Resolution on the "Health of Migrants" in Vietnam

Discussion Paper

Submitted to the International Organization for Migration (IOM) in Vietnam

by

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ASEAN	Association of Southeast Asian Nations
DOLISA	Department of Labour, War Invalids and Social Affairs
GMS	Greater Mekong Sub-Region
HIV	Human Immunodeficiency Virus
IOM	International Organisation for Migration
JUNIMA	The Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia
MHP	Migrant Health Program
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids, and Social Affairs
MOU	Memorandum of Understanding
NGO	Non-governmental Organisation
PHAMESA	Partnership on Health and Mobility in East and Southern Africa
POEA	Philippines Overseas Employment Administration
TB	Tuberculosis
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organization

PREFACE

The complexities of migration and health have been increasingly recognised by governments and programme implementers, especially acknowledging the need for multi-sector approaches and cohesive policy development. It is anticipated that this document will contribute to the review of Vietnamese efforts to achieve the principles of the Resolution on the "Health of migrants," which was endorsed by the World Health Assembly in 2008.

This discussion paper has been drafted based on prior activities implemented between the Ministry of Health and the International Organization for Migration related to the resolution. These have included an assessment and desk review, two consultation workshops, and targeted research.

The process for this discussion paper did not include additional research. It did, however, include additional documents to ensure the results are relevant to Vietnam and the Resolution on the "Health of migrants". Documents reviewed in this process were primarily documents already collected or were identified on the internet.

The issue paper has been drafted to identify why migrant health requires targeted approaches and the fundamental principles of public health approaches. Additionally, the current situation in Vietnam has been summarised to establish the context for the government's progress towards the resolution.

The review on the migration situation in Vietnam does not include migrants coming to Vietnam, as there is currently not sufficient data or knowledge of the situation. Although the numbers of immigrants to Vietnam are still relatively small, this aspect of migrant health will need to be reviewed in the future.

Advancements towards the Resolution on the "Health of Migrants" were reviewed based on the nine principles and recommendations of the resolution. The paper uses the four 'pillars' of migrant health that were finalised through the 2010 Global Consultation on Migrant Health organised by the European Union, the International Organization for Migration and the World Health Organization and which consolidated the resolution principles.

(Hanoi, August 2013)

I. INTRODUCTION AND BACKGROUND

Migration and health are intertwined throughout all phases, routes, and patterns of migration and mobility, including irregular[1] and circular migration. The phases of migration, consisting of pre-departure, travel and transit, destination and integration, and return each pose a different environment related to migrants' health. There are an estimated one billion migrants in the world today comprising of 740 million internal migrants, 214 million international migrants, and an unknown number who are regularly mobile and who are affected by many of the same conditions that create vulnerability for migrants.[2] People move and migrate to leave difficult, harsh, or violent conditions and seek safer living conditions within their country or across borders. These push and pull factors[3] that lead to migration are extremely varied and can greatly influence the different experiences of migration. Movement can be for short periods of time or long term, or in the case of mobile populations, such as drivers and assistants on buses and trucks, a regular and everyday occurrence.

Contrary to common perceptions, there is evidence that many migrants are relatively healthy when they depart, as most migrants are young and travel when healthy. Despite this, migrants and mobile populations are often blamed for the spread of disease and infections and for increasing the burden on existing services for non-migrants. Conditions surrounding the migration process can make migrants more vulnerable, but even when seeking health care, they often underutilize services and pay costs themselves. These vulnerabilities are related to the phases of migration as follows:

- Pre-departure**:** Health during the pre-departure phase is influenced by the political and policy environment, environmental factors, diet and available food, cultural and traditional lifestyles, biological characteristics, chronic and infectious disease patterns, and personal conditions.

[1] According to the International Organization for Migration, irregular migration is movement that takes place outside the regulatory norms of the sending, transit and receiving countries.

[2] These global estimates have been used in the United Nations Human Development Report, the World Health Organization, and the World Migration Report 2010 published by the International Organization for Migration.

[3] Push factors can include: poverty, unemployment and under-employment, lack of medical facilities, inadequate schools, land grabbing, lack of facilities and entertainment, insufficient electricity and water, lack of transportation, isolation, violence, conflict, environmental degradation, famine, drought, climate change, and frequent natural disasters. Pull factors can include: employment opportunities, education options, quality medical facilities, housing options, facilities and utilities, entertainment, and media.

- Travel and transit**:** The travel and transit phase affects migrants as they travel between their place of origin and a destination, and can be a risk environment for some migrants, especially if they are using irregular channels or informal arrangements. There are often concerns by transit communities that migrants are transporting and transmitting infections even though most migrants are healthy.

- Destination and integration: When migrants arrive and settle at their destination, they may often be in an environment of dramatic change, with a loss of established social networks, poor knowledge of the culture and customs, and subjected to stigma and discrimination. While many migrants take advantage of improved lifestyle opportunities and better health facilities and services, risk behaviours can change in destination settings to match the host population. Due to behavioural and environmental factors, migrants may be at greater risk of Human Immunodeficiency Virus (HIV,) reproductive health problems, poor pregnancy outcomes, and respiratory infections. Inadequate attention to non-communicable diseases and mental health at this stage further increases migrant vulnerability. The concern that migrants are responsible for disease transmission and a burden on health services often continues in this phase, with communities discriminating against migrants and governments requiring mandatory testing and enforcing restrictive migration policies.

- Return**:** Migrants may also return to their place of origin, either temporarily or to resettle. As many migrants left lesser-developed environments with inadequate services and facilities, returning to those settings may result in a lack of necessary care, especially if they return with chronic health conditions requiring on-going treatment; such as cancer, diabetes, hepatitis B or C, or HIV.

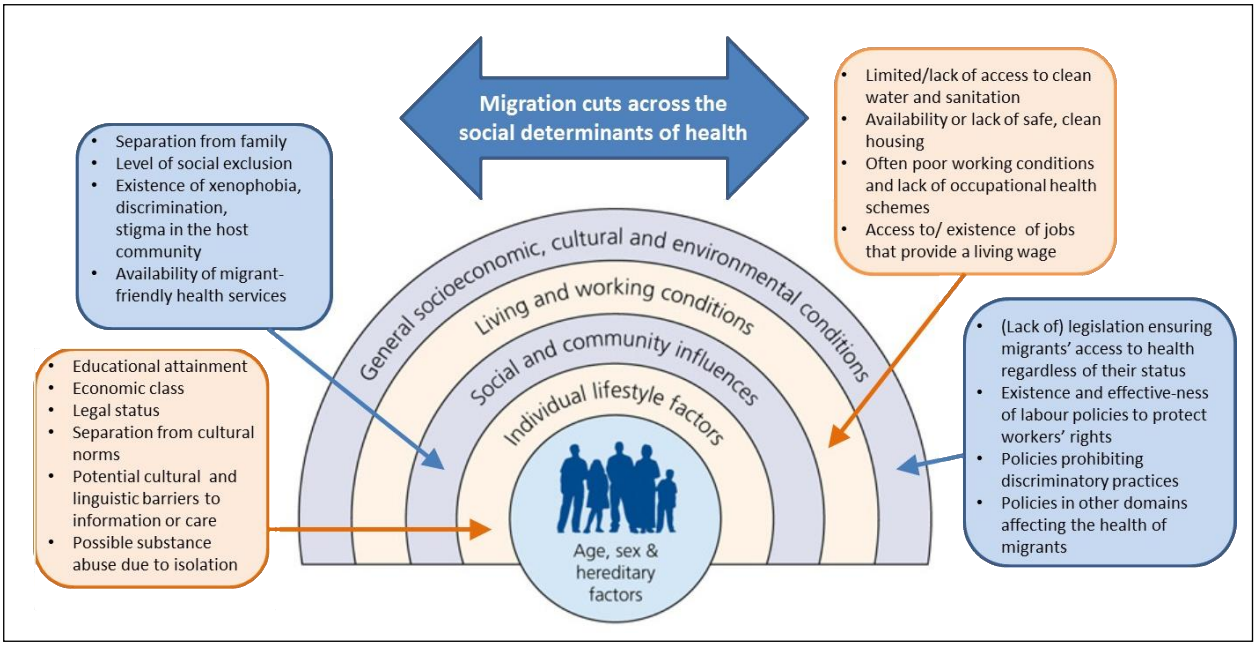
The impact of internal or international migration on the health of migrants is complex. Migration itself is not necessarily a risk factor for poor health, but marginalized migrants can face social and economic determinants of ill-health including adverse living and working conditions, and a lack of access to social protection, including health insurance. Migrants are not a uniform group and their vulnerability, risk behaviour, and constitutional factors differ greatly from person to person.

