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Ensuring rights to access health services for ethnic minorities in Vietnam in current context

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Abstract

Ensuring human rights of ethnic minorities, including the right to access health services, is one of the important contents, recognized and protected in international legal documents and nations' laws. Vietnam is a multi-ethnic country with 54 ethnic groups, of which Kinh people are the majority, accounting for about 87%, the remaining 53 ethnic minorities account for only 13% of the population but live in the large area, accounting for % of the whole country territory, mainly mountainous, remote, and border areas, where natural conditions are harsh, and socio-economic conditions are extremely difficult. Over the past years, the Government of Vietnam has made great efforts to ensure human rights in general, ethnic minorities' right to access health services in particular and in fact has achieved important results not only in improving laws and policies but more importantly, showing the progress in implementing the criteria: coverage, accessibility, acceptability and quality of service. Nevertheless, assurance about the rights of ethnic minorities to access health services, especially quality services with favorable conditions and reasonable costs, is still a challenge today. Based on the theoretical framework, approach method and evaluation criteria, the article outlines some of the advancements and challenges posed in improving the equitable accessibility of health services of ethnic minorities, from that, making recommendations on policies to ensure this right in accordance with the context of ethnic minorities in Vietnam.

Key words: Human rights; health services; ensuring rights; ethnic minorities; Vietnam.

Introduction

Vietnam is a multi-ethnic country with 54 ethnic groups, of which Kinh people are the majority and 53 ethnic minorities (only about 13% of the population) mainly live in mountainous and remote areas, where living conditions are extremely difficult. Therefore, ensuring the right of ethnic minorities in Vietnam, including the right to health, is always an issue that attracts the attention of the State and society. In recent years, many new studies have positively contributed to changing perceptions and developing diverse study methods related to assurance about the right to access health services of ethnic minorities in Vietnam.

Rob Swinkels and Carrie Turk in the article of *Explaining Ethnic Minority Poverty in Vietnam: a summary of recent trends and current challenges* mentioned health care policies for ethnic minority households in Vietnam: "Government policies of recent years have focused on alleviating the costs of curative health care for households defined as poor by the Ministry of Labour, Invalids and Social Affairs (MOLISA), either through the provision of healthcare cards that allow free treatment or by providing free health insurance. The VHLSS 2004 shows that there has been an increase in the proportion of the population covered by either free healthcare cards or health insurance. The increase has been more dramatic for ethnic minorities than for Kinh people and has been particularly striking in the North East, the North West, the central coastal regions and the central highlands. In several regions, more than 70 percent of ethnic minorities possess either health insurance or a healthcare card." (Rob Swinkels and Carrie Turk**,** 2006, P.11) Author Nguyen Thi Song Ha in the article of *Ensuring basic rights of ethnic minorities in Vietnam today* analyzed the situation of ensuring economic, educational, health and cultural rights of ethnic minorities and offered a number of solutions to improve efficiency in the process of implementing policies to ensure the economic, cultural and health rights of ethnic minorities in Vietnam today. (Nguyen, 2016)

According to the United Nations Development

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Program (UNDP) in the *Vietnam Human Development Report (2011)*, the legal and policy framework of Vietnam is to ensure universal access social, health and education services, that is in accordance with the fundamental principle of human rights and is a key prerequisite for equitable human development. However, the process of ensuring still remains a number of challenges that need to be addressed, for example, inequality and persistent disparities in access health services among ethnic minorities in Vietnam: Ethnic minority groups continue to face barriers in accessing health services; Health centers in poor communes are only equipped with the most essential facilities and medicines, much lower than the average level. The majority of those who are sick or injured, coming to see a village health facility have to overcome the average distance of 3,87 kilometers. Approximately 17% of cases are treated in better-equipped hospitals, with an average distance of 39 km or 3 hours by public transport. About 30% do not use any of the available medical services. (UNDP, 2011, P.81)

Research by the Committee for Ethnic Minorities, United Nations Development Program (UNDP) and Irish Aid in an *Overview of the Socio-Economic Situation of 53 Ethnic Minorities (2017)* has shown the need to combine theoretical analysis with evidence-based analysis to overcome subjective, one-sided assessments and make policy recommendations close to the actual context of groups of ethnic minorities in Vietnam. For ensuring ethnic minorities access health services in Vietnam, this study found that: The proportion of ethnic minorities using health insurance cards is not high; The proportion of ethnic minority women having antenatal examination is not popular; The distance from home to the medical station is quite far, especially for the ethnic groups of Mang, Lo Lo, Cong, La Hu; The customs of giving birth at home is very common among ethnic minorities. In all ethnic minorities, about 64% of all births are carried out in medical facilities. Meanwhile, a half of ethnic minorities still choose to give birth at home as the primary method,… This situation continues to raise questions for policy makers about the extent to which ensure ethnic minorities equal access health services in Vietnam today?

Using a qualitative approach method, interviewing primary health care professionals and informants, mainly Thai and Hmong ethnic women, author Shannon McKinn et al. Studied on factors affecting maternal health care of ethnic minority women. The study focused on three main topics to explore how and why ethnic minority women use maternal health care services and the factors that influence the decision to access or not access home-based care services for women and families. Research shows that there are a variety of factors that reinforce inequalities in health outcomes, for example, pregnant women attach importance to treatment over prevention, and improvement in infrastructure and services, economic situation to support access health services is less obvious for Hmong, primary health care facilities are of lower quality than hospitals, and women make decisions to access health services basing on this perception. According to this study, primary health care facilities are technically available and accessible for ethnic women, however, they will not use them if they are perceived to be of low quality. On the other hand, in addition to the fact that some of the women with access quality services are limited to lower quality services, that creates the possibility of reinforcing inequality. (Shannon McKinn, 2017)

