discrimination from society and families. As a result, they can be driven further underground and become isolated from their own community as a migrant (50). Due to their legal status and social stigma, they often live in hiding and fall victim to human rights violations. According to the 2015 Stigma Index Study in Viet Nam, 16.6 per cent of female SWs reported physical, mental and sexual abuse in the past 12 months (51).

SWs face difficulties in negotiation of safe sex with customers and deal with aggressive behaviour from customers as well as owners of bars, restaurants and guest houses. Some SWs perceive physical and sex abuse as part of their job (50). In some cases, health-care workers discriminate against SW and their HIV status, which makes SWs reluctant to access HIV and STD treatment, testing and counselling services at health-care facilities (52).

Previous research has indicated FSWs are at higher risk of HIV infection than the general population. In 2004, FSWs in five border provinces of Viet Nam had higher prevalences of HIV (3.6%) compared to general adults aged 15–49 in Viet Nam (0.03%) (53). According to the 2018 HIV sentinel surveillance, HIV prevalence among FSWs in Ho Chi Minh City and Ha Noi was 10 and 5.5 per cent separately (54). In addition to seeking help from professional services, SWs reported receiving advice and care from peers or friends (55).

Human trafficking poses severe health-related risks not only to female victims, but also male ones. Trafficked men and boys—mostly from Cambodia, Myanmar and Viet Nam—often worked in fisheries and manufacturing industries and face greater risk of physical injury and exploitation (56)(57). Risks range from physical injuries to severe violence and threats from employers (57).

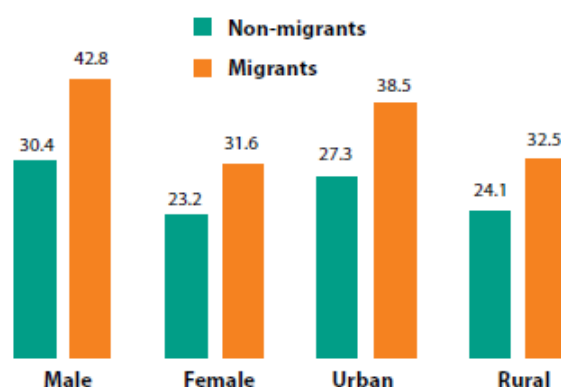
## Health status of migrants

Migrants are recognized as an often vulnerable population that WHA Resolution 70.15 has called for action from member states. The MOH faces a shortage of human resources for provision of migrant-friendly health-care services and limited information about health of migrants due to their mobility and residential status (43). In this section, the report examines the health status of migrants, risk behaviours and other aspects that may have negative impacts on migrants' health.

The 2015 National Internal Migration Survey in Viet Nam, conducted by GSO and UNFPA, reported that migrants claimed to be healthier than the general population (Figure 7). This is consistent with findings in other countries due to the "Healthy Migrant Effect" (58–60) that defines the majority of migrants as fit and healthy workers who have the ability and means to migrate. Those who have health issues or face other barriers to migration, such as age, are likely to remain. Therefore, on a population level, in many contexts migrant cohorts can be healthier than host populations. On an individual level, however, lack of access to preventative and curative health care, social and cultural factors, disease exposure and vulnerability factors can mean some migrants or groups of migrants are particularly vulnerable to health risks.

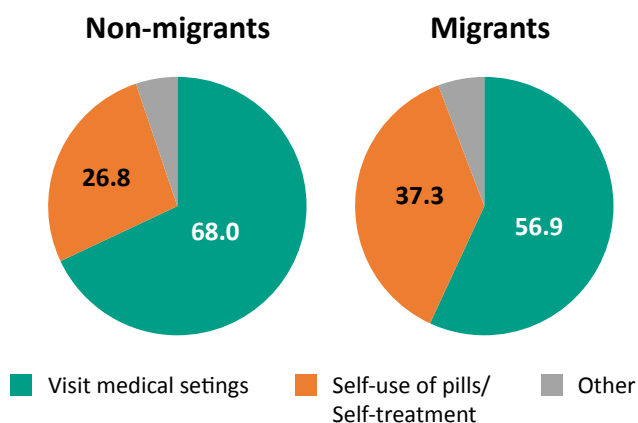
The 2015 National Internal Migration Survey in Viet Nam also describes accessing health care varied among migrants and non-migrants. Figure 8 illustrates that in the same survey, migrants were less likely to visit health facilities and more probable to practice self-treatment during periods of sickness compared to non-migrants (5).

**Figure 7. Percentage of migrants and non-migrants self-assessing their health as "good" or "very good" by sex and region**



Source: GSO and UNFPA, 2015 National Internal Migration Survey.

**Figure 8. Percentage of distribution of migrants and non-migrants by treatment methods at time of sickness**



Source: GSO and UNFPA, 2015 National Internal Migration Survey.

In 2006, a survey on cigarette smoking and alcohol consumption among 4,550 adolescents and young adults aged 15–24 in Ha Noi revealed that use by migrants from rural areas was higher than for non-migrants (61). Similarly, previous research showed that Vietnamese immigrant men were at high risk of tobacco use, with their smoking rates in homes (44.9%) the highest among other Asian immigrant groups in the United States (62). Vietnamese migrant men are at risk of developing diseases related to cigarette smoking, while women and children are susceptible to a number of diseases related to passive smoking (63).

With the aim to earn more money to support families and attain better jobs, the flow of internal migrants from rural to urban areas has grown (5). However, little is known about HIV infection risks among migrant populations. A study examined condom use among 450 male street labourers, mostly undocumented and low-skilled migrants, across 13 districts of Ha Noi in 2013. Study participants reported engaging in HIV high-risk behaviours such as sharing injection equipment with peers and inconsistent condom use during sexual intercourse with SWs. The study also emphasized limited access to HIV prevention services as a small number of male SWs had HIV tests in the 12 months prior to interviews. Yet, nearly 10 per cent reported not returning for test results (64). After three years, the research group replicated the study and reported inconsistent condom use remained (65).

Malaria is also a common health problem facing migrants in Viet Nam. Limited knowledge about prevention of malaria and delays in seeking care among migrants were seen in previous research (64, 65). Due to high levels of population mobility, migrants infected with malaria parasites might face difficulties in completing treatment at a same health-care facility. Incomplete treatment of malaria increases risks of developing drug-resistant malaria. Public health officers face challenges in estimating the epidemiological trend of malaria due to unreported cases from the private health sector and unauthorized pharmacies prescribing malaria treatment. Lack of information about how to access long-lasting insecticides, treated nets and hammock nets might hinder migrants from engaging in malaria prevention (67). There is no direct link inferred between vulnerability to malaria and mobility. But one common reason for under utilization of malaria prevention and treatment services among migrants is a lack of residential status. They also tend to live in areas where health-care stations are far from homes. Other risky features include early morning working hours, sleeping without nets near forests, lack of use of other mosquito repellent methods (mosquito incense and insect spray) and insufficient knowledge about malaria and prevention (66).

Another infectious disease within migrant communities is tuberculosis (TB). Viet Nam was one of 30 high-burden TB countries globally in 2016 (68). According to the Viet Nam National Tuberculosis Control Programme Semi-Annual Report 2018, the overall TB notification rate was 52.38 per 100,000 population in Viet Nam in 2018. Despite scarce data about TB among migrants in Viet Nam, it is evident that such vulnerable populations are at high risk of TB infection. During the migration process, poverty, poor and dangerous working conditions limited access to health-care services and social exclusion are significant factors that increase the risk of infecting and transmitting TB (68).

Outbound migrants from Viet Nam face various health-related risks. A systematic review and meta-analysis has highlighted that around half of international migrants had at least one occupational disease (69). Vietnamese outbound migrants face greater occupational health risks due to their typical types of work, known as “3-D jobs” (dirty, dangerous, and demanding), lack of proper training, language and cultural barriers, documentation status (69). Outbound migrants are at risk of developing not only physical health problems, but also mental ones such as depression (68, 69).

Previous research reported that Vietnamese immigrant women living in Taiwan Province of the People’s Republic of China were likely to have a low health-related quality of life compared to local women, which ranged from general health perceptions to mental health (72). Other research showed that Vietnamese marriage immigrants in Taiwan Province of the People’s Republic of China and Republic of Korea experienced discrimination that had direct and indirect negative impacts on their quality of life (73). Such phenomenon is also apparent in Europe. Research examined the relationship between severity of depression and acculturation among first-generation Vietnamese in Germany to

show that marginalized patients were more likely to have severer levels of depression than integrated patients (74).

Vietnamese outbound migrants might also face higher health-related risks because of their jobs. Previous research reported female Vietnamese migrant workers were likely to contract TB in Taiwan Province of the People's Republic of China compared to locals as the former tended to work as health-care workers and household workers that have a higher probability of having contact with aged people and people with chronic diseases who might have TB (75).

### Health impacts of migration on families left behind

Migration may not only disrupt traditional family structures, but also protection mechanisms for left-behind families. For instance, intergenerational co-residence plays an important role in supporting the elderly in lower middle-income countries where social welfare systems have underdeveloped provision of pension benefits and universal health care. A study reported intergenerational co-residence had a positive effect on the psychological well-being of the elderly in Viet Nam. If there are more job opportunities in neighbouring regions, adult children are more likely to migrate and less likely to stay with their elderly parents. The psychological well-being of elderly parents tended to decline in the absence of adult children (76).

The health of children left behind is also affected by migration of parents or guardians of children. The 2015 National Internal Migration Survey in Viet Nam, conducted by GSO and UNFPA, revealed that just 17.5 per cent of migrants had school-aged children who accompanied them. This number indicates either a significant number of children is left behind or young migrants have yet to have children (5). Children of migrant fathers had higher odds of suffering an emotional disorder compared to children living with both parents in Viet Nam. In particular, girls are at greater risk of emotional problems (77). Other studies also found negative impacts of mothers' migration on health of left-behind Vietnamese children as well as their cognitive ability. Left-behind children of migrant mothers were more likely to be stunted than children with parents. With migrant mothers away from home, children's dietary intakes might become less nutritious. In terms of cognitive ability, math scores of children were lower than those with parents. Academic performance of left-behind children might become poor in the absence of mothers' supervision (78). Similarly, some left-behind children might drop out of school, which increases their vulnerability to human trafficking, exploitation and violence.

Previous research revealed that parental migration affects not only the health of Vietnamese children, but also that of Vietnamese migrant parent(s) and co-residence carer(s) who stay behind to care for children of international labour migrants. Those who reported looking after children aged 9–11 years had higher odds of developing a common mental disorder, such as depression and anxiety, than those caring for younger children. A common mental disorder among carer(s) was also associated with the absence of social support and poverty (79).

Although migration can financially improve the living conditions of migrants' left-behind families, it might not be beneficial for their health. There is a need to establish social support mechanisms for left-behind families of migrants.

## CHAPTER 3. RESULTS

### FINDINGS FROM INTERVIEWS WITH MIGRANTS

Table 5 summarizes the characteristics of interviewed migrants at each study site. Among internal migrant groups, most interviewees were ethnically Kinh and only two were ethnic minority (H'mong and Thai). The average age of participants was 35.2 years, with an average monthly income of VND 6.6 million (USD 284).<sup>4</sup> The length of stay in urban areas varied from two months to four years. The minimum education grade was Grade 5, while university was the highest level of education. Thirteen participants reported living with family members or relatives and the remainder shared a rented room with friends. Fifteen participants had health insurance, but 50 per cent reported purchasing health insurance cards in their hometowns. Most believed their health was “good” or “fair”, while a small number reported poor health.

The average age of cross-border migrants was higher than for internal ones, with a difference of five years. Half of participants in the cross-border group were ethnic minorities from the Brau, H'mong and Muong ethnic groups. These interviewees fluently spoke their ethnic language, but Vietnamese was limited. The time cross-border migrants stayed in neighbouring countries was less than periods internal migrant groups spent away from their places of origin, at 7.5 months on average. Most cross-border migrants had health insurance from their hometown and incomes ranged from VND 1–12 million per month (USD 43–519). Education levels of cross-border migrants were lower with 6.7 years of education in general, compared to 9.5 years for internal migrants. Only one participant reported living with a spouse while working in a cross-border area.

**Table 5. Characteristics of migrants stratified by study sites**

Characteristics	Ha Noi N N=12	Ho Chi Minh City N N=12	Ha Tinh N N=9	Kon Tum N N=5	Ha Giang N N=5	All % (N) N=43
Migration Status						
Cross-border	0	0	9	5	5	44.19 (19)
Internal migrants	12	12	0	0	0	55.81 (24)
Age (%)						
18–30	3	8	0	2	1	32.56 (14)
31–40	2	3	2	0	4	25.59 (11)
41–50	5	0	4	2	0	25.59 (11)
51–60	0	1	3	1	0	11.63 (5)
61–	2	0	0	0	0	4.65 (2)
Mean	41.58	28.83	47.89	39.8	34	38.88
Sex (%)						
Female	6	6	4	3	2	48.84 (21)
Male	6	6	5	2	3	51.16 (22)
Language (%)						
Vietnamese	12	12	9	5	0	88.37 (38)
Other	0	0	0	0	5	11.63 (5)
Ethnicity (%)						
Kinh	10	12	9	2	0	76.74 (33)

<sup>4</sup> All currency calculations presented in this report between VND and USD are based on the FX rate on 11 December 2019 (Vietcombank)

H'mong	1	0	0	0	5	13.95 (6)
Brau	0	0	0	2	0	4.65 (2)
Thai	1	0	0	0	0	2.33 (1)
Muong	0	0	0	1	0	2.33 (1)
Other						
Length of stay at current residence (%)						
Less than 1 year	2	1	7	3	3	38.1 (16)
1–4 years	8	7	2	1	2	47.62 (20)
4–5 years	2	4	0	0	0	14.29 (6)
Have labour contract						
No	10	12	8	4	5	90.7 (39)
Yes	2	0	1	1	0	9.3(4)
Have health insurance						
No	4	4	0	3	0	26.19 (11)
Yes	7	8	9	2	5	73.81 (31)
Income per month						
< VND 3 million	1	4	0	3	5	30.23 (13)
VND 4–8 million	6	7	7	2	0	51.16 (22)
> VND 9 million	4	1	1	0	0	13.95 (6)
No answer	1	0	1	0	0	4.65 (2)
Years of education (mean)	9.17	9.83	12	6.75	1.8	8.62
Have family member(s) living with a migrant						
No	1	0	9	4	3	39.53 (17)
Yes	4	100	0	1	2	37.21 (16)
Have friend member(s) living with a migrant						
No	1	0	1	1	4	16.28 (7)
Yes	6	3	0	1	0	23.26 (9)
No answer	0	0	8	3	1	27.91 (12)
Perceived health status						
Excellent	0	0	0	0	0	0 (0)
Good	4	1	6	2	0	30.95 (13)
Fair	6	9	3	2	5	59.52 (25)
Poor	2	2	0	1	0	11.63 (5)
No answer	0	0	0	1	0	2.33 (1)

## Reasons for migration

### For employment

Employment opportunities remain the leading reasons for all forms of migration, including internal and cross-border. As most migrants come from less developed areas, they expect to find better financial sources at destinations. Despite dramatic economic growth and improved living standards many people in Viet Nam, especially agricultural households and those in areas with unfavourable natural conditions, encounter difficulties in their daily lives. Disparities in living standards between rural and

urban areas have created a major driving force for rural-to-urban migration.

Regarding internal migration, rapid development of industrial zones requires a large number of workers and in the process of urbanization, many farmers who lost farmland became unemployed and had to migrate to earn a living. These two factors are key drivers of migrant workers. Of the 24 internal migrants interviewed, more than 83 per cent migrated due to labour reasons, with four student respondents the exceptions.

*“I’ve been coming to Ha Noi for 13 years. I work as a street vendor and earn VND 4 million (USD 173) per month. Every year, I return to my hometown to work during the harvest. At home, I still have 5 acres of field. All my children live in the countryside. Here in Ha Noi, I rent a place to live with a few more people.”* Female internal migrant (Ha Noi)

For cross-border migration, seeking a higher income is also the main reason for migrating from Ha Giang, Ha Tinh and Kon Tum provinces. Most respondents migrate post-harvest or when there is a need for additional income. All 19 cross-border migrants, except for three Brau women in Kon Tum province, migrated for labour reasons.

*“Many people in my village go to China for business, males and females. Usually they are hired to plant banana trees and they are paid annually, depending on the field they were assigned to. The payment is generally quite high. On average, they earn about 40,000 yuan a year, equivalent to more than VND 100 million (USD 4,320).”* Male cross-border migrant (Ha Giang)

#### *For family reasons*

Among all respondents, only female cross-border migrants in Kon Tum reported family-related reasons for migration. With the close proximity to Cambodia, many women in the area married Cambodian men. According to customs, “the woman follows her husband” to stay at the husband’s house. However, they frequently travel between the two countries.

*“My husband is Cambodian, 14 years older than me, working at the border post. Normally, my husband comes home once a week, if our child gets sick he might come back sooner. I’m staying here now, but later on if my husband moves to a unit far away, I’ll move with him.”* Female cross-border migrant (Kon Tum)

#### *For studying*

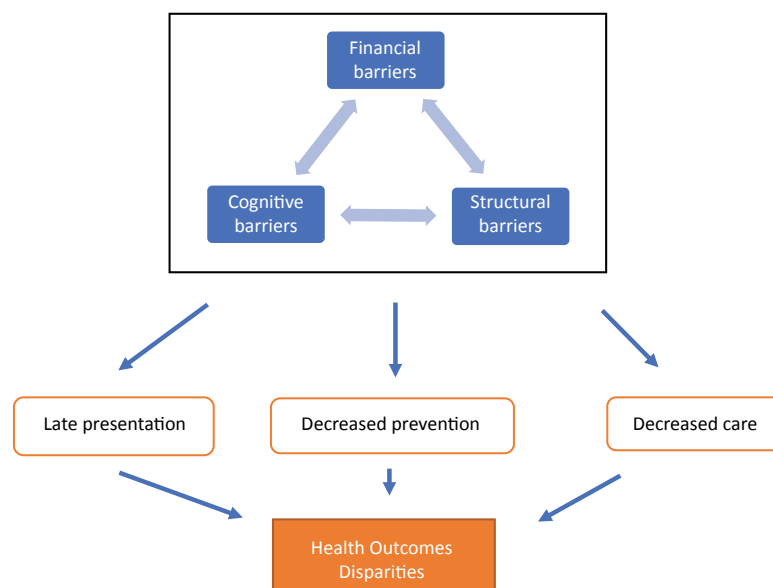
In contrast, study was only a driver for internal migrants in Ho Chi Minh City (four out of 24), with those aged 18–22 enrolling in universities and most working part-time to generate incomes and support their families.

