SOCIO-CULTURAL INFLUENCES on the reproductive health of migrant women

A REVIEW OF LITERATURE IN VIET NAM

UNFPA

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Aidan Dockery / UN Viet Nam

Foreword

Socio-economic development resulting from the *Doi Moi* reforms in Viet Nam has resulted in increased internal migration as people have moved away from their places of origin in search of economic opportunities. According to the 2009 Population and Housing Census, 6.6 million people changed their place of residence between 2004 and 2009, a significant increase from the 4.45 million captured in the 1999 Population and Housing census. Women are increasingly represented in the internal migrant population; most of them are young. These women primarily seek employment in industrial zones and factories, in the 'entertainment' sector and as domestic workers. Many of those who are unable to find formal employment resort to sex work as a means of earning an income.

A concern regarding migrants in Asia, including Viet Nam, is with respect to the neglect of their rights, including rights to access reproductive health information and services. Barriers to accessing services are frequently institutional, exposing migrants to greater risk of illness than non-migrant people and often excluding them from formal medical systems. At the same time, socio-cultural factors play a part in influencing the behaviour of migrant women, as well as their access to reproductive health services.

To gain a better understanding of the links between socio-cultural factors and the reproductive health of migrant women, UNFPA Asia Pacific Regional Office commissioned literature reviews in four Mekong sub-region countries – Cambodia, Lao PDR, Thailand and Viet Nam. This report documents the findings of the Viet Nam review and makes recommendations on how policy makers, employers and service providers could better address the reproductive health needs of migrant women.

For many women, moving to another part of the country is disruptive. Lack of familiarity with new locations, less access to traditional support systems, exposure to different lifestyles and influences, and vulnerability to exploitation and abuse are some of the factors that impact on migrant women's health. This report describes social and gender norms in Viet Nam that define women's roles in society which frequently impact on their ability to access reproductive health information and services. Traditional values and beliefs influence their health seeking behaviour. Negative service provider attitudes compound the difficulties many migrant women face in accessing services.

Building on work already started by the United Nations in Viet Nam to promote the rights of migrants, the recommendations of this review will contribute to commitments articulated in the *One UN Plan 2012-2016* to support the Government of Viet Nam to improve access to quality essential services and social protection, particularly for most vulnerable and disadvantaged groups, which includes migrants. The review synthesizes the findings and experience of development partners working with migrants in Viet Nam, enhancing our knowledge of the challenges such women face in trying to access reproductive health information and services, and documenting culturally sensitive approaches that appear to have had been successful in helping them to realize their rights.

I hope that the findings will be useful in informing future policy and service provision.

Bruce Campbell
UNFPA Representative, Viet Nam

Executive Summary

This paper reflects a review of available literature from nearly two decades identifying how socio-cultural factors positively or negatively influence the sexual and reproductive health of internal female migrants in Viet Nam. The United Nations Population Fund (UNFPA) commissioned the review as a way to explore how such factors affect the sexual and reproductive health choices of migrant women, with a view to identifying how to improve service provision for these women, many of whom are considered to be vulnerable to reproductive health problems. It is one in a series of reviews of the situation in four Mekong countries, which also covers Cambodia, Lao People's Democratic Republic and Thailand. Additionally, the review examined both the barriers and enabling factors influencing access to reproductive health information and services, and aimed to identify good intervention models for reaching female migrants.

Due to market reforms in Viet Nam, the geographical movement of people has increased significantly over the past two decades, especially affecting younger women, who are leaving home to seek employment as migrant workers. The literature reviewed found female migrants to be vulnerable to reproductive health problems, including sexually transmitted infections (including HIV), unwanted pregnancy, and unsafe abortion. Viet Nam's legal frameworks and enforcement capacities are not yet sufficiently developed to ensure the benefits for, and the protection of, people who choose to migrate internally. Certain factors associated with migrant mobility, including the absence of traditional norms and constraints, renders migrant women vulnerable to risk behaviours and ill health. Ironically, their marginality means that they are often excluded from reproductive health services.

Female migrants risk behaviours, as well as their access to reproductive health services, are influenced significantly by socio-cultural factors. To date, the connection between socio-cultural factors and sexual and reproductive health has received little attention in the Vietnamese context. Further insight into these factors is needed so that the Government and other service providers can better understand and address the needs of internal migrant women.

Review findings

Important socio-cultural factors influencing female migrants' sexual and reproductive behaviours include:

- gender-related issues such as patrilineal, patrilocal family systems; a strong matriarchal heritage; domestic violence; and oppressive values of Vietnamese Confucian society
- traditional values, norms and beliefs, such as perceptions of femininity, sex taboos, the value placed on female virginity, the fear of losing "face", and a belief in fate and karma
- impacts of the transitional process: social transition due to *doi moi* renovation policies, and socio-cultural transition from rural to urban environments
- positive and negative influences of social networks in risk behaviours
- social segregation: both geographical and social or cultural segregation
- sex education in school: current programmes fail to equip students with the knowledge and skills necessary to engage in safe sexual behaviour and other coping skills

Barriers preventing female migrants from accessing reproductive health services include:

- inadequate coverage of health insurance
- cultural barriers, such as the importance of maintaining self-control until having gained trust in health care providers; traditional values and traditional health beliefs; stigma, discrimination and other negative attitudes among health care providers; limited services for adolescents and unmarried women
- structural and institutional barriers, such as the lack of an adequate and enforced legislative framework for female migrants; mobility status; long working hours; discriminating attitudes from local authorities towards migrants

- lack of adequate knowledge and information on sexual and reproductive health

The review identified information gaps and recommended increasing the knowledge base through research, by:

- implementing large-scale research that will generate representative information for different geographical areas
- improving the quality of national surveys (census and household surveys, for example) to capture all migration types, including temporary and circular movements, and information on their reproductive health status
- employing a mixed-method approach combining quantitative and qualitative methodologies to provide both representative data as well as in-depth information about the influence of politico-socio-cultural factors
- exploring the structural and political environments that shape socio-cultural norms and traditional values
- examining the sexual and reproductive health situation and needs of migrant subgroups, such as ethnic minorities, adolescents and street children

Recommendations

The review also identified literature describing sexual and reproductive health intervention models targeting migrants, in order to identify successful approaches. The findings recognised the value of migrants' social networks using peer educators, as well as the importance of providing adequate knowledge and information through provision of training on sexual and reproductive health issues. However, it appears that other important socio-cultural influences, such as gender, traditional values, norms and beliefs, social segregation and stigma, have not yet received sufficient attention.

Future interventions should consider the following recommendations:

- in addition to targeting females in destination areas, awareness raising interventions should be conducted at migrant places of origin
- churches, pagodas and temples are the heart of a community – places where people seek spiritual guidance and support; future projects should tap into positive religious beliefs and religious networks

- address gender issues and violence against female migrants
- help health care providers change their attitudes towards migrants through training in culturally sensitive service provision; and provide clarity on, and alternative narratives to, local myths and misconceptions among migrants
- empower female migrants and promote their self-confidence and identity to better protect themselves, physically and psychologically
- private employers and managers of large companies in industrial zones need to be included in awareness-raising and anti-stigma campaigns.

Migration is a missing link in current development policies. Despite the increasing trend of internal migration, the Government has so far kept a distance from voluntary internal migration and related issues. As the trend continues to increase, the Government should recognize migrants as a priority group for sexual and reproductive health interventions. To sustain such interventions for migrants, it is essential that sexual and reproductive health-related information, plans and programmes be integrated into the health, education and development plans of communes, districts and provinces. This can only be done when the Government creates policies to support migrants.

Aidan Dockery / UN Viet Nam

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
DLISA	Department of Labour, Invalids and Social Affairs
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
PEPFAR	US President's Emergency Plan for AIDS Relief
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization

CHAPTER ONE

Background

This paper reflects a review of available literature on how socio-cultural factors positively or negatively influence the sexual and reproductive health of internal female migrants in Viet Nam. The United Nations Population Fund (UNFPA) commissioned the review as a way to explore how such factors affect the sexual and reproductive health choices of migrant women, with a view to identifying how to improve service provision for such women, many of whom are considered to be vulnerable to reproductive health problems. It is one in a series of reviews of the situation in four Mekong countries (see the annex for an overview summary of the findings from all four countries, which also covers Cambodia, Lao People's Democratic Republic and Thailand). Additionally, the review examined both the barriers and enabling factors influencing access to reproductive health information and services, and aimed to identify good intervention models for reaching female migrants.

Evidence from international literature suggests that interventions that focus exclusively on individual motivation and behaviour change are only partially effective.[1] Female voluntary migrants, who are doubly vulnerable because they are both female and migrants, typically have little control over the choice to engage in high-risk behaviours. Their risk behaviours as well as their access to reproductive health services are influenced significantly by socio-cultural factors. The connection between socio-cultural factors and sexual and reproductive health is well recognized in the global literature but has received little attention in the Vietnamese context. Insight on these factors is needed so that the Government and other service providers can better understand and address the needs of internal female migrants.

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Viet Nam's legal frameworks and enforcement capacities are not yet sufficiently developed to ensure the benefits from migrating through protection of people who choose to migrate internally, especially women. Unfortunately, the available literature on migration in Viet Nam has concentrated on the economic impacts, urbanization and fertility. There is an obvious neglect of research on female migrant's sexual and reproductive health,[2] although a few studies have looked at the prevalence of sexually transmitted infections (STIs), HIV or risk behaviours among mobile populations. These few studies have focused on individual factors and fail to take into account the socio-political and socio-cultural environments that shape individual factors. Additionally, they have highlighted individual explanations of risk behaviour, thus imposing a "victim-blaming process" on a very vulnerable group.

1.1 The increase of internal migration

Among the many changes taking place in Viet Nam's transition from state socialism to a market economy, known as *doi moi* (economic renovation) and initiated in 1986, has been a loosening of the once-tight control over population mobility.[3] This openness on residency has led to an ever-increasing movement of people within the country.

In its migration-related policy documents, the Government divided migration into i) organized migrants – people who migrate in response to a government plan for relocation, or a natural calamity, or who volunteer to move to an economic zone and ii) spontaneous migrants – people who want to move, and do so outside of any government scheme. Comparatively, the spontaneous, or voluntary migrants have less social protection because even though they are recognized, they are not encouraged, supported or even authorized to move.

Initially male dominated, internal migrants have increasingly become more female of late.[4] Women appear to be the most vulnerable group among migrants because, typically, they are channelled into a small range of occupations in which they are highly susceptible to exploitation and abuse of various kinds. Their experiences have differed in comparison with the men, with female migrants found to be particularly vulnerable to worse health than non-migrant females, and even worse health than male migrants.

Literature reviewed indicated concern regarding female migrants' reproductive health, such as a high prevalence of HIV and other STIs, unwanted pregnancy,

unsafe abortion and sexual abuse. This is of particular concern because migrants are often excluded from reproductive health services whilst, at the same time, are likely to be engaging in risk behaviours.[5]

1.2 Review methodology

Overall scope of review

Available literature and documents covering almost the past two decades were reviewed to identify the links between socio-culture factors and the sexual and reproductive health of internal female migrants. Diversified search methods helped to identify the relevant studies and interventions. This included searching electronic databases, collecting literature by hand, and conducting interviews with contacts. Both published and "grey" literature with a focus on female migrant sexual and reproductive health – including maternal health, family planning, sexually transmitted infections, HIV and AIDS, and gender-based violence – was collected. Studies not published in Vietnamese or English were excluded.

Search for published literature (books, journal papers)

Internet searches used the PubMed electronic database and the "Google Scholar" search engine (a site linked to scholarly or academic web page links). The following key words were used in the search:

- Migrants/Vietnam/sexual reproductive health/socio-cultural factors
- Migrants/Vietnam/HIV/AIDS/socio-cultural factors
- Migrants/Vietnam/interventions for sexual and reproductive health
- Migrants/Vietnam/health services

These searches led to very limited sources on PubMed so the scope was broadened by searching for:

- Review of socio-cultural factors and sexual reproductive health of migrants with special focus on studies done in Asia, South East Asia
- Review of social-cultural factors and sexual reproductive health for general population in Viet Nam with special focus on studies done among rural population (because most of internal migrants were from rural to urban areas)
- Review of health services accessibility/availability for migrants in Viet Nam

References cited in some key review papers/books were also scanned to find related information.

Searching for grey literature

'Grey' literature, including reports, theses and dissertations, conference literature, popular media, monographs, work-in-progress papers, and specialist literature and primary data sources was searched for, from both electronic sources and in hard copy.

To obtain a comprehensive overview of relevant grey literature, experts in the field of migration and sexual reproductive health were consulted in order to identify: i) possible open access databases which might have provided related information, ii) international and/or domestic agencies and organizations working in related fields and iii) local NGOs that might be providing sexual and reproductive health services for migrants.