Based on a combination of different research methods to assess the perspectives of ethnic minority women in six provinces of the Central Highlands and the Northern Midlands and Northern Mountains region of Vietnam, United Nations Population Fund (UNFPA) (2017) found that, in addition to the rather optimistic situation in some indicators and some ethnic groups, inequality persisted in all ethnic minority groups compared with national figures. This is shown in four indicators: 1) The proportion of ethnic minority women accessing antenatal care services (at least 04 times of antenatal examination) is 58 percentage points lower than the national average (16% vs. 74%). 2) The proportion of giving birth at health care among ethnic minority women participating in the study was 53 percentage points lower than the national estimate (41% vs. 94%). 3) The proportion of births with the support of a qualified health worker is 45 percentage points lower among ethnic minority women participating in the study compared with the national estimate (49% vs. 94%). 4) The proportion of ethnic minority women participating in the study with adequate prenatal care (e.g. blood pressure, blood and urine tests) is 38 percentage points lower than the national estimate (18% vs. 56%). Research has identified four main reasons why women do not access or inadequately access maternal health care services, including: 1) The degree of acceptance of maternal health care services by cultural and social factors; 2) Appropriateness of the quality of maternal health

care services; 3) Accessibility of on-site maternal health care services; 4) The ability to pay for maternal health care services. In some areas, ethnic minority women do not access maternal health care even though they live right next to the commune health centers.

Author Bich Diem in the article of *Ensuring health care for ethnic minorities in Vietnam* has built a general analysis framework on the process of implementing laws and policies in Vietnam in this field, including contents such as: legal framework, policy; health insurance support, administrative procedure reforms, improvement of the quality of medical examination and treatment for ethnic minorities, ... Based on the results of the sociological survey, the author has discovered shortcomings related to the implementation of laws and policies, and cognitive and cultural characteristics, affecting the quality of accessing health care services for ethnic minorities. For example, the issuance of health insurance cards for ethnic minorities in some localities is slow and not timely; making health insurance card duplicated for objects; making statistics and making lists of ethnic minorities confused; decentralization of management, unclear and incomplete identification of beneficiaries in some documents according to the Law on Health Insurance and Decree 105 of the Government. On the side of the people, there is a situation where the cards are not carried in medical examination and treatment, the procedures are often missing such as personal paper with photo identification, hospital transfer sheet, ... hindering admission to hospital. (Bich, 2017) The author Do Hong Thom in his research on *Implementing the laws on economic, social and cultural rights for ethnic minorities in the northern mountainous provinces of Vietnam* has researched, analyzed and evaluated systematically implementation of the laws on economic, social and cultural rights for ethnic minorities in the northern mountainous provinces, stating achievements, weak limitations, forecasting impact trends and feasible solutions to ensure the implementation of the law on economic, social and cultural rights, including the right to health care for ethnic minorities in the current northern mountainous provinces. (Do, 2015)

Regarding challenges in equitable access to health care services for ethnic minorities, author Hoang Van Minh identified three criteria: 1) *Population coverage* (Width-based health care coverage), such as: Limited access to health services due to existing geographic distances. Language is also a barrier to access and use of health care services in some ethnic minority areas. The rate of using health insurance for medical examination and treatment will not increase significantly because many ethnic minorities do not use health insurance, resulting from not understanding the role and value of health insurance. 2) *Service coverage* (Depth-based health care coverage): The coverage of maternal and child care services still remains many indicators (for example, use of family planning methods, 4 or more prenatal examination, deliveries by qualified people, immunization of children...), not meeting the Millennium Development Goals for ethnic minorities associated with the following sustainable development goals 2015. While the burden of diseases caused by non-communicable diseases is on the rise, health care services for non-communicable diseases for ethnic minorities in Vietnam are still in short supply. The lack of health care services at the grassroots level will result in transgression when needed (with the current inter-district health insurance policy). 3) *Financial coverage* (Health coverage for height): Ethnic minorities will still face financial difficulties when going to medical examination and treatment because some localities have not yet provided food, travel and living allowances for ethnic minorities when going for medical examination and treatment at medical facilities. HIV counseling, testing and treatment services are not always available. Providing prevention and control services for emerging infectious diseases (for example, COVID-19) will remain difficult. In particular, for the elderly, the poor, people with serious diseases and when the grassroots health system is incapable of providing necessary and quality services, there will be a phenomenon of many people not using services due to lack of money or falling into borrowing, debt, property sales ... resulting from medical examination and treatment costs. (Hoang, 2020)

The author Hong Minh analyzed how to implement health care policies for ethnic minorities in Lao Cai province - a mountainous province in the North of Vietnam. In additions, some results and researches have pointed out shortcomings from the subjects who are obliged to provide health services, such as the lack of names of technical services in medical examination and treatment at database. In particular, after privacy policy has been applied since January 1, 2016, the form of outpatient examination and treatment at the commune health station is very low. Initial

medical examination and treatment facilities cannot be managed and controlled when the patient comes to other medical facilities, especially the patient's failure to go to the commune level, leading to both overcrowding and increasing costs for examination and treatment that is not covered by the Health insurance. (Hong, 2017)

Research by Vu Thi Minh Hanh on the current situation and ability to provide health services in public medical facilities in 5 Central Highlands provinces also shows that there is a disparity in equipment between same level examination and treatment facilities and between provinces and intra-provincial district level. Specifically, over 80% of provincial general hospitals meet the list of equipment of the Ministry of Health with 4 specialties in Emergency resuscitation, Internal Medicine, Obstetrics and Pediatrics. For surgical medicine, the average response rate of equipment was only 60.5%. At the district level, the Department of Surgery, Intensive care and Internal Medicine have the proportion of hospitals equipped according to regulations, respectively 75% -79%, 77% -80% and 71,5% -73%. In the Department of Obstetrics, 60% - 65% of medical facilities have proper equipment and facilities, while only about 58% -60% of the District General Hospital are fully equipped according to regulations. Some of the consequences of this situation are that ethnic minorities living in the Central Highlands have the highest rate of sickness/ illness (84.5%); Ethnic minority women aged 15-49 years living in this region have the lowest rate of gynecological examination (42.9%); the lowest rate of pregnant ethnic minority women having antenatal examination at least 4 times (19.6%); Ethnic minority women have the lowest rate of postpartum visits (68.5%) and the lowest rate of giving birth at medical facilities (85.7%). (Vu, 2013)

It can be said that, in the context of international integration, the studies as outlined above have created important changes in approaches and research methods to understand multidimensional challenges and responsiveness of health services for ethnic minority health care needs.