*“I’m from Quang Ngai, I’ve been in Ho Chi Minh City for almost a year now. Normally I teach through a referral centre. I earn around VND 1.4 million per month (USD 61).”* Female internal migrant (Ho Chi Minh City)

#### Health-care access barriers model

The team analyzed data using the health-care access barriers (HCAB) model from Carrillo, J. E. et al. (80). The model defined three barriers: (1) financial, (2) structural and (3) cognitive barriers that hinder access to health-care services (Figure 9). The root cause of poor health outcomes can be explained by a single barrier or combination of two or three. Under each key theme, the authors also suggested possible relating subcategories for analysts’ reference. The research team used these categories as a reference in categorizing and analysing possible causes that prevent migrants from accessing health-care services.

**Figure 9. Health-care access barriers model**



Source: Carrillo, J. E., Carrillo, V. A., Perez, H. R., Salas-Lopez, D., Natale-Pereira, A., and Byron, A. T. (2011). Defining and Targeting Health care access barriers. *Journal of Health care for the Poor and Underserved*

In the HCAB model, the term *financial barriers* refers to “the cost of care and health insurance status barriers”. *Structural barriers* encompass “institutional and organizational barriers”. *Cognitive barriers* describe “knowledge and communication barriers”.<sup>5</sup> By referring to the definition of key themes in the HCAB model and using a general inductive approach for data analysis, the research team developed two tables that reveal barriers to migrants accessing health-care services. The research group added a fourth key theme *social support barriers* to highlight “insufficient social welfare and labour law compliance and enforcement” to include broader barriers reported during the interviews.

The research team identified 22 barriers among cross-border migrants and 16 barriers among internal migrants and grouped them into relevant key themes. Tables 6 and 7 illustrate the list of categories.

**Table 6. Barriers to health care based on perspectives of cross-border migrants**

Key theme	Category	Number of respondents mentioning the key theme	Percentage (%)
Structural barriers	Lack of interpreters	14	74
	Limited health communication programmes	9	47
	Lack of time/excessive waiting times	6	32
	Complex administrative procedures for purchase and use of health insurance	5	26
	Location of health-care facilities	5	26

<sup>5</sup> Communication and language barriers are highly prevalent due to the evolution of diverse populations due to migration. Language interpreters are key to minimizing these barriers, without which difficult situations for patients and professionals arise and impede the access and delivery of healthcare. Other communication problems may arise due to differing levels of education and health-care professionals’ lack of understanding about poverty, patient situations and associated multifaceted needs. Cultural and attitude barriers mostly incorporate aspects of discrimination and include dimensions of socioeconomic position, individual beliefs, social groups, languages, race, ethnicity and religion. Negative experiences from mistreatment or prejudice result in reluctance to attend services and negatively impacts perceptions of health.

	Need for portable health insurance across borders	2	11
	Need for gender-sensitive health services	2	11
	Need for cross-border referral systems	2	11
Financial barriers	Lack of health insurance due to high health insurance premium	8	42
	Affordability of health-care costs	5	26
	Financial burden on migrants	3	16
	High out-of-pocket costs with health insurance	1	5
Cognitive barriers	Lack of knowledge about destination countries	7	37
	Attitudes of health-care professionals and administrative officers towards migrants	3	16
	Limited understanding and knowledge of access to health-care services	2	11
	Lack of knowledge about benefits of health insurance	2	11
Social support barriers	Lack of support from employers	6	32
	Lack of health and social welfare support in destination countries	5	26
	Legal status of migrants	4	21
	Lack of official employment contracts	1	5

**Table 7. Barriers to health care based on perspectives of internal migrants**

Key theme	Category	Number of respondents mentioning the key theme	Percentage (%)
Structural barriers	Limited health communication programmes	24	100
	Lack of time/excessive waiting times	17	71
	Complex administrative procedures for purchase and use of health insurance	4	17
	Complex administrative procedures in the household registration book system	3	13
Financial barriers	Affordability of health-care costs	8	33
	Lack of health insurance due to high health insurance premium	5	21
	Pay out-of-pocket costs with health insurance	4	17
	Financial burden on migrants	4	17

Cognitive barriers	Limited understanding and knowledge of access to health-care services	15	63
	Lack of knowledge about benefits of health insurance	12	50
	Attitudes of health-care professionals and administrative officers towards migrants	11	46
Social support barriers	Legal status of migrants	9	38
	Lack of official employment contracts	4	17
	Lack of support from employers	2	8

In each corresponding theme, challenges in accessing health care were similar within the two migrant groups. Therefore, instead of presenting results for each group separately, this next section provides an overall picture of causes and barriers related to both groups and highlights barriers only observed in either cross-border or internal migrants.

### Structural barriers

Structural barriers are institutional and organizational by nature. In practice, they can be encountered at any step of the health care-seeking process. Migrants face these challenges inside or outside health-care facilities. For this key theme, the research group identified nine challenges as subcategories.

Similar barriers	Different barriers	
	<i>Cross-border migrants</i>	<i>Internal migrants</i>
<b>Complex administrative procedures for purchase and use of health insurance</b>	Need for portable health insurance across borders	Complex administrative procedures in the household registration book system
<b>Need for gender-sensitive health services</b>	Lack of interpreters	
<b>Limited health communication programmes</b>	Location of health-care facilities	
<b>Lack of time/excessive waiting times</b>	Need for cross-border referral systems	

#### *Complex administrative procedures for purchase and use of health insurance*

The research team in interviews found that both groups did not encounter obstacles in purchasing health insurance and all interviewees knew where they could buy health insurance in their hometowns. Only one interviewee in Ha Giang province, who used to be a village leader, reported an administrative problem in purchasing health insurance. Although he submitted additional documentation (copy of the household registration book) to Department of Labour, Invalids and Social Affairs staff, he had not received the card at the time of interview and no appropriate answer had been provided. Despite being a permanent village resident, he still faced problems in accessing health-care services and obtaining health insurance.

In contrast to purchasing health insurance, using it at health-care facilities was a significant challenge for migrants. Common migrant characteristics (mobility, informal employment arrangements and frequent changes in residential status) demand a flexible health insurance-related patient referral system. However, the current patient referral system was developed under the household registration book system, which creates significant barriers for internal migrants to obtain health insurance and

access public health-care services as they must register a new residence in the new area. As a result, migrants either pay out-of-pocket for health care, self-medicate or return to their registered residence to access health care. All options result in significant financial burdens.

*"I worked in Ho Chi Minh City and when I went to hospital, I only received 30 per cent support from health insurance. I had to return to Ha Tinh province to take a referral paper to get a full package of support. However, if I took a referral paper from my hometown, they would have transferred my case to hospitals in Ha Noi instead of Ho Chi Minh City."* Male cross-border migrant (Ha Tinh province)

*"I need to return home to access health care as my health insurance card is registered there, not Ha Noi. It is well known how complicated health insurance is in Viet Nam. I need to be referred from my commune to district, from district to province. If I want to be treated at a central hospital, I need a referral letter provided by a provincial hospital."* Male internal migrant (Ha Noi)

### *Need for gender-sensitive health services*

There was a difference in attitudes towards reproductive health care between ethnic groups. Migrants interviewed from the dominant Kinh ethnic group tended to be more open to discuss reproductive health care or gynecologic issues, compared to other ethnic groups. Even when health-care staff were deemed friendly, ethnic minorities still felt uncomfortable. Furthermore, there was a general tendency among male interviewees to avoid talking about reproductive or sexual health and provide stock answers inferring they were female-related issues, claims self-reported good health meant reproductive/sexual health checks were redundant and men avoided use of SW services. In-depth interviews gave no indication that male internal and cross-border migrant groups engaged in reproductive health check-ups. Only one female internal migrant reported going to a health facility for a reproductive tract infection, yet she felt "embarrassed" during the check-up.

Ethnic minorities tended to receive insufficient information on reproductive health care. Half of cross-border migrant interviewees were ethnic minorities and their ability to communicate in Vietnamese was limited. Moreover, illiteracy is common among ethnic minorities over 35 years old. One female cross-border migrant reported the scarcity of female village and commune health-care staff who could speak ethnic minority languages was a barrier to access reproductive health information. This underlines a shortage of bilingual health-care providers in ethnic minority areas, especially within border areas. The majority of health communication reported for this woman's commune was through speakers and regular public meetings using local language(s) and dialects. Cross-border migrants were often excluded from such activities due to long absences and work schedules. The lack of health communication also made them more hesitant to access gender-related health services, especially female cross-border migrants. In the internal migrant group, male attitudes towards reproductive or sexual health showed a subtle gap in gender sensitivity.

*"I had a reproductive health check-up at a public hospital. I had to wait several hours for my turn. However, the doctor was not friendly and yelled at me 'what is your job, why did you come here?'"* Female internal migrant (Ha Noi)

*"There was village health care staff of Nung ethnicity, but it was a male. He retired years ago and the new staff could not speak the ethnic language."* Female cross-border migrant (Ha Giang)

### *Limited health communication programmes*

In interviews, migrant groups rarely received health-care information in their communities. For cross-border migrants, they were not included in local communication programmes due to prolonged absences nor at destination countries despite living abroad for up to one year. Similarly, internal migrants seldom participate in communication programmes due to work schedules. Some interviewees had received health-care information from home visits by village health-care staff, including information from speakers or posters in their villages. But, they reported the content was limited in value. The

need for health-care information was highly demanded by both migrant groups. While female migrants were often concerned about reproductive health, public communication programmes provided little support. Moreover, female migrants from ethnic groups did not directly express their need due to the sensitive nature of reproductive health. In addition, a shortage of female village health-care staff who can speak ethnic minority languages exaggerated tension in accessing reproductive health-care information. The female participants aged 40–68 years and male interviewees could not communicate concern about health conditions or risks of non-communicable diseases.

*“Health care staff at this ward were very good and enthusiastic. I lived here for a while and they sometimes came to my room to ask about my health and taught me that I should keep clean to protect health. When they came, they didn’t give me any leaflets and that was all the information I remember. Spraying mosquito insecticide was a recent activity from the community health care station.”* Female internal migrant (Ha Noi)

*“No health care staff visited my living area. I usually read the news on the information board near my rented room, but there was no information about health.”* Male internal migrant (Ho Chi Minh City)

Limited speaker systems could be a reason for low rates of internal migrants receiving health-care information.<sup>6</sup> The majority of interviewees in Ha Noi and Ho Chi Minh City said there were no speaker systems at destinations. In other provinces, speaker systems and monthly public meetings played important roles in disseminating health-care information and updated regulation changes. However, migrant groups appeared excluded from host communities. A considerable number of internal migrants in Ho Chi Minh City and Ha Noi have not received invitations to quarterly meetings at ward level. Cross-border migrants seldom participate in commune meetings due to long absences.

*“While living in Laos, I was a household helper and the host family was very nice. When I got sick, they gave me medicine with no fee.”* Female cross-border migrant (Ha Tinh)

*“I didn’t know when the ward meeting was held. I did not join in any meeting like that, even I lived here for a while.”* Female internal migrant (Ho Chi Minh City)

### *Lack of time/excessive waiting times*

One common problem mentioned by many migrants was excessive waiting times at health facilities. While authorities are aware and taking steps to address overcrowding, it can make people hesitate to visit health facilities.

*“Medical services at public hospitals are reliable, but I’m afraid to go there because it’s too crowded. I had to visit K hospital from 3am to line-up. To be honest, it is less hassle to just go to a private facility.”* Female internal migrant (Ha Noi)

*“I wanted to check my reproductive health, but I didn’t have time to visit health care facilities because my working time was excessive. Normally, I went out at 8am and came back home around 7pm or 8pm.”* Female internal migrant (Ho Chi Minh City)

Lack of time was the most common answer given when asked why they had not visited health-care facilities. Most internal migrants were shoe-polishers, street vendors or construction workers which require them to work weekends. Cross-border migrants generally only had one or two days per month to return to hometowns. Excessive waiting times in hospitals also significantly affected migrants’ access to health-care services. From their viewpoints, losing a day of potential income could not justify health checks. Therefore, they looked for professional health-care services only once sickness became unbearable or unmanageable.

*“Honestly, it was too crowded and the waiting time was too long. So, I hardly went to hospital, I felt disgusted when thinking about that scene.”* Male internal migrant (Ha Noi)

<sup>6</sup> Street-based speaker systems are used for public information announcements in some communities.

*“Crowds and waiting for a long time are inevitable when checking health with health insurance. But I didn’t have money, so I had to accept that.”* Male cross-border migrant (Kon Tum)

*Need for portable health insurance across borders, lack of interpreters, location of health-care facilities, Need for cross-border referral systems (Cross-border migrants)*

Cross-border migrants encountered specific barriers. Most cross-border migrants could speak and only understand simple words in Lao People’s Democratic Republic, Cambodian or Chinese for work purposes. They faced obstacles in communicating with local people in daily conversations, while health-care facilities in neighbouring countries do not have interpreters. Moreover, Vietnamese migrants are unlikely to be priorities of neighbouring governments. Many migrants relied on support from local friends to access health-care services during emergency situations. Aside from serious illness, the study respondents often tried to endure pain or treated themselves with traditional or western medicines even without a doctor’s prescription.

*“The biggest problem for me while living in Laos was the language. I can say a couple of words during trading and they still manage to understand. But, it is more difficult to communicate with them on health-related topics.”* Male cross-border migrant (Ha Tinh)

*“But every time I was sick, I rarely visited health care facilities in Cambodia, I’d rather go back to Ho Chi Minh City to seek care. Because of language barriers, it’s difficult for me to communicate with health care providers.”* Female cross-border migrant (Kon Tum)

Working in informal sectors like forestry, farming or small-scale trade made migrants particularly vulnerable as they cannot benefit from health insurance at destinations. Participants described facing two options when suffering from sickness or injury while abroad. The first and preferred option was to return to Viet Nam to obtain health care and treatment. The second was visiting health-care facilities near their workplace and was preferred if urgent care was needed. After receiving first aid, they were usually referred to hospitals in Viet Nam without support from health-care staff regardless of long distances. Due to a lack of health insurance in destination countries, patients were charged full fees that many migrants were unable to afford.

*“When I was in Laos, if the illness was too serious, I would have to travel. One option was to return to Viet Nam quickly and another was to go to a hospital in Vientiane, depending on which was closer. I would have to bear the transportation expenses myself. Because I am not a Lao citizen, I don’t have Lao health insurance.”* Male cross-border migrant (Ha Tinh)

Viet Nam, like many countries, lacks an international patient referral and health insurance reimbursement system. Cross-border migrants mostly work in the informal sector without employment contracts and health insurance. This lack of flexible trans-border health-care systems puts them at higher risk of health problems and increases their financial burden. Moreover, other factors, such as language barriers and distances from work places to health-care facilities, can aggravate their situation.

*“It would be great if there were agreements between countries for patient referral systems, especially for people without identification papers. Sometimes people without paperwork cannot return home.”* Male cross-border migrant (Ha Tinh)

In addition, aside from financial reasons, Vietnamese migrants choose to return home for medical examinations due to the perceived poor quality of border health facilities.

*“When I worked in Laos, it was difficult to access care. The level of medical expertise is much lower than in Viet Nam. Every time we encountered an accident or illness, we only received first aid and emergency care there. But, we would return home for medical treatment. In Laos, people’s awareness of health is still low.”* Male cross-border migrant (Ha Tinh)

Regarding domestic medical care in rural areas, migrants still faced difficulties due to geographical distances and high travel costs.

*“From here to Ngoc Hoi hospital costs VND 100,000 (USD 4), to Kon Tum costs VND 600,000 (USD 26) for a round trip by car.”* Female cross-border migrant (Kon Tum)

*“It is not troublesome to take the car to the district for a medical examination and return home. However, travel is expensive. A one-way trip by car is VND 200,000 (USD 8), plus the taxi fare is VND 600,000 (USD 26) in total.”* Male cross-border migrant (Ha Tinh)

### *Complex administrative procedures in the household registration book system (Internal migrants)*

Despite positive changes to administrative requirements to obtain the household registration book, some internal migrants remained discontented. Based on the Residence Law 2013, internal migrants must obtain a temporary residence registration paper/book. However, when the research team enquired about this procedure, participants stated the requirements were unclear. Even if cognizant of the procedures, administrative problems could still be encountered.

*“I did not know about the administrative requirements for temporary residency registration. But, I guess it could be very complicated. One of my friends complained she came to the People’s Committee several times without result.”* Female internal migrant (Ho Chi Minh City)

*“My friends registered for temporary residency, but I didn’t. It seems like at the place I rent, people don’t register. Because the landlord said he must be present for us to register for temporary residency, we can’t do it.”* Female internal migrant (Ho Chi Minh City)

## Financial barriers

Cost of care and health insurance status are categorized under financial barriers. Based on the definition of Carrillo, J. E. et al., financial barriers encompass the reasons why migrants are uninsured and unable to pay health-care fees. After data analysis, four obstacles were identified. There were no differences between migrant groups.

### *Lack of health insurance due to high health insurance premium*

Kon Tum had the lowest percentage of interviewee health insurance holders compared to Ha Giang and Ha Tinh. In Ha Giang, all cross-border migrants were ethnic minorities and priority targets of the 2014 Law on Health Insurance and its government-subsidized premiums. Cross-border migrants in Ha Tinh reported higher incomes and awareness of health insurance’s necessity. As a result, all interviewees in Ha Giang and Ha Tinh were insured, in contrast to two in Kon Tum. The remainder reported being financially unable to purchase health insurance, with unstable incomes cited as a barrier.

*“I only earn a small amount of money. In the wet season, I can’t earn enough for living costs. VND 700,000 (USD 30) is not enough [for a health insurance premium].”* Male internal migrant (Ho Chi Minh City)

*“My family used to have health insurance as we were a poor household. But now, we don’t have a health insurance card anymore. I don’t buy insurance because I can’t afford it. If I happen to be sick, I will buy medicine by myself.”* Female cross-border migrant (Kon Tum)

### *Affordability of health-care costs*

In general, migrants with low incomes perceived having insufficient money for hospital fees. As highlighted earlier, deduction of living costs and supporting families at home meant migrants’ income was largely insufficient to meet health-care costs. Even with health insurance, without a referral document they faced higher hospital fees. Moreover, transportation and loss of daily income were financially burdensome. This could partly explain why self-medication is common among migrants.