For electronic sources, the same key words as above were used to search for published literature - including reports, policy briefs, working papers, primary data sources - using the Google internet search engine, websites and open access databases of international and national agencies working in the field of migration or sexual reproductive health (e.g., IOM, UNDP, UNFPA, General Office for Population Family Planning, PLAN, Ministry of Health, etc)
Special forms for keeping records of literature searches were used during the review process.

Regarding hard copy sources, organizations working in fields related to the subject of the review were contacted (see Annex I). In some cases face-to-face meetings or phone interviews were conducted to collect information on existing resources and to discuss intervention models. Where materials were available on intervention models – such as reports and information, education and communication (IEC) materials – these were also collected. These materials were reviewed to identify examples of good practice, or methodologies illustrating culturally sensitive approaches towards addressing migrant women's reproductive health needs.

CHAPTER TWO

Review Findings

2.1 Trends in female migration

Internal migration in Viet Nam has been increasing significantly since the *doi moi* renovation period was initiated in 1986, in both absolute and relative terms. According to data from the 2009 census, an estimated total of 6.6 million people (nearly 7 per cent of the population) migrated internally (both within and across provinces) between 2004 and 2009. Among those moving across provinces, the estimated number increased to 3.4 million people in 2009, from 2 million in 1999 and 1.3 million in 1989; its share within the total population increased to 4 per cent in 2009, from 2.9 per cent in 1999 and 2.5 per cent in 1989.

A projection based on those trends for inter-provincial migration indicates the number will likely rise to almost 6

IOM Viet Nam

million people, or 6 per cent of total population in 2019. (In the census data, migrants are defined as people whose place of residence five years prior to the time of the census was different from their present place of residence).

This increasing trend relates to economic development policies, lack of jobs in rural areas and the easing of previous restrictions on migration.[6] However, these estimations were based on the five-year definition in the census and thus excluded short-term, temporary migrants; thus the actual number of internal migrants is probably much larger. It is these "uncounted" populations who are especially vulnerable because they move without registration papers and thus cannot access services in the area of destination. Additionally, they are typically working in the informal economy, without an employment contract or any social protection, including medical insurance.

According to the 2009 census: the average female migrant was 27 years old; 42 per cent of the female migrant population was single, while 58 per cent of them had up to a secondary school level of education; and 15 per cent of them were characterized as having a very poor socio-economic status. Again, this profile did not include the short-term, temporary migrants.

Internal migration can be further classified into centrifugal flows (towards agricultural opportunities) and centripetal flows (movements to urban centres). The centrifugal flows were largely encouraged during the 1980s through the strong control and support of the Government, including resettlement to new economic zones. These were gradually replaced by the spontaneous centripetal flows that began in the 1990s.

The "feminization of migration" phenomenon is clearly apparent in the 2009 census data. Females accounted for more than half of the migrant population in almost all types (the exception is urban-to-rural migration, but the female proportion was very close to 50 per cent).[7] According to analysis found in the existing literature, the feminization of migration trend has been attributed to the decline of the agriculture sector and the rise of job opportunities for women in urban areas and industrial zones.[8]

In addition, there was an evident gendered pattern to the participation of migrants in the urban labour market, particularly in the informal sector; men have taken more jobs in the construction and transport sectors, while women have been more engaged in the textile, garment and service sectors.[9] Job opportunities for young female migrants have increased in urban areas in

both the informal sector, such as in domestic housekeeping, restaurants, karaoke bars and street trading, and the formal sector, such as in the textile, footwear and garment factories, which have favoured women as a cheap, reliable and "nimble-fingered" workforce.[10]

The internal migrant population, especially female migrants, has been getting younger. The median age of inter-provincial, inter-district and intra-district migrants was 24, 25 and 26 years, respectively, in 2009. The median age of female migrants dropped to 23 years from 24 in 1999 and 25 in 1989, while the median age of female non-migrants increased sharply to 31 years from 28 in 1999 and 25 in 1989. The concentration of migrants of young adult age has been highest among migrants moving from rural to urban areas.[11] Voluntary migrants moving from rural to urban areas have been young and single, while government-arranged migration to rural areas has more usually involved families.[12]

The 2009 migration rates varied significantly across provinces. In some provinces the migrant population contributed to more than 10 per cent of total population, such as in Ho Chi Minh City, Ha Noi and Binh Duong province. In contrast, the migrant population in many other provinces accounted for less than 1 per cent of the total population. The net gain of population through migration was almost 1 million people in Ho Chi Minh City and half a million people in Binh Duong province. In contrast, Thanh Hoa province experienced a net loss of almost 200,000 people and Nghe An province lost more than 100,000 people.[13]

2.2 Legal status and social protection of female migrants

The Government uses the *ho khau* (household registration) system to control and monitor changes in people's residence. The resident status of people in the *ho khau* system determines their access to government services – only residents registered where they reside are fully entitled to government services; all others must pay for the services or are excluded.

After various reports identified that the *ho khau* system and associated requirements were creating difficulties and social exclusion for migrants moving from rural to urban areas, reforms were initiated to relax the restriction on rural-to-urban migrants, such as through Government Decree No. 108, the Ministry of Public Security's Circular No. 11 in 2005, and the Law on Residence in 2007. However, the reforms have not been as effective

as expected due to inconsistency in interpretation and application by local authorities. Some provincial authorities, such as in Ho Chi Minh City, still use the previous system with its four categories (KT1-KT4) while others, such as in Ha Noi, have implemented the new two-category system (permanent and temporary residence).[14]

Although some restrictions in the registration system for migrants have been lifted, the *ho khau* system still remains highly influential in terms of migrants' access to education and social and health services. As phrased by Nguyen et al., "their body is in the city and far from their village but their fundamental rights and duties are at their home villages".[15] Recently, the Government started to reinforce restrictions on migrants for obtaining permanent residence in large cities, such as Ha Noi or Ho Chi Minh[16] out of fear that migrants were contributing to social problems, such as increased crime, prostitution, gambling and intravenous drug use.[17]

Currently, there is no government agency assigned to manage issues related to migration. Agencies such as the Ministry of Agriculture and Rural Development, the Ministry of Public Security, and the Ministry of Invalids and Social Affairs are responsible for various aspects of the migration process. Concern has been raised about coordination among the agencies, particularly among the departments or agencies under the Ministry of Health that are in charge of migrant health services.[18] Voluntary migrants are recognized, but no legal framework supporting and promoting their rights has yet been created.

2.3 Socio-cultural factors that influence sexual and reproductive health behaviour of female migrants

Socio-cultural factors significantly influence the sexual and reproductive health behaviour of the female migrant population, as well as their access to health services. Norms and positive values derived from or influenced by religious and cultural traditions need to be properly understood so that they can be used as creative tools to promote sexual and reproductive health awareness among particularly vulnerable female migrants. As noted, there is little literature on the link between socio-cultural factors and the sexual and reproductive health of female migrants, although some research has been conducted on socio-cultural impacts on sexual and reproductive health in general, and especially among rural women. The findings of such studies

have been extended in this review, and applied to migrant women, given that many of them are likely to constitute the same group.

Religion

According to Ministry of Foreign Affairs data, around 80 per cent of the Vietnamese population is religious, with four major religions having significant influence on their spiritual lives: Confucianism, Taoism, Buddhism and Christianity. Confucianism is without doubt the most influential, with traditions developed from a mix of Confucian philosophy, and feudal and colonialist history. However, Buddhism accounts for the largest proportion of the religious population (about 10 million).[19]

The reviewed literature spoke of the link between religion and sexual and reproductive health: through religious influences on individuals, culture and policies, the different religions critically shape people's and the Government's attitudes towards reproduction and sexuality.[20] For example, the Department of HIV/AIDS Prevention and Control signed a memorandum of understanding with religious leaders to promote the role of religion in fighting the spread of HIV.

However, very few studies have examined the influence of religion on sexual and reproductive health within the general population or a specific vulnerable group. A 2004 migration survey revealed that in a comparison with people reporting no affiliated religion, Buddhists had a significantly lower level of knowledge on HIV, AIDS and STIs; this finding applied to both migrants and non-migrants.[21]

Ethnicity

Viet Nam has 54 ethnic groups, the largest of which is the Kinh, accounting for 86 per cent of the population. The remaining 53 ethnic (minority) groups reflect a high degree of diversity in terms of language, gender relations, culture and traditional norms and beliefs. The review of reproductive health research reports regarding minority groups found that, compared with the Kinh, minority groups had a significantly higher prevalence of reproductive tract infections, unwanted pregnancies and poor access to sexual and reproductive health information, non-clinical services (such as contraception) and clinical services.[22]

According to the 2009 census findings, 122,453 female migrants identified as an ethnic minority, accounting for 2 per cent of the total minority population.[23] However, this is considered an under-reported finding because the census data excluded certain migrant types, such as migrants who had been living elsewhere for more than five years, seasonal and temporary migrants who had moved within the previous five years, and migrants who had left and returned within the five years prior to the survey. Due to barriers in language, socio-economic status, and cultural and traditional norms, minority female migrants have been considered the most vulnerable among female migrants in Viet Nam.

Gender issues

Recently reported national indicators on male and female life expectancy, maternal mortality, adult literacy, access to basic education and primary health care, show that Viet Nam compares favourably with other South-East Asian countries having a similar level of gross domestic product. In the Gender Development Index (United Nations Development Programme), Viet Nam ranked 83 of 177 countries in 2003, performing better than some countries with the same or higher levels of development.[24] Although gender-related issues in Viet Nam may not exhibit extreme forms of inequality in life expectancy, health or basic education, gender differences in roles and responsibilities, as well as cultural values, persist and give rise to patterns of inequality in education, labour and decision-making power.[25]

The sex ratio at birth is a reliable indicator of women's status in terms of gender inequality. Viet Nam's sex ratio at birth has been rising steadily for the past few years, from an average of 105 boys (to 100 girls) in 1999 to 110.5 in 2009. Culturally, gender inequality is attributed to Confucian values (which prize sons over daughters and men over women) and a patrilineal society. More than 90 per cent of the Vietnamese population belonging to the Kinh ethnic group have a patrilineal, patrilocal family system. Under the roles of this system, a couple must have at least one biological or adopted son to maintain an unbroken line of descent, running from father to son through the generations. Hence the common saying, "If you don't have a son, you are considered finished. You don't have happiness or luck in your life."

The patrilineal, patrilocal family system clearly disadvantages women in terms of inheritance. Vietnamese civil laws of inheritance state that sons and daughters have equal rights. However, the customary inheritance law in rural

William A. Ryan / UNFPA APRO

areas often favours sons over daughters. Typically, sons will inherit the land and the house (the most significant assets) as they will live with and care for parents in their old age, because the daughters leave after marrying, and are thus considered "outsiders".

Although constitutional and legal provisions promote the principle of gender equality, and it is considered a criminal offence to prevent females from participating in political, economic, cultural and social activities, society is still male dominated and women have yet to fully take advantage of their rights. For instance, under the Law of Land, 2003, the names of both a husband and wife must be registered on the certificate of land use right. However, only 3 per cent of land use certificates are registered in a woman's name, and only 3 per cent are jointly held.[26]

Strong imprints of Confucian ideology and norms have supported a strictly hierarchical order within the family, in which women are obliged to the "three obediences" – to their father before marriage, to their husband after marriage, and to their eldest son when the husband passes away. Vietnamese women are also expected to nurture "four virtues", consisting of domestic skills, beauty, calm speech and virtuous character.[27] The reviewed literature refers to the phenomenon of Vietnamese women subordinating their own interests and health to their responsibility for family.[28] Some studies also referred to female migrants who had been forced to migrate to urban areas to help their

families, who were then lured or forced into selling sex to increase the money they earned for the family. This they considered as "sacrificing myself for the big family".[29]

The achievement of gender equality in Viet Nam today is limited by eight "risk factors": i) the society's strong matriarchal heritage has at times led to the disingenuous proposition that there is no need for a feminist movement; ii) poverty and the country's long history at war have together overshadowed gender issues; iii) the women's movement has not evolved into a doctrine with a structured basis that is independent from nationalism, socialism or even literary movements; iv) gender equality has become one of three elements, along with nationalism and socialism, comprising a fixed unit; v) the rule of law has traditionally been considered secondary to customs derived from the oppressive values of Vietnamese Confucian society and the autonomy of the agricultural villages; vi) women's rights advocacy has been caught up in the universality-versus-cultural-relativism discussion, further complicated by the question of whether there should be "Asian-styled gender rights" in Viet Nam; vii) Viet Nam, despite its age, is a new nation with a wide variety of philosophical bases, legal traditions and paradoxical values; viii) the single-party political system of modern Viet Nam renders any feminist movement susceptible to Party politics.[30]

The Vietnamese culture does not encourage its people, especially women, to be free thinkers. Independence and critical thinking are not valued. Consequently, women and female adolescents lack skills and power to negotiate safe sex because the culture does not encourage them to confront such issues, especially with their partner.[31] According to traditional values, women are responsible for the household, child care and the happiness of their family, even to the extent of sacrificing their personal goals. To respect this responsibility, a good wife should exhibit kindness, tidiness, domestic skills and, most of all, obedience, as her virtues.[32]

Domestic violence is deeply rooted in the cultural perceptions of women's obedience to her husband, making it difficult to address gender-based violence. For instance, a 2001 Women's Union report referred to the attitudes of commune officers towards domestic violence: "Unless serious physical harm was incurred, physical or verbal abuse from a man towards his wife was normal." "I thought being a wife, women should accept many things and please her husband's feelings. This is the most important factor."[33] A

UNFPA study in 2007 revealed that "women often referred to their obligation to accept unwanted sex as a wife's duty towards her husband rather than as a violent act."[34]

Traditional values, norms and beliefs

Perception of femininity: Previous research indicated that in Viet Nam, especially in contemporary rural society, the common perception of femininity is that "women should maintain a certain control of themselves, should be active within boundaries or have limited equality".[35] Due to this perception, many women "actively chose to behave passively in front of her man so as to maintain their relationship" and women's choices regarding sexual and reproductive health "has been made within the boundaries of a constructed femininity in a transitional society – the *doi moi* era of Viet Nam".[36]

Sex taboos: Vietnamese attitudes towards sex are changing, and there is a new openness to the topic. Education information about sex and sexuality has become popular in the media, in newspapers, television shows, websites and books. However, among some groups, such as women, followers of certain religions and people living in rural areas, there remains a taboo on openly discussing sexual matters.