Theoretical framework

The article applies the following mainly theoretical frameworks:

Everyone has common rights, including the right to access medical services (Medical services include all services for diagnosis and treatment of illness and care and rehabilitation operations – WHO) as documented in international human rights documents. According to the Oversight Committee of the International Covenant on Economic, Social and Cultural Rights (CESCR, 2000) (Vietnam National University, 2010), Article 12(2)(d), Right to use facilities, goods and health services are to facilitate to ensure that all people enjoy both physical and mental health services and medical care, including ensuring equal and prompt access to basic health prevention, treatment and rehabilitation services and health education; regular examination programs, treatments appropriate to common diseases, casualties, and disabilities, preferably at the community level; providing essential medicine, appropriate mental health care and treatment. In line with the universality of this right, WHO has adopted the concept of "Universal health coverage": Universal coverage, or universal health coverage, defined as the assurance that health enhancement, prevention, treatment, rehabilitation and palliative care can be accessed by all people well and efficiently when necessary, while ensuring that the use of these services does not expose users to financial difficulties (WHO, 2010). Recognizing this principle of universality, the Vietnamese Constitution 2013 has recognized: Everyone has the right to protection, health care, and equality in the use of health services (Article 38); and the Vietnamese Ministry of Health has also published the Report on Health Sector Overview 2013: Towards universal health coverage.

Respect the principles of equality and non-discrimination. This is a particularly important principle of the International Human Rights Code. In the health sector, the principles of equality and non-discrimination in access to health services need to be emphasized in order to protect and meet the needs of vulnerable groups such as ethnic minorities, the poor, women, children ... enjoyed essential standards of care and essential health insurance. WHO has recognized: Vulnerable groups in society tend to suffer an unfair share of health issues. Public or non-public discrimination breaks fundamental human rights principles and is often the root cause of poor health. In fact, discrimination can spread to poorly and improperly oriented health programs and limit access to health services (WHO, 2002)

Ethnic minorities' right to access health services has an interactive and interdependent relationship with other rights. The Universal Declaration of Healthcare Rights (2000), approved by CESCR, states that the right to health care is closely relevant and dependent on the realization of other

human rights (WHO, 2002). Understanding the multidimensional barriers to ethnic minority in accessing health services shows that these rights challenges are relevant to the ineffectiveness of some basic rights; For example, freedom of movement, the right to work and have a proper standard of living, the right to participate in public and social management, the right to complain, the right to access information, the right to use private language and preserve traditional cultural values ... However, this core characteristic has not been integrated in the formulation and implementation of government policies as well as the operation of social and professional organizations in the field of health service provision for ethnic minorities.

Fulfill the national obligation completely in ensuring the right of ethnic minorities to access health services. According to WHO, the right to health care does not mean the right to be healthy, or that poor governments have to set up expensive health services that they do not have the resources to support. But it requires government, and regulatory agencies to implement policies and action plans to make health services available and accessible to everyone in the shortest possible time (WHO, 2002). The full fulfillment of the national obligation to ensure this right must meet the following criteria: 1) Implement at all three levels: respect, protection and responsiveness; 2) Exercise by all appropriately legislative, executive, judicial measures and others; including special measures; 3) Bind legal responsibility of the competent state agencies and the medical community; 4) Available administrative or judicial mechanisms to meet the needs and requirements of people related to health care; 5) Publicity, transparency and accountability in periodic reports on implementation of laws and policies to ensure this right; accept the supervision of international and domestic organizations. (WHO, 2010)

Approach methods

This article applies the following major approach methods:

First of all, Human right-based approach (HBA).

This approach is encouraged by many international and regional organizations, such as: Office of the United Nations High Commissioner on Human Rights (OHCHR), EU, WHO, UNDP ... Human right-based approach is a method of using human right standards as a basis for determining expected results, while recognizing human rights principles as the framework and conditions for achieving results. According to WHO, the right-based approach to health care refers to the process of: i) Using human rights as a framework for health care development. ii) Evaluating and identifying the human rights effects of a health policy, program or law. iii) Making human rights an integrated part of developing, implementing, monitoring, and evaluating policies and programs related to health care in all aspects, including politics, economics, society. (WHO, 2002) Rights-based approach has fundamental implications for policies and laws, such as: 1) Consider both results and process aspects ; 2) Identify and remedy inequalities; 3) Enhance capacity, especially institutional capacity (organization, structure, resources); 4) Openness, Transparency and Accountability.

Second, a substantive equality approach

This is a common approach in research that guarantees the rights of vulnerable groups, such as women or ethnic minorities. The aim of this approach is to uncover long-standing contradictions between equality in law (equality of form) and equality in practice (equality of outcomes). Between ethnic groups or between groups within the same ethnic group, different outcomes of care are often received due to multiple reasons from the obligor and the beneficiary. Therefore, this approach focuses on analyzing the diversity and factors that create specific disadvantages, such as residence, language, culture, economic circumstances, social status ... through that, identifying special and appropriate measures to develop capacity and promote equal access to health services of ethnic minorities.

Third, a fair approach.

Ensuring ethnic minorities' right to access health services is relevant to equity goals of health for ethnic minorities. Central to this approach is that every citizen, regardless of economic circumstances, social status, ethnic origin or disease status, has access to essential health services without depending on their financial ability. In other words, it is unfair if a health system does not provide readily available, basic, and accessible health services to all people, all target groups; at costs consistent with the financial capacity of the user, not dependent on the state of their illness. Since the market cannot solve the problem of equity, this approach emphasizes the role of state intervention in building and developing the health system to meet the

objective of equity health for the ethnic minorities.