*"I went to check my health only once last year and did not go for re-examinations because of money. The hospital fee was expensive, I could not afford it even though I really wanted to go."* Female internal migrant (Ho Chi Minh City)

*"When I got sick, I just bought some medicines at a pharmacy instead of going to hospital. In Laos, the hospital fee was very expensive."* Female cross-border migrant (Ha Tinh)

For cross-border migrants, exchange rate differences can make medical care abroad more costly. Even basic medicines can be priced higher than in Viet Nam. As a result, many cross-border migrants buy medicines before departure to prepare for ill health.

*"Medicine in Laos is expensive, about three times higher than in Viet Nam. For example, an Effergan tablet (an antipyretic), costs 10,000 kip, equivalent to VND 30,000 (USD 1), which is three times higher."* Male cross-border migrant (Ha Tinh)

*"Before departure, I bought mosquito nets and medicines, for diarrhea and colds, in case I needed them."* Male cross-border migrant (Ha Tinh)

### *High out-of-pocket costs with health insurance*

Some interviewees stated they paid all costs for some services, despite having health insurance. For example, based on the 2014 Law on Health Insurance, children aged under 6 can receive full health-care system support. However, some migrants reported having to pay vaccination fees for children due to missing vaccination dates and home commune health-care centres running out of vaccinations. This issue could be a consequence of limited communication outreach on health-care programmes. In Ha Giang, some interviewees bought medicine at a private pharmacy due to commune health-care centre shortages.

During an interview, one participant reported his family bribing health-care staff to obtain a referral paper when urgently needing his appendix to be surgically removed. Without the referral, he could not have surgery at a provincial hospital. During treatment, doctors demanded he buy a particular medicine costing VND 3 million (USD 129) not covered under health insurance. If he had declined, the doctor would not have continued treatment.

*"What matters is money. My uncle was the vice director of a provincial hospital, so I know that. Health insurance in Viet Nam is so bad. I bought health insurance a long time ago, but I still had to pay a large amount of money."* Male internal migrant (Ha Noi)

### *Financial burden on migrants*

Interviews with participants showed migration tended to increase individual incomes. However, this did not necessarily translate into sufficient disposable income for health-care needs, as a proportion of their income was sent to financially support families. Such a barrier, combined with other issues, exacerbates migrants' financial burden.

*"Each month I could earn VND 6–7 million (USD 259–302) and I send VND 3–4 million (USD 129–172) to my parents at home in Thanh Hoa province."* Male internal migrant (Ho Chi Minh City)

*"Here, VND 3–4 million (USD 129–172) was my income per month, but I had to take care of three children. My oldest child was 17 years old, she looked after the younger brother/sister when I was in Ha Noi."* Female internal migrant (Ha Noi)

Limited financial capacity also negatively affects migrants' willingness to pay for health services. Most surveyed migrants claimed they were in good physical health and believed regular health check-ups were unnecessary, with a doctor's visit a last resort. In addition, spending nearly a day for a health check-up reduced income, so self-medication was the first choice. They perceived the financial burden of a regular health check-up as outweighing its benefits.

*“I can work and do not have any symptoms of illness. Why do I need a check up? It is a waste of money.”* Male internal migrant (Ho Chi Minh City)

## Cognitive barriers

Cognitive barriers include aspects related to knowledge and communication. The research team categorized the impact of factors on migrants’ access to health-care services under six sub-categories.

Similar barriers	Different barriers	
	Cross-border migrant	Internal migrant
<b>Attitudes of health-care professionals and administrative officers towards migrants</b>	Lack of knowledge about destination countries	
<b>Limited understanding and knowledge of access to health-care services</b>		
<b>Lack of knowledge about benefits of health insurance</b>		

### *Attitudes of health-care professionals and administrative officers towards migrants*

The research team received negative responses from migrants regarding staff attitudes at health-care facilities, with doctors’ conduct deemed unwelcoming and unreceptive to migrants’ needs. They also mentioned discrimination against poor people at health-care facilities, especially in Ha Noi and Ho Chi Minh City. Such unprofessional attitudes might discourage migrants from seeing doctors as they could reflect an insufficient level of care.

*“They [doctors] only cared about money. It was totally different in my hometown. They knew the residents were poor, but they were really enthusiastic.”* Female internal migrant (Ha Noi)

*“Many people had support from health insurance. Most were poor, but doctors were quite hard to patients.”* Male internal migrant (Ho Chi Minh City)

*“If doctors had been enthusiastic and given us advice on my health and explained about the use of medicine, I would have visited health care facilities.”* Female internal migrant (Ho Chi Minh City)

### *Limited understanding and knowledge of access to health-care services*

Most interviewees completed middle school or high school, with some from Ha Giang and Kon Tum having dropped out during or after primary school. This limited education could narrow channels to obtain health-related knowledge and information, as reflected by migrants’ inability to access health-care services at destinations. Migrants often did not know commune health station addresses, dates of child vaccinations or other public consultant services. In addition, cross-border migrants often lack language skills critical to access information. While the internet was a popular tool to seek health-related information, it may provide unofficial or misleading information. One interviewee visited a private hospital in search of free reproductive health-care services on the basis of an advertisement. The expenditure was beyond her expectation and ability to pay. The causes of her decision are linked to the “affordability of health-care costs” and “lack of time/excessive waiting time” barriers. This case illustrates internal migrants’ insufficient knowledge to identify reliable health-care facilities in a new community.

*“I didn’t know anything about health care services, benefits for people living in my community. No one told with me about such information. I was a migrant from rural Thanh Hoa province, I didn’t have any relationship with the host community.”* Female internal migrant (Ho Chi Minh City)

Lack of health-care system knowledge caused many migrants not only to lose money and time, but also exposed them to other health risks. With development of information technology, many people search for health information online, leading to risks of false health information or even being deceived into visiting low-quality medical facilities.

*"I had breast fibroids, and I was told that if I didn't get cancer examination, I would die. Then they took me to a private clinic and found nothing. After that, I had to visit K hospital for proper check-up."* Female internal migrant (Ha Noi)

### *Lack of knowledge about benefits of health insurance*

A high percentage of interviewees had health insurance, only 27 per cent were uninsured. Interviewees in Ha Tinh, Ha Giang and Kon Tum were all local residents, hence they easily found support for health insurance-related procedures in hometowns. Internal migrants living in Ha Noi and Ho Chi Minh City stated they could not use their health insurance in these cities and did not bring their health insurance cards with them. Some were unaware of their right to transfer registration status to other health-care facilities and recent changes to the Health Insurance Law 2008. They still believed returning to home was necessary to receive full health insurance support. In structural barriers, scarcity of health-care communication programmes and unfriendly attitudes from health care or administrative officers were also reported.

*"I could not use my health insurance card in Ho Chi Minh City, as the registration hospital was in Thanh Hoa province. Hospital fees were high [in Ho Chi Minh City], while high transport costs and time [necessary to return home], means I just bought medicine at pharmacies when I got sick. Luckily, until now, I haven't had any acute symptoms."* Female internal migrant (Ho Chi Minh City)

*"I have just bought health insurance in my hometown, no need to buy another one here. It is true that I spend most of my time here, but I leave my health insurance card at home in the countryside. I did not know that having temporary residency here allowed me to buy health insurance, so I still go home to purchase insurance cards."* Female internal migrant (Ha Noi)

### *Lack of knowledge about destination countries*

Cross-border migrants often receive little information about destination countries from peers and could be unaware of inadequate health-care facilities, living costs or emerging diseases in neighbouring countries. One interviewee, who worked in Lao People's Democratic Republic, said her limited language skills isolated her from the community and posed health-related risks due to poor understanding of regulations. Forest-goers usually work in remote areas where social networks are hard to develop, preventing them from accessing important information, such as locations of health-care facilities. As a result, one interviewee did not know how to access care and when his colleague was severely injured in the forest, he brought the patient to Viet Nam without proper first aid.

*"I did not know the telephone number of health care facilities and had no idea about other stuff. With the accident, I called friends for help and found a way to transfer the patient out of the forest. We then asked help from drivers on main roads to deliver the patient to Viet Nam."* Male cross-border migrant (Kon Tum)

## Social support barriers

The research team identified four additional categories. These highlight the necessity for employers' compliance to regulations and local community support to enable migrants to access health-care services. The term of "social support barriers" is used to define these categories. There are four barriers under this key theme and only one applied to cross-border migrants.

Similar barriers	Different barriers	
	<i>Cross-border migrant</i>	<i>Internal migrant</i>
<b>Lack of official employment contracts</b>	Lack of health and social welfare support in destinations	
<b>Lack of support from employers</b>		
<b>Legal status of migrants</b>		

### *Lack of official employment contracts and lack of support from employers*

Some 91 per cent of interviewees reported not having employment contracts as they worked in informal sectors (street vendors, farmers, domestic helpers, construction and manual workers). For migrants with short-term or unstable work, labour contracts are rare. Only two internal interviewees had official contracts. Similarly, only one interviewee in the cross-border migrant group had an official contract. Lack of employment contracts makes it difficult for migrants to access health-care services.

As social security systems are different across countries, cross-border migrants become more vulnerable than internal migrants in accessing to health-care services. Respondents reported limited support from employers when working in Cambodia, China or Lao People's Democratic Republic. Sickness was often addressed by employers by administering medicine instead of helping migrants visit health-care facilities at destination places. Moreover, due to a lack of official work agreements, they only received a lump sum that included salary and other fees. This left them vulnerable to unexpected costs or non-payment.

*"The family hiring me did not buy health insurance for me, but was very nice to me. When I got sick, it gave me some medicine and let me return to Viet Nam to take treatment."* Female cross-border migrant (Ha Tinh)

*"I received a lump sum for my salary that included all fees and I did not have a work contract, we just had the verbal agreement. Usually when people got sick, they came back to Viet Nam for treatment. I heard one of my friends got sick and her employers were very nice to her. They gave her medicine."* Female cross-border migrant (Ha Giang)

### *Legal status of migrants*

As discussed, Viet Nam's current health insurance system was developed under the household registration book system. Individuals without residential status are unable to purchase voluntary health insurance nor change the registered hospital on the health insurance card. Although lack of temporary residence registration was not common among the internal migrant group, one interviewee reported she did not have identification papers as her household registration book was taken by police at her hometown as she failed to regularly report it to authorities. To renew it, she said a large police bribe was necessary. Therefore, she decided to live in different provinces without official papers and had become homeless. Although this case does not paint a common picture, she is an example of an undocumented migrant without residential status. This problem could make people vulnerable to high cost health care and exclude them from social support in local communities. Especially, out of wedlock children in Ha Giang and Kon Tum provinces suffered problems around lack of nationality as they might only have a Vietnamese father or mother. However, due to no official papers from either country, they were unable to acquire citizenship or birth certificates at the time of interviews.

*"My child had an official paper from Laos, but when I submitted my papers to Vietnamese authorities, they denied to issue citizenship and a birth certificate for my child. My child received free vaccination services, but I had to pay all other fees when my child got sick."* Female cross-border migrant (Kon Tum)

## Lack of health and social welfare support in destinations

In addition, social relations barriers were reported by migrants. When leaving home to move to another location, social relationships (family and friends) are interrupted and cause many people to face psychological problems. Moreover, for many low-educated migrants who cannot access official sources of information, it is important to seek help from relatives. As a result, migrants feel overwhelmed and lack information when in new locations and struggle to access reliable medical facilities.

*“Well in general, if you know someone they can bring you to the hospital. But I don’t know which hospital is good. I have only been here for a few years. In my hometown, there were three hospitals [provincial and district]. But in Ha Noi there are many private hospitals, how could I know which hospital is good?”* Female internal migrant (Ha Noi)

*“I came from the countryside and I don’t know anyone here. Sometimes I want to go to a medical centre or a hospital for medical treatment, but I don’t go.”* Female internal migrant (Ho Chi Minh City)

Participants also reported insufficient support from receiving countries for cross-border migrants. As cross-border migrants mostly find informal jobs in often inhospitable areas, health-care facilities are usually under-invested and lack skilled health-care staff. This situation is compounded by the lack of legal status, employment contracts or working in remote areas leading to migrants’ exclusion from host communities.

*“People like me without education are not respected in Laos. Luckily, I met local people who could speak Vietnamese to help me. I was just a small trader and I did not do illegal things. However, Lao people looked down on Vietnamese. If something happened, protection for citizens like China is very strong, but Vietnamese do not have that right. There was no support for us even in the case of death.”* Female cross-border migrant (Ha Tinh)

## RESULTS OF STAKEHOLDER INTERVIEWS AND FOCUS GROUP DISCUSSIONS

The research team conducted two FGDs with government stakeholders, such as policymakers and public health officers, involved in migrant health in Ha Noi.

Public health officers, health-care providers and other government officers who work with cross-border migrants also participated in nine FGDs at commune, district and provincial levels at Ha Giang, Ha Tinh and Kon Tum. FGDs provided an opportunity for stakeholders to discuss challenges and barriers in provision of health care services for migrants. Table 8 shows the number of study participants in FGDs. The research team also interviewed 11 experts with experience of working in migrant health from United Nations agencies, CSOs and NGOs (list of participants in FGDs and interviews in Annex 3).

**Table 8. Number of study participants in FGDs**

	Ha Noi	Ha Tinh	Kon Tum	Ha Giang
National level	23	0	0	0
Provincial level	0	16	10	11
District level	0	9	11	10
Commune level	0	19	11	8
Total	23	44	32	29

This report presents findings of its stakeholder analysis in accordance with four thematic areas of the Madrid Framework to evaluate prior achievements, identify issues to be addressed, and provide stakeholders with guidance on next steps. This report also aims to identify stakeholders’ challenges in implementing strategies, policies and programmes, and stakeholders’ perceived barriers to migrant health care services. Table 9 summarizes key themes, sub-key themes and categories found in the stakeholder analysis.

**Table 9. Challenges in migrant health based on perspectives of stakeholders**

Key theme	Sub-key theme	Category
Coordination and Partnerships		Need for cross-border referral systems and collaboration
		Limited collaboration between public and private health sectors
		Insufficient networking and collaboration across ministries and/or departments
Policy and legal framework		Inconsistency in policy implementation
		Impractical policy at local level
		Insufficient monitoring and evaluation in policy implementation
		Need for effective enforcement of laws on pre-departure health screening and training (undertaken by sending agencies)
Monitoring migrant health		Difficulties in identifying and reaching out to mobile and migrant populations
		Need for improved monitoring systems of migrant populations
		Lack of follow-ups among migrants
		Need for effective quarantine systems
Migrant Sensitive Health Systems		Need for gender-sensitive health services
		Limited health communication programmes
		Limited funding for provision of quality of health care
		Stigma
		Lack of interpreters
		Complex administrative procedures for purchase and use of health insurance
		Complex administrative procedures in the household registration book system
		Lack of time among migrants
Migrants' challenges from stakeholders' perspectives	Financial barriers	Lack of health insurance due to high health insurance premium
		Affordability of health-care costs
		Lack of health insurance due to high health insurance premium
	Cognitive barriers	Attitudes of health-care professionals and administrative officers towards migrants
		Limited understanding and knowledge of access to health-care services
		Low perceived benefits of health care
		Lack of knowledge about benefits of health insurance
		Lack of knowledge about destination countries
		Lack of awareness about risks of irregular migration
		Lack of support from employers
	Social support barriers	Legal status of migrants

## Coordination and partnerships among stakeholders

### *Insufficient networking and collaboration across ministries and/or departments*

In Viet Nam, migration and migrant-related health issues are not specifically assigned to one government agency. For example, the Ministry of Public Security oversees household registration and social order and the MOLISA is focused on employment-related issues and labour sector management. The MOH, meanwhile, is responsible for providing health care services to all citizens, including migrants. As a result, migration-related policy and implementation is embedded across different ministries and branches. Therefore, to effectively provide health services to migrants, the MOH is reliant on close cooperation with other ministries and sectors, such as for the availability of periodic data, provision of health information related to cross-border workers and monitoring of labour conditions. Currently, the MOH faces numerous challenges in coordinating with other sectors to collect information on migration as well as manage the health of migrants.

*“The difficulty is health agencies and the police do not coordinate in the management of medical examinations and treatment. Police manage information on people who go and leave, which is not shared with health departments. We only receive information when they [migrants] return home to do business or from a foreign country and get sick.”* Officer from district health-care centre, FGD at district level (Ha Giang)

*“At present, coordination in terms of monitoring migrants is very limited. We have not met the need for data yet.”* Officer from Department of Health, FGD at provincial level (Ha Giang)

Aside from the lack of inter-ministerial coordination mechanisms, the sharing of information between different management levels to oversee the health of migrants is limited. Provincial Departments of Health are responsible for managing their respective local population’s health situation, however, they encounter difficulties in collecting data on migrants’ health.

*“Regarding the border gate, it is the responsibility of both sides, the preventive medicine centre and epidemiological hygiene institute. But at commune level, migration is not manageable because most people use their temporary border pass to enter and exit the country. This is not the responsibility of the commune health station.”* Medical doctor, FGD at commune level (Ha Tinh)

### *Need for cross-border referral systems and collaboration*

The lack of uniformity and cooperation mechanisms between Viet Nam and other countries also hinders the management of cross-border migrants’ health, especially for migrants infected with TB and HIV where collaboration, sharing of data and synchronization of protocols are of great importance. Such migrants who are registered and have insurance face hurdles due to inadequacies in health insurance and the lack of bilateral integration. Informal migrants without labour contracts are especially vulnerable due to the inability to access social insurance or health care.

*“Vietnamese who go abroad to work also have to pay some kind of insurance [in Viet Nam]. The current level of payment as prescribed is still high. In addition, workers must pay insurance overseas, so they pay twice. At present, Viet Nam has not signed memorandums of understanding [with destination countries] on how to connect insurance and accumulate the total period of participation in insurance, so Vietnamese workers abroad do not have to continue to pay insurance fees in Viet Nam. Because of the lack of agreements with some countries, workers cannot have life insurance policies in case of accidents, for example.”* Programme officer from an international organization

### *Limited collaboration between public and private health sectors*

Private clinics and hospitals are commonly selected by migrants in need of medical treatment. However, general medical reporting is not systematically shared with State authorities. This is symptomatic of the

limited information-sharing linkages between the public and private health systems that impede the government's ability to deliver equitable health outcomes to migrants.

*"A large number of people who migrate choose private examinations, so it is difficult to manage as there is no exact data sent from private clinics to district health departments. Every year, private health facilities report on medical examinations and treatment, but the reports are inaccurate. Currently, there are about 300 private clinics in the district, which have no software to connect them."* Officer from district health-care centre, FGD at district level (Ha Tinh)

In areas with large numbers of internal migrants, the provision of public health services is often impeded by overwhelming demand. However, ensuring the quality of services delivered to people with financial difficulties through enhanced coordination remains a major challenge.