1.1. Migration and health and migrant health approaches

Although the Constitution of the World Health Organization defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,' countries

define and interpret the right to health differently; especially for migrants. Due to legal and residency status, language, cultural barriers, and income levels, migrants are often affected by various social determinants of health, the quality of health services, and health-prevention efforts, which may increase their vulnerability to poor health. As migrants often have different health needs than other populations due to the nature of their work, their working hours, living conditions, and access to services, health-care services often do not cater to these specific needs, and lack the necessary data and information to improve services. Stigma and discrimination against migrants can cause inequities in accessing quality health services. In addition, loneliness, boredom, and being away from family and community pressures can lead to behavioural changes and potential risk. Migrants are often doubly stigmatised as residents discriminate against them for being migrants and the assumption they carry infections, such as HIV, tuberculosis (TB) and sexually transmitted infections, and are seen as a burden on health systems. These factors are influenced by the political, economic, and social environments that affect the health of all people, including migrants, and are referred to as social determinants of health.

Social Determinants of Health



(Adapted from: Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.)

There are various levels of determinants that influence health and range from the general socioeconomic, cultural and environmental environment, the physical environment (such as living and working conditions and social and community factors,) and such individual determinants, such as physical, lifestyle and behavioural factors, as well as age and sex. Social determinants of migrants' health include the following:

Structural determinants (general socioeconomic, cultural and environmental determinants)

Laws and policies related to health-care service delivery and preventative programmes, as well as the legal status of migrants are often a barrier to health care.

Intermediary (or physical) determinants (living and working conditions and social and community influences)

Many migrants live in poor quality and overcrowded housing, increasing the risk of respiratory infections, such as TB. Work-place environments can lead to greater risk for occupation injuries, especially for unskilled and semi-skilled migrants. Psycho-social issues may arise through the process of leaving family, coping with job insecurity, legal problems, and unfamiliarity with the new environment or culture. Lack of migrant-inclusive services and health staff trained in migrant-health needs are also often major barriers. Social isolation, stigma, discrimination, and marginalisation often lead to migrants not having access to services providing prevention, screening, counselling or treatment.

Individual determinants (biological, genetic, lifestyle and behavioural)

Many migrants maintain healthy behaviour and lifestyles in their home communities and throughout their migration process. Others, however, adopt risk behaviours leading to increased chronic and communicable diseases and infections. Many migrants are not reached with appropriate health information and programmes, making it more difficult to adopt protective measures against chronic diseases and communicable infections. Being outside of their home communities and facing language and cultural differences can lead to loneliness, susceptibility to peer pressure, and difficulty in accessing information about risks and health care and become more vulnerable. Living in crowded housing, with little privacy or choice for recreation, some migrants choose to spend their disposable income on available entertainment, which may include alcohol, illicit drugs, and local sex services.

Addressing the structural, physical, and individual social determinants of health promotes the well-being of all, including documented and undocumented migrants. The health of migrants, however, continues to be a major challenge faced by governments and societies. This global challenge led to

the World Health Assembly (WHA) endorsing the Resolution on the "Health of migrants" in 2008.

1.2. World Health Assembly Resolution 61.17 on the "Health of migrants"

Health disparities continue to exist between source and destination countries and between migrant and non-migrant populations, leading to many migrants becoming more marginalized and excluded from health services, which affects their health and the health of others in their community. This is especially true for migrants that lack necessary documents or approval to reside at their destination. To prevent and reduce disparities, there are fundamental principles that have been identified to influence the development of a multi-sectoral, comprehensive, public-health approach for migrants. These principles include ensuring migrants' health rights, removing impediments to migrants' access to preventive and curative interventions, putting in place interventions to reduce excess mortality and morbidity, and minimize the negative impact of the migration process on migrants' health outcomes. The World Health Assembly affirmed these principles in the 2008 Resolution on the "Health of migrants" as follows:

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.

1.3. WHO and IOM approaches to migrant health

Two intergovernmental organisations that have engaged member states, networks, other organisations, and communities to address migrant health are the International Organization for Migration (IOM) and the World Health Organization (WHO).

IOM provides and promotes comprehensive, preventive and curative-health programmes, which are equitable, affordable, and accessible, for governments, communities, migrants, and mobile populations. Bridging the needs of both migrants and governments, IOM contributes towards the physical, mental and social well-being of migrants, enabling them and communities to achieve social and economic development as equitable access to health care for migrants result in a reduction in health and social costs, improved social cohesion, and healthier migrants in healthier communities.

WHO recognises that the health of migrants and health matters associated with migration are crucial public-health challenges faced by governments and societies. Migration is an ever-present phenomenon in a globalized world that is defined by rapid growth and development as well as profound disparities, skill shortages, demographic imbalances, natural disasters, climate change, and economic and political crises. Migration is also essential for some societies to compensate for demographic trends and skill shortages and to assist home communities with remittances. This notion of migration and health formed the basis for the Resolution on the "Health of migrants," which was endorsed by the Sixty-first WHA in May 2008. WHO's work in the domain of migrant health is guided by the action points of this resolution.

During the 2010 Global Consultation on Migrant Health (which was co-sponsored by the Spanish Government, WHO and IOM,) the nine principles[4] of the Resolution on the "Health of migrants" were combined and merged into four pillars of migrant health. These are as follows:

[4] The ninth principle on the global deficit of health professionals is incorporated into all four pillars when relevant.

1. Monitoring migrants' health - Incorporating the following two principles of the Resolution on the "Health of migrants":

    - Establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
    - Gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination.

2. Policy and legal frameworks affecting migrants' health - Including the following principle of the Resolution on the "Health of migrants":

    - Promote migrant-sensitive health policies.

3. Migrant-sensitive health systems – Incorporating the following four principles of the Resolution on the "Health of migrants":

    - 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;
    - Devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
    - Raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
    - Train health professionals to deal with the health issues associated with population movements.

4. Networks, partnerships and multi country frameworks on migrant health - Including the following principle of the Resolution on the "Health of migrants":

    - Promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process

I.4. Responses and good practices

Since the 2008 Resolution on the "Health of migrants," responses to achieve the resolution's principles have included a number of national, regional, and global initiatives, some of which are noted below.

Global Consultation on Migrant Health

The Ministry of Health and Social Policy of Spain, along with WHO, and IOM, organized a global consultation on migrant health in March 2010 to support the resolution. Over 100 participants from

various governments and sectors from across the world, representatives of non-governmental agencies, UN and intergovernmental agencies, migration networks, academics, and experts, reviewed obstacles to generating comparable global data on migrant health; identified policies and legislation on the health of migrants; identified key actions to create migrant-sensitive health systems; and developed and strengthened national, regional and global platforms to foster dialogue between the various sectors involved in migration and health.

The Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia (JUNIMA)

JUNIMA is a partnership forum that works on universal access to HIV services for migrant and mobile populations. This initiative initially focused on the six countries of the Greater Mekong Sub-Region (GMS) and the southern provinces of China, but has since expanded to cover all the remaining Southeast Asian countries. The partnership is diverse with government, UN and intergovernmental organisations, non-governmental organizations (NGOs,) and civil society. JUNIMA identifies priorities and gaps, and supports programmatic, policy, and advocacy actions to reduce mobility-related HIV vulnerability, as well as care and support throughout the migration cycle. JUNIMA's strategy is to produce strategic information, promote regional advocacy and policies, and strengthen multi-sector mechanisms at the regional and country level.

Migrant Health Program (MHP)

The 'Migrant Health Program' was one of the first programmes in Thailand to address migrant health issues through collaboration between community and government networks and was implemented by the Thai Ministry of Public Health in partnership with IOM. The integration of full-time migrant community health workers, recruited from the targeted migrant communities, forms the foundation of the project's achievements. The MHP established a comprehensive primary health care approach targeting both migrants and host communities in order to minimize inequalities in health-related knowledge and health-care access amongst diverse populations. The goal of the MHP was to improve the health and well-being of registered and unregistered migrants through strengthening the capacity of various sectors of government to provide migrant-sensitive health services, and to promote ownership of the programme. The MHP programme focused on increasing access to migrant-friendly health services, developing replicable, sustainable migrant health models, strengthening collaboration between government and non-government stakeholders for multi-disciplinary approaches, and advocating for the development and implementation of positive migrant health policies.

National Consultation on Migration Health

The Government of Jordan organized a national consultation on migration health in 2012. Government representatives from countries that send migrants to Jordan (Egypt, Indonesia, Iraq, the Philippines, and Sri Lanka) attended the consultation to identify effective migrant-health practices and promote policies for positive, proactive communication and collaboration. Approximately 70 participants attended from governments of sending counties, government ministries, embassies, United Nations agencies, international organizations, civil society, and migrant communities. Group discussions led to joint information sharing, and identifying gaps and solutions, to strengthen international cooperation on migrant health. The national consultation is the foundation for an operational framework with defined priority actions for policy makers and other stakeholders. The consultation made a number of achievements including raising knowledge of the WHA resolution, facilitating information sharing and cooperation, developing policy recommendations to be incorporated into a national action plan, and validating the findings of the assessment.

Partnership on Health and Mobility in East and Southern Africa (PHAMESA)

From 2004 to 2010, IOM implemented the Partnership on HIV and Mobility in Southern Africa with the aim of reducing HIV vulnerability of mobile populations in the Southern African Development Community region. In 2010, to respond to the larger health vulnerability of migrant and mobile workers in East and Southern Africa, the partnership broadened its coverage to include the East Africa region leading to the formation of the 'Partnership on Health and Mobility in East and Southern Africa'. PHAMESA responds to the public-health needs of host communities in 10 countries through partnerships with Regional Economic Communities, National AIDS Councils, various ministries, UN partners, NGOs, the private sector, labour unions, and IOM national and regional offices. The objective is to contribute to the improvement in physical, mental, and social well-being of migrants, mobile populations, and communities affected by migration by responding to health needs through all phases of migration processes, as well as the public-health needs of host and sending communities in East and Southern Africa. PHAMESA includes five inter-related components - service delivery and capacity building; advocacy for policy development; research and information dissemination; regional coordination and; governance and control;

Report cards on the WHA Resolution

Sri Lanka and the United Kingdom have gone through a process to assess their progress towards the resolution. Through a participatory, consultative process the two countries included government

agencies, intergovernmental organisations, academics, non-governmental organisations, and other specialists to assess the progress of the country in achieving the resolution on migrants' health;[5]

Philippines Overseas Employment Administration (POEA)

The Philippines has an employment-driven emigration policy that emphasizes temporary labour migration, worker protection, and maximising the development impact of remittances. The Migrant Workers and Overseas Filipinos Act of 1995 institutes the policies of overseas employment and establishes a higher standard of protection and promotion of the welfare of migrant workers, their families and overseas Filipinos in distress. The POEA, together with the Overseas Workers Welfare Administration, are in charge of the implementation of this act. The Department of Foreign Affairs is also included in the 'one country' approach to labour migration governance. POEA implements national migration policies, monitors the departure of migrant workers, educates potential migrants on their rights and the possible dangers, and provides pre-employment orientation in cooperation with local government units. POEA also regulates private recruitment agencies and approves contracts, monitors malpractices, and prosecutes violators of recruitment standards. As a requirement of the POEA processing of applications, a membership fee has to be paid. Migrant workers pay an application fee of US$ 25, are required to sign-up for medical insurance, and receive pre-departure training on social and working conditions abroad. Incentives are provided for migrants who return, including loans for business capital and eligibility for subsidised scholarships. The POEA has also carried out campaigns to educate potential migrants in rural areas on the negative consequences of irregular migration and common illegal recruitment practices and about 66 per cent of the pre-employment orientation is held in rural areas and the remaining 34 per cent were conducted in Manila.

Sri Lanka Migration Health Programme

From 2009-2012, the Sri Lankan government established the National Migration Health Programme addressing internal, outbound, and inbound migration. Before the programme, little was known about the impact of migration on the 10 per cent of Sri Lankans who work overseas, nor the health status of the families that they leave behind. The government has also became better informed that growth in the post-conflict economy is leading Sri Lanka to become a labour-receiving country. The

[5] The Sri Lanka report card can be viewed at http://www.migrationhealth.lk/progress_on_WHA_resolution__SL.pdf and the UK report card at http://www.cumberlandlodge.ac.uk/Resources/CumberlandLodge2011/Documents/Programme/Reports/Migrant%20Health%20Report.pdf.

programme included a progress report, which was presented in 2012; the first country in the WHA to present progress.

Vietnam Ministry of Health

MOH organised its first consultative workshop on migration and health in Hanoi in 2011, which was attended by senior officials, academics and UN partner agencies working in the field of migration health. Vietnam also conducted research and a review on migration and health to be better informed and have access to current information.

2. MIGRATION AND HEALTH IN VIETNAM

The history of migration, both internal and international, in Vietnam is complex, as it has been heavily influenced by colonial rule, war, political change, and rapid economic growth. Since the country undertook economic reforms in the late 1980s, however, migration patterns have become increasingly steady, and have become predominantly based on seeking economic and employment opportunities.

Internal migration began to increase in the early 1990s, when over 80 per cent of the population lived in rural communities. Laws were revised allowing unrestricted internal mobility and the possibility to change residence. The World Bank describes the present urbanization process in Vietnam as an 'incipient stage transitioning to an intermediate stage with rapid urbanization.' Currently, 30 per cent of the population resides in urban areas, with cities growing approximately 3.5 per cent per year.[6] While this growth is due to natural population growth of permanent residents, it is largely fuelled by internal migrants. (Vietnam's population growth rate was estimated in 2011 to be 1.05 per cent.[7]) In addition to cities, a rapidly increasing number of migrants also seek employment in various industrial zones located throughout the country. Government-managed social-service providers estimate that the migrant populations in cities such as Ho Chi Minh City and Hanoi may already exceed 30 per cent of the population, which could mean the migrant population in Hanoi and Ho Chi Minh City, alone, would exceed 5.4 million people. The actual numbers (and growth rates) are unknown, as many migrants do not report their mobility and do not undertake official procedures to change their residency to a new location. Ho Chi Minh City, Hanoi, and Danang are responding to this rapid growth by drafting legislation in efforts to restrict further migration. All three cities state that antiquated public services, such as schools and hospitals, have become overwhelmed with the increasing populations leading to efforts reduce migration.