Value placed on female virginity and the fear of losing face: Quach pointed out in 2008 that "Vietnamese society still places a high value on female virginity and regards having the hymen torn as a huge mistake for a girl."[37] Khuat reported in 2003 that Vietnamese women were still expected to be sexually innocent until marriage.[38] These perceptions and norms have led women to ignore their rights in making safe sex choices or in accessing reproductive health services. For instance, Belanger and Khuat found that unmarried women failed to use contraceptives because they wanted to give their boyfriends an image of themselves as sexually inexperienced, which they thought men prefer. Belanger and Khuat's study also revealed that due to the fear of losing "face" if anyone discovered they were already sexually active before marriage, these women would not seek the reproductive health services they needed. Buying contraception, or asking for information about reproductive health services, was considered risky in case someone they knew saw them. The authors even concluded that the fear of losing face and family reputation was stronger than the fear of unwanted pregnancy or other risks.[39]

Reputation is considered very important to Vietnamese people, whose lives are shaped by public opinion. Individual behaviours reflect on families and communities. Thus, the desire to maintain face is deeply rooted, and its consequences in terms of stigma and discrimination likely increase women's vulnerability. Fear of losing face also prevents women from seeking support in the community in cases of domestic violence. A female victim of domestic violence reported in 2007 that "we are already old enough. If this leaks out, I am afraid of being mocked. My husband is a state employee. If the authority intervenes, it can also affect his job."[40]

Belief in fate and karma: Vietnamese people tend to attribute undesirable events to fate. Consequently, people don't consider that they create what they experience. This means they also don't consider their own responsibility or accountability and become passive in all decision making. Consequences, such as unwanted pregnancy, drug abuse and HIV infection, are attributed to fate. The more people believe in fate, the more they distance themselves from responsibility and accountability for their own lives, and the less chance they have of making healthier choices in terms of sexual and reproductive health behaviour, or regarding risk behaviour.[41] Hien and Maher remarked in 2008 that Vietnamese people "use fate to justify their risky behaviour".[42]

In Buddhism and Hinduism, karma refers to the belief that the sum of a person's actions in life determine the individual's fate in the next life. While belief in karma creates passive living, or the stoic acceptance of one's destiny, it can also prevent people from doing "bad" things because they believe that they are responsible for the "next cycle of life", or "what goes around comes around", and that bad karma in the next life is associated with bad things done in the current life. For instance, participants in the Hien and Maher study reported that they did not want to be drug dealers because drug dealers are associated with "bad karma" in the next life.[43] Karma and fate are very popular beliefs in Viet Nam, especially in rural areas and among the uneducated population.

Because the majority of internal female migrants originate from rural areas, IEC materials that target them about risky sexual and reproductive health behaviour, need to unveil the myth of fate and karma and help them to realize that bad consequences are directly related to the choices they make, and the risks they choose to take. The more exposure people have to certain risky situations, the more likely they will end up at risk and harmed by those behaviours.

Trapped in the transitional social context

As noted, most internal female migrants tend to be young and have moved from rural to urban areas. Thus they have been affected by both the transition of the social context since the *doi moi* period, and the transition of the socio-cultural environment between urban and rural areas.

Social transitional periods: The *doi moi* renovation policies thrust Vietnamese society into a transitional phase in the late 1980s. The policies "liberalized the circulation of cultural products from Asian and Western countries and brought about a relaxation of the State's efforts to promote traditional norms regarding sexuality, marriage and the family".[44] Consequently, younger female generations have experienced a sense of feeling trapped between a "new tendency toward individualism and more liberal sexuality, and the heritage of conservative values and norms regarding women's gender and sexual roles".[45] In trying to balance the old and new views of love, virginity and premarital and extramarital sexual relations, younger female generations may have become a victim of the transitional social context.[46]

Socio-cultural transition: Being far from home, female migrants, especially the younger ones, experience a relative freedom from family control, as well as a difference in traditional values and norms. But they also typically do not feel as if they fit in with the city environment. The 2010 Huong et al. study found that migrant workers often considered themselves as "the observers and outsiders" of city life or the "lower class".[47] However, the old environment, "back in their village", may not accept them anymore. The 2004 Nghiem study found that migration was still considered a moral risk for young women, and that those who migrate may be stigmatized by preconceptions about social behaviour in the cities. Female migrants moving from rural to urban areas were considered to have a more "open attitude" towards sexuality, or to be "easier" with sexual activities, for instance.[48]

Social networks and positive and negative influences

Just as with values, social networks can be divided into traditional and new relationships. The traditional network involves villagers and family members. It is often through such a network that women may decide to move to the city to find a job. It is clear that this traditional network has a critical influence on making the decision to move, and where to move. The Government's 2004 migration survey revealed that most people who moved did not make the

Michael Foley Photography

decision alone. About 67 per cent of the male and 80 per cent of the female migrants reported that other people were involved in their decision to migrate. Relatives and friends constituted the largest influence on decisions of where to move. Formal networks (government or private employment offices) were only used by 1 per cent of the respondents.[49] Recruiters, including traffickers, for all kinds of jobs, typically turned to those traditional social networks.

A recruitment agency network has a prominent role in connecting migrants open to domestic work, with jobs. They aggressively seek out as many recruits as possible, typically through local authorities, because they receive half a month's salary for each placement. Certain mass organizations, such as the Women's Union or the Youth Union, or local charities, also operate employment agencies, and include domestic work. Even though domestic work is not perceived as having favourable working conditions, recruitment agencies heavily promote it as a good option for female migrants. Rarely is there a work contract; agencies often make their own rules, and many are known for deceiving both workers and employers.[50]

The new social network is the circle of relationships a migrant finds in the place of destination. Both traditional and destination networks provide social

protection in terms of money, assets, information and direct assistance. Because the Vietnamese tend to follow other people's advice, obey commands, and want to blend in within a group rather than distinguish themselves, the influence of a social network on female migrants' sexual and reproductive health behaviour, including choice of health services, is very strong.

The reviewed literature highlighted both positive and negative impacts of social networks on migrants' vulnerability. Thuy and Joshua, for example, examined extramarital sex among migrant construction workers in Ha Noi in 2008. They interviewed two groups of workers: members of the first group, including the employer, came from the same village, while members of the second group were from different villages. The first group was more reluctant to seek out sex services because they worried about acquiring a bad reputation as accounts of their behaviour were transmitted home quickly. Commercial sex was much more popular in the second group because there were no direct links home; thus it was easier to hide their activities and maintain a certain reputation, at least in their original community. The authors suggested that "when a peer breaks the standard of what is acceptable, other peers play the role of supervisor": a kind of influencing force against risk behaviour.[51]

In addition to the support and positive influences of a social network, there are often negative influences as well. Upon arriving in an unknown destination, migrants are unlikely to have any contacts and are more willing to trust people, which makes them extremely vulnerable to those who intend to exploit them. For instance, the Starink and de Bruin qualitative study in Ho Chi Minh City in 2001 found a strong correlation between social networks and engaging in sex work: i) female migrants who had no network waiting for them in the city were more vulnerable to sex work and ii) social networks made by women upon arrival, or in the initial stage of relocation within the city, led women to sex work. Many of the sex workers reported being exploited and manipulated by someone in their social network, resulting in their involvement in the sex industry. The study also found that female sex workers relied on their peers' advice regarding sexual and reproductive health practices, such as hygiene and contraceptive use.[52]

Social segregation

Living in the city is expensive, and there are not many residence choices for migrants. Low-income migrants often choose to live in a slum house (which does not have legal registration of land use or legal permission for house

construction) because of its cheap rent. Thus, geographical segregation of migrants, as well as social segregation, has been observed in cities such as Ha Noi and Ho Chi Minh.[53] Gender-based segregation is very common in many industrial zones because some sectors favour female labourers, while others require male workers. Sexual and reproductive health related issues, such as late marriage and abortion, have been reported in popular migrant areas that segregate by sex.[54]

Sexuality education in school

Sexuality education and family life education were introduced into the teaching curriculum in Viet Nam within a subject called "population education" in secondary schools in 17 provinces in the 1980s.[55] Basic information on the biological aspects of sexuality is taught in biology, such as the reproductive anatomy and physiology. The social aspects of sexuality are incorporated into the subject "citizen education". This subject provides an introduction to the moral norms of society and basic laws. In secondary schools, citizen education moves towards a more comprehensive analysis of the ethical and legal responsibilities and duties of every Vietnamese citizen.[56] It thus emphasizes moral standards and the ethical and legal responsibilities people are expected to conform to.

Behaviours that present the possibility of HIV infection are related to "social evils"[57] and are perceived as likely to damage the social fabric of Vietnamese society. The influence of Confucian morality, which considers sexuality as a taboo topic, together with the placing of HIV and other STI awareness within the framework of citizen education, makes it hard for school-based education to equip students with the knowledge and skills necessary to engage in safe sexual behaviours.

To make matters worse, staff capacity in teaching sexual and reproductive health in schools is reported as inadequate. Due to cultural barriers and lack of training, teachers in 2000 were described as failing to convey appropriate messages to young people and often neglecting these sensitive issues, or covering them just enough for the sake of "completing their requirements".[58]

There have been efforts more recently to renew the school curriculum on sexuality education. UNFPA and UNESCO, for instance, provided technical assistance to the Ministry of Education and Training to develop a National

Education and Training Programme on Reproductive Health and Population Development. The project increases the capacity of school teachers to discuss sensitive, uncomfortable topics and helps them develop counselling skills. A new curriculum was developed in 2005 that includes lessons on puberty, STIs, HIV and AIDS, reproduction and contraception.

Unfortunately, there is no official or government programme on sexuality education for children who have never attended school or dropped out. In some provinces, there may be some reproductive health education for street children, such as through the Friends for Street Children Association, in which teachers and other educators are trained in counselling, advocacy, intervention and other traditional areas of social work. The programme only serves limited areas however, and does not reach all out-of-school children.

2.4 Barriers preventing female migrants from accessing sexual and reproductive health services

Migrants appeared to have poorer health compared with non-migrants in the reviewed literature; amongst them, the group most vulnerable to poor health were temporary migrants, known as "guesthouse" migrants.[59] However, health service use was shown in general to be less common among all migrants. Data from the Government's 2004 migration survey showed that the proportion of female migrants who self-treated was 76 per cent, and 70 per cent for male migrants.[60] These figures may reflect an underestimation because the survey sample excluded certain types of migration.[61]

This section of the report highlights possible barriers to accessing reproductive health services. Although there is very little information available on female migrants' access to such services, general information is available about the impact of socio-cultural influences on people's use of health services. (This information is presented to provide a context for interpreting the experience of female migrants with reproductive health services).

Sexual reproductive health services

The following table presents a summary of the basic reproductive health services available in Viet Nam and particularly in the commune health centres (CHCs), which are most accessible for rural women, and indicates which ones are covered by health insurance.