*"Local governments must also see how public-private partnerships work to ensure the quality of services provided. Public service providers must guarantee quality services for migrants at affordable prices, so migrants don't face high out-of-pocket expenses for health, education and social services."* Programme coordinator from an international organization

## Policy and legal framework development

### *Inconsistencies in policy implementation*

Participants in FGDs pinpointed the inconsistent implementation of policies at local level as a barrier to migrants accessing social welfare services. This was also noted in interviews with migrants. As an example, migrants encounter difficulties in processes for naturalization and birth certificates for their children. The research team recorded numerous cases of children failing to gain birth certificates in areas near border gates and hence not receiving health insurance support for medical examinations and treatment as well as later school enrollment.

*"The unit sent a written request to the Ministry of Justice and other local units to help these children get registered. At the same time, the Ministry of Justice affirmed that the law on Vietnamese nationality did not obstruct the naturalization and civil status process for children. But I don't know how to guide units as there are so many unregistered children without civil status/nationality to ensure their rights."* Officer from Department of Children, MOLISA, FGD at central level

As highlighted earlier, fragmented multi-sector coordination is a key challenge faced by authorities in implementing activities to enhance the health of migrants. Limited data collection and information sharing among authorities on the situation of migrants was also highlighted in FGDs. While this delayed the updating of some policies, repeated changes to other policies also caused confusion in implementation at local level.

*"In general, the MOH issues general guidelines for the whole country to apply. However, we need guidance on flexible application. There are many new documents, instructions and standards every day that no one can follow."* Programme officer from an NGO

This results in grassroots level officials, especially at district and commune levels, struggling to remain cognizant of updated policies. This is compounded by a general lack of capacity to interpret and implement new policies, as opposed to better resourced and practiced district-level authorities.

*"One of the difficulties in policy implementation is that lower level State authorities do not have sufficient conditions to fully and promptly study health policies, leading them to always being passive with such changes. In fact, at district level, they do a lot of multi-tasking, but at commune level they have no ability to do that. So, it is extremely difficult to implement changes."* Programme officer from a NGO

*“If a woman has a child with a Chinese man and brings her child to Viet Nam, that child is Chinese, not Vietnamese. So, in such cases, she cannot proceed with naturalization.”* Police officer, FGD at commune level (Ha Giang)

### *Impractical local-level policies*

The process of implementing and applying policies from central to grassroots levels requires a consistent approach and investment in resources. This process may succeed in one locality, but fail in another due to many factors - including cultural ones.

Numerous national laws and programmes have been revised to enhance the legal and policy framework. However, study participants reported a need to build evidence-based legislation through reviewing past results.

*“The National Strategy for HIV/AIDS Prevention has just ended after 10 years’ application. People see limits in its coverage and the need for new target audiences. A new strategy or approach is required. This is the time to revise and evaluate the programme to provide a new and more appropriate direction.”* Programme officer from an international organization

*“According to Decree No.146, when patients need to be transferred from district to central hospitals, the transportation fees are covered by health insurance. However, patients have to cover the transportation fees from provincial to central hospitals themselves. This provision in Decree No.146 is extremely unreasonable.”* Medical doctor from Provincial General Hospital, FGD at provincial level (Ha Giang)

### *Insufficient monitoring and evaluation of policy implementation*

An effective policy system demonstrates sound input and output standards, with robust inspection and supervision functions. However, such inspection and control activities in Viet Nam have scope for enhancement to address shortcomings in policy implementation and increase the level of transparency in the application of the law.

*“Departments of Labour, Invalids and Social Affairs conduct periodic inspections of enterprises and determine sanctions, but these inspections are insufficient.”* Programme officer from an international organization

Amid Viet Nam’s rapid industrialization and modernization, the number of companies and industrial parks has grown to drive rural-to-urban migration in search of employment. This development has placed considerable pressure on State authorities to inspect and supervise operations and labour conditions at all facilities. While a mechanism is needed to ensure compliance with supervision team requirements as well as monitoring and implementing policies, a study participant reported that current administrative sanctions were an insufficient deterrent to law-breaking firms.

*“Actually the sanction mechanism is only at administrative level, which is not serious. As for having health clinics at companies, they fail to follow through on commitments. Therefore, inspectors should ensure compliance and a completion deadline is required.”* Programme officer from an NGO

### *Effective enforcement of laws on pre-departure health screening and training*

Some study participants reported that many Vietnamese workers met pre-departure domestic health requirements, yet failed health checks upon arrival at work places overseas forcing them to return home. This costs migrants, who are often poor and have borrowed to pay brokerage costs, money and time they can ill afford to lose.

*“There are cases where [migrants] return home early due to health reasons. They came to work, then went for a check-up and did not pass the health requirements possibly caused by [sub-standard] pre-departure health examinations.”* Programme officer from an international organization

Pre-departure training and retraining programmes for workers are clearly specified in Decision No.18/2007/QĐ-BLĐTBXH (MOLISA, 2007). However, an interviewee expressed concern that the quality of labour export company trainings was a pressing issue for authorities.

*“We can’t know whether the organization or workers receive the [required] 74 sessions of training. There is no way to precisely know the percentage of people going through training. However, according to reports and discussions with workers, most said they did not learn anything. Before going, the company gave them advice for a few hours, but they did not study methodically.”* Programme officer from an international organization

*“There is the rule to provide 74 sessions of training for workers. However, there is no supervision of this.”* Programme officer from an international organization

## Monitoring migrant health

### *Difficulties in identifying and reaching mobile and migrant populations*

Human resources are also a barrier to implementing policies, especially migrant-related ones. Due to the highly mobile and complex nature of migrants, the process of bringing them health care requires a deep network to reach remote locations, especially ones commonly home to ethnic minorities.

*“The problem with malaria right now is that we have the available service, but it is difficult to reach remote places. If the patient has a disease and can reach the facilities, then health care is easy. The problem is I have to bring these services to people which is difficult.”* Medical doctor, international organization

The majority of FGD respondents at study sites reported there was no discrimination between migrants and non-migrants. However, ensuring health service coverage and communication with all migrants was challenging, especially in mountainous border provinces. Moreover, authorities reported capturing information from returning migrants was difficult due to sporadic household re-registration.

*“When a migrant returns, they don’t come back to the same place. For example, a household from Hoang Su Phi migrated to the Central Highlands, but then went to Dong Van to live. There is no discrimination among resettled or migrated households in terms of health care. But they move without notice. Regarding the fact that management of household registration is not strict, it is because family members do not declare departures to commune police.”* Officer from district health-care centre, FGD at district level (Ha Giang)

Due to general limits in monitoring migrants, tracking their health treatment is also problematic. According to data collected in the three border provinces of Ha Giang, Ha Tinh and Kon Tum, local officials acknowledged difficulties in collecting information on migrants, especially those who regularly crossed borders.

*“It is difficult to know the number of people who move across the border because the number of people working in China is large. In terms of management, a low number of people use passports to [formally] cross the border. As the border is long, people cross it via forest roads.”* Doctor from district health-care centre, FGD at district level (Ha Giang)

Dangerous contagious diseases such as TB, malaria and HIV require patients to follow treatment regimes to avoid infecting the community. However, as analyzed earlier, information on this population is limited with systems not classified according to migration status. Hence, monitoring of migrants with dangerous infectious diseases is exigent.

*"If the patient moves to another area, they will be transferred by the medical system to the patient's new location. However, some patients cannot be followed-up and managed."* Medical doctor from National Tuberculosis Control Programme (NTP) FGD at central level

### *Need for improved monitoring systems of migrant populations*

Due to the dynamic nature of migration, a comprehensive migrant monitoring system is essential for the Vietnamese Government and policymakers. However, building this system is challenging considering the country's rapid urbanization and modernization, along with various ethnicities and complex topography. Limits to a migrant monitoring system were pointed out by experts during in-depth interviews and FGDs. These limits are reflected in current State information collection systems, which do not classify migration status nor information related to the health status of migrants. In addition, the Ministry of Public Security in its resident management role does not use the concept of "migration", but bases a resident's status on "permanent" and "temporary" residence.

*"During an examination, it is primarily about diseases, not people's movements. Only in case of an epidemic must a patient tell their history of migration. Because the law doesn't require regular medical examinations to gather migration information, medical examinations and treatment facilities do not collect it. For police, population management is based on law on residency and does not use the word 'migration'. Depending on the needs of that person upon arrival in the area [study, work, marriage] and all the required documents, we decide on permanent or temporary registration."* Medical doctor from General Provincial Hospital, FGD at provincial level (Ha Tinh)

Internal migrant workers receive financial and other types of support from Confederation of Labour, with skills improvement programmes also recording workers' information. Currently, most workers join Confederations of Labour of respective enterprises, but efficient migrant monitoring systems are necessary for those who change jobs or workplaces.

*"Migrants don't grasp information about joining labour federations. For members of the State system, it is easy to manage through the Confederation of Labour. But, private sector workers such as in construction and transportation are not able to manage because they don't participate in labour federations."* Officer from Provincial Confederation of Labour, FGD at provincial level (Kon Tum)

Through central to local level FGDs, the lack of a national database to monitor migrants was reported as the root cause of a lack of effective monitoring systems for migrants. Lack of data on migrants makes it difficult for authorities to develop and implement policies, especially health ones.

*"Data collection is important and should include migration abroad and other areas, such as trafficking, health status, gender and quantity of migrants. These statistics can underpin planning and enhance cooperation between ministries and agencies."* Officer from Consular Department, Viet Nam's Ministry of Foreign Affairs from FGD at central level

### *Need for effective quarantine systems*

The MOH and other authorities have made efforts in terms of quarantine and disease controls for migrants. Authorities in border areas usually have annual meetings with counterparts from neighbouring countries to exchange migration information. These efforts have helped Viet Nam and its neighbours control infection risks and protect people's health.

However, the quarantine process is still inadequate as it is based on symptom monitoring of high-risk people with a lack of a specific mechanism. According to Circular No.46/2014/TT-BYT on medical quarantine procedures for people who present risk factors in the entry, exit and transit across the country, medical declarations are necessary in accordance with Circular No.32/2012/TT-BYT (24 December 2012, MOH) to check international immunization certificates and medically review people

who are contaminated or suspected of contamination. However, migrants do not always give accurate declarations.

*“The most difficult thing is that they [migrants] do not provide accurate information. I rely on declared information from patients.”* Officer from General Department of Preventive Medicine, MOH, FGD at central level

For migrants not at risk, body temperature checks and casual observations are not effective to fully detect infectious disease risks.

*“As for people who cross the border unofficially, it is more difficult to control them. The only way to check their health is through quarantine when they cross borders. During quarantine, they measure body temperatures and some other things. The procedures are not strict, especially immunization or disease history.”* Officer at Department of Health, FGD at provincial level (Ha Tinh)

Even for people at risk of infection, health facilities in border areas of Viet Nam and neighbouring countries have limited capacity to make an accurate diagnosis.

*“Regarding quarantine, I cannot make conclusions about diseases. I can only monitor their symptoms. For example, if I suspect they might carry a disease, I can send them to a specialist facility. I can also transfer them to another hospital, but I can’t exactly detect their disease. Even higher level hospitals cannot diagnose disease, let alone at border gates.”* Officer from General Department of Preventive Medicine, MOH, FGD at central level

## Migrant-friendly health-care system

### *Lack of community health care communication programmes*

To support migrants’ access to health services, community-based communications is crucial to enhancing migrants’ health awareness. However, policymakers acknowledged that health communication programmes in Viet Nam had not evolved and insufficient migrants were reached.

*“Migrants only receive knowledge through the community, such as through the speaker system.”* Doctor from commune health-care station, FGD at commune level (Ha Tinh)

Currently, localities rely on communication materials or speakers to provide community information. However, migrants from other countries or ethnic minorities slip through the cracks as materials are not in local languages. Depending on the characteristics of migration in each region, communication materials should be produced in ethnic or foreign languages. This issue has yet to be addressed and was reflected in FGDs with communities.

*“In addition, we should include indigenous languages. When we translate into such languages, people will understand better. Otherwise access to services is more limited.”* Officer from district health care centre, FGD at district level (Kon Tum)

### *Need for gender-sensitive health services*

Gender-sensitive health care services means health care workers can understand gender differences to make appropriate decisions and take action. Migrants, especially women, reported that health care workers were not fully aware of gender sensitivities when providing reproductive health care services. Thus, female migrants were reluctant to visit health facilities.

*“Because women have their own boundaries, for example with sexual or reproductive health, it is not easy for them to ask such questions.”* Programme officer of an international organization

*“Sometimes, they find sensitive issues uncomfortable to share.”* Programme officer of an NGO

While there is growing gender awareness within society, such activities mainly centre on domestic violence and sexual abuse without a particular focus on migrants. However, migrant women are victims of gender violence and a vulnerable group within society.

*“For female workers, especially after returning from working abroad, often face a number of psychological problems and difficulties in reintegrating into the community and family. But, there are no services to support them.”* Programme officer of an international organization

*“Regarding female migrant workers, there are many policies and related programmes. For example, labour laws in foreign countries, laws on prevention of human trafficking, handling violent acts against women. However, these laws are not only about migrant workers, but women in general.”* Programme officer of an international organization

### *Limited funding for quality health care*

Interviews with study participants in FGDs underlined how the application of health policies, especially for migrants, faced financial and human resource shortages.

*“Now the budget is being cut, health programmes are reducing. Implementation is very difficult. Moreover, human resources are also a problem, yet alone the equipment shortages.”* Project coordinator of an NGO

At local level, especially in border areas, the lack of grassroots health investment can be acute. In discussions with local authorities, difficulties in delivering quality health services due to budget constraints was regularly reported. Moreover, monitoring of migrants’ health status is arranged through village health workers and collaborators, while immigration monitoring is conducted by police visiting households in border areas. However, funding to carry out such activities related to migrant health is limited.

*“Currently funding for health programmes and village health teams is too low. Most target preventive health programmes are no longer supported, so it is difficult to carry out professional work. In fact, the work is not guaranteed.”* Doctor from district health care centre, FGD at district level (Kon Tum)

*“Because it is difficult to reach migrants, a team of collaborators is needed. But, there is no funding to cover this team.”* Officer from district health care centre, FGD at district level (Ha Tinh)

*“There are few regulations for it [village health team]. So it goes back and forth to the border. Because funding is not available, this is difficult and there is no transportation.”* Doctor from commune health care station, FGD at commune level (Ha Tinh)

### *Migrant stigma*

Stigma surrounding migration is a barrier for migrants to access social services, especially medical ones. Negative stereotypes about migration were even evident during in-depth interviews with migration experts.

*“Previously, policymakers believed migration had bad consequences, such as overpopulation, environment or traffic. So people had negative viewpoints about migration.”* Programme officer from an international organization

*“Authorities must be aware that migrants do not put pressure on budgets. Instead, migrant workers contribute to GDP and are financial and labour resources for provinces. As such, they need to understand that migrants are entitled to policies that treat them like local people because migration also contributes to the development of the province or city.”* Programme officer from an international organization

## *Lack of interpreters*

Language barriers are a major obstacle for migrants to access health and social services. These barriers make it difficult for health officials to fully understand patients and convey medical instructions and indications, which can easily fracture the patient and health care provider relationship or lead to misunderstandings during treatment.

*“Interpreters are required because many health workers do not know the language. Some can speak Nung language, some cannot. If someone can’t speak, he/she can tell the village health worker or call someone who knows their language. We know a little bit. Village health workers will translate.”* Nurse from commune health care station, FGD at commune level (Ha Giang)

In addition, in border areas, government workers face difficulties in communicating and exchanging information with neighbouring countries. English, the international language, is rarely applied in such exchanges. In Kon Tum, during exchanges between Lao People’s Democratic Republic and Vietnamese health officers on disease control issues in border areas, Laotian and Vietnamese languages are mainly used. Hence, the information shared between the two countries is limited as health workers cannot communicate effectively with each other.

*“Most of these people have families or relatives who are Vietnamese, so when they are sick they ask them to guide them. If public servants who work at border gates do not know Vietnamese, they ask a group at border gates to interpret.”* Medical doctor from District General hospital (regional), FGD at district level (Kon Tum)

## *Time constraints on migrants*

The impact of migrant shift work narrowing the window to access medical services was repeatedly mentioned during discussions with authorities and international organizations. As such, many health promotion programmes have not been tailored to address this need.

*“For migrants in industrial zones and export processing zones [health services] are extremely difficult to access. Firstly, people work in shifts. Secondly, these areas are not easily accessible.”* Officer from Maternal and Child Health Department, MOH, FGD at central government level

*“People have to work when health facilities are open, so it is very difficult to seek medical treatment.”* Programme coordinator from an NGO

*“The restriction is shift workers are very tired and break time is only from 45 minutes to one hour, including mealtime.”* Programme coordinator from an NGO

In addition, due to frequent changes in residence, provision of drugs and health monitoring for migrants is challenging. At present, local health authorities remain passive as there is no response mechanism and they must depend on self-awareness of migrants.

*“Normally, patients with chronic diseases need long-term treatment. But, it will take a lot of time for them to come back to the same health care facilities. Sometimes such difficulties make them pick up medicines late or miss follow-ups.”* Medical doctor from NTP, MOH, FGD at central government level

## Migrant challenges from stakeholders’ perspectives

### *Complex administrative procedures*

For internal migration, most interviewed experts referred to household or temporary registration as a major barrier to implementation and application of policies. Temporary registration is difficult for internal migrants as they do not have formal labour contracts and stable housing. As a result, this group

cannot freely approach social services in destinations, especially health services, due to regulations relating to registration of the initial medical examination and treatment locations.

*“A lot of people don’t have health insurance. The main reason is they haven’t got identity cards, they’ve been away from their place for too long or they cannot get ID cards and household registration to register for health insurance.”* Programme officer from an international organization

In fact, the procedure for buying and using health insurance has been streamlined. However, for migrants, administrative procedure problems related to health insurance mainly stem from the relationships between health insurance and household or temporary registration. Although the division of medical care and insurance coverage partly helps to reduce the burden on high-level medical facilities, increasing numbers of rural-to-urban migrants want to be treated in cities instead of hometowns, which costs money and time. The latest change to the Law on Health Insurance facilitates low-level referrals at district and commune levels within provinces. But at provincial and central levels, people still need referrals from their initial place of medical examination.

### *No health insurance due to high fees*

In FGDs, the main reason given for informal sector migrants not having voluntary health insurance was its high cost. Interview results revealed that monthly income was often sent to relatives in hometowns and to cover living expenses at destinations. Many migrants, especially from poor provinces such as Kon Tum, did not have sufficient income and savings for voluntary health insurance.