International and labour migration has been steadily increasing in the past decade due to employment opportunities in countries in the region and the Middle East, and the government's concerted efforts to escalate labour migration to increase employment and remittances. Through government-sanctioned agreements, approximately 80,000 migrants have gone overseas for work

[6] The World Bank and the One UN (through UNDP) both state a 3.4-3.5 per cent urban growth. (Internal Migration: Opportunities and challenges for socio-economic development in Viet Nam. UN. 2010)

[7] Vietnamese and UN reports state the Vietnamese population growth rate is 1.05 per cent, but is stated as one per cent by the World Bank in their country indicators website - http://data.worldbank.org/indicator/SP.POP.GROW

each year over the past eight years and there is currently an estimated 500,000 workers abroad.[8] This figure does not include labour migrants who have made their own arrangements (through regular or irregular channels,) or migrants who have gone abroad for personal, health, or education reasons.

Although accurate data are not available, movement into Vietnam is also increasing, but not yet at levels warranting a national response.

2.1. Migrant-health profile - protective behaviour, vulnerability, and risks

Internal migration includes benefits, such as greater employment opportunities and increased income, better schools and education, and better quality health care (in both the public and private sectors). Much of the available work, however, is in the informal sector and can be unsafe and includes risks.

The social determinants of health for Vietnamese migrants are similar to those that affect migrants globally. For most unskilled and semi-skilled internal migrants, the most readily available work often involves jobs that local residents are no longer willing to do and often involve construction, factories, domestic labour, rubbish collection, and sewage cleaning. Much of the work available to migrants has greater risk for workplace-based, occupational injuries. Additionally, the living environment of many migrants can greatly increase their vulnerability to illness, infections, and other health problems. Pressure from families to earn greater income, coupled with periods of unemployment and strong competition for work, affects the mental and physical health of many internal migrants. This is exacerbated by isolation and loneliness, stigma and discrimination, and a lack of affordable leisure activities. The crowded and unhygienic accommodations, poor selection of nutritious food, and expensive health care, can lead to weakening health and poor treatment. The reliance on social networks and increased exposure to unprotected sex and drugs can also result in greater vulnerability to a variety of infections, including HIV, hepatitis, and sexually transmitted infections. As many migrants do not have permission for long-term residency in urban areas, they often live in temporary housing and work in the informal sector where they are not provided preventative services and health information. The lack of residency also influences their access to medical services and affordable care, and the nature of their work often means that they do not have health facilities

[8] The Vietnamese government reports labor migration figures annually, but these number were reported by IOM's 6 January 2012 Press Briefing - http://www.iom.int.vn/joomla/index.php?option=com_content&task=view&id=281&Itemid=294

at their workplace, or services that are available at times and locations when they can use them. Mental-health care services are not available as they are they are extremely limited in Vietnam, and particularly for migrants who are not supported by their employer to seek treatment.

Vulnerability is not the same for all migrants, however, and migrants are affected differently based on the nature of their migration and residency. There are two primary channels of internal migration in Vietnam: organised and individual migration.

Organised (inter-province) migrants

The government facilitates officially arranged internal migration, and provincial governments and state-owned enterprises will make agreements to arrange for migrants at specific workplaces. Many of these migrants are rural-rural migrants, where they migrate from one rural area to another rural area to work on a cash crop, such as coffee or cashews. As these migrants have contracts and support mechanisms, and generally work in environments with accommodations, insurance, and health facilities, their vulnerability is relatively low.

Individual migrants

Sometime referred to as spontaneous or free migrants, these migrants often rely on social networks to identify potential work and make their own arrangements for their travel and employment. Since the mid-1990s, individual (or spontaneous) movement has replaced organised migration and comprise the largest group of migrants.[9] While some of these migrants are able to find employment in large factories in industrial zones and urban areas, and access the same conditions as organised migrants, many others seek work in informal settings with no support, insurance, or services. Vulnerability differs amongst migrants based on the type of migration. Short-term migrants tend to find jobs related to agricultural work and return to their home community after several months; whereas long-term migrants tend to be younger and not own land, allowing them to move from their home communities permanently. While some individual migrants find professional work in offices, schools, and enterprises, most lack adequate education and experience. As these long-term unskilled and semi-skilled migrants tend to find work in restaurants and coffee shops, construction, and factories, and entertainment (including karaoke bars, massage parlours and prostitution), their vulnerability is often higher.

[9] Hardy 2000. Hardy, A. (2000). 'Agricultural colonisation in Lam Dong province, Vietnam.' Special issue on migration, markets and social change in the highlands of Vietnam, *Asia Pacific Viewpoint* 41(1)

In addition to the two channels of internal migration, vulnerability also depends on the migrants and the type of work and livelihood available to them. Vulnerabilities of internal migrants in Vietnam often include the following factors and determinants:

Women

Initially the vast majority of migrants were men seeking employment in male-dominated sectors, such as construction. Over the past decade, however, this has changed considerably and now over half of internal migrants are women.[10] Although many women migrants are successful in finding work in factories or other formal employment, many others have difficulties finding work, especially as they are discriminated against for being women and for being migrants. This can lead to women finding work as domestic workers or rubbish collectors which can lead to being more exposed to greater risks. Women migrants often have greater vulnerability to health issues, as family obligation and pressure to increase household income is particularly strong on women, making it difficult to be selective in choosing work or leaving when conditions are dangerous or risky. Some women migrants have greater risk to sexually-transmitted infections and reproductive-health conditions, due to greater unprotected sex with more sexual partners. Women may also have increased vulnerability as they can be exposed to violence by colleagues and when travelling between their workplaces and their accommodations.

Youth

The majority of migrants are youth (15-24 years).[11] As youth are disproportionality affected by violence, mental-health conditions, and sexually transmitted infections, young migrants are even more vulnerable when lacking adequate information to protect themselves and access to health-care facilities.

Workers in dirty, dangerous and difficult jobs

The dirty, dangerous and difficult (or demeaning) jobs (3D jobs) are often the most available work for migrants. As the nature of the work is low paid and risky, these workers are more exposed to occupation hazards and risk. These migrants generally do not have contracts or insurance. It is

[10] Hardy 2000. Hardy, A. (2000). 'Agricultural colonisation in Lam Dong province, Vietnam.' Special issue on migration, markets and social change in the highlands of Vietnam, Asia Pacific Viewpoint 41(1)

[11] The majority of migrants being youth is raised in numerous sources and can be found in the UN document 'Internal Migration: Opportunities and challenges for socio-economic development in Viet Nam' from 2010

especially difficult to access health care for low-paid migrants, even though their work places them at greater risk.

Sex workers and drug users

Sex workers and drug user comprise a particularly vulnerable category of migrants. Many become migrants when attempting to remain unnoticed by the police and authorities. Their fear of arrest and detention make them difficult to reach with health prevention and information, and they may be reluctant to use government services. Many sex workers have unprotected sex with multiple partners, increasing their risk to HIV and sexually transmitted infections. Many drug users share syringes and have fuelled the HIV epidemic in Vietnam.

Victims of trafficking

Human trafficking occurs within the internal and international migration process, and many cases of trafficking occur during the search for employment opportunities. Once trafficked, the would-be migrant usually loses their power to protect themselves or have control of their lives. Vulnerability for sexually transmitted infections, HIV, violence and mental-health conditions, therefore, is very high.

Mobile populations

Although not migrants, people working in employment requiring regular travel have many of the same vulnerabilities as migrants. Mobile populations include bus and truck drivers, assistants on buses and trucks, sales staff, military, and traders. As they are often away from their family and home community, and have access to sexual services and casual sex partners, they can be more vulnerable to HIV and sexually transmitted infections. Additionally, it is difficult to access health care services away from their homes.

Professionals, students

Not all migrants are unskilled and un-educated. Many migrate to become students and to take on professional positions with companies, government offices, and state-owned enterprises. Although these migrants generally have accommodations, income, and health insurance, their vulnerability can change due to being in a new environment with different social networks, and exposure to a variety of entertainment, including sex-related services.