Domain	Subcategories	Available at CHCs	Covered by health insurance
Safe motherhood and newborn care	▪ Counselling services for each stage of pregnancy ▪ Antenatal care, including management of pregnancy ▪ Normal delivery ▪ Complicated delivery ▪ Post-partum care up to 6 weeks after delivery ▪ Abnormalities of pregnancies	✓ ✓ ✓ ✓ may be referred to upper level	✓ ✓ ✓ ✓ ✓
Family planning	▪ Counselling ▪ Instructions for contraceptive methods	✓ ✓	✓ ✓
Reproductive tract infections, STIs and HIV	▪ Counselling, diagnosis, testing and treatment	✓	✓
Adolescent sexual health	▪ Counselling on reproductive tract infections, including STIs and HIV/AIDS, menstruation, adolescent pregnancy and contraceptive methods	✓	✓
Safe abortion	▪ Counselling ▪ Medical abortion up to 7 weeks from the last menstrual period ▪ Dilatation and curettage ▪ Dilatation and evacuation for 13–18 weeks	✓	✓ ✓ ✓ ✓

Family planning services are not covered under health insurance, but contraceptive pills and IUDs are provided free through the family planning programmes.

Health insurance in Viet Nam includes several types: compulsory insurance (for school and university students, government employees and any workers who have an employment contract for more than three months), poor insurance (for low-income people and designated by the local government), free insurance for children younger than 6 years, and voluntary insurance, which is the most applicable for internal migrants. Theoretically, anyone can apply for voluntary insurance, but their application must be submitted to and processed by the local authority where they have either permanent residence or a temporary residence permit. Consequently, it is often difficult for migrants to apply for health insurance in an area where they have relocated. Due to the insurance referral system, even if they have health insurance in their place of origin, when migrants want to use a primary health care service, they have to go back to their home village health centre where they are registered, to get a referral for treatment in the place of relocation.

Although the Government's 2004 migration survey findings show that migrants working in industrial zones are more likely to have health insurance than non-migrants, the report also noted that it was only applicable for female migrants with an employment contract. Female migrants in domestic work and the sex industry have little opportunity to access health insurance. Lack of health insurance and low income were found to be major factors preventing migrants from using a health facility when sick. The annual cost for voluntary insurance is 320,000 dong (US$16) in urban areas, and 240,000 dong (US$12) in rural areas.

Cultural barriers

Although the prevalence of sexual and reproductive health problems among female migrants was reported quite high in the reviewed literature, their use of relevant services was reported as very limited. The available research reports indicated several significant cultural barriers to their access, especially among the urban-based migrants who had originally come from rural areas: fear, stigma and the loss of face, self-control, the need to establish trust with health care professionals, traditional health beliefs, and discriminating attitudes of health care workers. These are described in more detail below.

Stigma, loss of face and wanting to hide problems: The reviewed research illustrated the Vietnamese nature of hiding stigmatized health problems from the community, the family and even the doctor and other health professionals.[62] Because STIs and HIV are still associated with "social evils", and sexual prejudice still exists in Viet Nam, women with related symptoms are often reluctant to go for check-ups or treatment in a timely manner. For female migrants, the fear of losing face is even greater, due to their relatively small social network, which is typically directly linked to their home village.

Female migrants would rather bear their misfortune alone than bring shame to the family, and thus stigma and discrimination, whether actual or perceived, are major barriers to access mainstream health services. Stigma and discrimination may also prevent female migrants from using public services, forcing them instead to use private services, which are more expensive and not always safe (for instance, abortion at a private clinic instead of in a hospital). A 2000 study of factory workers found that condom use was commonly associated with "illicit or bad" sex, and so young female migrants from rural areas would rarely insist on using them. The study also found that female migrants related HIV with "easy-going sex" and "persons having sex with many people" and thus believed that HIV would not affect them because they were not involved in "social evils".[63]

Truong's study of self-employed female migrants in Ha Noi in 2009 found that more than 44 per cent of the respondents regarded females buying condoms as "not normal", and 54 per cent were afraid to buy condoms. They related STIs and HIV to "social evils", and thus more than 70 per cent of the respondents considered such infections as shameful. Although routine gynaecological check-ups were considered important, female migrants reported rarely seeking out such services because of work burdens, time pressures, and the cost of such examinations. Only 40 per cent of female migrants in the Truong study planned to have a gynaecological check-up. The frequency of using a condom when having sexual relations was greater among female migrants who considered it as "normal for females to purchase condoms".[64]

Because of cultural traditions and values, Vietnamese women of all ages have experienced embarrassment and cultural rejection when approaching health centres and family centres for contraception. This was reported as particularly acute among unmarried women and sex workers.[65]

Self-control and trust: Vietnamese people find it hard to express their feelings to people they do not know and often maintain a reserved attitude towards strangers. People without this "self-control" were perceived as being of "weak mind".[66] According to Quynh and Thao, a certain level of "trust" between a patient and health service providers must be achieved before a patient will reveal a health issue and follow health care advice.[67] Additionally, there is the Buddhist-related belief that suffering, including pain and disease, is an unavoidable part of life and that one must bear pain and misfortune in silence.[68] Thus, seeking medical care for physical pain may be delayed or considered inappropriate.

Traditional values: The reviewed research also revealed how recruitment agencies' operations have been influenced by gender norms that emphasized the "sacrifice virtue". These agencies, for example, have promoted domestic work as a way for women to "sacrifice to give their children a better life" and have insisted that recruits be diligent and honest in their work and maintain proper appearance and speech.[69]

Traditional values seem to be particularly biased against sex workers, who are perceived as bad, dishonest women, engaging not in "work" but performing "tricks" on men. Cultural patterns have a strong influence on ways in which sex work takes shape in a specific context; sex workers thus have become "women with split or multiple identities". In this cultural atmosphere, sex workers do not want to be recognized by people from their home community and thus avoid public services and seek out private services. Due to the costs involved, they were less likely to access services frequently.[70]

Traditional health beliefs: Traditional health beliefs impact the use of health services as well as adherence to treatment regimes. The concept of "balance" is important to many Vietnamese, especially the rural and uneducated population. In the past, illnesses were often thought to be caused by a lack of balance in one's spiritual life.[71] The belief in a natural process and bodily balance has led to a preference for natural remedies and the assumption that Western medicine offers "invasive procedures, long-term side effects and symptomatic relief only". These beliefs have thus heightened migrants' reluctance to seek medical assistance.[72]

Attitudes among health care providers: The attitude of health service providers towards sexual and reproductive health is sometimes swayed by

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their cultural values. For instance, Vivien et al. found in 2002 that adolescents asking about reproductive health were perceived as admitting they were "not good". Their study also found that health care providers blamed women with STI symptoms for their poor personal hygiene; such an attitude inhibited female patients from seeking health care.[73]

Limited reproductive health services for adolescents: Sexual and reproductive health programmes have started to pay more attention to adolescents. However, while young people may be more aware of related issues than their age group in previous generations, they often find it hard to access services that will help them to address risk behaviours, such as unprotected sex. For instance, Khuat attributed the low use of contraception among adolescents in 2003 to a lack of access to contraceptive supplies, counsellors and health care providers. Free contraception services target married couples in the national family planning programme and are generally unavailable to single young people. Even when young people want to pay for contraception, some pharmacies have reportedly been reluctant to sell them condoms. Khuat also noted that cultural prejudice and social disapproval of premarital sex and contraceptive use have led to a disdain for planned sexual activity with some type of contraception on hand.[74] The lack of attention to adolescent reproductive health needs is reflected through the fact that all national statistics on sexual and reproductive health are only collected for married men and women.

Structural and institutional barriers

Lack of adequate and enforced legislative framework for female migrants: Most reproductive health-related policies and strategy documents have not considered internal migrants as vulnerable and in need of protection. Rather, these documents tend to associate this group with problems. For instance, the Population Strategy 2001–2010 stated that migrants were associated with negative consequences of development, rather than positive ones. The National Strategy on HIV/AIDS identified migrants as a high-risk group for HIV infection. The Reproductive Health Strategy 2001–2010 makes no reference to the migrant population, even though most internal migrants are young and vulnerable to many social and health risks. The Master Plan for Youth and the Youth Law also do not include reference to migrants in any plan or programme. The draft Population and Reproductive Health Strategy for 2011–2020 mentions the migrant population, but includes no specific provisions.[75]

The current Labour Law has not yet recognized internal migrants and thus provides no legislative framework to protect them. The reviewed research includes reports documenting how these migrants have been disadvantaged compared with non-migrants in terms of income, job security and social protection. Significant proportions of urban migrants were either self-employed or worked in short-term or casual employment, without a labour contract. A 2007 study conducted in Ha Noi, Ho Chi Minh City and Da Nang found that only 36 per cent of the surveyed migrants had a labour contract, 38 per cent of employed migrants received no assistance from employers, only 12 per cent were permitted to take a day off when needed, and 99 per cent had neither social insurance nor work-related accident insurance.[76]

Although domestic work is the dominant occupation among female migrants, it is not covered by the Labour Law or Migrant Law because the home is not defined as a workplace.[77] The Ministry of Labour is preparing a decree on the management of domestic work. For the first time, domestic work will be mentioned in the Labour Code. The new law attempts to regulate domestic work as a profession by setting working hours, wage level and management procedures. However, there is doubt about the feasibility of the new law given the spontaneity of work agreements and the non-specificity of the tasks, as well as the State's capacity to enforce the proposed legal document.[78]

Within the reviewed literature, female sex workers were reported to be one of the most at risk groups among migrants. The reviewed studies reported that a large proportion of those working in the sex industry were migrants and many of the female sex workers (men were not studied) hadn't intended to be in that work when they left home; their migration journey ended there after other options failed, or they were forced to engage in sex work. In some cases, women at the outset of their migration journey were deceptively recruited or transferred into sexual servitude, or forced into slavery-like circumstances of employment in other sectors. Human trafficking across national borders is criminalized by Article 3 of the Protocol to Prevent, Suppress and Punish Trafficking in Persons and also under the Vietnamese Penal Code, but internal trafficking is not covered by either.[79] More importantly, female sex workers experience a specific political disadvantage in that prostitution is illegal and prosecuted as a "social evil", with sex workers arrested and detained in re-education centres. Out of fear of arrest, sex workers might not respond to safe-sex education and disease-prevention programmes. This also places sex workers in a disadvantaged, vulnerable position.

Mobility status: According to Duong and Bach in 2008, being new to their place of destination, migrants often do not know the local health care system or the location of a health clinic, which could delay the seeking of services.[80] Their often mobile status also makes it hard for local programmes to reach them. The 2009 Truong study found that the longer migrants stayed in one place, the more likely they were to receive information about reproductive health care and the more likely they were to seek out health care services.[81]

Long working hours: The Marie Stopes 2005 survey of migrants working in industrial zones found that, on average, they worked 12 hours a day; most of the respondents said they spent their free time sleeping because they were tired from the long working days. The workers reported they would not visit any health care service unless they had a very serious condition or disease, because of the time and money required. Female migrants in general said they did not care about their health as long as they were still able to work.[82] To compound the situation, all government health services operate during regular business hours. If migrant workers need health services, they are forced to use private services, which are much more costly (and they will thus delay seeking them out). Some factories – but not all – have an on-site health clinic. But according to Tan in 2006, many women did not use the services because the staff seemed more motivated to send women back to work as quickly as possible – even when they were too weak to work.[83]

For female migrants engaged in domestic work, the hours are even worse due to the spontaneous and self-regulating nature of the employment. Live-in domestic workers (accounting for most situations as the majority of live-in domestic workers also are migrants) are typically required to be available any time, leaving the worker with no time for herself; she can only take rest when she is really sick, or when she returns home on a special occasion.[84]

Exclusion from reproductive health services: The reviewed studies found that due to their temporary registration status many migrants did not have health insurance. Whatever policy they might have had in their place of origin could not be used in their relocated residence. In industrial zones, only migrants with a formal employment contract can receive reproductive health care through the formal health system, because they are covered by health insurance included in their contact. The registration system has forced migrants to seek out private health care providers and other supporting services that are often more expensive compared with the public services.

The Government's 2004 migration survey findings indicate that of those domestic workers who were treated at health facilities when sick, 84 per cent had to pay for the service and medication from their own pocket. Only 12 per cent reported that their treatment was covered by the family they were employed by. None had health insurance.[85] Given their low-income status, the increased use of cash-based health services has created a tremendous obstacle for migrants to access adequate health services in a timely way. For instance, many migrants in big cities such as Ha Noi and Ho Chi Minh reported that the cost of a medical examination and treatment was twice their monthly income.[86]

Because the majority of female migrants are young, they thus have a need for reproductive health services. However, very few programmes or interventions have recognized and addressed this need. In the available literature, female migrants were shown to have little knowledge about STIs, HIV and AIDS, resorted to self-medication rather than seek support at a health facility and had a significantly lower rate of contraceptive use compared with their non-migrant counterparts.[87] The frequency of sexual and reproductive health risk behaviour was also reported to be higher among migrants. However, a 2010 United Nations Viet Nam report attributed this higher frequency not only to behavioural and situational factors but also to migrants' lack of access to government services.[88] In the case of HIV prevention, most state interventions, such as media information, behaviour change communication

and other information and education activities, are often ineffective in reaching migrants due to their long work hours and mobile status.