Third, a context-based approach.

General international principles and standards on human rights and health should be explained and implemented in the specific context of each country, locality or ethnic group. Relating directly to ethnic minorities' right to access health services, the context includes such diverse factors as: location of residence and place of residence; economic level; Conception and practice of using methods for healthcare, reproduction, disease treatment, newborn care; and factors influencing health, such as clean water, sanitation, nutrition, housing, education and risky behaviors (smoking, alcohol use, violence). For example, in Vietnam, many ethnic minority groups face language barriers when accessing health care information and using health services (especially using health care services in medical facility not in the locality where they live). There are also many ethnic minorities who want to have many children and give birth at home. The fact that ethnic minorities rely on worship for medical treatment ... These factors often differ between localities, regions and ethnic groups. This approach is a necessary complement to the aforementioned approaches and requires that information and data collected must be disaggregated concretely by ethnic group, sex, religion, age, education, occupation, economic circumstance to accurately measure ethnic minority access to health services.

Evaluation criteria

As a basic human right to health, the assessment of the degree of ensuring ethnic minority access to health services can be based on the standards recognized by CESCR. (Do, 2015, P.115)

(a) Availability: Well-functioning public health and medical facilities, goods and services, as well as programs must be available in sufficient numbers.

(b) Accessibility: The medical facilities, goods and services are accessible by all people without distinction within the framework of public responsibility. Accessibility has 4 intertwining parts: 1) No discrimination; 2) Access to geographic location; 3) Economically accessible (costly acceptable); 4) Accessible in terms of information.

(c) Acceptability: All medical facilities, goods and services must respect medical ethics and be culturally and sexually appropriate to the life circle, as well as built with the principle of respecting secrecy and improving the health conditions of those served.

(d) Quality: Medical facilities, goods and services must be medically and scientifically suitable and of good quality.

The above criteria are scientific, guided by an organization competent to oversee the implementation of the ICESCR (International Covenant on Economic, Social and Cultural Rights, 1966); Therefore, this standard requires that policies, laws and specific professional, administrative, judicial, and financial measures in the health sector all aim to achieve universal standards mentioned above and should be achieved at the highest possible level, consistent with national and local contexts. In Vietnam, some of these standards have been regulated in policies and laws on innovation in health service delivery in recent years. Since 2009, some of these standards have been specified in the Component Indicators of the PAPI (Provincial Public Administration and Public Administration Performance Index), for example, the public health content of PAPI includes indicators such as: The proportion of people with health insurance and the effectiveness of the health insurance card; Free medical service for children under 6 years old; Total quality of district hospitals (10 criteria), ... The United Nations Population Fund (UNFPA) and the Ministry of Health of Vietnam have also used such standards as: availability, accessibility, acceptability, affordability, and suitability to evaluate the level of access to health services by ethnic minorities in Vietnam. (UNFPA, 2017)

Research contents

Laws and policies on ensuring the right of ethnic minorities to access health services in Vietnam: Renovating priority service delivery and assistance

In Vietnam, to achieve the goal of equitable access to health services of ethnic minorities as well as other vulnerable groups, it is required the first change in perception and thinking from section on building state laws and policies.

- *In terms of accessibility and payment methods for medical services*. Implement the Constitution 2013 (Article 38), the Health Insurance Law 2014 has created a legal basis for important changes in this matter: People from poor households, ethnic minority living in areas with difficult socio-economic conditions are eligible for health insurance (Article 12 (h). Ethnic minority people and poor households participating in health

insurance are living in areas with difficult socio-economic conditions, areas with extremely difficult socio-economic conditions; Health insurance participants living in island communes or island districts, when taking medical examination and treatment at the wrong level by themselves, shall be covered by the health insurance fund for medical examination and treatment expenses at district hospitals, inpatient treatment at central and provincial hospitals with the benefit levels specified in Clause 1 of this Article (Article 22 (3). (National Assembly, 2014)

- *Regarding priority support to protect ethnic minorities against financial risks in accessing health services.* Joint Circular No. 41/2014/TTLT-BYT-BTC dated November 24, 2014 of the Ministry of Health and the Ministry of Finance, guiding the health insurance regimes on the beneficiaries of health insurance paid by the State budget, including: People from poor households and ethnic minority, living in areas with difficult socio-economic conditions; people who are living in regions with extremely difficult socio-economic conditions; people, living in island communes and districts under the Government's resolutions, the Prime Minister's decision and Minister and Chairman of the Committee for Ethnic Affairs. (MOH & MOF, 2014)

- *Ethnic minorities' access to health services has been integrated into government programs,* such as: Resolution No. 30a/2008/NQ-CP on poverty reduction support for 62 poor districts, (where there are 90% of ethnic minorities with more than 2.4 million people) have provided on-the-job training of professional staff and grassroots health workers for children in poor districts; increasing resources for the implementation of the population and family planning policy; promoting communication, mobilization in combination with the provision of family planning services to improve the quality of the population in poor districts; using development investment capital in the annual budget balance, government bonds, capital from programs, projects, and ODA capital to prioritize investment in socio-economic infrastructure projects, including: schools, district hospitals, regional hospitals, district preventive medicine centers, and certified commune health stations (including housing for health workers); inter-village roads. (The Government, 2008) Decision No. 1722/QD-TTg dated September 2, 2016, approving the national target program on sustainable poverty reduction for the 2016-2020 period. Based on the criteria: poverty rate, ethnic groups, and selected communes will be prioritized for investment in order to sustainably reduce poverty, facilitating access to health services, education, clean water ... The health target by 2020 is that 60-70% of communes meet the national health criteria, 80-90% of commune health stations are eligible for medical examination and treatment covered by health insurance. (The Government, 2016a)