International migrants from Vietnam tend to be more uniform than internal migrants, as many are recruited through government-managed agencies that arrange employment, contracts, and travel. The primary types of international migrants include:

Regular migration

Migrants who have their employment opportunities arranged through recruitment agencies tend to travel safely and have sponsors in the host countries. While much of the vulnerability is reduced through these arrangements, these migrants are still vulnerable due to the lack of language skills, the working conditions in many countries, and the level of debt they incurred to pay the various recruitment fees. Many migrants are expected to work multiple shifts without days off and little access to medical facilities, and lack negotiation options when employers retain their passports and threaten not to pay salaries. Although pre-departure orientation and training is required, many migrants depart without adequate knowledge or skills. Migrants using regular channels may encounter greater vulnerability if they arrange their own contracts, visas, and travel and do not have support. Health insurance is generally provided to labour migrants working on government-arranged contracts, and regular migrants making their own arrangements often lack insurance.

Irregular migration

Accurate data are not available on Vietnamese migrants using irregular channels in the region, but China, Laos, and Hong Kong have all reported a growing number of migrant workers. China has increasingly become a destination as undocumented migrants are able to work at half the Chinese minimum wage, but still make considerably more than in Vietnam.[12] Migrants using irregular channels can be vulnerable as they have no legal support, and are easily exploited. Additionally, they often have poor language skills, lack social networks, and have increased disposable income. Globally, irregular migrants are the most vulnerable as they live with the risk of arrest and deportation. This is often exploited by employers who require migrants to work long hours with little or no pay. Irregular migrants generally avoid government health and social services for fear of being reported and often seek health care only when medical problems are very serious.

[12] According to the South China Morning Post (23 April 2010) "Workers at the factory say that the Vietnamese have often comprised 10 per cent of its 1,000-strong workforce."

Other international migration

There are many reasons for international migration that are not associated with labour. These include marriage, education, family, and health care. The levels of vulnerability depend on social networks, advanced planning, and country of destination. Marriage-related from Vietnam has been a particular migration issue. According to IOM, 133,000 Vietnamese women married foreigners between 2005 and 2010.[13] While most of these marriages have positive outcomes, the media has reported numerous cases of abuse, exploitation and trafficking, as well as suicide.

Returning migrants

The health of returning migrant workers is not often included in health systems planning or services. Pre-departure training and information, and increasing support for labour migrants while working in host countries is increasing, but identifying health concerns and providing necessary services on their return is rarely provided. Labour migrants will likely have had some form of health-care while abroad, but there are numerous reports of employees over-working migrants and not providing time or facilities for medical treatment. Migrant workers who used irregular migration channels are often more vulnerable, which can result in requiring greater health-care support when returning. For all migrants, their return is not supported with targeted services for their specific health needs and, at best, are provided with general health information. When they return to their home community, the health services often have no experience with migration and may not recognise health issues in light of the migration process. For many migrants, their next contact with a medical professional may be during a pre-departure exam for a new contract.

The Vietnamese health system has made considerable progress over the past 20 years developing a strong, functioning health system in a period of dramatic economic change. While many tertiary hospitals are well equipped with qualified personnel, health-care facilities at all administrative levels are being pushed beyond their capacity with overcrowding, insufficient numbers of health staff, inadequate salaries, and health staff involvement in the private sector. These constraints affect the quality of care for all patients, but migrants are particularly affected as they often lack insurance and residency, and health staff are not aware of the particular health concerns and needs of migrants.

[13] This figure was reported on the IOM website - New Study on Vietnamese Migration Shows Increasingly Diverse Migration Trends - http://www.iom.int/cms/en/sites/iom/home/news-and-views/press-briefing-notes/pbn-2012/pbn-listing/new-study-on-vietnamese-migration-shows.html

2.2. Advancement towards the Resolution of the "Health of migrants" in Vietnam

The Government of Vietnam began to review and assess its strategy towards the Resolution on the "Health of migrants" in 2010 and has implemented several activities to collect data and information and determine an effective approach to migrant's health. Although there has not been national policy and programme efforts to specifically achieve the resolution, the context of migration in Vietnam can be viewed using the principles of the Resolution on the "Health of migrants" (and consolidated by the Madrid Consultation) to establish the current situation and to review the progress towards the resolution.

2.2.1. Monitoring migrants' health

Incorporating the following two principles of the Resolution on the "Health of migrants":

- Establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- Gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination.

Migrants are not specifically included in any surveillance or health monitoring activities. Internal migrants are often not living at their registered residency and are not included in national or local surveys, or the national census resulting in a lack of understanding about migrant health and services for migrants. Pre-departure medical exams are performed for international labour migrants, but the results are not collated into a migrant-health profile to support future training or programming. Additionally, there are no post-return medical exams to determine if health status changes during the labour migration process or if labour migrants need additional health-related support.

2.2.2. Policy and legal frameworks affecting migrants' health

Including the following principle of the Resolution on the "Health of migrants":

- Promote migrant-sensitive health policies.

Political will to ensure the health of migrants, and to support the resolution on the health of migrants, can be determined by the development of national laws and policies that ensure access to health services and information, and the enforcement and implementation of laws and policies.

Vietnam has demonstrated political will through a number of policies and laws that include, or affect, migrants, but most were issued prior to the resolution. Although laws specifying migrants largely address labour migration, recognition of internal migrants can also be seen in the inclusion of migrant of more recent legislation. The policy and legal framework related to migrants' health can be seen in terms of internal and international migration.

Internal migration

Vietnam has numerous laws and policies that affect health care and access to health services. Most notably, the two laws affecting internal migrants are the law on residency and the law on health insurance. In both cases, these laws tend to be more restrictive than protective and make access to health services more difficult.

Laws related to mobility and residency have been amended over the past 25 years, opening the possibility for internal migration. Prior to 1993, any movement from the place of residence had to be approved by local police. These laws greatly restricted internal travel, and over 80 per cent of the Vietnamese population lived in rural communities. When these restrictions were lifted early 1990s, there became opportunity for internal travel and migration and large numbers of migrants entered major urban areas. The law on residence (passed in 2006,), however, still restricts the ability to move residence, forcing most migrants to live in urban areas without permission and without access to affordable public services.

The law on health insurance affects internal migrants' access to health services. With over 50 million people insured in Vietnam (approximately 60% of the country's 85 million population), health insurance is widely used and has an important role in the provision of health-care services. There are, however, restrictions in the use of insurance and attending higher-tiered hospitals or hospitals in other localities than the place of residence is only supported with referral or paying costs without insurance reimbursement. This is reinforced by the State Budget Law, which decentralises budget expenditure to the provincial level.

As insured migrants are generally unable to return to their homes to access the health-care system, they often need to pay for services that would have otherwise been covered by health insurance. Additionally, many migrants working in the informal sector are not insured through their employment and cannot afford, or do not pay for, the insurance premiums. Perceived, or anticipated, stigma and discrimination also requires many migrants to go to private doctors or self-medicate at pharmacies.

Increasingly, laws and policies have acknowledged internal mobility. In 2006, the Ministry of Transport developed guidelines on health care and HIV control and prevention for the workforce of transportation construction projects. These were developed in cooperation with MOH. The 2006 'Law on HIV/AIDS Prevention and Control,' for example, does not have provisions to provide care and treatment specifically to migrants, but does specify that migrants and mobile populations can be more vulnerable to HIV and must be included in HIV-related health prevention activities. The law states "People's Committees of communes, wards or townships shall be responsible for organizing propaganda about HIV/AIDS prevention and control among new residents coming from other areas," and that mobile populations, and other vulnerable populations will be given priority access to information, education and communication on HIV prevention. There are no specific guidelines on reaching migrants, however, and no national programmes or budget are in place to ensure migrants are provided preventative activities. Additionally, while the law recognizes greater vulnerability amongst migrants, there are no provisions for the treatment of HIV for migrants.