Attitudes of local authorities towards migrants: In addition to being excluded from government programmes, such as health insurance, migrants are not covered within community budgets and services in their relocated areas; such services are exclusively available for people registered in that locality. Being marginalized and excluded from both government and community services, migrants have had very limited access to sexual and reproductive health information and programmes.[89] As already noted, migrants are often aligned with "social evils", such as crime, gambling and sex work. Consequently, local residents and authorities treat them with mistrust and unease.[90] This prejudice may also hinder their seeking assistance from local authorities or health care workers when needed.

Knowledge and access to information

Several studies attributed the high rate of self-treatment among migrants to their lack of information and limited knowledge on sexual and reproductive health. For instance, the Government's 2004 migration survey found that female migrants with poor knowledge of the causes of STIs, also had poor awareness of their sexual and reproductive health in general.[91] Truong's 2009 study found that sexual and reproductive health knowledge is a significant determinant of hygiene practices and condom use among female migrants.[92]

Migrants' knowledge of related issues is generally limited for two major reasons: i) they have likely had very little previous exposure to sexual and reproductive health issues in their places of origin, and ii) they have had few opportunities to access information and services in their places of destination. The Government's 2004 migration survey findings revealed that the majority of migrants did not know the causes of STIs, or preventive measures and treatment; although the majority of them were able to cite five to six causes of STIs, only 9 per cent of them knew that both partners need to be examined if one of them is infected. Most notable, 40 per cent of those interviewed believed that "unclean sexual organs" was the main cause of STIs.[93] Truong's study further revealed that 17 per cent of the surveyed female migrants had never heard about STIs; 23 per cent of them could not name one STI, and 65 per cent of them could name fewer than three diseases. More significantly, their awareness on how to prevent STIs as well as detect infections at early onset was very limited. More than 60 per cent of the respondents could not

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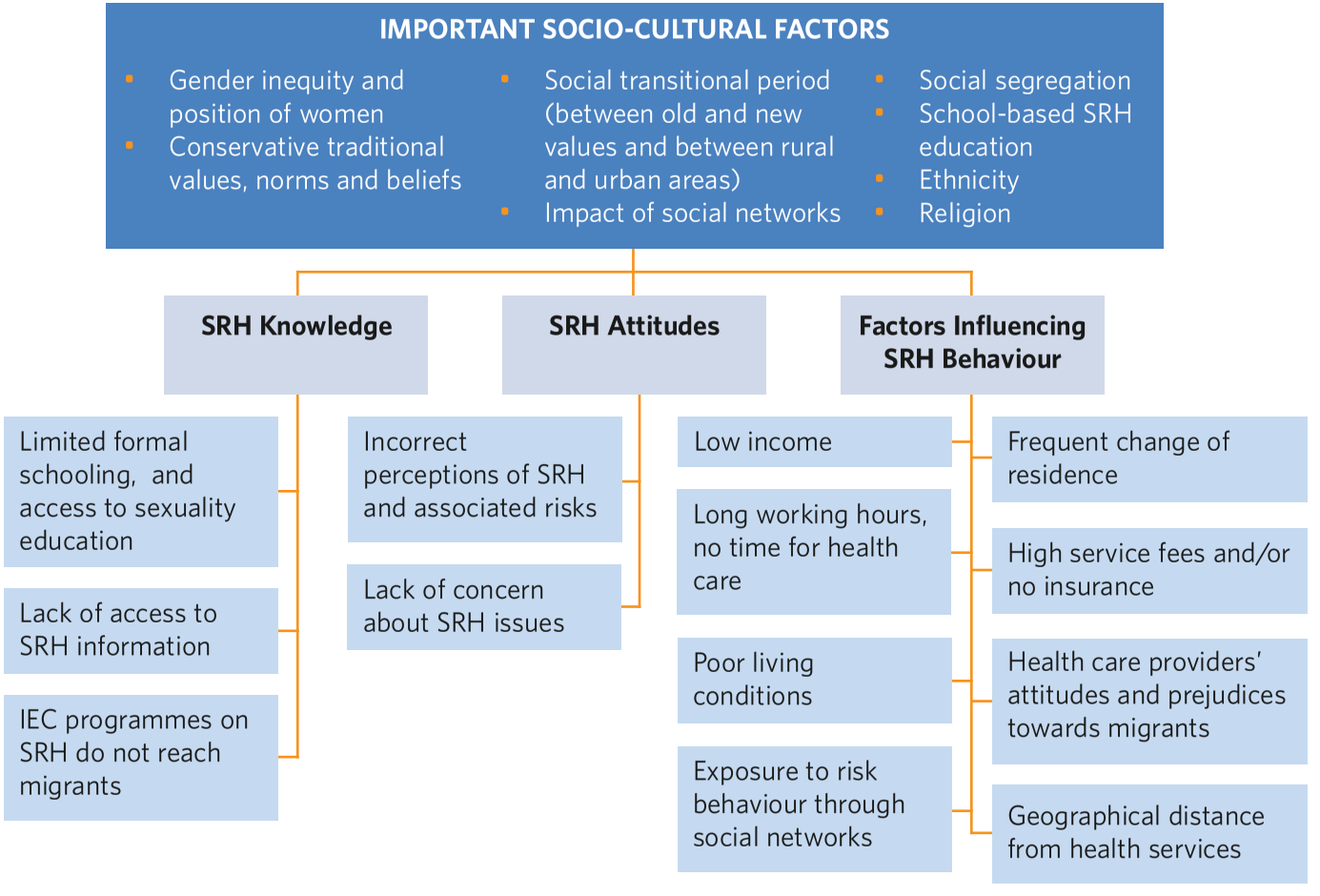
cite any symptom, and 35 per cent of them could not name three symptoms. When rating their awareness of STI prevention, 23 per cent did not know of any method, and the rest had inadequate or incorrect understanding.[94]

The report of the Life Centre's 2006 baseline survey on HIV vulnerability among migrants and mobile populations in Can Tho province noted that "while most respondents had some basic knowledge about the main modes of HIV transmission, the mobile workers, both male and female, did not perceive themselves at risk of contracting HIV because according to some, they do not do the wrong things; other common misunderstandings included lack of understanding about the difference between HIV and AIDS and of the means and methods of prevention."[95]


IMPORTANT SOCIO-CULTURAL FACTORS
Gender inequity and position of women
Conservative traditional values, norms and beliefs
Social transitional period (between old and new values and between rural and urban areas)
Impact of social networks
Social segregation
School-based SRH education
Ethnicity
Religion
SRH Knowledge
SRH Attitudes
Factors Influencing SRH Behaviour
Limited formal schooling, and access to sexuality education
Lack of access to SRH information
IEC programmes on SRH do not reach migrants
Incorrect perceptions of SRH and associated risks
Lack of concern about SRH issues
Low income
Long working hours, no time for health care
Poor living conditions
Exposure to risk behaviour through social networks
Frequent change of residence
High service fees and/or no insurance
Health care providers' attitudes and prejudices towards migrants
Geographical distance from health services

2.5 Intervention models

The review identified information on eight projects dealing with reproductive health issues and/or HIV prevention, and two projects addressing violence against migrants. This section will first provide a brief description of these ten interventions, and then discuss their relevance and constraints as a means of identifying good models for the Viet Nam context.

The ten project models addressing female migrants can be divided into three groups: those for migrant workers in industrial zones, those targeting "freelance" migrant workers, and those for high-risk migrants.

Interventions for migrant workers in industrial zones

The number of female migrants working in the industrial zones has increased significantly over time. Most of them are very young and unmarried and thus, without timely or proper access to information and services, face a risk of unwanted pregnancy or sexual or reproductive health-related illness because some are sexually active. Interventions for this group are at an advantage because: i) most workers live in the same area or in the same collective accommodation, making them easier to reach than other groups of migrants and ii) most industrial zones have trade unions and health service facilities, making it easier to provide information and services.

There are certain difficulties however: i) migrants have fixed work schedules, with long working hours. They do not like external activities during working hours because it reduces their productivity and income; it is difficult to arrange suitable schedules for IEC sessions, or behaviour change communication (BCC) activities because of the different shifts in the factories; ii) sometimes factories do not have enough accommodation for all workers and some rent rooms from local residents; those living outside factory areas have more limited access to media reports and IEC material than workers living in factory-provided accommodation; iii) it has been difficult to establish and maintain networks of peer education volunteers from among the migrant workers, who could help sustain such initiatives, because they are often tired after working long hours; volunteering only makes their long day longer; iv) it has been hard to get long-term cooperation from employers: they do not welcome activities in their factories, especially during work hours.

PROJECT

Improve the Sexual and Reproductive Health among Workers of Supplier Factories of Adidas

Implementing agency: ActionAid International and Marie Stopes International
Sponsoring agency: Adidas
Beneficiaries: Young workers
Project areas: Ha Noi and Ho Chi Minh City
Time: 2005–2008

APPROACH

Support for migrant workers in industrial zones is very limited, while the number of industrial zones and their female migrant workers has increased dramatically over time. As most workers are young and unmarried, they have urgent needs for reproductive health information and services. This project aimed to raise awareness among young migrant workers on issues of reproductive health, including HIV prevention, and provided clinical services in workplaces through a mobile medical team and at a reproductive health clinic in Binh Duong province. The capacities of the factory medical staff were strengthened so they could provide counselling on reproductive health issues and contraceptive methods, and more sensitively serve the workplace employees. Peer education played an important role. A referral network was established, involving the participation of public and private health facilities and pharmacies to help increase the availability of information and services on sexual and reproductive health to factory workers.

PROJECT

Reproductive Health Care and HIV Prevention for Young Workers in the Private Sector

Implementing agencies: Centre for Reproductive Health Care and HIV/AIDS Prevention and the Viet Nam Trade Union
Sponsoring agency: UNFPA
Beneficiaries: young workers in the private sector
Project areas: Binh Duong province (Hung Hoa rubber plantation), Da Nang province (Da Nang Textile Company), Nam Dinh province (Nam Son Textile Company), Hai Phong (Sao Vang Company Ltd), Ha Noi (Doan Thi Diem Centre for Women Workers)
Time: 2002–2005

APPROACH

This project aimed to improve the reproductive health of young workers in the private sector, with a focus on reproductive tract infections, STI and HIV prevention, through direct conversation, small group counselling services, information leaflets and gynaecological examinations. The project involved leaders of private businesses employing the young workers by getting their commitment and providing them with training on the importance of health care.

Interventions for freelancer migrants

Freelance female migrants are not a homogenous group, but can be divided into subgroups according to their occupations and migrant status. Freelance female migrants tend to be clustered in one of several categories: live-out workers, live-in workers, cleaner-cum-junk traders, and private carers in hospitals. Each subgroup requires a different intervention approach. The reviewed projects targeting freelance female migrants did not include tailored-made intervention for each subgroup. Compared with female migrants working in the industrial zones, freelance migrants tend to have less access to reproductive health services because they usually do not have health insurance. Access to such services with affordable fees is an important issue for this group. Most projects partnered with district health centres to provide free services. Although this approach seems to be economical, it had some limitations: migrants often went to health centres only when they were seriously ill and thus, if communication activities are not strong enough to raise migrants' awareness of the importance of regular reproductive health check-ups, they are unlikely to visit health centres.

This group is also more mobile compared with migrants working in the industrial zones. They tend to migrate to cities seasonally, or when their jobs are not stable. Peer education, which has proven important for reaching migrant workers, is fraught with challenges, largely because the peer educators frequently move away from places where they have been trained. Frequent changes affect the sustainability of such initiatives. The hardest-to-reach group among the freelance female migrants are the live-in workers because they have very limited access to community IEC/BCC programmes. Freelance migrants typically have unstable jobs, are preoccupied with their basic survival, and are thus not able to participate in many activities.[96]

William A. Ryan / UNFPA APRO

PROJECT

Violence Against Women: A Rights-Based Approach to Empowering Migrant Women Affected by Violence

Implementing agency: International Organization for Migration; Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents; Light Community Health and Development Organization; Research Center for Family Health and Community Development
Sponsoring agency: European Union
Beneficiaries: migrant women in Ha Noi, such as factory workers, rubbish collectors, students and domestic workers affected by violence

APPROACH

Project area: Ha Noi
Time: 2008–2009

The goal of the project was to contribute to national efforts in reducing violence against women and improving the protection and support offered to those who have experienced violence. The approaches included capacity building for peer educators, establishing self-help groups for migrants who had experienced violence, establishing a service referral system to support female migrants affected by violence, and providing social and health services to the women affected by violence, such as mental health and counselling support.