- *Regarding the determination of metrics of responsibility for providing health services*. Decision No. 2348/QD-TTg dated December 5, 2016 of the Prime Minister, approving the Project on constructing and developing the grassroots health network in the new situation, with the targets by 2020: 95 % of district health centers can perform at least 80% of the list of technical services of the district level; At least 90% of commune health stations have enough conditions for medical examination and treatment to be covered by health insurance, and fulfill at least 80% of the list of technical services of the commune level; 70% of communes meet the national criteria on communal health; strive for 90% of the population to be managed and monitored for their health; completing the investment in health stations in communes with difficult and extremely difficult socio-economic conditions. (The Government, 2016b) Decision No. 1624/QD-BYT dated March 6, 2018 of the Ministry of Health, stipulating that by 2025, the following objectives must be achieved: a/ Health insurance participation rate will reach 95% of the population; b/ The proportion of households' direct spending on health reduced to 35%; c/ The rate of expanded vaccination reaches at least 95% with 12 vaccines; d/ The under-five and under-one year mortality rates were declined 18.5% and 12.5%, respectively; e/ The rate of stunting of children under 5 years old is less than 20%; f/ Strive for over 90% of the population to be managed by electronic records; 95% of commune, ward and township health stations perform prevention, management and treatment of a number of non-communicable diseases; g/ Reach 30 hospital beds, 10 doctors, 2.8 university pharmacists, and 25 nurses per 10,000 people; h/ The rate of people's satisfaction with health care services is over 80%. The aforementioned goals are fundamental innovations, aiming to build a fair health system that meets the health care needs of the people, especially groups like ethnic minorities, women, children, the poor and other

vulnerable groups.

Accordingly, it can be seen that the Vietnamese State laws and policies are quite comprehensive and synchronous, covering the contents of the rights of ethnic minorities to access health services. The legal and policy system has aimed towards fairness, quality and efficiency, in accordance with international laws on ensuring the right to protect health and the rights of ethnic minorities. However, the system of policies on access to health for ethnic minorities still has certain limitations such as: overlap, inconsistency, insufficiently particular management policies, some unsustainable policies and especially lack of resources to ensure implementation. The advantages and limitations of the legal and policy system on the right to access health services are evident in the real health life of ethnic minorities in Vietnam now.

Some of the main results about ensuring the right to access health services for ethnic minority groups in Vietnam

With strong commitments to the policies of universal access and administrative reform, Vietnam has made some progress in improving access to health services of ethnic minority group as follows:

- Availability (coverage) of health services in ethnic minority areas is increasingly improved and developed. According to the Committee for Ethnic Minority Affairs (Committee for Ethnic Minority Affairs, 2015), the entire communes of ethnic minority areas have 4113 commune health stations (of which: 2788 permanent health stations, 1276 semi-permanent health stations, 49 others); In 2010, there are 841 communes meeting the national health education standards, in which the target is that by 2020 there will be 1885 communes meeting the national health education standards. The Central Highlands region includes 5 provinces: Dak Lak, Dak Nong, Gia Lai, Kon Tum and Lam Dong. The population of the region is nearly 5.46 million people belonging to 54 ethnic groups, of which the ethnic minorities account for about 38%. By 2015, the health care facilities of the Central Highlands Region's provinces have increased rapidly and formed a system of health care networks that covers quite a lot (607 commune health stations), the number of health workers in hamlets and villages are constantly increasing. By 2020, the entire Central Highlands Region will reach nearly 50% of communes and wards that meet the national health education standards. Currently, the Central Highlands Region's General Hospital with a 1,200-hospital bed-scale has officially inaugurated and performed its operations, then increasing its opportunities for accessing modern health services and saving costs for ethnic minority communities in the Central Highlands Region and two neighboring countries including Laos and Cambodia.

The coverage of commune health stations in ethnic minority areas is as follows: In the Northern Midlands and Mountains, there are 2056 health stations out of a total of 2069 communes, accounting for 99.85; the Red River Delta area has 110 health stations/110 communes; the North Central Region and North Central Coast area has 735 health stations/736 communes; in the Central Highlands Region, there are 607 health stations/607 communes; the Southeast (Vietnam) region has 256 health stations/256 communes; The Mekong River Delta region has 349 health stations/356 communes in ethnic minority areas. (Committee for Ethnic Minority Affairs, 2015) By 2016, many large-scale and modern Medical Works and hospitals in provinces with a large number of ethnic minorities will continue to be completed and put into use. For example, in the Northwest (Vietnam) region, Yen Bai General Hospital consists of 500 hospital beds, Bac Kan General Hospital consists of 500 hospital beds; In the Southwest (Vietnam) region, there are 200 hospital beds at Ca Mau Traditional Medicine Hospital, at An Giang General Hospital, there are 600 hospital beds, and Soc Trang General Hospital has 700 hospital beds, and Vinh Thanh District's General Hospital consists of 100 hospital beds in Can Tho, there are 100 hospital beds in Binh Tan district, Vinh Long; In the Central Highlands Region, the 1,200-hospital bed general hospital was officially inaugurated and operated, in which meeting the requirements of medical examination, treatment and health care, and access to modern health services. and cost savings for the ethnic minority communities in the Central Highlands Region and two neighboring countries including Laos and Cambodia. (Vietnam Ministry of Health, 2017)

Along with the formation of an extensive health care network, the Government and local authorities have also paid attention to training, recruiting and arranging medical staff in health facilities of ethnic minority areas. According to the statistical results created, the country currently has 26,557 health workers working at commune health stations in ethnic minority areas, including 3,258 doctors; 15,212 physicians, and nurses; 4,212 midwives; 2,128 pharmacists, 606 druggists

and 1,141 other employees. (Committee for Ethnic Minority Affairs, 2015)