Vietnam adopted an international agreement related to the health of migrants initiated by the International Labour Organization titled 'Recommendation Concerning HIV and AIDS and the World of Work,' which calls for the delivery of workplace safety and health, and HIV prevention, treatment and care to all workers and their families, and in all labour forms or arrangements including formal and informal sector workers, sex workers, migrant workers and people in the uniformed services.

International migration

Laws and policies related to international labour migration specifically target migrants, but most focus on labour rights and obligations of migrants and the agencies involved in recruiting and deploying migrants. The Ministry of Labour, Invalids, and Social Affairs (MOLISA), the Ministry of Finance, and MOH developed a joint circular in 2004 specifying the procedures for medical exams for labour migrants, and the Law on Vietnamese Guest Workers (developed and approved by the National Assembly in 2006) requires migrants have medical exams and health certificates. MOLISA's 2007 Decision on pre-departure training for Vietnamese migrant workers included the need to include HIV.

In 2007, the Prime Minister's office issued the Decision on 'Mechanism for Collaboration on Cross-border HIV/AIDS Prevention and Control.' This decision detailed the responsibilities of ministries, sectors, and People's Committees, at all administrative levels, for collaboration with bordering countries and for implementing cross-border agreements and services, such as counselling, testing,

care, and treatment along border areas. Although this decision focused on the bi-lateral cooperation, the intent was to improve the health of migrants by creating an enabling environment in border areas.

In addition to Vietnamese laws and policies, Vietnam has also adopted regional and international agreements related to the health of migrants. These include the Association of Southeast Asian Nations (ASEAN) 2007 Declaration on the Protection and Promotion of the Rights of Migrant Workers, where the health of migrants falls under the obligation 'Promote fair and appropriate employment protection and access to decent working and living conditions.' ASEAN has discussed the health of migrants as a component of promoting migrants' rights. The Declaration on the Protection and Promotion of the Rights of Migrant Workers does not specify migrant health, but has a principle stating, "Intensify efforts to protect the fundamental human rights, promote the welfare and uphold human dignity of migrant workers." The ASEAN "Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths" also includes migrants as a vulnerable population. The Fifth ASEAN Forum on Migrant Labour in 2012 included recommendation ensuring the human rights of labour migrant, addressing the vulnerabilities of migrants, and promoting transparency, accountability and affordability. The November 2012 ASEAN Human Rights Declaration specifies migrant workers as an integral and indivisible part of human rights and fundamental freedoms.

2.2.3. Migrant-sensitive health systems

Incorporating the following four principles of the Resolution on the "Health of migrants":

- 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;
- Devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
- Raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
- Train health professionals to deal with the health issues associated with population movements.

As national policies do not specifically support or include migrants and, in some cases, restrict access to services, health facilities and providers have not been developed to ensure non-judgemental, supportive services. Government services are generally placed in locations that are not convenient

for migrants, and many migrants cannot take time out of their day to seek health care because of the nature of their work. Often services are closed when migrants are able to leave work. Private services and pharmacies are more convenient for migrants, but tend to be more expensive and the quality of services is varied. Stigma, and self-stigma, often prevents migrants from accessing services.

Although contracts for labour migrants are required to include the provision of health care, international migrants do not have a guarantee to health facilities and services. Some have reported quality service and straightforward access, whereas others reported no services and not being able to take time to access medical services. The Vietnamese government is often unable to ensure access to services when arranging labour migrant contracts and agreements. Labour migrants returning to Vietnam are not provided specialised services related to their time as labour migrants.

2.2.4. Networks, partnerships and multi-country frameworks on migrant health

Including the following principle of the Resolution on the "Health of migrants":

- Promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process.

Within Vietnam, MOH has a strong network of partnerships with various international and national organisations. In the past five years, the Government of Vietnam became an integral partner of the One UN Initiative. In the Vietnam model of the One UN, the UN agencies came together to deliver as one system under one structure, and the Vietnamese government then became a partner with equal planning and decision-making responsibilities. Since 2009, two of the One UN Programme Coordination Groups have partnered directly with MOH to address various health issues, and HIV. Additionally, migration issues have also been raised with MOLISA, the Ministry of Foreign Affairs, and the Ministry of Planning and Investment. Migrants, and migrant health, have been included in assessments on human development and migration, research on trafficking, and pilots on migrant resource centres and interventions with migrant drug users. The One UN supported the Vietnamese Government in using the census to disaggregate migrant data and draft a series of monographs, and a development paper titles "Internal Migration and Socio-economic Development in Viet Nam: A Call to Action."

Vietnam has been an active participant of various regional and international networks and consultative processes. With the exception of JUNIMA, none of these regional consultative

processes, regional networks, and regional frameworks specifically address the health of migrants. They do, however, provide a regular venue for discussion and dialogue and have been used to raise health issues. Participants of these networks and collaborative partnerships from the National Assembly and the Ministries of Foreign Affairs, Labour, Health, and Transport indicate that while most do not produce binding resolutions and declarations, they have greatly supported the development of policy and programming in Vietnam. Some of these networks and process include the following:

- Abu Dhabi Dialogue - Ministerial Consultations on Overseas Employment and Contractual Labour for Countries of Origin and Destination in Asia;
- ASEAN - Association of Southeast Asian Nations ;
- APC - Inter-Governmental Asia-Pacific Consultations on Refugees, Displaced Persons and Migrants;
- Bali Process - Bali Ministerial Conference on People Smuggling, Trafficking in Persons and Related Transnational Crime;
- Colombo Process - Ministerial Consultation on Overseas Employment and Contractual Labour for Countries of Origin in Asia;
- COMMIT - The Coordinated Mekong Ministerial Initiative Against Trafficking;
- JUNIMA - Joint UN Initiative on HIV/AIDS in Southeast Asia.

3. IDENTIFICATION OF CONCLUSIONS, PRIORITIES, AND POINTS FOR DISCUSSION

Despite efforts to ensure the health of all Vietnamese, and an increasing recognition of the distinct health needs of migrants, there remain areas where further advancements could be made in addressing the health of migrants and achieving the Resolution on the "Health of migrants."

3.1. Monitoring migrants' health

There is no mechanism to collect migrant-specific health data for internal migrants. Even the national HIV monitoring framework, which was developed with the understanding of the vulnerability of migrants, did not include migrant and mobile populations. This results in a lack of understanding about migrant-health priorities, access to services, and further isolates migrants. Although pre-departure medical exams are performed on labour migrants going overseas, the data from the exams are not used in pre-departure orientation or planning. Data and medical information on returning migrants are not collected, preventing an analysis of how the labour migration process affects the health of migrants. According to the World Health Organization (at their annual regional meeting in Hanoi in September 2012,) the lack of funding to monitor migrant patterns could result in worsening the spread of drug-resistant malaria, as resistance can spread due to widespread migration across borders and internally within Vietnam.

Points for discussion:

- Current data on internal and international migration and mobility trends and situation should be the foundation for the development of laws and policies affecting migrants;
- Migrants and mobile populations should be incorporated into national and local data-collection activities to determine use of services and access to information;
- The experience developing the Vietnam National Monitoring and Evaluation Framework for HIV Prevention and Control Programmes and indicators, and other relevant surveillance, should be applied in incorporating migrants and mobile populations into national data collection.