PROJECT

Reproductive Health Information and Services for Migrants, 7th Cycle

Implementing agency: General Office for Population Family Planning, Ministry of Health, with Light Community Health and Development Organization providing technical assistance
Sponsoring agency: UNFPA
Beneficiaries: freelance migrants
Project areas: Ha Noi (Ba Dinh district) and Ho Chi Minh City (Go Vap district)
Time: 2007–2009

APPROACH

This project piloted a model to provide reproductive health information and services for freelance migrants in Ha Noi and Ho Chi Minh City. Activities included: i) developing Guidelines for Migrants that provided essential information together with addresses of places where migrants could seek support; ii) producing brochures on sexual and reproductive health care and HIV prevention; iii) producing a referral card with useful details, such as facility locations that provide information and services for migrants; iv) awareness raising among service providers (health care workers and pharmacy staff) and migrants; and v) providing sexual and reproductive health care counselling and services.

The project relied on various networks, such as owners of boarding houses, community leaders and heads of migrant groups, pharmacy staff and health care staff in both the private and public sectors. The project also took advantage of indirect communication channels, such as sub-district' notice boards and radio broadcasts, for their IEC activities.

PROJECT

Improvement of Spiritual Life and HIV Prevention among Migrant Women in Ha Noi Seeking Employment

Implementing agency: Research Centre for Gender, Family and Environment in Development
Sponsoring agency: Inter-church Organization for Development Cooperation in the Netherlands
Beneficiaries: freelance migrants
Project areas: Ha Noi (Ba Dinh and Hoan Kiem districts)
Time: 2006–2008

APPROACH

The focus of this project was to create better working opportunities and living conditions for female migrants in two communes in Ba Dinh and Hoan Kiem districts in Ha Noi. In addition, the project sought to improve knowledge, attitudes and practices among female migrants towards HIV prevention through training sessions. The project involved local authorities in the activities and thus promoted positive attitudes towards female migrants working in their areas.

PROJECT

A Community House for Migrant Workers in Ha Noi

Implementing agency: Light Community Health and Development Organization and World Concern
Sponsoring agency: Tearfund UK
Beneficiaries: freelance migrants
Project areas: Ha Noi (Phuc Xa commune in Ba Dinh district)
Time: 2007–2010

APPROACH

This project created an accessible location for freelance migrants to receive sexual and reproductive health information and services. The community house was located in a commune where migrants are most concentrated. It provided general information, as well as information on sexual and reproductive health care, and offered scheduled services. The project supported a library for migrants to use, and peer educators were trained on related issues. In addition to providing sexual and reproductive health services for migrants, staff also helped them complete the referral process from their places of origin to their relocated areas.

Interventions for high-risk migrants

High-risk migrants encompass female sex workers and street youth. Funding for interventions for high-risk migrants is typically more available and sustainable over time. However, the interventions identified during the review focused on HIV and AIDS, and neglected other sexual and reproductive health issues, such as reproductive tract infections and safe abortion. Two major challenges to interventions targeting female sex workers are their legal status and the stigma and discrimination levelled against them. As prostitution is illegal in Viet Nam, if sex workers are caught they will be arrested and detained in re-education centres; thus sex workers often feel

reluctant to engage in community events. Additionally, because sex workers are correlated with "social evils", so interventions targeting them often meet obstacles from within the community. Inclusion in a high-risk group for HIV infection also increases their stigma and vulnerability.

PROJECT

HIV Prevention for Street Migrant Children

Implementing agency: Save the Children US, Light Community Health and Development Organization, Center for Health Education and Communication Ho Chi Minh City
Sponsoring agency: President's Emergency Plan for AIDS Relief (PEPFAR)
Beneficiaries: street migrant children
Project areas: Ha Noi and Ho Chi Minh City
Time: 2006–2008

APPROACH

This project provided knowledge and skills to migrant children in Ha Noi and Ho Chi Minh City, focusing on preventing HIV infection and sexual abuse. The IEC approach entailed using peer educators, leaflets and suitable events to reach the children, as well as advocating with policy makers and other authorities on the need for more favourable conditions for street children. The project also included free sexual and reproductive health care services for street children.

PROJECT

HIV Intervention Models for Sex Workers

Implementing agency: Various local NGOS
Sponsoring agency: Government of Viet Nam and PEPFAR
Beneficiaries: sex workers
Project areas: multiple provinces
Time: 2002 to now

APPROACH

The intervention models were implemented by various NGOs with funding from PEPFAR. For instance, in Ho Chi Minh City, the government AIDS Committee opened two "condom coffee shops" for sex workers, one called Hope (in district 1) and the other called Believe (in district 2). These coffee shops provide free medical check-ups, HIV and STI tests, treatment and help from peer educators. As a result of cooperation between the Aids Committee and the Women's Union, several peer educators conduct outreach to sex workers.

PROJECT

Far Away From Home Club

Implementing agency: provincial multi-sector team (including the city health department, Department of Labour, Invalids and Social Affairs and trade unions)
Sponsoring agency: Canada-Southeast Asia Regional HIV/AIDS Program
Beneficiaries: migrant workers and sex workers
Project area: Can Tho City
Time: 2004–2007

APPROACH

The Far Away From Home Club provided a supportive and empowering environment for sex workers and other migrant workers in Can Tho City. This project had five objectives: i) to provide migrants and mobile populations with adequate knowledge and skills to protect themselves from HIV infection; ii) to facilitate conditions in which migrants and mobile populations had access to health, social and legal services; iii) to build up the capacity and assist service providers and enterprises in developing and implementing HIV-prevention policies and programmes in their workplaces; iv) to assist relevant central and local government bodies to establish regulations and penalties for employers who refuse to develop a company HIV prevention policy and programme; and v) to strengthen the capacities of the various parties involved in the project in planning and implementing migrant and mobile population-centred HIV-prevention programmes. The project involved many groups, from migrants and service providers to factory owners and central and local government officials and staff. All training activities were conducted by peer educators and facilitated by the Migrant Worker Support Network.

PROJECT

Training Catholic Migrant Female Workers in Ha Noi on Gender, Family and Reproductive Health Issues and HIV Prevention

Implementing agency: Research Centre for Gender, Family and Environment in Development
Sponsoring agency: World Bank
Beneficiaries: freelance Catholic migrants
Project areas: Ha Noi (Thai Ha church)
Time: 2008–2009

APPROACH

This project promoted social inclusion through activities aimed at raising awareness among Catholic female migrants working in Ha Noi of their human rights, especially their sexual and reproductive health rights. The project's training courses had four objectives: i) to raise awareness on gender, gender equity and family issues; ii) to promote access to information related to reproductive health and sexual and reproductive health rights; iii) to prevent sexually transmitted infections, including HIV, and unwanted pregnancies and abortions; and iv) to prevent sexual violence, abuse and harassment. Three training courses were organized, each with ten sections that were held for two hours in the evenings. This was one of only two projects identified that addressed gender, gender inequalities and prevention of domestic violence among migrants.

2.6 Important socio-cultural factors that shaped the interventions

This section examines the socio-cultural factors that the previously described intervention models took into consideration in their approaches. The information is drawn from telephone and face-to-face interviews, or from information brochures. Although the research team exerted considerable effort and time, it was very difficult to collect comprehensive information on all the approaches used because of the poor documentation and distribution of intervention results. Consequently, the extent to which identified socio-cultural factors were taken into account in design of these interventions might not have been fully captured in this report.

Impact of social networks: Taking into account the significant impact of migrants' social networks and peer influences, all the projects employed peer educators as the main providers of information, or others with influence on the targeted audience (such as the Women's Union or Youth Union members or other collaborators). Peer educators live under the same roof or in the same area as the migrants and, in many cases, come from the same provinces, so they share a culture, making communication easy. However, although the peer educator approach was found to be effective, it was difficult to maintain these due to the high mobility of migrants, as both migrants and trained peer workers are likely to move frequently.

A weakness of such programmes was that non-migrants living in the communities where migrants tended to live did not receive adequate

Vietnam HIV TWG

information about the programmes, and consequently developed hostile attitudes towards migrants, which never changed due to the continued perception that "migrants are associated with social evil".[97]

Knowledge, attitudes and practices of migrants towards sexual and reproductive health: Acknowledging the importance of informed knowledge, attitudes and practices in relation to improved sexual and reproductive health outcomes among migrants, all the projects organized training activities designed to provide knowledge and life skills to assist migrants to better protect themselves. They all applied a range of communication methods, from direct communication (such as face to face, topical talks, forums for dialogues) to indirect communication (distributing leaflets at boarding houses, sub-district notice boards and radio broadcasts). Most, but not all of the projects favoured the face-to-face method because it was proven to be effective for migrants; the time, place, and main messages for IEC could be flexible and tailor-made to suit the needs of the targeted audience.

Accessible reproductive health services: Most of the projects provided counselling and reproductive health services through the use of state clinics in enterprises or in district health clinics, which was an appropriate approach for migrants. However, there were serious issues: i) health staff were paid overtime only during the project lifetime, so out of business hour services

became unavailable after the project ended; ii) migrants were still reluctant to use services at state health facilities, mostly because of persistent negative attitudes of health workers which did not change during the project duration; and iii) counselling played an important role, but the quantity and quality of counsellors in the state clinics was extremely poor.

The reviewed literature suggested that service providers should be trained to explore and change their own values and attitudes in order to provide efficient reproductive health services.[98] This is especially important when providing services for internal migrants who mostly originate from rural areas; service providers in urban areas largely have had a Western-style education and often view traditional beliefs negatively. Although most of the projects cooperated with health staff in state clinics to provide reproductive health services for migrants, none of them described any efforts made to sensitize health care workers in terms of cultural values and traditional health care beliefs. Thus, while services were made more available for migrants out of business hours, the targeted beneficiaries were still reluctant to use them because they felt that the "health care workers do not speak the same language"[99] as them.

Violence and gender-related issues: Legal status, social isolation, diminished contact with family and community networks, inadequate access to appropriate jobs, and limited knowledge of their rights have heightened female migrants' vulnerability, especially when they end up in abusive situations. Violence has been shown to be deeply rooted in gender-related issues, such as cultural perceptions of women's position and rights. However, only two projects analysed during the review addressed these issues: Violence Against Women: A Rights-Based Approach to Empowering Migrant Women Affected by Violence, and Training Catholic Migrant Female Workers in Ha Noi in Gender, Family, Reproductive Health and HIV Prevention. Other projects did not take into account the potential influence of gender inequalities in their scope of interventions.

Religion: Religious beliefs often provide the framework in which individuals operate and can act; religion can be an important entry point for reproductive health programming. Other countries, such as Cambodia, have had programmes that employ Buddhist values of moderation, self-discipline and compassion to fight the spread of HIV and tolerance towards people with HIV or AIDS.[100] Viet Nam has also had programmes based in pagodas to provide care and support for people with HIV or AIDS. In terms of sexual and reproductive health interventions for migrants however, only one project was

identified that took into account the influence of religion and used the church as the setting for intervention activities. According to follow-up evaluations, this approach was appreciated by the Catholic migrants. Future intervention models could possibly replicate this model because of the importance religion plays in Vietnamese society.

Ethical sensitivity: Strict confidentiality of information is very important for clients in relation to sexual and reproductive health matters, such as STIs, unwanted pregnancy, HIV infection and family violence. Fear of losing face, gaining a negative reputation, or being discriminated against because of stigma, were reported to be the most significant barriers impacting on migrant access to health services. However, it was unclear from the reports of the reviewed projects dealing with reproductive health as to how confidentiality issues were handled. Confidentiality appeared to be better addressed in the projects addressing HIV and AIDS prevention, care and support. The Far Away From Home Club may be considered the better practice in this regard.[101] The project followed international recommendations on HIV prevention for marginalized and stigmatized groups. For instance, the Department of Labour, Invalids and Social Affairs, which has a policy of arresting and detaining sex workers, was involved in this project and, through that commitment, shifted its policy position and agreed to create an empowering environment for sex workers to help them access information and services.

Mobilizing the participation of local leaders, business owners and other community members: The participation of local community members and authorities at different levels is vital when implementing a project and for sustaining the intervention. All the reviewed projects tried to involve local leaders and community members in their activities. However, there was a lack of diversity and representation of local leadership involved: most projects mobilized local leaders, but only those representing an organization. Consequently, most projects were not able to gain full support and coordination between different organizations. The role of the lead agency in the intervention project was also very important because currently the Ministry of Health does not have a national programme for reproductive health care for migrants, so there was no government office with clear responsibility for continuing or expanding these models after the projects ended. Perhaps the Far Away From Home Club project was the most successful in mobilizing the participation of local leaders because it created a Provincial Multi-sector Team that included the Department of Labour, Invalids and Social Affairs (DLISA), trade unions, the Provincial Aids Committee and HIV/AIDS/STD community

clinic networks. Using the DLISA as the lead agency was extremely prudent because it provided needed leverage in approaching local policy authorities to support the project's activities, despite the illegal status of some migrants and sex workers, and the provision of condoms in public venues.