The rapid increase in the number of doctors at commune health stations is mainly due to the policy of rotating doctors from district hospitals to commune health stations to work at. In addition to the health workers at the commune health stations, there are also health workers in the hamlets and villages, participating in examining and treating basic diseases, providing initial treatment for the victims or delivering to the women giving birth but not reaching the commune health stations or district hospitals in time. According to the survey results, the country has 41,121 hamlets with their health workers, accounting for 85% of the total 48,364 ethnic minority areas' hamlets, of which the North Central Region and North Central Coast area has a coverage of health workers in hamlets in the largest percentage with 5,887 people/6,089 hamlets, accounting for 96.7%; followed by the Northern Midlands and Mountains that is with 24,563 people/25,525 hamlets, accounting for 96.2%, the Central Highlands Region is with 6,207 people/6,578 hamlets, accounting for 94.4% and the Red River Delta is with 998 people/1109 hamlets, accounting for 90%, the Mekong River Delta is with 2,270 people/2,681 hamlets, accounting for 89.7%. The Southeast (Vietnam) region has the lowest percentage of health workers over total ethnic minority areas' hamlets with 18.7% (1,196 people/6,382 hamlets). (Committee for Ethnic Minority Affairs, 2015) Notably, the Northern mountainous areas, the Central Highlands Region and the Mekong River Delta are the ones with a large number of ethnic minorities living, the socio-economic conditions that are really difficult but the coverage level of health workers in the hamlets are very high.

With the international assistance, especially the European Union and the efforts made of the Government and local governments, a health care network has been gradually formed, including the regional, provincial hospitals, district medical centers and commune health stations with an increasing contingent of health workers in ethnic minority areas, then facilitate the ethnic minorities to access to health services. Thus, there are techniques that require modern and highly qualified equipment, as many health facilities can handle, for example, in the HIV/AIDS field, all 63 provinces and cities are can test to confirm HIV as positive; Some provinces in the mountainous areas have piloted the community counseling and testing model with peer educators or hamlet and village health workers trained in direct HIV testing, HIV testing for the people who have high risk of HIV infection in the community in Thai Nguyen, Dien Bien, Thanh Hoa, Nghe An. (Vietnam Ministry of Health, 2017)

- Related to the accessibility to health services of ethnic minorities. This criteria that is satisfied through the implementation of Law on Health Insurance, the reform policy of administrative procedures, transparency and health financing reform in the localities of ethnic minorities. In Vietnam, the right to obtain the health insurance of all people, regardless of ethnicity, gender, religion, or health status, etc. is constituted in the Constitution 2013 and detailed in the Law on Health Insurance 2014. The National Assembly and the Government of Vietnam have set a target to increase the health insurance participation rate to over 90% by 2020 and 95% by 2025. The roadmap and criteria of provincial health insurance are included in the annual government plan. In general, many provinces have met and exceeded the target of issuing health insurance cards for ethnic minorities, then increase opportunities for accessing affordable and appropriate health services.

Regarding the work of prevention, ethnic minority areas have achieved a relatively high rate of vaccination in recent years; In the Northern Midlands and Mountains provinces, the number of communes with ethnic minority children vaccinated from 90% or more including 1784/2069 communes; in the Central Highlands Region, there are 465/606 communes. (Committee for Ethnic Minority Affairs, 2015)

The work related to disease examination and treatment free of charge serving the poor and ethnic minorities has been improved; particularly including the improvement in administrative procedures, in which facilitating the ethnic minorities to better access public health services. The health services in the Southwest (Vietnam) region not only has been improved more than the medical networks (general hospitals, regional general clinics, commune health stations, community health care networks) but has been also improved related to the ability to satisfy the health care demands of Cham people and Khmer people of this region. The percentage of Cham ethnic women who have at least one antenatal check-up at medical facilities is quite high (84.2%) and the percentage of Khmer ethnic women going to medical facilities giving birth is also very optimistic (91.3). In the Southwest (Vietnam) region, the percentage of Cham ethnic women

having at least one antenatal check-up at medical facilities is quite high (84.2%) and the percentage of Khmer ethnic women going to medical facilities giving birth is also very optimistic (91.3). (Committee for Ethnic Minority Affairs, 2017)

Regarding the level of using health services: The accessibility to health services with reasonable costs depends decisively on having health insurance and using health insurance or not. In recent years, the use of health insurance among ethnic minorities has seen positive changes. According to the quantitative survey results of 12 provinces in 2019. (Hoang, 2020) showed that the percentage of ethnic minorities using health insurance for medical examination and treatment was 88.5%. Ethnic minorities in the Northern Midlands and Mountains have the highest percentage of using health insurance (95.6%), followed by ethnic minorities living in the North Central Region and North Central Coast (93.5%) and the Central Highlands Region (78.2%). Ethnic minorities in the Mekong River Delta region have the lowest percentage of using health insurance (69.1%). The Lahu people have the highest percentage of using health insurance (100%), followed by the Ta Oi people (98.5%), the Mong people (95.9%) and the Bru Van Kieu ethnic group (94.9%). The Mnong and Cham An Giang are the two ethnic groups with the lowest percentage of using health insurance (56.7% and 49.8%, respectively). The percentage of using health insurance for ethnic minority men is not significantly lower than that of ethnic minority women (88.4% compared to 88.6%). Ethnic minorities aged 65 and over have the highest percentage of using health insurance (91.5%), followed by 55-64 years old (89.9%). The ethnic minority children under 6 years old have the lowest percentage of using health insurance (84.2%). Ethnic minorities who do not speak Vietnamese language have a slightly higher percentage of using health insurance than ethnic minorities who speak Vietnamese language (88.7% compared to 88.5%). The ethnic minority groups who are working have the highest percentage of using health insurance (90.6%), followed by the ethnic minority pupils and students (85.8%). The unemployed ethnic minorities have the lowest percentage of using health insurance (85.5%). Ethnic minorities who do not follow the religion have a higher percentage of using health insurance than ethnic minorities with religion (92.8% compared to 79.2%). Ethnic minorities in households with poor economic conditions have the highest percentage of using health insurance (94.5%), followed by ethnic minorities in near poor households (90.1 %). Ethnic minorities in non-poor households have the lowest percentage of using health insurance (86.6 %).