3.2. Policy and legal frameworks affecting migrants' health

Few laws and policies on health specifically include or identify migrants, particularly internal migrants. Migrants and mobile populations continue to experience difficulties accessing treatment and care as a result of their mobility, long working hours, location of work sites, and lack of official residency. Although the laws and policies apply to all Vietnamese citizens, laws on residency and

insurance can restrict migrants from utilising services if they do not return to the community where they are registered. For many migrants, taking the time and money to return is not possible, as they would lose their job or the opportunity to find work. Due to the requirements on residency and the lack of recognition of migrants who do not register residency changes, current policies and laws will continue to exclude the growing number of internal migrants.

When laws and policies do include migrants and mobility, the implementation and enforcement of the laws is not consistent. The HIV law is the only health-related law that specifically includes migrants. According to the 2012 report by the Vietnamese government to the United Nations General Assembly Special Session on HIV/AIDS, there are examples where implementation does not follow the HIV law.[14] These include:

- "While it is not official policy, there have been reports of PLHIV [people living with HIV] having to provide their identity card and proof of household registration before they can access treatment and there is the perception among PLHIV that this is the official policy";
- "Provincial budgets and services are planned using the household registration system. Therefore, migrants and mobile populations are often not included in local HIV plans and/or may need to pay more for services";
- "There are provisions regarding HIV prevention for mobile people, particularly for mobile people who are employed; however, there are no provisions for non-discrimination and the protection of mobile populations who are not employed";
- "As residency in the district of a treatment centre is one of the eligibility criteria for the current national pilot methadone maintenance therapy programme, migrants without official residency are not able to access these services."

The Vietnamese media has reported discrepancies between the laws and enforcement. Research conducted between MOH and IOM[15] highlights an article in the Vietnamese newspaper "Bao Moi" in 2012, reporting on health insurance for children. According to the article, a government decree rules free health insurance for children under six years old. Although this includes the children of migrants, Ho Chi Minh City reports many cases of children without residence being refused insurance. According to the article the local Department of Labour, War Invalids and Social Affairs (DOLISA) ruled that only individuals with long-term residence are eligible to apply.

[14] Viet Nam AIDS Response Progress Report. National Committee for AIDS, Drugs, and Prostitution Prevention and Control. 2012

[15] MOH and IOM conducted research on the situation of migrants' health and policies in Vietnam in 2012 as a component of the process of assessing progress towards the resolution on migrants health.

Laws on international migration are not always well enforced due to a lack of capacity of responsible stakeholders, a lack of understanding of the law, and the lack of influence and staff in countries where Vietnamese labour migrants have gone to work. For example, the Law on Vietnamese Guest Workers states that enterprises arranging and managing labour migration have various responsibilities, including:

- To ensure working conditions, living conditions and social insurance for workers under the laws of Vietnam and the country where they work;
- To ensure that workers have regular health checks and medical examination and treatment when they are sick or meet with accidents.

As stated in the research between MOH and IOM, "even though the law regulates the responsibilities of labour export agencies in managing and protecting the rights of the workers, serious violations to the health of the workers have happened in the process. The conditions to ensure the rights of the workers such as health insurance and social insurance based on the law were also not paid adequate attention." Migrants who have government-arranged contracts are required to have health insurance, but many migrants who make their own arrangements lack access to insurance. In many cases, the labour attaches, consular staff, and other government officials in embassies and diplomatic offices, are not aware of the law and when cases arise in foreign countries, they are generally not reported back to recruitment enterprises and government in Vietnam.

The coherence of policies[16] related to internal and international migration between ministries and departments is weak as policies are developed without consultation with other ministries. For MOH, this may be largely due to not allocating responsibility for migration and mobility to any department within the ministry. Additionally, there is no government ministry responsible for internal and international migration. Policies that affect the health of migrants are largely related to international labour migrants pre-departure medical exams and training issued by MOLISA, of which some include the following:

- Decision 18/2007/QĐ-BLĐTBXH dated 18/7/2007 on curriculum for pre-departure capacity for labourers;

[16] Policy coherence is defined by the OECD as the systematic promotion of mutually-reinforcing policy actions across government departments and agencies creating synergies towards achieving the agreed objectives. Within national governments, policy coherence issues arise between different types of public policies, between different levels of government, between different stakeholders and at an international level.

- Decision 19/2007/QĐ-BLĐTBXH dated 18/7/2007 on regulations of the operation and mechanism in sending Vietnamese workers overseas and specialized units in providing pre-departure training for labourers;
- Decision 20/2007/QĐ-BLĐTBXH issued on 02/8/2007 on the issuance of the Certificate of Completion of pre-departure basic knowledge for workers.

The Ministry of Transport requested the support of the Ministry of Health when issuing an "Official Letter No. 1695/BGTVT-CGD" on the implementation of health care and HIV control and prevention programmes among the workforce of transportation construction projects. This demonstrated the value of having MOH input in the Ministry of Transport's policy development and the potential for greater inter-ministerial collaboration.

While the HIV-related policies and laws have greater inclusion of migrants and mobile populations, other strategies that do not specify migrants include the 2011 "National Nutrition Strategy," and the "Comprehensive Development Design for Health Systems." The "National Five Year Health Sector Development Plan (2011-2015)" does highlight the increasing numbers of migrants and makes the provision of services for family planning and reproductive health for them.

Policy of MOLISA requires pre-departure training for labour migrants, with information on health (prevention and treatment), but according to studies with migrants, the training is inadequate and does not include the specific situation of the country they are going to. HIV was not included in the pre-departure training except for pilot projects. Pre-departure training makes efforts to include relevant cultural information and language skills, but the quality of the pre-departure training has been documented as not adequate or sufficient. Although pre-departure training includes relevant language and culture, reports of the weakness of Vietnamese labour migrants include the fact that foreign language skills are poor.[17]

Points for discussion:

- Frameworks and monitoring indicators should be developed to determine the effectiveness of laws and policies that include or affect internal and international migrants;
- Models and standards for migrants' health should be based on effective practices from within Vietnam, as well as the region and globally;
- Each ministry with responsibilities related to migration should have a migration focal point;

[17] www.qdnd.vn/army/vietnam.economy.Qutstanding-activities.5522.qdnd

- One of the existing departments at MOH should have responsibility for migration and mobility;
- One government ministry should have overall responsibility and coordination for migration (internal migration and mobility and regular and irregular international migration, and immigration);
- A government working group on migration should be formed with all relevant ministries to integrate an inter-agency approach to review the situation of migration and plan for services and programmes to ensure protection and ensure adequate capacity and knowledge;
- Social-protection and health policies should specifically include internal and international migrants (as seen in the HIV law,) to ensure access to health care and prevention, and health insurance;
- Government ministries, law and policy makers, and decision makers MOH should coordinate with MOLISA to incorporate the health of migrants into national labour and migration policies;
- Migrant-specific policies should be developed to address the specific needs of vulnerable migrants, (such as the Prime Minister's 2007 Decision titled "Decision on Mechanism of Collaboration on Cross-Border HIV/AIDS Prevention and Control");
- The national health insurance scheme should include an opportunity for labour migrants to contribute while working overseas, so they have access while they are abroad and on their return to Vietnam.

3.3. Migrant-sensitive health systems

There are no national policies or government health services that ensure the inclusion of internal migrants. Migrants continue to have difficulties accessing health-care services, or believe that they cannot access them. For many migrants, their lack of official change in residency places restrictions on using their insurance policy, if they have one. Many migrants report they generally are not able to take the time and resources needed to return to their home province to access services. There have been small-scale efforts to address health and migration; most notably, ensuring TB treatment for internal migrants in Ho Chi Minh City. Health staff are not trained in migration issues and the importance of including migrants in health-care services, which contributes to stigma and discrimination at health facilities. Where laws and policies have included migration and mobility, such as the Law on HIV/AIDS Prevention and Control, enforcement and implementation is weak and many responsible government authorities are not aware of their role and responsibilities related to the law. As seen with the Law on HIV, relevant national programmes have not been developed ensuring HIV prevention reaches migrants and mobile populations.