*“For freelance workers, the main reason for no insurance is lack of finance.”* Doctor from General Provincial Hospital, FGD at provincial level (Ha Giang)

*“In the past, ethnic people were granted health insurance. But recently, people who are ethnic but not from poor households are not entitled to insurance. This is difficult not only for Brau, but other ethnic groups. In general, people’s lives are very difficult. For example, a family of eight people buys an insurance card costing VND 700,000–800,000 (USD 30–35) per year. On average it costs VND 2 million (USD 87) a month to run a household, but now people do not have enough money to eat. So, where do they get money to buy the card?”* Nurse from commune health care station, FGD at commune level (Kon Tum)

### *Affordability of health care costs*

Migrants confirmed as coming from poor households are entitled to numerous social assistance policies, but those from near-poor households do not have the ability to cover health services and voluntary health insurance cards. In border areas, health facilities recorded cases of cross-border migrants with low incomes and unclear nationalities who could not meet medical expenses.

*“The extraordinary difficulty is most are poor, but they do not have support policies.”* Doctor from General Provincial Hospital, FGD at provincial level (Kon Tum)

*“Near-poor households not provided free health insurance, yet they are still very poor and do not have enough money to buy health insurance cards. They wait until they really need to borrow money to buy insurance, but it takes a month to get support. In a month of waiting for insurance, they dare not go to the doctor as the cost is too high.”* Programme officer from an NGO

### *Attitudes of health workers and administrative staff towards migrants*

Sharing similar views to migrants, experts participating in the study highlighted unprofessional health worker and administrative staff attitudes as barriers to migrants accessing health care. This perceived lack of support, also reflected in health counseling and administrative processes, fractures the relationship between migrants and administrative health officials. Experts also pointed to limited counseling skills as contributing to misunderstandings between health workers and migrants.

*“Ordinary people who go to authorities to carry out procedures are also afraid, not to mention those from disadvantaged groups who are even more afraid. Counseling is not effective. People need a lot of information from a healer, but health workers are often unfriendly and make people frustrated.”* Programme officer from an NGO

### *Limited knowledge about access to health care services*

Migrant workers, especially informal ones, possess limited knowledge on accessing health care services, which leaves them vulnerable to exploitation. Thus, there is a critical need to increase their awareness of health care and health insurance.

*“People from the commune work in China, but they don’t stop their health insurance. They still have insurance and household registration in the commune. But their educational level and awareness are low, so incorrect information is often on insurance cards. They don’t know about it, leading to medical examination and treatment difficulties. However, we guarantee that all people here have insurance cards.”* Nurse from commune health care station, FGD at commune level (Ha Giang)

Health insurance is key for migrants with low incomes to access health services more easily. However, many migrants choose not to buy health insurance as they are not cognizant of its benefits as well as have a false sense of security about personal health. However, hospital visits result in out-of-pocket payments.

*“The commune informs people to come to the people’s committee to make health insurance cards, but many households do not come. But when they get sick and face hospital fees, they come to the commune and question why there is no card.”* Police officer, FGD at commune level (Ha Giang)

The number of migrant study participants with health insurance cards was quite high, but many did not fully understand card benefits. Information about district level insurance coverage, lost and reissued cards or changing places of initial medical examination registration was rarely known by interviewees. Many migrants believed returning to hometowns for medical treatment was necessary to receive 80 per cent co-payment support from health insurance. This issue, also highlighted by experts who participated in the study, results from limited communication of social security policy changes to communities.

*“For example, when asked about losing a health insurance card, many people don’t know how to resolve it. For them, losing means buying, but they don’t know they can exchange. Even if they have health insurance, they must go through the referral system from the initial medical examination at their hometown.”* Programme officer from an NGO

### *Low awareness of health care benefits*

Another obstacle for migrants, who often do not have stable jobs and are more at risk, is limited awareness of health care.

*“Most come here just to make money and don’t care about health, so medical examinations or health checks don’t matter for them. Usually only when people get sick do they go to health institutions. Normally, less migrants access health facilities than non-migrants, and the percentage of migrants who self-medicate is high. Migrants from rural-to-urban areas do not have information and do not care about health care.”* Programme officer from an international organization

Border areas are mostly populated by ethnic minorities who often have low education levels and do not fully understand the importance of health care. In addition, local customs and practices—such as rituals, worshiping and healing by folk methods—affect people’s thinking about modern medical examinations and treatment.

*“At present, the phenomenon of worshipping when getting sick still happens in some remote areas, even though it has greatly reduced. Health education has made its way to remote areas, only a few households still follow the old customs.”* Officer from Department of Health, FGD at provincial level (Ha Giang)

*“The vaccination rate in this commune is very low compared to other communes. The educational level here is much lower than other communes.”* Nurse from commune health care station, FGD at commune level (Ha Giang)

### *Lack of destination knowledge*

Pre-migration preparation for outbound migrants is crucial for a successful and safe migration process. In particular, knowledge of destinations will help migrants gain a comprehensive view of where they will live and work, including social security. However, migrants often move based on informal recommendations and primarily target places where they can find jobs with suitable wages. Such migration creates management challenges in points of origin and destination.

*“Partly because previous generations have migrated and shared their lives in Dak Lak and Dak Nong, it is easy to do business and the land is vast. Therefore, up to seven households migrate in some months. Local officials try to increase people’s understanding and help them improve the economy. But people don’t listen and they leave anyway. After moving for a few months, they return saying weren’t informed. But, in fact, they just didn’t listen.”* Police officer, FGD at commune level (Ha Giang)

Largely focused on increased wages and income streams, many migrant workers are not aware of work and living challenges at destinations. As migrants, they often work at higher intensity that can cause fatigue and other health problems. Activities to support migrant workers are still limited and do not really help them.

*“Migrants sometimes aren’t ready for the high work intensity and as some must pay high brokerage fees, they are willing to work long hours. There are many cases of strokes because of too much work and pressure. Psychological support for workers after returning home is not really available.”* Programme officer from an international organization

### *Lack of awareness about irregular migration risks and migrants’ vulnerabilities*

In recent years, the wave of rural-to-urban and cross-border migration has accelerated, with wide-ranging consequences at origin and destination points. In rural areas, people with low education levels who commonly fall into financial difficulties and unemployment see migration as a solution without awareness of the various potential pitfalls.

*“These people go through unsuitable channels, their health care benefits are greatly reduced because they don’t have legal papers. If they have accidents, they face expenses without any rights or benefits.”* Programme officer from an international organization

*“Informal migrants don’t have any documents, therefore they don’t receive support to access health care or schools.”* Officer from Ministry of Justice, FGD at central level

This also presents challenges for central and local governments to meet migrants’ social security needs.

*“We encourage migrants to go to the representative office and register. There is a website, but the migrants do not care.”* Officer from Consular Department, Viet Nam Ministry of Foreign Affairs, FGD at central level

### *Lack of support from employers*

Health care for migrant workers depends heavily on employers or business owners. Results from in-depth interviews and FGDs revealed limited employer support of workers, especially those abroad who require timely interventions or to return home.

*“Although there is a provision for supporting workers returning home, there is a lack of programmes and policies to support these workers, especially female ones or those who face many risks, such as domestic workers or those who have accidents.”* Programme officer of an international organization

*“On the business side, they are for-profit organizations. Some businesses are aware of their responsibilities to workers, but others are not. This is a key barrier.”* Programme officer of an international organization

Significantly, many migrant workers are engaged in the informal sector without labour contracts. As a result, they do not receive medical assistance. This is compounded by a reluctance to purchase health insurance or medical treatment.

*“Labour migrants here, who say help build roads, are not supported by employers. The number of businesses that avoid paying trade union fees is very high, but the number of employees is unknown as many are informal and mobile.”* Officer from Provincial Labour Federation, FGD at provincial level (Kon Tum)

*“Most businesses in industrial parks evade insurance, which means workers’ health insurance is not secured.”* Programme officer of an international organization

Migrants also face discrimination from employers when they encounter health problems. Permission to leave for medical treatment is often not granted.

*“Labourers always say that being sick is dangerous and their health condition is terrible.”* Programme officer of an NGO

*“Business owners manage time very tightly and it can be a barrier for migrants to access reproductive health care services.”* Programme officer of an international organization

### *Legal status of migrants*

The legal status of migrants directly affects their access to health services. Cross-border and informal migrants often do not have identification and cannot receive benefits. Hence, undocumented migrants face greater risks than formal ones.

*“These people do not have legal papers. Their health care benefits are greatly limited and if they have an accident, they must pay themselves.”* Programme officer of an international organization

This issue not only affects migrants, but also their children. In border areas, children commonly do not have a formalized nationality. Hence, without legal status they cannot access their rights.

*“When women return they bring their children back. If they do not have paperwork such as a birth certificate, the children will not be entitled to health insurance and go to school as prescribed.”* Officer from provincial Women’s Union, FGD at provincial level (Ha Giang)

*“There is a group of migrant children of unknown nationality, who accompany their parents working around Viet Nam especially the provinces of Tay Ninh, An Giang and Can Tho and to Cambodia and Laos. At present, it is difficult to implement policies for these children as they have almost no identification.”* Officer from MOLISA, FGD at central level

*“Many migrant children don’t have papers, even birth certificates. Therefore, these children do not receive any support.”* Programme officer of an NGO

## CHAPTER 4. DISCUSSION

This research explored migrant barriers to health care through interviewing migrants as well as stakeholders, such as health care providers, government agencies and international organizations. Almost all self-reported obstacles that prevented migrants from accessing social services were underlined by expert participants in the research. Such barriers were found to range from a scarcity of public data on migrants and unsuitable policy, to a lack of migrant-sensitive health services. Importantly, the study pinpointed the residency book (*ho khau*) system as a hidden obstacle that prevented migrants from accessing social services at destinations as access to such services is limited to the registered residency location. Inconsistent and burdensome administrative procedures to register new housing residency were documented by participants. As a result of not registering in a new location and insufficient knowledge of health insurance rights, internal migrants are forced to pay out-of-pocket expenses or practice self-medication. The abolishment of the book system and introduction of electronic management, with the new ID card in 2020, are expected to mitigate the problems of migrants' residence registration and access to social welfare services.

Being on the move is the essence of migration. This tends to make migrants more socially isolated from communities at destination and origin, which could lead to limited information about social and health services as well as difficulties in the targeting of public health communication programmes. This was a major finding in both migrant groups. In fact, movement or migration in itself was not a risk factor to health. Migrant groups' heightened physical and mental health vulnerabilities were a result of circumstances surrounding the migration process.

This report analyzed barriers from various dimensions "Policy-Legal Frameworks", "Monitoring Migrants' Health", "Migrant-Sensitive Health Services", "Partnerships, Networks, and Multi-Country Frameworks", SDGs 3 and 5 and "Social support, understanding, and cooperation for migrant health".

### Policy-legal frameworks

There have been some improvements to policy-legal frameworks for migrant health. In 2016, the flexible district-level medical referral system within a province was enforced according to the Law on Health Insurance. This allows people with health insurance to claim the same benefits at different district hospitals across a registered province. However, as migrants usually move outside their home provinces for work or learning purposes, the full benefits of this particular reform have not been realized by migrants. If migrants visit district hospitals outside their home provinces, health insurance only covers 48–60 per cent of the service fee (depending on the person's condition). Migrants must bear higher fees for health services at the destination and still face the same challenges rooted from their permanent residency. While this reform could have positive impacts on small groups of people moving within a province, from a big picture perspective, little change is expected to migrants' health and access to health care services.

According to the Law on Health Insurance, the flexible referral system will be transferable across all provincial hospitals nationwide and higher charges for in-patient health care services removed from 2021. When migrants visit the facilities and present their health insurance cards, the health insurance fund will cover 80–100 per cent of service fees. But this reform will only apply to inpatient services and exclude outpatient services (29). Hence, a referral system more suitable to migrants' characteristics is needed.

In general, the effectiveness of migrant-related health policies in Viet Nam is impeded by inconsistent implementation at local level and a lack of resources, communication between central and local governments and monitoring at border areas. While the Government of Viet Nam has embarked on some legal framework changes which could improve the health of migrants, the reality on the ground requires the Government of Viet Nam to build a comprehensive action plan to maximize potential

improvements to migrants' health and access to health care. At the present time, thorough and consistent policy implementation is essential.

In addition, there seems to be recurring violations on pre-departure health screening and training among recruitment agencies, which poses significant health risks to migrants (81). Furthermore, some migrants reported a lack of official employment contracts. Thus, the Vietnamese Government should strengthen the current monitoring and evaluation system. By monitoring and evaluating policy implementation, the government will become more cognizant of policy and service delivery gaps between central and local governments to result in more effective policy formation, consistent implementation and delivery of resources.

With significant reforms in the pipeline, it is important the government informs citizens – current and future migrants—of these policy changes and subsequent impacts. If migrants do not know their rights, they cannot claim them. This report's findings show that a significant number of migrants are not fully aware of their basic rights, despite the latest health insurance package being released nearly five years ago. Although it is a challenge for authorities to reach every population group, especially migrants and those in remote ethnic minority-populated areas, the need to provide migrants with updated health and migration information about new policy changes as well as regular health care programmes in host communities is clear.

### Monitoring migrants' health

Establishing more effective migrant-focused monitoring systems could improve the situation of migrant health. Local governments underlined difficulties in identifying and reaching geographically mobile and migrant populations, which may impede such populations' ability to obtain health care knowledge on a timely basis. This also poses a challenge for health care providers to follow-up treatment among migrants. A shortage of mechanisms to share migrant data among ministries and limitations in health data disaggregated by migration history might be a reason for this issue. This lack of data on migrants could lead to health care programmes not tailored to migrants' limited windows for consultations.

Lack of effective quarantine systems was also reported. Inbound and returned outbound migrants often cross borders with communicable diseases. With effective quarantine systems, a country can prevent communicable disease from spreading nationally. While it is challenging to monitor border areas thoroughly, a system could be established in Viet Nam to enable local governments and medical services to identify and treat infected migrant patients before diseases spread.

The research team also found a problem relating to the legal status of migrants. As the household resident book is still a tool for managing populations and the foundation for health insurance, it may exclude undocumented internal migrants from health databases at destination places. This leaves such migrants vulnerable to health-related risks and poses a challenge for authorities to develop suitable annual health care plans for migrants.

### Migrant-sensitive health services

Through migrant interviewees and FGDs with experts, the study identified several health care barriers related to the lack of migrant-sensitive health services.

Cross-border interviewees reported a lack of ethnic minority interpreters at commune health care stations as a reason for migrants' reluctance to seek health care services. Internal migrants also found attitudes of health care professionals and administrative officers as unhelpful and discriminatory in cases. Indeed, nine stakeholders reported "stigma" as a possible barrier. Unprofessional attitudes of health care and administrative officers in Viet Nam were documented by several interviewees. While the government has taken steps to make health care and administrative officers more responsive to the health needs of citizens in general, this was not discerned by many migrants and could discourage some from engaging in the formal health system. Some cases of bribery were reported. Such incidents cannot be generalized without further study, but could be more widespread and require attention from authorities. Although this could be the result of misunderstandings from a lack of interpreters and

scarcity of health care information at destination places, it might result in migrants' mistrust of medical services. In addition, there is a general reluctance from migrants and ethnic minority groups to discuss reproductive health. These findings highlight the necessity for linguistically and culturally sensitive service delivery. Bilingual and culturally competent health care staff, interpreters and translated documents will help facilitate communication with migrants.

Effective health communication programmes are also key to provision of migrant-sensitive health services. Stakeholder interviewees expressed concern about the limited coverage of health communication programmes due to funding constraints. In less developed provinces such as Ha Giang, Ha Tinh and Kon Tum, improving people's awareness demanded greater efforts and long-term health promotion activities to reach largely ethnic minority populations in remote locations with low levels of education.

In addition, health care service providers should be aware of migrants' time constraints. With income the key driver for migrants to often work in remote and challenging environments, many will prioritize working over health care, unless the latter becomes critical (82). Similarly, excessive waiting times were also reported as a barrier to health care access. Wherever possible, mobile clinics or additional facilities should be located strategically. In addition, health communication programmes should broaden migrants' knowledge on health care, health insurance and the value of regular health check-ups.

### Partnerships, networks, and multi-country frameworks

Partnerships and collaboration between various actors in migrant health should be strengthened to improve migrants' access to health care as well as the quality of care received. As highlighted in the Results section of this report, a lack of collaboration between private health care providers and public health entities is apparent. The role of private health care facilities in migrant care is more significant than previously estimated, with numerous interviewed migrants stating it was common to obtain medical care at such facilities. Hence, private facilities have access to significant information on migrants' health, yet regulations requiring the recording and submission of such reports to local authorities remain ineffective. For example, private facilities are required to submit paper reports to local departments of health, whereas public facilities can submit electronic reports through the centralized health information system. With more robust regulations, a valuable stream of information on migrant health could be delivered from the private sector. This focus on private facilities could include development of efficient mechanisms to manage and monitor private health care facilities to ensure the quality of services in parallel to migrant-friendly fee structures.

Within central government, there is no formal inter-ministry cooperation mechanism to focus on migrants' issues. As a result, numerous inefficiencies result from a lack of communication, coordination and partnerships between related actors, as presented in the Results section of this report. In response, the Government of Viet Nam is encouraged to identify and promote primary and effective partnerships among actors.

In addition, Viet Nam and other destination countries have yet to reach agreement on a trans-border health insurance referral system and continuum of care, as reflected by results of FGDs. Cross-border patient referrals remain irregular rather than systematic due to the absence of guidelines on patient transfers and health insurance reimbursement. Furthermore, follow-up treatment is not possible for migrants with diseases requiring continuous attention, such as HIV or TB.

Finally, this report's findings have underlined the critical need for strengthened multi-country frameworks for migrants' health. Viet Nam has made certain commitments to enhancing the health of refugees and migrants, such as prevention and control of HIV, promoting the rights of migrant workers and participating in Mekong Basin Disease Surveillance to monitor communicable diseases across border areas from 2001. The Government of Viet Nam has also committed to achieving SDGs at global level and to combat HIV, malaria and TB at regional level. These are foundations for ministries to build upon when developing health care programmes in border areas. Such programmes should be coordinated by Vietnamese ministries with counterparts in neighbouring countries.

## SDG 3. Good Health and Well-Being

### Target 3.8 Achieve Universal Health Coverage

Viet Nam has made great efforts to ensure its population benefits from financial risk protection through health insurance. According to Report No.413 (20 September 2019) of the Vietnamese Government, health insurance coverage encompassed 88.5 per cent of the population by the end of 2018. However, this study revealed that only 74 per cent of interviewed migrants confirmed they had health insurance. While the number of study participants was limited, this finding illustrates the gap in health insurance coverage between the general population and migrants. In addition, many migrants stated that even with health insurance, they still had to pay a significant amount of money for health services relative to their financial situation.