- Acceptability to health services of ethnic minority groups. This criteria requires, for the health services serving ethnic minorities, along with respecting occupational ethics, the medical facilities and health workers must behave reasonable with the culture of ethnic groups and their difficult living conditions. This criteria has been improved in recent years, through some measures, such as: training ethnic language and recruiting the ethnic minorities.

Before the officials working at the communes of ethnic minority areas, the local health department has concerned training ethnic language and particularly focused on training the health workers who are ethnic minorities and arranged the local health workers in medical facilities. The survey results showed that, in total of 26,557 health workers working at commune health stations of ethnic minority areas, there are 13,026 workers who are ethnic minorities, accounting for nearly 50%. The health workers who are ethnic minorities account the highest proportion in the Northern Midlands and Mountains with 8,580/12,166 people, accounting for 70.52% and the lowest is the Southeast (Vietnam) region with 147/1,977 people as ethnic minorities, accounting for 0.74%. (Committee for Ethnic Minority Affairs, 2015) The workers who are ethnic minorities have the advantage in the professional practice because of the ability to use ethnic language in the process of health care as well as deeply undertand the customs, practices, psychology of ethnic minorities.

Other significant measure is just to develop the model “village midwife”. This model with its starting step is an initiative of Tu Du Hospital in Ho Chi Minh city, supported and developed by Ministry of Health and the international partners implemented through the projects such as: The project “Capacity building for the Ministry of Health to implement the Vietnam’s National Strategy on Reproductive Health Care 2001-2010, funded by UNFPA, The Netherlands-sponsored Maternal and Newborn Mortality Reduction Program, Reproductive health project funded by Pathfinder, Reproductive health project under the National Target Program, etc. The model called “Village Midwife” focuses on training ethnic minorities interested in the medical practice or working in health field by experience and traditional medicine in the hamlets and villages of

ethnic minority areas. From this training to support them with knowledge and skills obtained at basic qualification to carry out the reproductive health care activities at the community, the maternal health care before and after their giving birth, the children health care at home and the consultancy related to Family Planning. (Vietnam Ministry of Health, 2017)

The above mentioned measures that meet the criteria acceptable related to the culture, gender of the medical system of ethnic minority areas. Acceptability of health services has expressed clearly the satisfaction level and usage level of health services among ethnic minorities. The survey results among 1800 ethnic people under ethnic minority areas under 12 provinces in 2018 showed that, the majority of people participated in all have their positive attitude to the health services. Particularly, with the question "Can you present your satisfaction level to the health services in case of illness and diseases as well as maternal and children health care?", in which, there are 426 people having their answer equivalent to "very satisfied", accounting for 23.7%, there are 1,125 people having their answer with "satisfied" level, accounting for 62.5% and only 249 people who give an answer of unsatisfied level, accounting for 13.8%. (Committee for Ethnic Minority Affairs, 2017) A number of investigation results in recent time showed a positive signal at some indexes and ethnic groups. For examples, there is a little difference from the percentage of using modern contraceptive methods among ethnic minority groups compared with the national average; The percentage of access to maternal health care services is relatively high in Bac Kan with more than 75% of women receiving antenatal care at commune health stations; More than 85% of Tay and ethnic minority women in Gia Lai province received support from qualified health workers during their last birth. (UNFPA & MOH, 2017)

- Regarding the quality of medical system of ethnic minority areas that is improved through a number of measures such as an increase in investment in medical equipment; provision of essential medicines; building and training a contingent of staff, physicians, doctors, health workers, village health workers on professional expertise, technology, etc.

Over the past 10 years, the Ministry of Health has directed many Northern mountainous provinces, the Central Highlands Region and the Southwest (Vietnam) region to actively implement Project 1816 (On sending alternate professional staff from higher level hospitals to support lower-level hospitals to improve the quality of medical examination and treatment); coordinate with central hospitals and major cities, such as Hanoi and Ho Chi Minh City to implement the satellite hospital project for the period 2013-2020; In a pilot to send young doctors to volunteer to work in mountainous, and remote regions, borders, islands, and regions with extremely difficult socio-economic conditions, etc to improve the quality of health services, then meet the health care demands of people of ethnic minorities in this area. (Vietnam Ministry of Health, 2017) According to the research conducted by UNFPA and Ministry of Health (2017): The point of quality of commune health stations at the Central Highlands Region's provinces is higher than the one of the Northern Midlands and Mountains provinces (the average point is 66% compared to 61%); about 92% commune health stations have at least one official who is a person of ethnic groups and 97% commune health stations have at least one official speaking the ethnic language; the average point of medical facilities based on each ethnic group that fluctuate from 59% to 70%: the Ba Na (66%), Dao (64%), Gia Rai (61%), Ha Nhi (70%), Hmong (64%), Mnong (68%), Xe Dang (63%), Tay (63%), and Thai (59%). (UNFPA & MOH, 2017)

General assessment: The above analysis showed that, the right to access health services of ethnic minority groups in Vietnam, in the past years, has obtained many positive results as per the criteria such as: Availability (coverage); Accessibility; Acceptability and Quality of Services. The commune medical facilities and health workers, village midwife represent their attendence at almost communes of ethnic minority areas, 100% districts own their medical centers and doctors; the percentage of childred under 5 years old falling in malnutrition reduced to 25%; many incentive policies that are related to health care free of charge, and the health insurance used for the people of difficult ethnic minority areas are implemented. Some diseases that are previously common in ethnic minority areas and mountainous areas such as malaria, goiter, leprosy and tuberculosis have been prevented and repelled; the protection and health care for mothers and children, and malnutrition prevention have achieved many remarkable achievements. (UNFPA & MOH, 2017)

A number of positive results above mentioned generated from the major reasons as follows:

(i) Innovations in awareness and policy stance of the State of Vietnam on building a fair, quality

health system towards realizing health care coverage and universal health insurance; in which all people are entitled to their health management and care, and are guaranteed equal rights and obligations in participating in health insurance and enjoying health services. To properly and fully calculate health service prices, and have a price and co-payment mechanism in order to firmly develop the grassroots medical system.