Points for discussion:

- It should be recognised that many migrants lack official residency where they are living, and efforts are still necessary to ensure they have access to health care and preventative services. Committed efforts to address mental health, sexually transmitted infections, TB, HIV, and other health concerns that may affect migrants at their destination location should be developed;
- Migration and mobility should be included in continuing education and training for doctors, nurses, and management staff of health facilities;
- Health-insurance schemes should be established that are not dependent on residence, and which account for short-term, cyclical, and long-term mobility and migration;
- Migrant-friendly facilities should be included when renovating and replacing antiquated hospitals and health centres. These would include health staff with training on migration, services that are provided regardless of residency, facilities convenient to migrants, and the provision of information relevant to migrant health needs;
- Health services should be made accessible that are available at times migrants are not working and in locations where migrants work, while not establishing a parallel health system for migrants;
- Migrants should be incorporated into the health-care system as community health workers and advisors. Trained labour migrants should also support the pre-departure training to ensure migrants have relevant knowledge and skills. When migrants of different ethnicities use services and facilities, efforts should be made to provide services with appropriate languages, with migrants from those ethnicities involved in service delivery;
- Partnerships with private-sector service providers should be developed to expand services and to support experience and information sharing with services supporting migrants;
- Ministries with responsibilities towards migrants should regularly coordinate to ensure adequate health services are available for labour migrants through labour migration agreements and contracts;
- Returning migrants should be offered voluntary and free health checks to identify health needs that may be missed by migrants and health services. (Data from these medical exams should be used in monitoring migrant health to determine the health needs of migrants, and to compare to pre-departure data to determine health risks while abroad.) These medical exams are particularly important to ensure medical conditions and infections are identified while labour migrants can still access health insurance schemes provided for their work overseas.

3.4. Networks, partnerships and multi-country frameworks on migrant health

The Government of Vietnam has been active in regional networks, partnerships and multi-country frameworks on mobility, labour migration, human trafficking, and HIV. Participation in these networks has included MOH, MOLISA, the Ministry of Transportation, and the Ministry of Foreign Affairs. While there has been regular government attendance and involvement, there remain gaps in the achievements of this participation. Many of these networks, such as the Colombo Process and the Bali Process, are designed for information sharing and do not include binding declarations

requiring national-government involvement. At times when governments try to use these networks to advance specific issues, involvement from other country governments is not assured. In the case of Pakistan using the Colombo Process to improve the protection and health services for labour migrants, many of the other countries did not participate. For these networks to advocate and change protection and services for migrants, the active involvement and collaboration of country governments is essential.

Another gap in successfully achieving the results agreed on in regional networks is national implementation. For example, the 2001 'Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement' within the JUNIMA framework included a commitment to allocate one per cent of construction costs to fund HIV prevention initiatives, especially when the infrastructure-project budget did not adequately fund HIV programming. The 2011 Memorandum of Understanding (MOU) also included strengthening HIV policies and services for migrant and mobile populations, including some of the following:

- Support improving policy environment and facilitate the development and adoption of legislations to reduce HIV vulnerability, stigma & discrimination, and promote access to prevention, treatment, care and support by improving systems of governance on development related mobility;
- Promote community-based development approaches using people-centered approaches by empowering communities affected by development-related mobility to prevent HIV infection;
- Enhance information dissemination, education and behavior change communication in HIV prevention for the community of migrants and mobile populations;
- Support strategies that ensure access to comprehensive HIV prevention, treatment, care and support for migrant and mobile populations.

These agreements, and the policy to allocate one per cent of the budget, have not been further developed since the signing of the MOUs and the regional strategy.

Points for discussion:

- Migration-health dialogues and cooperation within Vietnam across sectors and among key cities, regions and countries of origin, transit and destination should be developed and strengthened;
- Partnerships with the One UN, NGOs, and civil society organisations should be further developed and strengthened to acquire further global experience, obtain support from a variety of expertise and technical knowledge, and access financial support for targeted objectives that may have not been allocated in the ministry's budget;

- Regional networks and consultative processes should be utilised to gain greater leverage to advance issues and strengthen protection;
- Local, regional, and international migration dialogues and processes should be used to support government efforts in coordinating and harmonizing policies and regulations related to health and the determinants of health for migrants;
- Cooperation amongst ministries should be strengthened to ensure migrant-health matters are included in global and regional consultative migration, economic and development processes;
- The inclusion of migrant-health needs in existing regional and global funding mechanisms should be promoted.

ANNEX ONE

List of relevant resources related to the Resolution on the "Health of migrants", public-health approaches to migrant health, Vietnamese policies, declarations, and tools.

Vietnamese laws, policies, and plans

Agreement on the project Health care and HIV/AIDS control and prevention program for the workforce of Transportation construction projects. No. 6636/BGTVT - CGD. Ministry of Transportation. 2006

Decree on regulation and guidance on the law for overseas workers (126/2007/ND-CP). Government of Vietnam. 2007

Decision on mechanism of collaboration on cross-border HIV/AIDS prevention and control. No. 38/2007/QD-TTg. Prime Minister Decision. 2007

Five-Year Health Sector Development Plan 2011-2015. Ministry of Health. 2010

Law of Health Insurance (25/2008/QH12). National Assembly. 2008

Law on HIV/AIDS Prevention and Control (No. 64/2006/QH11). National Assembly. 2006

Law of Medical Care and Treatment (40/2009/QH12). National Assembly. 2009

Law for Overseas Workers (72/2006/QH11). National Assembly. 2006

Law on Prevention and Control of Infectious Diseases. No. 03/2007/QH12. National Assembly. 2007

Law on State Budget. (1/2002/QH11). National Assembly. 2002

Regional declarations and commitments

The 5th ASEAN Forum on Migrant Labour: Recommendations. ASEAN. 2012

ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths. ASEAN. 2011

ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers. ASEAN. 2007

Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement in the Greater Mekong Sub region. 2011

Bangkok Statement on Migration and Development. Outcome document of the Asia-Pacific Regional Preparatory Meeting for the Global Forum on Migration and Development 2010.

The Dhaka Declaration. (Declaration of Colombo Process Member Countries.) The Colombo Process. 2011

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”Agricultural colonisation in Lam Dong province, Vietnam - Special issue on migration, markets and social change in the highlands of Vietnam.” Andrew Hardy. Asia Pacific Viewpoint 41(1). 2000

“An Assessment of Principal Regional Consultative Processes on Migration.” IOM Research Series. No 38. IOM. 2010

“Asian Labour Migrants and Health: Exploring Policy Routes.” Jaime Calderon, Barbara Rijks and Dovelyn Rannveig Agunias. IOM. 2012

“Baseline research on improving capacity and life quality for migrants.” Asia Foundation. 2010

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“Internal Migration and Socio-economic Development in Viet Nam: A Call to Action.” United Nations Viet Nam. 2010

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“Mandatory HIV testing for employment of migrant workers in eight countries of South-East Asia: From discrimination to social dialogue.” ILO. 2009

“Practice Guidelines for Harmonizing HIV Prevention Initiatives in the Infrastructure Sector: Greater Mekong Subregion.” Asian Development Bank. 2010

“Sex Work and Mobility from A Gender Perspective: Findings from Three Cities in Viet Nam.” MOLISA. 2012

"Viet Nam AIDS Response Progress Report." National Committee for AIDS, Drugs, and Prostitution Prevention and Control. 2012

"Vietnam Population and Housing Census 2009." Migration and Urbanization in Vietnam: Patterns, trends and differentials. Ministry of Planning and Investment. General Statistics Office. 2011

"Vietnam Urban Briefs." No.1. World Bank. 2012

"Vietnam Urbanization Review: Technical Assistance Report." World Bank. 2011