According to the 2015 National Internal Migration Survey conducted by GSO and UNFPA, the major reasons for the lack of health insurance coverage were its perceived high premiums and redundant need (5). The premium for voluntary health insurance is around VND 800,000 (USD 35) per person per year.<sup>7</sup> Some 56 per cent of this report's research participants' income ranged between VND 4–8 million (USD 173–346) per month. Nearly one-third of participants earned under VND 3 million (USD 130) per month. Fifteen per cent of participants' salaries were more than VND 9 million (USD 390) per month. However, the majority of internal migrants paid rent for accommodation, while around 90 per cent of non-migrants lived in their own houses (5). The finding is consistent as some migrants who participated in the Situation Analysis of Migrant Health in Viet Nam also reported not purchasing health insurance due to financial constraints related to the cost of accommodation and food. Some also reported that administrative procedures for purchasing and using health insurance were too complex. Regarding the recognition of health insurance as too expensive, the Government of Viet Nam should try to disseminate the importance and value of health insurance through health communication programmes as well as simplifying its administrative procedures (82). This measure could also lead to greater migrant awareness of health insurance's value and change their view of it being "too expensive". The Government of Viet Nam should also consider ways to alleviate the burden on low-income households to purchase health insurance. Ten migrant interviewees in this report's research stated they did not to purchase health insurance due to the perceived expensive premiums. In addition, the government reformed nationwide medical service fees in 2019 through Circular No.13/2019/TT-BYT, which increased fees for some services. This may lead to more migrants bearing high out-of-pocket costs for health care services.

According to the National Internal Migration Survey in 2015, 69 per cent of migrants without household registration had to pay health care costs for recent bouts of sickness without health insurance support (5). These migrants claimed they paid higher costs for medical treatment than those from the host community. Therefore, the government's plan (according to the Law on Health Insurance) to grant full health insurance benefits outside the initially registered health care facilities to all Vietnamese at provincial level is welcomed. However, its nationwide implementation should be ensured. As already stated in Policy-legal frameworks subsection in this chapter, a monitoring and evaluation system is crucial to ensure that this policy is implemented effectively and coherently. In addition, the study suggests the higher health care charges at hospitals outside individuals' places of residence should be abolished.

For outbound migrants, there is a scarcity of data on health insurance coverage in destination countries. The Government could collect data in collaboration with governments of destination countries and increase coverage by ensuring pre-departure training provides outbound migrants with sufficient information on health-related regulations in destination countries (82).

<sup>7</sup> According to Decree No.146 2018/NĐ-CP (17th October 2019), Vietnamese residents can participate in voluntary social health insurance with the premium fee calculated as 4.5 per cent of individuals' common base salary. In 2019, the common base salary was set at 1,490,000 VND/month (around 65USD) by the National Assembly in Resolution 70/2018/QH14, and it is used to calculate the salaries for employees in state-owned organizations/enterprises as well as premium rate of social insurance in Vietnam. To encourage more Vietnamese citizens to participate in social health insurance, the premium fee will decrease if more people from the same household are registered for health insurance.

## SDG 5. Gender Equality

### Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights

The necessity for gender-sensitive health services was underlined by migrants and stakeholders. Among interviewed migrants, many women reported a reluctance to see health professionals due to “embarrassment” when discussing reproductive health issues. This situation could be a result of a lack of common languages, gender-sensitivity of health care professionals or ethnic minority-related cultural differences. The challenges for female migrants to access care were also reported in the 2015 National Internal Migrant Survey, which pointed out women’s hesitation to declare sexual behaviour due to strongly conservative attitudes toward premarital sex regardless of ethnicity (5). The survey also stated that around 30 per cent internal migrants were not fully aware of the spread of Sexual Transmitted Infections (STIs) (5). Closer communication between ethnic minority women and health care professionals was necessary to determine reasons for the trust deficit. In particular, as female migrants might face sexual-related problems more often because of their vulnerable social status, providing gender-sensitive health care might contribute to improved migrant health.

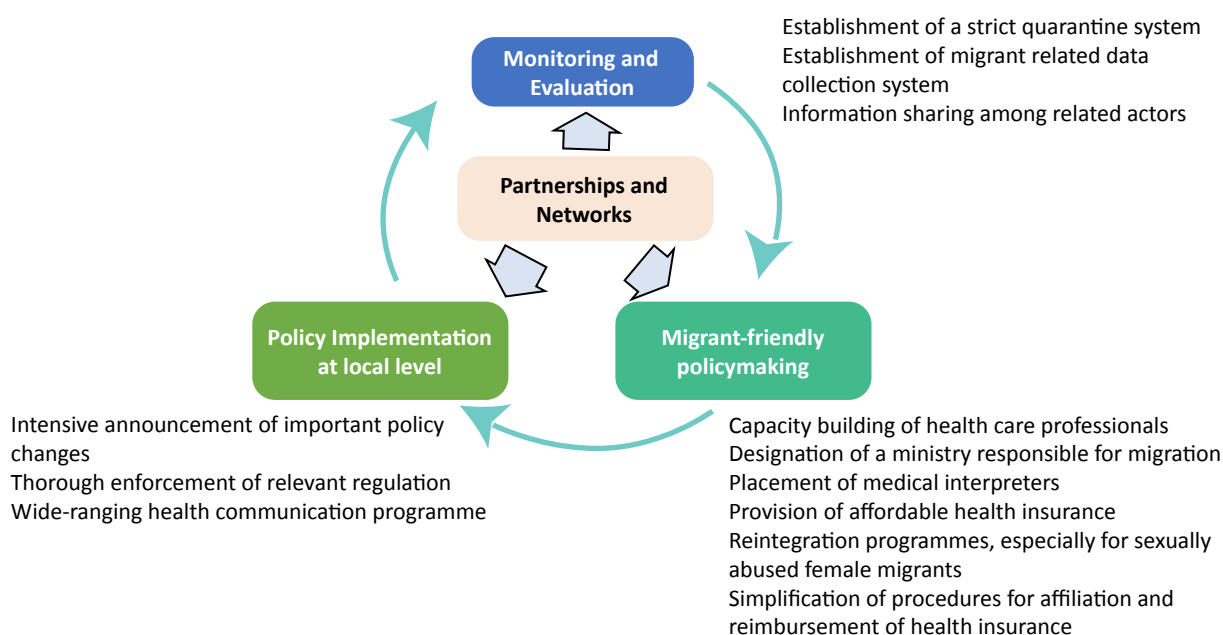
### Social support, understanding, and cooperation for migrant health

Migrants face various cultural differences in destination areas or countries as shown in 3.1.4. *Social Support Barriers*. In such situations, all relevant entities surrounding migrants should be supportive for their health and broader inclusion. Firstly, employees should ensure all workers have employment contracts, as stipulated by the Labour Law in Viet Nam, as that such conditions are reflected in working environments. Although the majority of interviewees in the internal migrant group worked in informal sectors, the vast majority were eligible for labour contracts. According to the 2014 updated Law on Social Insurance, people with short-term contracts were subject to compulsory social security. However, few internal migrants have labour contracts. This could be explained by employers’ perceived limited prioritization of employee contracts and social protection. Hence, effective advocacy is necessary to encourage employers to focus on employees’ well-being, such as supporting registration of residency status, dissemination of information on health care facilities and provision of appropriate sick leave.

Dynamic movements in migrants is seen at Viet Nam’s borders. Recently, Asian countries have made a strong commitment to facilitate transportation and trade among countries, especially within the ASEAN Economic Community, which has translated into a growing number of documented and undocumented workers migrating between countries. Protecting cross-border migrants’ health and welfare is as necessary as protecting their host communities’ health and welfare. The social security laws in Viet Nam as well as Cambodia, China and Lao People’s Democratic Republic only apply to its citizens and official foreign workers. Hence, undocumented cross-border migrants cannot join health insurance systems at destination places and rely on support and interpretation from employers and host communities. As a result, there is a need for greater collaboration between countries to alleviate the vulnerability of cross-border migrants.

The findings draw a complex web of inter-linked factors impacting on migrants’ access to health care. Thus, to address these barriers, an integrated approach from central government and all stakeholders is essential. Firstly, the government is encouraged to establish a data collection system on migrants’ health status as a foundation for policy formation and implementation. Secondly, a detailed range of migrant-focused policies should be developed, ranging from capacity building of health care professionals encompassing gender and migrant sensitive issues, to simplification of health insurance procedures. Thirdly, such policies should be thoroughly implemented at local level, especially enforcement of regulations on protection of migrants’ rights. The extent of implementation and enforcement can be checked through monitoring and evaluation systems and utilized for future policy-making. Finally, partnerships and collaboration should be enabled and encouraged in every aspect, particularly networks between local and central government, neighbouring countries, international organizations and stakeholders at grassroots level.

**Figure 10. Integrated approach for migrant health in Viet Nam**



Source: Figure produced by IOM based on WHA Resolution 60.17 and 70.15.

### Study limitations

This study has a number of limitations. Firstly, the sample number of participants, especially cross-border migrants, is limited and may not be representative.

Secondly, the study team interviewed only internal migrants and returned outbound migrants due to resource and time constraints. Inbound migrants were not interviewed because only less than 0.1 per cent of the total population in Viet Nam is inbound migrants (24). Viet Nam is also known as a migrant-sending nation, rather than a host country.

Thirdly, some interviews were conducted in Vietnamese, not ethnic minority languages. Migrants who cannot speak Vietnamese fluently and are illiterate could potentially fail to understand the research questions and answer appropriately. In such cases, the research team communicated clearly without jargon and explained in detail the purpose of the research.

Fourthly, some interpreters were police officers and this could affect the reliability of participants' responses due to fear of repercussions. To cross-check the information, the research team interviewed these participants again with a different interpreter.

Fifthly, returned outbound migrants from developed regional countries, such as Japan and Republic of Korea, were not interviewed as they were likely to have migrated through formal channels with pre-departure training and screening. Hence, their health system and potential health-related challenges at destination would be different to those of internal migrants. In this regard, further research that includes more comprehensive interviews and quantitative analysis would be meaningful.

Sixthly, the study team was comprised of Vietnamese Government and UN agency representatives. Potential interviewer and respondent bias needs to be considered.

Finally, this study is based on WHA resolution 61.17 on the Health of Migrants endorsed by WHO member states in 2008, to develop the study's methodology. In May 2019, a more recent resolution – WHA 72.25 on Promoting the Health of Refugees and Migrants: Draft Global Action Plan 2019–2023 – was approved. This most recent resolution was not adapted to the study methodology due to time constraints (this study was designed and data collection performed in late 2018 to early 2019). However, during finalization of this study report, WHA 72.25 was taken into consideration while writing the Discussion as well as the Conclusion and Recommendations sections to provide the most up-to-date and comprehensive report.

## CHAPTER 5. CONCLUSION AND RECOMMENDATIONS

This research “Situation Analysis of Migrant Health in Viet Nam” anchors the WHA 61.17 Operational Framework Priorities and Madrid Framework as a conceptual model to analyze the challenges faced by migrants in Viet Nam as well as perspectives from government stakeholders, NGOs, UN agencies and migrant groups. This research mainly focused on internal migrants in Ha Noi and Ho Chi Minh City and cross-border migrants from Ha Giang, Ha Tinh and Kon Tum provinces. The research team conducted interviews with these migrants to explore the challenges faced when accessing health care. In-depth interviews and FGDs with stakeholders were also undertaken to analyse policy implementation problems.

Through these efforts, the research team identified key factors that impact on the health of migrants and their ability to access health care: fragmented policy implementation at local level, insufficient migrant health monitoring systems, lack of effective partnerships and networks between stakeholders, limited migrant and gender sensitivity among health care professionals, administrative officers and broader society. To address these interconnected issues comprehensively, the research team proposes the following multiple action points in each key theme in line with recommendations of Resolution WHA 70.15, and six priorities of the Draft global action plan, 2019-2023 presented at WHA in May 2019.

While the study team adopted an evidence-to-decision approach in guiding recommendations for the Government of Viet Nam to advance the migrant health agenda, a more rigorous iterative consensus process is required for stakeholders. Important considerations such as feasibility analysis, financial assessments, potential impacts of interventions, resource requirements, implications for health and welfare systems, cost-effectiveness and acceptability for each proposed action must be assessed through extensive stakeholder consultations facilitated by, for instance, an inter-sectoral committee on migration health as exemplified in other contexts, such as the Philippines and Sri Lanka (83, 84). Establishing such an inter-ministerial working group or committee at national level would enable the Government of Viet Nam to manage migrant-related health issues and coordinate with relevant governmental entities to foster the design and implementation of more migrant-friendly policies.

### Policy-legal frameworks

- a) Establish an interministerial working group or committee at national level, to manage migrant-related health issues and coordinate with relevant governmental entities to foster the design and implementation of more migrant-friendly policies.
- b) Each ministry engaged in migrant-related issues should be cognizant of sharing subject-specific information and develop effective interministerial communication channels.
- c) Develop regulations that require employers and labour agencies to thoroughly disseminate information to pre-departure migrants on labour regulations and available support at destination countries.
- d) Initiate multilateral agreements with neighbouring countries to establish a transnational referral system to ensure continuous and consistent treatment for cross-border migrants and health insurance coverage beyond borders. Moreover, existing transnational health information sharing systems, especially on infectious disease outbreaks, should be strengthened.
- e) Include returning migrants and short-term/irregular inbound migrants in regulations to provide affordable and quality health care services. For instance, migrants are accounted for in health insurance coverage policies, inclusion of migrants in early warning and risk reduction systems, proof that migrants and dependent family members are eligible for social protection programmes (2).
- f) Reform administrative requirements for all migrants to purchase health insurance regardless of residential status.

- g) Review health insurance premiums to guarantee affordable health care for all migrants, especially informal sector workers.
- h) Encourage the engagement of the private sector, industry groups and organizations, academic networks and professional associations to participate and promote the migrant health agenda.
- i) Develop a national framework to promote migrant health and involve migrant groups in prevention and management programmes related to communicable and non-communicable diseases and psychological health.
- j) Each local government should form a smaller-sized and similar multisectoral working group to make migrant-related policies suitable to each local context.
- k) Advocate employers and labour recruitment agencies, especially in informal sectors (agriculture, construction, maritime/fishing, mining), support basic social welfare for migrant workers. For example, in addition to mandatory provision of health insurance, employers should be encouraged to support migrant health through equitable sick leave and advice on health care.
- l) Frequently monitor employers' implementation of labour laws and administer legal sanctions for violations, such as exploitation of migrants and failure to provide social welfare.

#### Monitoring migrants' health

- a) Data from censuses, national statistics and routine health information systems should be disaggregated by relevant categories such as permanent residents, internal migrants, cross-border migrants, origin hometown/district and international migrants (non-Vietnamese).
- b) Research on country-specific migrant experiences is needed to develop interventions with respect to migrants.
- c) A more effective quarantine system is needed to identify inward and outward migrants with contagious diseases or migrants with presumptive symptoms and deliver treatment before becoming prevalent.
- d) Establish a coordination mechanism between health care at local and central levels to gather and document information and best practices to meet migrants' health needs (core competencies, standard operating practices and assets to respond to migrants' health needs in the context of migration flows).
- e) More research is needed to examine health-related barriers for cross-border and undocumented migrants with little coverage in current literature.
- f) STI/HIV integrated behavioural and biological surveys among migrant workers in border provinces of Viet Nam should be undertaken to identify STI/HIV risks and develop interventions for migrants.

#### Migrant-sensitive health services

- a) Strengthen reintegration programmes to prevent sexually abused migrant women and their children from being stigmatized and discriminated against.
- b) Establish a national hotline to provide migrants with information in emergency situations and covering employment, health insurance and social support at destinations.

- c) MOLISA should ensure employers adhere to internationally agreed Occupation Safety and Health (OSH) standards in workplaces that employ high numbers of migrant workers.
- d) Eliminate any form of discrimination against migrants in health screening practices as a condition for employment (HIV, TB, pregnancy).
- e) Develop an effective communication programme to disseminate information about the benefits of health insurance, and procedures for enrolment and renewal for all migrants.
- f) Build health care workers and administrative officers' abilities to deliver migrant-friendly services (enhance cultural and gender sensitivity to migrants' health issues, language competencies).
- g) In line with MOH's communication programme, Departments of Health at local level should develop communication materials tailored to the characteristics of migrants in their area(s) on use of health insurance, procedures for enrolment and renewal for all migrants.
- h) Increase the number of ethnic minority health care workers, particularly in areas with dense cross-border populations of ethnic minority migrants.
- i) Determine vulnerabilities and resilience of various migrant groups in different contexts, address these challenges through structural policy action and provide medical services that fit migrants' characteristics.
- j) Organize dialogues (directly or indirectly) between health care providers, administrative officers and migrants to gain a better understanding of migrants' challenges and address migrants' distrust of health care professionals and administrative officers.

#### Promote partnerships, networks, and multi-country frameworks

- a) Promote coordination with countries that accept significant numbers of Vietnamese migrants, ranging from infectious disease prevention to social security, to ensuring migrants' health insurance coverage without the double burden of premiums and developing a health care system that provides migrants with continuous health care services.
- b) Collaborate with destination countries to ensure migrants can obtain sufficient knowledge about labour regulations and available support.
- c) Cooperation with international organizations and NGOs should become an effective way to mobilize international expertise, first-hand knowledge and information towards policy-making, implementation and evaluation.
- d) Conduct a situation analysis about outbound migrants' health insurance coverage in destination countries and collaborate with governments of destination countries to ensure Vietnamese people's health coverage.
- e) Collaborate with destination countries' health-related ministries to share information about migrant-related infectious disease trends, successful interventions and tackle broader issues, such as infectious disease outbreaks and monitoring mobile populations.
- f) Collaborate with country, regional and global scientific and professional associations, medical journals and other publishing houses to create a platform for knowledge sharing on migrant health to better promote such research.

- g) Develop international collaboration to share and exchange knowledge, best practices and policy briefs on the inter-linkages between migration, health and development, in which Viet Nam can learn from others' experiences.

There are also several limitations to this report, including scarcity of data, the need for critical analysis of policy formulary and legal frameworks as well as limited generalizability of the findings. Nevertheless, given the dearth of information about migrant health in Viet Nam, this report is an important milestone in providing the Government of Viet Nam with a baseline situational assessment to guide action in addressing migrants' needs, gaps and priorities for future planning. Collaboration across departments of MOH and other ministries through taking inter-sectoral action is crucial for advancing the migrant health agenda in Viet Nam.