2.7 Interventions targeting areas of origin

All the reviewed projects focused on the areas of destination for migrants and neglected the areas from which they originated. Interventions at destination sites could certainly address a diversified (geographically and ethnically) population of migrants. However, lack of awareness of the various local myths and risk behaviours linked to the sexual and reproductive health of each group of migrants could possibly result in ineffective interventions because they might lack cultural sensitivity.

Understanding the context and source of myths and their links with risk behaviours can inform the development of suitable strategies for behaviour change; for example, use of IEC materials that provide information by providing alternative narratives to local myths could be very effective. According to the 2009 census data, provinces such as Thanh Hoa and Nghe An, had a very high rate of outmigration. Using information related to local beliefs and myths to target sexual and reproductive health interventions among potential migrants would help to better protect them, irrespective of whether they stay or ultimately leave.

2.8 Sustainability and replicability

Internal migration is a phenomenon across many provinces. However, most of the reviewed projects implemented had limited geographical coverage, short duration and limited audience and thus it was hard to judge their effectiveness and impact. After nearly all the projects ended, no further information about the sustainability or replicability of the interventions was gathered. There was one exception: the Far Away From Home Club in Can Tho province. Because that project successfully mobilized the participation of many actors, and shared lessons learned and project reports with authorities and organizations in other provinces, the intervention model will be replicated in Ho Chi Minh City and other provinces.[102]

It was also hard to assess each project's effectiveness due to their limited coverage and time frames. However, the Far Away From Home Club again

seems to be the most successful model, for several reasons: i) it integrated socio-cultural factors, such as the role of social networks, peer educators and emphasised strict confidentiality of information; ii) it mobilized a provincial multi-sector team, with the Department of Labour, Invalids and Social Affairs as the lead agency, which is a very strong government office for dealing with most vulnerable migrants, such as intravenous drug users and sex workers; iii) it documented all activities and lessons learned in detail and shared the findings with other partners; iv) the model will be replicated in other provinces due to the evidence of its success in Can Tho province.

2.9 Knowledge gaps and opportunities for future research

Lack of research on socio-cultural factors that influence migrant's sexual and reproductive health-related risk behaviours: as previously noted, available literature on migrants' sexual and reproductive health is very limited. Most of the large-scale studies on migrants' health took the form of surveys, and often failed to examine important factors influencing the sexual and reproductive health of migrants, such as cultural influences and gender relations. Although available literature describing sexual and reproductive health among rural women identified strong links between socio-cultural factors, risk behaviours and access to health services, no study explicitly looking at such links was identified during the review.

The reviewed quantitative studies mostly provided data on the overall reproductive health status of migrants, their knowledge, attitude and practices regarding sexual and reproductive health, or their access to information and services in general. More attention was paid to the physical environment of migrants, such as their living conditions and access to clean water. Impacts of the politico-socio-cultural environment were barely touched on. Those that did address such issues were very small scale and focused only on STIs, HIV and AIDS, thus neglecting other important issues, such as reproductive tract infections, contraception, unwanted pregnancy, unsafe abortion and adolescent health.

Lack of representative or accurate data on migrants' sexual and reproductive health: the vulnerability of migrants to sexual and reproductive health problems, including HIV infection, should be well demonstrated to policymakers in order to advocate for more supportive policies. However, the reliability of the limited available data on migrants' sexual and reproductive health is questionable, for several reasons:

- most of the surveys were conducted in a small geographical area, such as one or two districts, thus the data cannot be generalized to the whole population
- most of the surveys were conducted in two big cities, Ha Noi and Ho Chi Minh City; other provinces – such as Binh Duong and Da Nang – have increasing rates of outmigration, but data on their situations was not available
- most of the surveys did not capture all types of migrants. Even the largest survey, the Government's 2004 migration survey, omitted some types of migration, such as temporary, short-term and circular movements

Lack of research on access to reproductive health services for migrants: Very few of the research studies examined the accessibility or availability of reproductive health services for migrants. Those that did only presented descriptive information on the use of certain specific services, such as contraception or gynaecological examinations, without providing any insights into enabling factors or barriers to access. In addition to descriptive studies, future research should analyse the determinants of accessibility or availability of services for migrants, including examining the negative impact of the *ho khau* registration system, as well as considering how to implement suitable health insurance policies for this group.

Lack of research on migrant subgroups such as ethnic minorities, street children and adolescents: It is important to acknowledge that migrants are not a homogenous population; rather they can be stratified by ethnicity, age groups, or purpose of migration. Each subgroup has their own needs for sexual and reproductive health services, and their own barriers in accessing them. Future research should provide stratified information on these groups that can be used to create more suitable strategies and policies. Due to their double vulnerable position, some groups, such as ethnic minorities or adolescents, deserve more attention.

Inadequate study design: Most studies applied a cross-sectional design, which provides only a "snapshot" of the migration populations, thus failing to capture the dynamic changes among them. Longitudinal studies that follow subjects over time should be conducted in the future to provide regular reliable and accurate information on migrants. Additionally, studies often use a purely quantitative or qualitative approach, while neither is sufficient to provide a comprehensive understanding of the interfaces between socio-

cultural factors, migrants' sexual and reproductive health, and their access to health services. A mix of quantitative and qualitative methods would be the best approach.

Lack of data on violence: The 2010 National Study on Domestic Violence Against Women, launched by the Government and the United Nations, revealed that 34 per cent of ever-married women reported having experienced physical or sexual violence from their husband at some time in their life. Ever-married women who were experiencing either type of violence at the time of the survey amounted to 9 per cent. However, there is no representative data about the prevalence of violence among female migrants. Qualitative studies have reported a high level of violence experienced by female migrants. Although qualitative studies are suitable for providing in-depth information about complex socio-cultural roots of violence, quantitative data on the prevalence of violence among this population is important to show policy makers the scope and burden of violence in order to push forward with policy regulations. Without this data, it is hard to advocate for interventions and policies to prevent violence against female migrants.

Lack of evaluation studies: In most of the identified projects, baseline surveys were conducted to provide background information to assist in the design of the intervention. However, after the interventions had ended, most projects were not evaluated, so the impact of the activities was not analysed and documented. This was partially due to the lack of funding, short project implementation time, and the mobile status of the targeted population. Still, without impact evaluation results, it is hard to judge the success of the different models and to make decisions on whether or not to replicate them in other areas.

Lack of research on the structural or political environment of socio-cultural norms: Cultural norms and values are individual to each community and are deeply rooted in the history, politics, religion and geography of the Vietnamese people. However, these norms and values are still dynamic and continue to change as aspects of structural and political environments. To change negative sexual and reproductive health behaviours, further research needs to explore the impacts of the structural, political and educational environments that shape traditional values and cultural norms.

CHAPTER THREE

Conclusion and Recommendations

Understanding the links between culture, gender and reproductive health is vital for any intervention programme for female migrants. This review provides an overview of the socio-cultural factors that influence sexual and reproductive health behaviours of female migrant populations and their access to related services. The review of literature on the sexual and reproductive health of female migrants in Viet Nam has prompted the following recommendations.

Michael Foley Photography

Recommendations for interventions

Future projects should consider the following issues to make interventions more socio-culturally appropriate:

- All interventions reviewed targeted migrants only in destination areas. This approach often experienced the following obstacles: unstable job security and frequent movement of residence among migrants led to limited sustainability of interventions; busy working hours of migrants prevented them from attending peer education or intervention activities. Future interventions should also target places of origin of migrants to provide information and education on the importance of sexual and reproductive health care, access to services, and life skills, so that the benefits of these interventions can be realized when they are in destination communities – where they can be influenced by peers and relatives from their places of origin – in addition to when they return home for holidays and on important occasions. Targeting places of origin would also result in the creation of IEC materials that take into account local myths and misconceptions about sexual and reproductive health issues.

- Churches, pagodas and temples are typically the heart of a community: places where people seek spiritual guidance and support. These locations are often popular and convenient places for community events for both locals and migrants. Gathering together for religious activities may help break through boundaries between migrants and locals. Future projects should tap into positive religious beliefs and religious networks.

- As the trend of female migration continues to increase, and as the problem of violence against them persists, future projects should address gender-related issues and violence.

- Collaboration with state clinics to offer reproductive health services for migrants is necessary; however, the literature reflected a reluctance among migrants to use these services, so future projects should consider providing training for health care workers in order to: i) change their attitudes towards migrants, ii) help them to provide culturally sensitive services and iii) help them to provide clarification and alternative narratives to local myths and misconceptions among migrants.

- Most interventions use a network of volunteers and peer educators to provide information; future projects should consider using these networks to deliver non clinic-based reproductive health services, such as the distribution of condoms and contraceptive pills.

- All reviewed projects targeted migrants and those in closest relationship to them, such as landlords and employers. Migrants are still associated with "social evils" by both local residents and authorities, which leads to the isolation of migrant populations. The feeling of being "isolated" or a "foreigner" may prevent migrants from accessing information and services. Community involvement is therefore necessary for all interventions.

- Community participation gives migrants a sense of ownership and helps ensure that services are acceptable, appropriate and sustainable. Although not directly linked to the focus of this review, so not described in the preceding section on interventions, an example of a good practice to help migrants integrate with the local community is the PhotoVoice Project by Marie Stopes International. An exhibition of photos taken by migrants was created that reflected their lives, and was accompanied by narratives written by the participants, explaining the thoughts, ideas and situations behind the images. The exhibition gave migrants a direct opportunity to reveal their experiences and feelings to local communities, the media and government officials, who in turn expressed their support and understanding to the participants.

- The review identified no intervention addressing important socio-cultural barriers to reproductive information and services, such as fears about stigma, being associated with social disapproval, or the expected obedience and sacrifices of female migrants. Future interventions should try to empower female migrants, promote their self-confidence and identity to better protect their physical and psychological integrity.

- A number of "community-based" programmes were designed in response to identified needs of communities, and provided services to promote migrant sexual and reproductive health care, such as the Community House for Migrants project by the Light Community Health and Development Organization and the Train Catholic Migrants in Thai Ha Church project. These interventions were designed for delivery in a local community, but did not simultaneously focus on fostering positive

attitudes within the local community by also targeting the host community to address negative attitudes towards migrants. Commitment and participation of local partners and leadership is vital for the success and sustainability of a programme. Choosing the right leading partner for an intervention is very important, as was proven in the Far Away From Home Club.

- Private employers and large companies in the industrial zones need to be included in awareness-raising and anti-stigma campaigns and encouraged to provide more client-friendly services in on-site clinics.

Recommendations for policy makers

- Migration is a missing link in current Viet Nam development policies. Despite the increasing trend of internal migration, the Government has so far kept a distance from voluntary internal migration and related issues. As the trend continues to increase, the Government needs to recognize migrants as a priority group for specific interventions, including sexual and reproductive health information and services.

- Local leaders' commitment and support was evident during each project's life cycle, but tended to fade away once projects ended. To sustain reproductive health interventions for migrants, it is essential that information and service plans and programmes be integrated into the health, education and development plans of communes, districts and provinces. This can only be done when government creates policies to support migrants.

- The Government and Ministry of Health should review the health insurance policy so that migrants can afford to take out insurance, and suitable arrangements should be made so that migrants can obtain health insurance at their places of destination.

Recommendations for research

- To advocate for better policies for female migrants, there is a need for accurate and representative data on the situation of migrants' sexual and reproductive health, as well as a better understanding of the socio-cultural factors influencing their behaviours. This could be achieved by:

- *implementing large-scale research that will generate representative information for different geographical areas*

- *improving the quality of national surveys (census and the household living standard survey, for example) to capture all migration types, including temporary and circular movements; in addition, more sexual and reproductive health-related questions should be added to questionnaires to gather comprehensive information*

- *to capture the specific social and cultural dynamics of internal migration populations, more research should be done to evaluate their relevance; however, it is important to bear in mind that Viet Nam has 54 ethnic groups and 3 major geographical regions (North, Middle and South), with diversified socio-cultural environments, so questionnaires would need to be adjusted to reflect the differences among ethnic groups or those regions*

- *employing a mixed-method approach combining quantitative and qualitative methods so as to provide both representative data and in-depth information on the influence of politico-socio-cultural factors*

- *exploring the structural and political environments that shape socio-cultural norms and traditional values*

- *examining the sexual and reproductive health situations and needs of migrant subgroups, such as ethnic minorities, adolescents and street children*

- Project impact evaluation is another area that needs to receive more attention. There is a critical need to know whether an intervention works or not before decisions are made to replicate or change it. For instance, although the peer educator system was used extensively in many sexual and reproductive health intervention programmes for migrants, its effectiveness has never been evaluated. If future research can show evidence of its effectiveness, the peer educator system could be incorporated into a broader system, such as a non-governmental interdisciplinary system of community educators, with support from doctors and teachers.

- Most social science research on sexuality, gender and socio-cultural realities has been done by international researchers and published internationally. Due to language barriers and limited access to international journals, much of the information does not reach Vietnamese policy makers. All research work should be made accessible to policy makers, including translations.