## Annex 1

### **Interview guide for stakeholders (health policy makers)**

We believe that your role involves migrant health. We are interested in health of migrants including internal, outbound and inbound migrants.

1. Please tell us your work that is involved in migrant health for Viet Nam.
2. What aspects of migrant health-related to laws, strategies and decrees well and what do not work well? Please explain the reason.
3. What is your partnership and network with other departments/ministries/organizations/neighbouring countries for migrant health?
4. What communication tools do you use to ensure the dissemination of policies, decrees and strategies to your partner organization?
5. What were some barriers if any, that you encountered working with other organizations for migrant health?
6. What recommendation do you have for future efforts for the implementation/enforcement of laws related to migrant health in the country?
7. Is there anything more you would like to add?

### **Interview guide for stakeholders (management agencies e.g. department of health and health centre)**

1. Please tell us your work that is involved in migrant health for Viet Nam.
2. What aspects of migrant health-related to laws, strategies, decrees and programmes well and what do not work well? Please explain the reason.
3. What is your partnership and network with other departments and health care facilities for migrant health?
4. What communication tools do you use to ensure the dissemination and implementation of policies, decrees and strategies to your partner organization and health care providers?
5. What were some barriers if any, that you encountered working with other organizations for migrant health?
6. What recommendation do you have for future efforts for the advancement of migrant health in the country?
7. Is there anything more you would like to add?

### **Interview guide for stakeholders (health care providers at hospitals and community health stations)**

1. Please tell us your work that is involved in migrant health for Viet Nam.
2. In your opinion, what are the challenges for migrants to access health care services? (medical costs, transportation costs, legal status, health professional attitude, etc.)

3. What are the enable factors for migrants to improve their health and access health care services?
4. What aspects of migrant health-related to laws/programmes/projects/collaboration work well and what do not work well? Please explain the reason.
5. What programs, interventions and tools, etc., would you recommend be sustained and/or scaled up to improve migrant health? Please provide a justification for your response.
6. What is your partnership and network with other health care facilities for migrant health?
7. What were some barriers if any, that you encountered working with other organizations for migrant health?
8. Have you referred patients from your province to Cambodia/Lao/China for continuing their treatment (TB, HIV, STIs)?
9. What recommendation do you have for future efforts for the advancement of migrant health in the country?
10. Is there anything more you would like to add?

### **Interview guide for migrants**

The focus of our project is to improve health care services and accessibility for migrants. We would like to have some of your views and inputs to make sure we are addressing concerns that you might have.

#### *Socioeconomic background*

1. What is your nationality? Where were you born?
2. How old are you?
3. What is your ethnicity?
4. What is your gender?
5. What language(s) do you speak?
6. How long have you lived in the study province? \_\_\_\_ years \_\_\_\_ months
7. What is your current occupation?
8. Do you have any labour contract? Does your job cover your cost for your health insurance?
9. How much do you earn per month?
10. What was your former occupation (if applicable)?
11. Do you have any family member(s) living with you?
12. How many children have you ever had? \_\_\_\_ children
13. How many years did you study at school? Years of education completed: \_\_\_\_ years
14. Do you have any health insurance? Poverty card or any other health card?

15. How long are you residing in this community? Where is your home town?
16. In general, how would you say your health is excellent, good, fair or poor?
17. What types of diseases do you usually suffer?
18. Where do you usually go to receive health care?

*Barriers and enablers to health care services (cross-border migrants in migrant communities)*

19. Did you go to see a health care provider in the past 12 months? For what reason? Were you satisfied with medical care? Did you have any difficulties prevented you from going to see a health care provider?
20. Did you receive any reproductive health care services including contraceptives, STI and HIV screening in the past 12 months? For what reason? Were you satisfied with reproductive health care? Did you have any difficulties prevented you from going to see a reproductive health care provider?
21. What obstacles have you ever faced in obtaining medical care? (medical costs, transportation cost, operational time, health professional attitude, distance from home, language barriers, migration status, administrative hurdles, cultural barriers, lack of information about entitlements, etc.)
22. Have you ever faced any difficulty in use of your health insurance? Is it convenient for you to use health insurance? For what reason?
23. Have you ever faced any difficulty in obtaining/renewing your health insurance? For what reason?
24. Who/What helps you get health care?

Local organizations? Family members? Other migrants? If yes, how? If no, why not?

25. What would make it easier for you to see a doctor? What suggestions do you have for improving health care for migrants? (health professional's attitude, discrimination towards migrants, health facility location, treatment or support costs, any support from government/private facilities, existence of health insurance schemes, employer, law and policy, etc.)
26. Is there anything more you would like to add?

*Barriers and enablers to health care services (cross-border migrants at health care facilities)*

19. How did you find out about where to get health care services? What information sources are there to find out about how to access services?
20. What are the challenges for you to access health care services? (medical costs, transportation cost, operational time, health professional attitude, distance from home, language barriers, migration status, administrative hurdles, cultural barriers, lack of information about entitlements, etc.)
21. Did you receive any reproductive health care services including contraceptives, STI and HIV screening in the past 12 months? For what reason? Were you satisfied with reproductive health care? Did you have any difficulties prevented you from going to see a reproductive health care provider?

22. Have you ever faced any difficulty in use of your health insurance? Is it convenient for you to use health insurance? For what reason?
23. Have you ever faced any difficulty in obtaining/renewing your health insurance? For what reason?
24. Who/What helps you get health care?

Local organizations? Family members? Other migrants? If yes, how? If no, why not?

25. What would make it easier for you to see a doctor? What suggestions do you have for improving health care for migrants? (health professional's attitude, discrimination towards migrants, health facility location, treatment or support costs, any support from government/private facilities, existence of health insurance schemes, employer, law and policy, etc.)
26. Is there anything more you would like to add?

*Barriers and enablers to health care services (internal migrants in migrant communities)*

19. Did you go to see a health care provider in the past 12 months? For what reason? Were you satisfied with medical care? Did you have any difficulties prevented you from going to see a health care provider?
20. Did you receive any reproductive health care services including contraceptives, STI and HIV screening in the past 12 months? For what reason? Were you satisfied with reproductive health care? Did you have any difficulties prevented you from going to see a reproductive health care provider?
21. What obstacles have you ever faced in obtaining medical care? (medical costs, transportation cost, operational time, health professional attitude, distance from home, language barriers, migration status, administrative hurdles, cultural barriers, lack of information about entitlements, etc.)
22. Have you ever faced any difficulty in use of your health insurance? Is it convenient for you to use health insurance? For what reason?
23. Have you ever faced any difficulty in obtaining/renewing your health insurance? For what reason?
24. Who/What helps you get health care? Local organizations? Family members? Other migrants? If yes, how? If no, why not?
25. What would make it easier for you to see a doctor? What suggestions do you have for improving health care for migrants? (health professional's attitude, discrimination towards migrants, health facility location, treatment or support costs, any support from government/private facilities, existence of health insurance schemes, employer, law and policy, etc.)
26. Is there anything more you would like to add?

### International and regional framework related to migration and health

Name	Year	Migration Health Related Provisions
Universal Declaration of Human Rights	1948	Article 13: Right to move freely within and between countries Article 14: Right to seek and to enjoy in other countries asylum from persecution Article 23: Right to work, including decent work conditions, equal work opportunities and forming trade unions.
World Health Assembly Resolution 58.3 on Revision of International Health Regulations (IHR)	2005	IHR aims to “prevent, protect against, control and provide a public health response to the international spread of disease in ways that were commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade”
World Health Assembly Resolution 61.17 on Health of migrants	2008	Call upon Member States 1) to promote migrant-sensitive health policies; 2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race; 3) to establish health information systems in order to assess and analyse trends in migrants’ health, disaggregating health information by relevant categories; 4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery; 5) to gather, document and share information and best practices for meeting migrants’ health needs in countries of origin or return, transit and destination; 6) to raise health service providers’ and professionals’ cultural and gender sensitivity to migrants’ health issues; 7) to train health professionals to deal with the health issues associated with population movements; 8) to promote bilateral and multilateral cooperation on migrants’ health among countries involved in the whole migratory process; 9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;
ASEAN Declaration of commitment on getting to zero new HIV infections, zero discrimination, zero AIDS-related deaths	2011	HIV prevalence remains high among migrant and mobile populations. Article 18. B) By 2015 improve treatment coverage, equity, effectiveness and efficiency by addressing key obstacles such as drug stockouts, financial barriers, stigma in health services loss to patient follow-up, and access barriers for migrant and refugee populations.

World Health Assembly Resolution 70.15 on Promoting the health of refugees and migrants	2017	<p>URGES Member States,<sup>3</sup> in accordance with their national context, priorities, and legal frameworks:</p> <ol style="list-style-type: none"> <li>1) to consider promoting the framework of priorities and guiding principles, as appropriate, at global, regional and country levels including using it to inform discussions among Member States and partners engaged in the development of the global compact on refugees and the global compact for safe, orderly and regular migration;</li> <li>2) to identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants in order to contribute to the development of a draft global action plan on promoting the health of refugees and migrants;</li> <li>3) to strengthen international cooperation on the health of refugees and migrants in line with paragraphs 11 and 68 and other relevant paragraphs of the New York Declaration for Refugees and Migrants;</li> <li>4) to consider providing necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants;</li> </ol>
Global Compact for Safe, Orderly and Regular Migration	2018	<p>The Global Compact provides an approach to international migration in all its dimensions through the cooperation of country members in a holistic manner. The principles of the Global Compact are firmly grounded in human rights, sustainable development goals, national sovereignty, non-discrimination, gender sensitivity, and international collaboration. The core value is people-centred that can optimize migrants' benefit in their communities. Under the guidance of the Global Compact, the country members can develop their national plan to assist migrants in addressing their challenges during the process of transit and integration.</p>
Dhaka Declaration Draft Dhaka Declaration of Colombo Process Member Countries	2011	<p>The Declaration promotes the leader of Ministries and senior officers from member countries in protecting the rights of migrant workers and their families. The Declaration exhorts participants from 11 countries, including Viet Nam, to concern migrants in development policies especially vulnerable groups such as women migrants, low-skilled and low-wage migrant workers. The recommendations are built upon four principles:</p> <ul style="list-style-type: none"> <li>• Promoting Rights, Welfare and Dignity</li> <li>• Services and Capacity-building</li> <li>• Emergency response and Emerging issues</li> <li>• Enhanced dialogue and Cooperation</li> </ul>

<p>Dhaka Declaration of the Global Leadership Meeting on Population Dynamics in the context of the Post-2015 Development Agenda 13 March 2013</p>	<p>2013</p>	<p>Based on the Dhaka Declaration in 2011, the global consultation calls Ministers and representatives of the participating countries to take action on addressing and integrating population dynamics into the post-2015 development agenda. Migration and human mobility is one of the priorities thematic areas that recommends to relevant Ministers and stakeholders with specific targets:</p> <ul style="list-style-type: none"> <li>I. Ensure that migrants are considered as agents of development.</li> <li>II. Ensure that migration is safe and orderly.</li> <li>III. Ensure that migration, which affects many areas of development, is integrated into national and sectoral development policies, strategies and programmes, particularly poverty reduction strategies and National Adaptation Plans of Action.</li> <li>IV. Strengthen policy coherence at all levels through local, national, regional and global cooperation, including deepening cooperation among origin, transit and destination countries, and establish global partnerships in the post-2015 framework to ensure that migration contributes to equitable and sustainable development.</li> <li>V. Promote matching of skills and jobs as well as labour supply and demand within and between countries; and facilitate circular mobility through enhancing portability of social security entitlements, recognition of educational and professional qualifications and adoption of enabling legal frameworks aimed at enlargement of freedom of opportunities of individuals.</li> <li>VI. Promote opportunities for migrants to seek employment abroad securely and at low cost, transfer savings and provide incentives to trade with and invest in origin and destination countries.</li> <li>VII. Consider internal and international migration as possible adaptation strategies in the context of addressing climate change, particularly in the most climate-vulnerable countries.</li> </ul> <p>Ensure human rights of, and non-discrimination toward, migrants, especially women and vulnerable groups, and promote social cohesion of communities through equal wages and working conditions, social benefits and protections as well as recognition of educational qualifications.</p>
<p>ASEAN Declaration of commitment on HIV and AIDS: Fast-Tracking and Sustaining HIV and AIDS Responses To End the AIDS Epidemic by 2030</p>	<p>2016</p>	<p>HIV is highly prevalent among key affected populations including migrant and mobile populations.</p> <ul style="list-style-type: none"> <li>8) FOCUS and TARGET HIV and AIDS programmes for key affected populations and priority geographical areas, according to national legislation, priorities and evidence about the epidemic in each Member State;</li> <li>9) SCALE UP and STRENGTHEN the coverage, reach and quality of a continuum of comprehensive integrated packages of prevention, testing, treatment, care and support services, similarly referred to as the cascade of services, for key affected populations in priorities and evidence about the epidemic in each Member State.</li> </ul>

ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers	2018	<p>25) The Sending State will ensure migrant workers meet the health requirements of Receiving State before departure.</p> <p>34) The Receiving State will through its relevant authorities or bodies, ensure that migrant workers are provided with adequate information within reasonable timeframe among others of their rights and responsibilities, occupational safety and health measures, avenues of assistance after their arrival in accordance with the labour laws, policies and regulations, and customs and traditions of the Receiving State.</p> <p>36.c) The Receiving State will regulate the employment of migrant workers by ensuring that clear employment terms and conditions such as wages, employment benefits, working conditions, health and safety, employment dispute mechanisms and repatriation are provided in national laws, regulations, contracts of employment, or other appropriate documentation.</p> <p>40) The Receiving State will, in accordance with its applicable national legislations, regulations and policies, provide fair treatment to migrant workers in respect of:</p> <ul style="list-style-type: none"> <li>a) Working condition and remuneration;</li> <li>b) Occupational safety and health protection;</li> <li>c) Protection from violence and sexual harassment; and</li> <li>d) Gender and nationality in the workplace.</li> </ul> <p>41) The Receiving State will provide migrant workers with access to adequate medical and health care in accordance with the applicable laws, regulations and policies of the Receiving State.</p>
Agreement between the Government of the Socialist Republic of Viet Nam and Government of the Lao People's Democratic Republic on Solving the Spontaneous Migration and Marriages without Registration in Border Areas of the two Countries (valid for 03 years from 14th November 2013)	2013	<p>The Agreement facilitated undocumented migrants and married couples without registration living in border areas between Viet Nam and Lao People's Democratic Republic in making official papers. This policy paves the way for local authorities to grant Vietnamese citizenship for these people based on their willing. The identification paper could support cross-border migrants in access to social welfare at destination places. Other cases, who were unwilling to change their citizenship or did not meet the criteria, were supported to come back their native country by both governments.</p>
The extension of MOU among Health Ministries of the six Mekong Basin Countries on the Mekong Basin Disease Surveillance (MBDS) cooperation 2015 (Cambodia, Lao People's Democratic Republic, Myanmar, Thailand, Viet Nam and China)	2015	<p>The initiative for regional cooperation in disease surveillance and response started in 1999 to prevent and control communicable diseases in the six countries of the Great Mekong Subregion. Following the discussion among countries, an MOU was signed in 5 years life span in 2001 and the second extension was in 2015. Besides, enhancing the surveillance system and building capacity of the staff were considered as key stakeholders in developing the surveillance system and collaboration among countries. The MOU strengthened cooperation mechanism in cross-border areas to have prompt outbreak response with priority diseases such as dengue fever, malaria, severe diarrhea, HIV/AIDS and tuberculosis.</p>

WHA 72.25 on Promoting the health of refugees and migrants: Draft global action plan 2019–2023	2019	The resolution developed a draft global action plan with six principles. The country members should build on these priorities to develop an action plan/national framework in line with national context, legal framework and national needs.
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#### National laws related to migration health

Name	Authority	Migration Health Related Provisions	Relevance
Constitution of Viet Nam; 2013	Government of the Socialist Republic of Viet Nam	Viet Nam's Constitution seems to distinguish between the rights of all humans and the rights of citizens in its second chapter, which relates to the "human rights, fundamental rights and obligations of citizens." However, Article 38 reads: "[e]veryone has the right to health protection and care, and to equality in the use of medical services, and has the obligation to comply with regulations on the prevention of disease and medical examination or treatment; human rights and citizens' rights may not be limited unless prescribed by a law solely in case of necessity for reasons of national defence, national security, social order and safety, social morality and community well-being."	Social Security
Law on Residence; Household Registration System Decree No. 51/1997/CP; 1997	Government of the Socialist Republic of Viet Nam	<p>The household registration system has a long history in Viet Nam and comprises four categories of registration statuses: migrants typically possess KT2, KT3 or KT4 registration status<sup>14</sup>, in contrast to those permanently registered in the district in which they reside (KT1). The KT2 to KT4 residents are limited with regard to receiving health = services, schooling and other social services within their district of residence, and are unable to receive these services in the new residence district. Additionally, those with KT4 registration status are registered as individuals without a family (in contrast to the other three categories), and cannot own land titles.</p> <p>Government services, such as health care (including reproductive health), schooling, HIV care and treatment, and access to poverty reduction services depend on this registration system, which restricts or allows access to those permanently registered at any given place. Over the last two decades, the government has also introduced social insurance and health insurance into the country's social security system. The current legal structure, however, does not cover unregistered internal (spontaneous) migrants.</p>	Social Security

Residence law 2006, No. 81/2006/QH11	National Assembly	In 2007, the new Law on Residence took effect, reducing the number of residence categories to just two – temporary and permanent – and easing conditions for obtaining permanent residency. Anecdotal evidence suggests that the law is being applied inconsistently by local authorities across the country due to a lack of guidance and differing interpretations of the law. This inconsistency has created confusion regarding what procedures people are required to complete when applying for different residency registration across Viet Nam.	Social Security
Residence law 2013 – amendment some articles of the Residence law 2006, No. 36/2013/QH13	National Assembly	The new law established expiration time of temporary residence book which required migrant people had to renew their residence book after two years.	Social Security
Decree on detailing a number of articles of the Children law; No. 56/2017/ND-CP on 9 May, 2017	Government of the Socialist Republic of Viet Nam	The migrant children and refugee children with unidentified parents or caregivers are defined as priority subjects of social welfare. In general, these children can receive a package of benefits such as health care insurance, educational tuition, and social subsidization. The Decree calls actions from related government ministries, especially MOLISA, MOH and Ministry of Education and Training, to ensure the children's rights.	Social security
National Law on Health Insurance No. 25/2008/QH12; 2009,	National Assembly	Inbound migrant workers can participate in the national health insurance. Employers are requested by law to provide social insurance and health or accident insurance for workers. However, many enterprises ignore this regulation.  Viet Nam has been introducing social health insurance (SHI) since 1992. The country's health insurance law was promulgated in 2008.	Health care
Amendment some articles in the health insurance law 2008 by Law No. 46/2014/QH13, enforced 2015.	Viet Nam Government	In 2014, updated amendment of Health insurance law clearly stated responsibility of paying premium fee for each entitled object. New law also made a significant change in benefits that patients, especially short-term migrants owning health insurance cards, could receive from Health insurance. Migrants have been able to receive full-package benefits at health care facilities at district levels since 2016. All inpatient treatment costs for migrants will be covered by Health insurance at provincial levels, expected to take effect in 2021.	Health care

Resolution on protection and enhancement citizen's health in new situation, No. 20-NQ/TW on 25 October, 2017	Central committee	The resolution declares targets in order to improve people's health including life expectancy; coverage of health insurance; vaccination proportion; proper nutrition; health promotion programmes to prevent communicable and un-communicable diseases; and the number of health workers at health care facilities.	Health care
Decree on elaborating and providing guidance on measures to implement certain articles of Law on health insurance; No. 146/2018/ND-CP on 17 October, 2018	Viet Nam Government	This Decree facilitates people living in cross-border areas utilize health care services at a health care station located in a neighbouring province with full-package.	Health care
Decree on elaborating social insurance law and occupational safety law regarding compulsory social insurance for foreign nationals working in Viet Nam; No. 143/2018/ND-CP on 15 October, 2018	Viet Nam Government	Inbound migrants who have a work permit / practicing certificate and employment contract with at least one year need to enrol in compulsory social insurance regimes: sickness; maternity; insurance for labour accidents and occupational diseases; retirement and death.	Social insurance

<p>Law on Prevention of Infectious Diseases 03/2007/QH12; 2007</p>	<p>National Assembly</p>	<p>Chapter 3. Health Inspection/quarantine at the border</p> <p>Article 35. Subject and location of health inspection</p> <p>(a) Subject:</p> <ul style="list-style-type: none"> <li>I. Humans entering, exiting or transiting through Viet Nam</li> <li>II. Vehicles entering, exiting or transiting through Viet Nam</li> <li>III. Goods entering, exiting or transiting through Viet Nam</li> <li>IV. Bodies, body parts, bio samples, cells, human tissue passing through a Vietnamese border</li> </ul> <p>(b) Locations: at all border gates, checkpoints (land, sea air).</p> <p>Article 36. Contents of border quarantine</p> <ul style="list-style-type: none"> <li>a) Objects of border quarantine specified in Clause 1, Article 35 of this law are subject to medical declaration.</li> <li>b) Medical inspection includes inspection of health-related papers and physical inspection. Physical inspection shall be conducted of objects originating from or going through epidemic zones or suspected of suffering from an infectious disease or carrying agents of infectious disease.</li> <li>c) Medical disposal shall be conducted after medical inspection has been conducted and objects of border quarantine are detected to carry agents of a class-A infectious disease. If receiving information reported by owners of means of transport or obtaining explicit evidences that a means of transport, a person or cargo carries agents of a class-A infectious disease, the means of transport, persons or cargo on board the means of transport must be isolated for medical inspection before it/they are allowed to carry out procedures for entering, leaving or transiting Viet Nam; if it/they fails/fail to comply with the isolation request of the border quarantine body, an isolation measure shall be taken against it/them.</li> <li>d) Infectious disease surveillance shall be conducted in border-gate areas under the provisions of Section 3, Chapter II of this Law”.</li> </ul>	<p>Migration Management</p> <p>Health care</p>
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Law on Vietnamese Guest Workers (No: 72/2006/QH11); 2006	National Assembly	<p>According to Article 17, 1e, 1i of the law, the labour contract must be in line with legislation of Viet Nam and of the receiving countries and include the following main contents: labour safety and protection, and health care.</p> <p>Based on Clause 6 of Article 30: enterprises sending employees to work abroad are obligated to ensure a regular health check-up and treatment in the event of illness or accident. If the labourer is no longer able to continue working overseas, the enterprise shall organize and bear the expenses for bringing the labourer home.</p>	
Law on Entry, Exit, Transit, and Residence for foreigners in Viet Nam (47/2014/QH13); 2015	National Assembly	Inbound migrants intending to work in Viet Nam must first get a work permit before applying for a visa as per the 2014 Law on Entry, Exit, Transit and Residence for foreigners in Viet Nam (47/2014/QH13).	Migration Management
Circular Guiding The Granting Of Work Permits To Foreigners Working at Enterprises and Organizations in Viet Nam (No 08/2000/LDTBXHTT); 2000	Ministry of Labour, Invalids, and Social Affairs	As per Article II, part 1.a of this circular, to apply for a work permit, inbound migrants are required to submit a health certificate issued by at least a provincial hospital in Viet Nam. If the certificate is issued outside of Viet Nam, it must comply with the country's regulations. The health certificate must have at least 6-month validity from the day the work permit application is received.	Migration Management

Decree providing for the recruitment and management of foreigners working in Viet Nam (34/2008/ND-CP); 2008; and Decree on recruitment and management of foreign employees in Viet Nam (46/2011/ND-CP); 2011	Government of the Socialist Republic of Viet Nam	These two decrees require that the MoH issues guidelines for agencies in charge of issuing health certificates for inbound migrants, and to clarify the validity of certificates.	Migration Management
Joint Circular on guidelines about medical check-up procedure and health certificates for Vietnamese employees working abroad; 16 December, 2004	MOH, MOLISA and Ministry of Finance	The Joint Circular permits hospitals to examine and issue a health certificate for Vietnamese labourers, specialists and trainees going to work abroad. This Circular details required standards for hospitals that perform health checking and issue a health certificate.	Migration Management
Circular on guidance about medical examinations No: 14/2013/TT-BYT on 5 May, 2013	MOH	The Circular explains technical requirements in health checks and classifications of health status for workers and students including <ul style="list-style-type: none"> <li>• Vietnamese and foreigners working and living in Viet Nam</li> <li>• New recruited employees</li> <li>• Freshmen students</li> <li>• Vietnamese working abroad under contract</li> </ul>	Migration Management

Decree on Regulation and Guidance on the Law for Overseas Workers (126/2007/ND-CP); 2007	Government of the Socialist Republic of Viet Nam	<p>According to Article 11 of the decree the responsibilities of the MOH include:</p> <ul style="list-style-type: none"> <li>• Set requirements for clinics that can provide health examination and health certificates for (Vietnamese) workers who want to work abroad under contract; collaborate with the Ministry of Finance and MOLISA to set a fee for the health examinations;</li> <li>• Lead and coordinate with MOLISA to set the health requirements for Vietnamese who want to work abroad in accordance with each country's requirements;</li> <li>• Collaborate with MOLISA to carry out periodic health assessment of Vietnamese workers abroad; and</li> <li>• Supervise, inspect, and regulate clinics and resolve violations in health examination as prescribed by law.</li> </ul>	Migration Management
Decision on the promulgation of enterprise's operating regulations and the specialized Department/system to provide essential supplemental training for workers prior to overseas; No 19/2007/QD-BLDTBXH on 18 July, 2007	Ministry of Labour, Invalids and Social Affairs	The Decision regulates enterprises that send workers on abroad employment, on establishing a department/system of education with qualified education background staff. The department is in charge of organizing training classes or outsourcing contracts to provide essential knowledge for employees.	Migration Management
Decision on curriculums of pre-departure trainings for employees working abroad, No. 18/2007/QD-BLDTBXH on 18 July, 2007	Ministry of Labour, Invalids and Social Affairs	Curriculums of pre-departure trainings has to include a section on knowledge about diseases, sexual abuse, drug use, sex work and HIV/AIDS.	Migration Management

Decision on issuance of certificates of pre-departure trainings for working abroad employees, No. 20/2007/QD-BLDTBXH on 2 August, 2007	Ministry of Labour, Invalids and Social Affairs	Department of Labour, Invalids and Social Affairs and Department of Overseas Labour Management are responsible for monitoring and inspecting the issuance of certificates from enterprises sending employee to work abroad.	Migration Management
Decree 44/2013/ND-CP on Labour Contract (part of the Labour Law); 2013	Government of the Socialist Republic of Viet Nam	Chapter 2 of this decree mandates participation in health insurance, social welfare insurance and unemployment insurance for all employees with a labour contract (including inbound migrants in Viet Nam).	Migration Management
Circular 30/2013/TT-BLDTBXH on October 25th, 2013 about guidelines for some Articles of the Government Decree 44/2013/ND-CP	Ministry of Labour, Invalids and Social Affairs	This circular details instructions for participation in compulsory social insurance, compulsory health insurance, and unemployment insurance for employees who had employment (including inbound migrant in Viet Nam) contracts with multiple employers under the Government's Decree No. 44/2013/ND-CP	Migration Management

#### Laws, Strategies and Guidelines related to migrants and infectious diseases (Malaria, TB and HIV)

Name	Authority	Migration Health Related Provisions	Relevance
Decision on the approval of the health care target – population program period 2016–2020, No: 1125/QD-TTg on 31 July, 2017	Prime Minister of the Socialist Republic of Viet Nam	<p>This decision explains targets for each programme components, priority strategies for highlighted areas, allocated resources and responsibilities of related authorities in implementation of the program. The program focuses on</p> <ul style="list-style-type: none"> <li>• Preventing and controlling epidemics at an early stage</li> <li>• Reducing morbidity and mortality rates of some life-threatening infectious diseases</li> <li>• Controlling and reducing the rate of HIV/AIDS infection in communities for socioeconomic development</li> <li>• Strengthening the cooperation between civil and military forces in the care and protection of people's health in border areas, islands and key areas of the national security and defence</li> </ul>	Malaria, TB and HIV

Decision on the approval of the National Strategy for the Control and Elimination of Malaria in Viet Nam, period 2011–2020 and Orientations towards 2030 (Ref. number: 1920/QD-BYT); 2011	Prime Minister of the Socialist Republic of Viet Nam	The strategy defines overall objectives, action plans, resources and competent authorities for the coordination and implementation of the action plan. This includes providing free of charge long lasting insecticide treated bed nets (LLINs) and treated hammock nets for those living in areas of medium and high malaria prevalence, including irregular migrants, border-crossing migrants and poor households as well as advocating use of treated nets in areas of low malaria prevalence.	Malaria
Decision on the promulgation of the Guideline for Malaria diagnosis and treatment No: 4845/QD-BYT on 8 September, 2016 (replace Decision 3232/QD-BYT, 2013)	Ministry of Health	The guideline details terminology, principles and instructions to undertake diagnosis and treatment for malaria cases. Only health workers from commune level and above shall be qualified to prescribe and provide self-medication to those who travel to highly malarious areas for at least 14 days (tourists, forest/field workers, border-crossers, etc.).	Malaria
National Strategy for Malaria Control and Elimination 2012–2015; 2012	Ministry of Health	<p>The strategy identifies some objectives that cover migrant populations.</p> <ul style="list-style-type: none"> <li>a) Ensure that all people have better access to early diagnosis, prompt and effective treatment of malaria at the public and private health facilities.</li> <li>b) Ensure the coverage of all people at risk of malaria by appropriate malaria control measures</li> </ul>	Malaria
Decision on the promulgation of the Action Plan for the Prevention of Malaria period 2015–2020 (Ref. number: 4717/QD-BYT); 2014	Ministry of Health	The action plan outlines the legal and scientific basis, objective and performance indicators, solutions, yearly work plan, budget, division of tasks and responsibilities, and coordination mechanisms between different government agencies at different levels for the purposes of preventing malaria. Concrete initiatives include ensuring prevention and protection measures, such as spraying chemicals, providing LLINs to malaria hotspots, such as forests or fields prior to the typical peak of malaria infection each year; expand the coverage of malaria prevention measures for all the population vulnerable to malaria infection; ensure access to early malaria diagnosis services and to safe, effective and timely treatment; ensure that malaria treatment is provided free of charge at private and public facilities. For areas where malaria is to be eradicated, the action plan indicates that the movement of migrants and malaria patients should be closely monitored; and active detection of malaria cases should be implemented.	Malaria

Decision on the promulgation of the Action Plan to Prevent Artemisinin-Resistance Malaria for the period 2015–2017 (Ref. number: 4718/QD-BYT); 2014	Ministry of Health	The action plan provides an overview of artemisinin resistance from 2010 to 2014 and includes a legal framework, target areas, objectives, performance indicators, yearly work plan, division of tasks and responsibilities and coordination mechanism between different government agencies at different levels. Initiatives include provision of LLINs free of charge to seasonal workers (one net per person); provide bed nets, hammock net and repellent products and instruction on how to use them, especially for seasonal workers, such as cashew and cassava workers; closely monitor MMP flow; and ensure provision of rapid-diagnostic tests and blood films at village level for timely and effective detection and treatment of MMP to avoid treatment failure. The action plan targets migrants as a risk group; however, the effectiveness of this plan remains to be seen as in the initial phase. The action plan does not specify if MMP also includes inbound migrants in Viet Nam.	Malaria
National Tuberculosis Strategy Implementation Plan 2015–2020	Ministry of Health	The strategy includes the objective that focuses on development, implementation and evaluation for TB screening and care in high risk groups including migrants. The work plan includes mapping the size of migrant populations in collaboration with the IOM for early case finding and adequate management of TB among migrants. The strategy lacks clear information if the target population also include undocumented migrants, inbound migrants as well as cross-border migrants.	TB
Decision on the promulgation of the National Strategy for Prevention and Control of Tuberculosis to 2020 and Vision to 2030; No. 374/QD-TTg; 2014	Prime Minister of the Socialist Republic of Viet Nam	The strategy indicates the country will cooperate closely with other countries in the region to solve the problem of TB detection, treatment and TB spreading across borders as well as the migrants. MOLISA will play a role in coordination with MOH and relevant ministries and sectors to study and promote guidelines and policies on TB prevention and control for migrant workers.	TB
Decision on the guideline of detection, treatment and TB control; No. 3126/QD-BYT on 23 May, 2018	Ministry of Health	The Decision details technical instructions in detection, treatment and control of TB for all populations including migrants.	TB

Decision No: 608/QĐ-TTg on 25 May, 2012 about approving National Strategy for HIV/AIDS prevention and control 2020 –2030	Prime Minister of the Socialist Republic of Viet Nam	The Decision defines general objectives, detail indicators, comprehensive solutions, prevention measurements, international cooperation, schemes of action, and responsibilities of relevant stakeholders. Bilateral and multilateral cooperation play a significant role in addressing HIV/AIDS. This decision emphasizes information sharing and maintaining the close collaboration with other countries. MOLISA coordinates with MOH in raising awareness of HIV prevention and control for migrant workers especially female labour migrants.	HIV
Law on HIV/ AIDS Prevention and control No: 64/2006/QH11 on 12 July, 2006	Chair of the National Assembly	Mobile populations are recognized as one of priority groups in information education and communication (IEC) for HIV/AIDS prevention and control. Local authorities are in charge of implementing IEC for migrants in communities.	HIV
Decision on mechanisms of cooperation in HIV/AIDS prevention and control in cross-border areas; No. 38/QĐ-TTg on 8 January, 2008	Prime Minister of the Socialist Republic of Viet Nam	The Decision stated principles, mechanisms and responsibilities of Government related agencies in collaboration for HIV/AIDS prevention and control in cross-border areas. The Decision aims to promote IEC activities; screening, detecting and treating STDs for people living in cross-border areas.	HIV
Decision on the guideline about treatment and care for HIV/ AIDS patients No: 5418/QĐ-BYT on 1 December, 2017	Ministry of Health	If HIV patients do not enrol in treatment, health care workers coordinate with the HIV Prevention and control agency in the patients' locality or peer groups to support HIV patients to participate in ARV treatment at an early stage.	HIV

## Annex 3

Lists of stakeholders participated in FGDs (government agencies) and interviews

Ha Noi and Ho Chi Minh City

	Agency	Number of participants
Ministry of Health	Department of Medical Service Administration	3
	General Office of Population and Family Planning	1
	National Lung Hospital	2
	Department of Maternal and Child Health	1
	National Institute of Malariology Parasitology and Entomology	1
	General Department of Preventive Medicine	1
	Ha Noi Medical University	1
Ministry	Ministry of Labour, Invalids and Social Affairs	3
	Ministry of Public Security	4
	Ministry of Justice	1
	Ministry of Social Security	2
	Ministry of Foreign Affairs	1
	Viet Nam Women's Union	2
UN Agency	Joint United Nations Programme on HIV/AIDS	1
	United Nations Population Fund	1
	United Nations Children's Fund	1
	UN Women	1
	International Labour Organization	1
	World Health Organization	1
NGO	FHI360	1
	Save the Children	1
CSO	S-House	1
	IECD	1
	LIN	1
	Total	34

Ha Tinh Province	Agency	Number of participants
Provincial level	Department of Police	1
	Department of Social Security	1
	Department of Health	3
	Department of Population and Family Planning	2
	Center for Disease Control	4
	General Hospital	1
	Lung Hospital	1
	Psychiatric Hospital	1
	Labour Federation	1

	Women's Union	1
District level	District Health care Center (DHC)	2
	Department of Reproductive Health, DHC	1
	Department of Public Health, DHC	1
	Department of Disease Control, DHC	2
	General Hospital	2
	Private Clinic	1
Commune level	Health care Station	9
	People's Committee	2
	Commune Health care center	2
	Women's Union	1
	Department of Police	1
	Volunteer Health care Worker	4
Total		44

Ha Giang Province	Agency	Number of participants
Provincial level	Department of Social Security	1
	Department of Health	3
	Department of Population and Family Planning	2
	Center for Disease Control	2
	General Hospital	1
	Lung Hospital	1
	Labour Federation	1
	Women's Union	1
District level	District Health care Center (DHC)	2
	Department of Reproductive Health, DHC	1
	Department of Public Health, DHC	1
	Department of Disease Control, DHC	3
	General hospital	1
	Private clinic	1
Commune level	Health care Station	5
	Police officer	1
	Volunteer Health care Worker	2
Total		29

Kon Tum Province	Agency	Number of participants
Provincial level	Department of Social Security	1
	Department of Health	1
	Department of Population and Family Planning	2
	Center for Disease Control	3
	General Hospital	1

	Labour Federation	1
	Women's Union	1
District level	District Health care Center (DHC)	2
	Department of Reproductive Health, DHC	1
	Department of Public Health, DHC	1
	Department of Population and Family Planning	1
	Department of Disease Control, DHC	5
	General hospital	1
Commune level	Health care Station	6
	Village Leader	1
	Volunteer Health care Worker	4
Total		32

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