- Documentation of project activities and the sharing of experiences and lessons learned among different agencies and partners should be fostered in order to gain and strengthen expertise in implementing socio-culturally relevant programmes for female migrants.

Recommendations for health service providers

- Health service providers sometimes reflect their own cultural or social values when dealing with sensitive issues, such as unwanted pregnancy, STIs or HIV. To provide better services for migrants, service providers need to be trained to explore and change their own values and attitudes towards sexual and reproductive health, including confronting their own critical or negative inferences about "social evils", and developing respect for migrant clients.

- Health service providers should rely on measures that ensure strict confidentiality of client information. These measures should be explicitly documented in the project protocol and announced to the service clients to reduce their fear of losing face or being stigmatized if associated with HIV, AIDS, STIs, abortion, extra-marital or pre-marital sex, etc.

- Traditional values often leave female clients reluctant to be examined by male health care staff. Health service providers should consider female-only clinics, with female-only staff performing gynaecological examinations.

- Health service providers should consider introducing hours of services that are convenient for migrants with long working hours, and should also offer outreach programmes for those are who hard to reach, such as sex workers or migrant domestic workers.

Recommendations for employers

- Employers should provide information and services on site to facilitate reproductive health care among migrants working in industrial zones. Lessons learned from previous interventions in the industrial zones showed that the employers were not very committed to intervention activities because they did not recognize the benefit to their companies. Often they felt annoyed because factory productivity and income was affected due to shortened working hours. Future projects should advocate with employers about how, in the long term, the interventions will promote a healthy workforce, which will lead to increased productivity, and that time lost to such activities will be offset by the time saved in preventing workers from becoming ill, or having to leave their employment because of lack of access to satisfactory treatment. This would alleviate the likelihood of having ill workers, or workers who leave because of poor health or inadequate, unhealthy working conditions.

Letizia Airoldi

ANNEX ONE

Endnotes

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ANNEX TWO

Organizations Consulted

Action Aid

ACTION AIDS

CARE International in Viet Nam

CEPHAD - Center for Public Health and Community Development

CEFACO - Research Center for Family Health and Community Development

CGFED - Research centre for Gender, Family and Environment in Development

CSAGA - Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents

FHI - Family Health International

General Office for Population Family Planning

General Statistics Office

ILO - International Labour Organization

IOM - International Organization for Migration

ISDS - Institute for Social Development Studies

LIGHT - Community Health and Development Organization

Marie Stopes International Viet Nam

National Committee for Population and Family Planning

Save the Children, US

SHAPC – STDs/HIV/AIDS Prevention Center

The Center for Health and Social Policy

UNFPA – United Nations Population Fund

Viet Nam Women Union and Market Development Research Center

WHO – World Health Organization

ANNEX THREE

Overview from four Mekong country reviews

The following is a summary overview of the analysis presented in a series of four literature reviews that the United Nations Population Fund (UNFPA) commissioned to identify socio-cultural factors that affect the sexual and reproductive health of female migrants. The reviews encompassed looking at research, study reports and other available documents, mainly from the past decade, on internal migrants in Cambodia, Lao People's Democratic Republic and Viet Nam, and international migrants from Myanmar in Thailand. The reviews were premised on the assumption that socio-cultural factors impact on the potential of female migrants to access sexual and reproductive health information and services and protection from violence. The consultants sought to identify factors enabling access to information and services, as well as examples of good intervention models that might be replicated or scaled up. Potential barriers to access of reproductive health services by female migrants were also described.

In the four countries included in the literature review, the majority of migrant women were found to be working in factories, the entertainment sector and domestic work. Almost all the literature available focused on the first two sectors, with no studies identified that looked specifically at the situation of domestic workers. Interviews with researchers, relevant staff from government institutions, United Nations agencies and non-governmental organizations, provided supplementary information on research, programmes and interventions addressing the sexual and reproductive health of migrant women.

Migration in South-East Asia

Labour migration grew dramatically in the early 1990s in South-East Asia, with Thailand becoming the main recipient

of migrants from other countries in the Mekong region. An estimated 1.8–3 million documented and undocumented migrants from neighbouring countries live in Thailand. Internal migration, however, dominates the flows of people within the region, despite the increasing movements of international migrants. At national level, internal migration rates vary significantly across provinces.

Generally, there are few restrictions on intra-regional migration in the Mekong region and simultaneously there are few initiatives to facilitate safe migration. Poverty and the inability for rural economies to sustain themselves have been identified as the main drivers of labour migration. Political factors are also a trigger in the case of some migrants coming from Myanmar to Thailand.

Internal migration has increased significantly in Cambodia, Lao PDR and Viet Nam for several reasons, including poverty and limited employment prospects in rural communities. Such movements have also been influenced by increased opportunities to work in factories and entertainment sectors as national economies have opened up.

Migration has grown more feminized in recent decades. In the Mekong region, a large proportion of migrants tend to be young, unmarried women who move without their families.[69]

Migration has lifted many women and their families out of poverty. But the absence of legal and institutional mechanisms to protect their rights shows that economic gains within the region have often not been matched by parallel advances in social protection. Migration for many women means working in precarious and dangerous jobs often characterized by low wages, poor work conditions and lacking employment benefits. Many migrant women lack awareness on how to protect their own rights, including the right to health care.

Review findings

The literature reviewed showed that many women migrants encountered institutional, legal, economic, social or cultural barriers in accessing public

health services. They usually lacked access to reproductive health information and services in their work destinations, a situation which was exacerbated by the fact that low-skilled migrants tended to have low levels of education, with a small proportion having had no education at all.

Several socio-cultural factors were identified as barriers to sexual and reproductive health information and services. For example, where women did not speak the same language as those in their migration destinations, language barriers were an important factor hindering access to relevant and timely health information and services. Unequal gender relations affected health-seeking behaviour. For example, in the countries reviewed, women were found to hold back on making decisions related to their sexual and reproductive health protection in deference to men. Young women were especially vulnerable to health risks because of their fear of it being found out that they were sexually active before marriage. Health service providers were reported to have prejudicial views of migrant women as not "respectable" and, in many cases, associated with sex work. Among migrants, therefore, there remained a strong preference for seeking traditional practitioners, private services, or over-the-counter medicine, rather than seeking treatment from public health facilities. In all four countries reviewed, significant numbers of unwanted pregnancies and unsafe abortions were reported.

Belief in traditional explanations regarding health also sometimes served as barriers to understanding the seriousness of medical conditions and the necessity to seek immediate treatment. Cultural values such as preservation of "face" were found to have a significant impact on health-seeking behaviour. The fear of being stigmatized as an individual who deviates from societal norms was strong. This finding was closely associated with gender norms ascribed to women, namely that they should remain 'good' women, sexually inactive before marriage. In spite of these expectations, in the role of economic provider many women were encouraged to seek employment away from home, often far from the security of traditional norms and support mechanisms. Nonetheless, community, and in particular the role of social networks, was found to be a critical factor influencing women migrants in general, including their sexual and reproductive health behaviour and, possibly, their health care choices.

There were substantial quantitative and qualitative studies conducted on broader migration issues in three of the four countries reviewed – Cambodia, Thailand and Viet Nam – but links between the socio-cultural factors and

sexual and reproductive health were rarely the specific focus of studies; such a link remains poorly documented. There is a need for more systematic research on internal migration, especially examining the migration trajectory of internal migrants and the effects on sexual and reproductive health outcomes.

Ethnic minority women who, until recently, were isolated from most development initiatives, are becoming increasingly visible among migrant populations, particularly in Viet Nam and Lao PDR. The nexus between minority cultures, beliefs and practices with migration has barely been explored at all. The literature on the situation of migrant women in Lao PDR is very limited and, given the increase in internal migration, research on a range of issues related to migration would strengthen the existing information available.

The literature review focused on female migrant workers. However, several of the reports noted the need for corresponding research in relation to male migrants, particularly because male perceptions, knowledge and behaviours are likely to have a significant impact on female migrants' sexual and reproductive health behaviour and outcomes in destination communities. In all four countries, migrant workers' social networks and relationships formed in destination communities were found to have an important role in influencing their decision making and choices in all aspects of their lives. In most contexts such networks include male migrants, as well as men in destination communities. Socio-cultural factors impacting on male knowledge, attitudes and practice in the realm of sexual and reproductive health, and the links of this with women migrants' health is thus deserving of greater investigation.

The available research and reports of interventions reflected a focus almost entirely on sexually transmitted infections (STIs) and HIV prevention among migrant women, suggesting that priorities have corresponded to national concerns about the spread of HIV and AIDs in the region. The report of the AIDS Commission on Asia in 2008 clearly identified that HIV transmission in Asia was primarily among high-risk groups – sex workers, men who have sex with men, and intravenous drug users – some of whom may be migrants. Although some migrant women engaged in sex work (either directly in commercial establishments, or as a side-line to supplement their income), the majority of migrants were employed in low-risk occupations, such as factory work and domestic work. However the high mobility between employment

sectors indicates that, potentially at least, the sexual and reproductive health of all migrant women is at risk.

The very narrow clinical focus on STI and HIV prevention, by both governments and non-governmental providers, means that migrant women's other identities – as girlfriends, wives and mothers – has been neglected. Given that a large proportion of migrant women appeared to be young and unmarried, and that societal norms and constraints are no longer necessarily applied or adhered to in migration destinations, potential needs for contraception must be addressed, particularly if unwanted pregnancies and unsafe abortions are to be avoided. To address the often high levels of unsafe abortion, emergency contraception should be added to the contraceptive mix in each country if not yet available. In Viet Nam and Thailand, significant numbers of the surveyed migrant women were also married and, in addition to contraceptive needs, they were in need of services including ante-natal and post-natal care and access to assisted deliveries and emergency obstetric care. Further research should be conducted to address the broader aspects of reproductive health and associated socio-cultural factors among these women.

Additionally, although a number of the documents reviewed referred to the violence experienced by some migrant women – especially during the migration process and for those engaged in the entertainment and sex industries – there were few projects or programme interventions identified that aimed at protecting them from violence and addressing their right to access related support services.

Several successful interventions to address the sexual and reproductive health needs of migrant women were documented. For example, to address the different language needs among migrant women from Myanmar in Thailand, information and educational materials were developed in the languages of the migrants and, in some locations, systems were established for bi-lingual migrant health workers and volunteers to accompany migrant women to public health services. Health clinics, including mobile clinics and drop-in centres in migrant communities, and clinics providing migrant-friendly services, including referral and counselling, have been successfully established in Thailand for migrants from Myanmar.

In all four countries reviewed, peer educators were recruited and trained to work with migrant women, usually in their places of employment, and most

often in work related to the entertainment industry where women frequently engaged in commercial or transactional sex. This approach was widely regarded as successful although often challenging due to the high mobility of migrants. Information, communication and education materials specifically targeting migrant women, which incorporate popular local beliefs, and which address relevant issues, were also noted as successful initiatives.

Recommendations

Given the general lack of regulatory systems in place to protect migrant workers, and insurance schemes to ensure their access to health services, a number of recommendations emerged from the reviews. A key identified need was for increased advocacy among policy-makers to ensure that migrant rights are included in all relevant national policies, and that service provision addresses their broad reproductive health needs.

Recommendations were made that employers of migrant women, particularly factory owners and those involved in entertainment sector establishments, should promote reproductive health information through the workplace, using peer education strategies. Factory owners should make services available on site, or create time when staff can access external services during work hours without docking their pay.

Health service providers would benefit from being trained in client-friendly service provision to ensure, in particular, that marginalized migrant women – such as unmarried women, those engaging in sex work, and those from ethnic minority communities – are not discriminated against.[49] This would entail strengthening the capacity of health providers to better understand socio-cultural influences on sexual and reproductive health, and the way gender norms affect health-seeking behaviour and the choices of female migrants. Increased attention should be paid to promoting behaviour-change communication strategies, and information and education materials, that respond directly to female migrants' health vulnerabilities, and that are presented in a language and format that suits their levels of education, existing knowledge and preferences. A shift from a purely biomedical approach focusing on STI and HIV prevention towards a holistic approach that addresses the full range of migrant women's reproductive, and other, health needs, in non-discriminatory settings, would likely encourage more women to use available services.

In addition, women migrant themselves need to be supported and empowered to advocate for and claim their own rights to health care and health protection. Migrant associations and NGOs could facilitate migrant women to set up support networks and groups to discuss issues related to migration, including sexual and reproductive health, and violence. The Thailand and Viet Nam reviews provide examples of such initiatives.

Work could also be done with workers and employers organisations, and law enforcement officers to facilitate women migrants' access to justice and to ensure that rights violations are addressed. In all four countries, this would entail considerable capacity strengthening, given the vested interests that some law enforcement officers are reported to have in colluding with negligent employers and other intermediaries involved in the migration process. Lastly, in some contexts, and because of their influence at the community level, religious leaders' capacity could be strengthened to support migrant women's rights.

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect.

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