(ii) Vietnam's legal and policy framework has initially identified a number of basic health standards that need to be met, approaching international standards and practices on the right to access health care services among vulnerable social groups such as women, children, the elderly, and ethnic minorities. The provisions on special priority and support for ethnic minority groups; preventing unequal state budget spending in the health sector (for example, a basic regulation is settled not to use the state budget to develop new health care service at higher levels); focusing on preventive and grassroots medicine; reforming mechanisms to reduce financial risks for patients; as well as criteria on the availability, quality, accessibility, and costs of health services are increasingly concerned and detailed in the laws and policies of the State.

(iii) The point of view and legal and policy framework above mentioned that have been applied and thoroughly grasped by the Government, ministries, sectors and governments at all levels in state governance reform and public administration, and integrated in the program of hunger eradication and poverty reduction, new rural construction in ethnic minority areas as well as health financing reforms have created a new driving force for the development of Vietnam's health sector in recent years, creating opportunities in order for ethnic minority groups to have more convenient access to quality, and appropriate and affordable health care services step by step.

Major challenges in ensuring the right of ethnic minority groups to access health services in Vietnam today

Besides some positive results, there are still many major challenges posed in ensuring the right of ethnic minority groups to access health services in Vietnam today. Viet Nam is one of 10 countries that have achieved rapid achievement of the Millennium Development Goals (MDGs) on health, but there are still great disparities between regions and ethnic groups.

Firstly, Health Insurance

Health Insurance is a basic criteria, significant for assessing the security level of right to access health services and other rights in health. Vietnam has obtained, although, the rapid progress in the percentage of ethnic people who have participated in health insurance is quite high, the percentage of using health insurance card of some ethnic groups still remains at low and unstable level. (Table 01)

Analysis of the data shows that, on average, ethnic minorities use their health insurance cards in medical examination and treatment only nearly 45%, especially for some ethnic groups, the percentage of using health insurance cards is very low, less than 30%. According to the survey data conducted by the Committee for Ethnic Minority Affairs, the percentage of using health insurance cards among ethnic minorities has improved over the years, but there are still differences among some ethnic groups, for examples, the percentage of ethnic minorities with health insurance and health care cards free of charge is always very high (93.5% in 2019). However, in 2019, only 43.7% of ethnic minorities use health care services with their health insurance cards. As of October 2019, there were 5,617,167 people of ethnic minority groups using their health insurance cards during medical visits out of a total of 12,867,449 people of ethnic minority groups participating in health insurance, accounting for 43.7%. This proportion remains the highest in the Brau (82%) and the lowest in the Lo Lo (28.8%). Some ethnic minority groups have not used health insurance cards effectively, such as Bru Van Kieu (32.1%); Chut (34.8%); La Chi (34.8%); Bo Y (34.9%). (Committee for Ethnic Minority Affairs, 2019)

This situation generates from many reasons, from the subject benefiting the right, for instances: ethnic minorities have their various options for medical treatment instead of going to medical facilities, such as self-treatment using traditional methods (folk remedies or traditional superstitions that have already been existing in the community, etc.), ethnic minorities only visit the commune health stations or district hospital when their sickness becomes too serious beyond their ability to treat; Moreover, their awareness of rights, benefits and usage of health insurance card is still limited.

According to research by the United Nations Population Fund (UNFPA) and Ministry of Health (2017), there are economic and perceptual-related reasons of low health insurance card use among ethnic minority groups of Vietnam for maternal

health care services. The survey 2016 showed that women with more favorable circumstances were more likely to use their health insurance cards than poor and disadvantaged women; Even when women already have health insurance cards, they still do not use these cards for these services, partly because women do not go to health facilities, but more important, because many women select to go to private (self-payment) clinics for antenatal care. The findings on the use of health insurance cards by ethnic minority groups in Vietnam over the past few years showed that, even though health services are provided free of charge, many ethnic women still do not use public health services to get care and treatment.

On the part of the subject obliged to provide health services: The policies and laws in the field of health insurance are still inadequate, the payment method of health insurance is not appropriate; Inpatient treatment costs support from medical insurance is also quite a long time; The list of medicines for health insurance is limited; The grassroots health system remains poor in terms of both human resources and equipment; organizational and human capacity, medical conditions, and equipment, hygiene, the attitude of health workers, etc. to take care of and treat at the commune and district level that do not meet the expectations of the ethnic minorities.

The fact that people do not have their proper understanding of the conditions to get health insurance shows that the Ministry of Health and local authorities need to do better in health education and communication to explain how to use and obtain benefits of health insurance. According to the "accessible information" standard, the health sector lacks effective, verifiable measures to provide ethnic minorities with quality information on health insurance as well as health issues.

Secondly, access to geography (distance and ability to travel from home to medical facilities).

In general, this distance is relatively far, in which it is especially far from some ethnic groups such as Mang, Cong, Lo Lo, La Hu, Ha Nhi, Chu Ru. According to the Committee for Ethnic Minority Affairs, (Committee for Ethnic Minority Affairs, 2015) on average, commune health station is about 3.8km away from home and 16.7 km from hospital. Ethnic minority groups in Vietnam often live in mountainous and highland areas, with inadequate and poor infrastructure, in which some ethnic groups live mainly in remote, border and naturally-divided terrain areas, difficult to travel, too far from the hospital, including some ethnic groups such as: O Du: 72 km, Ro Mam: 60.1 km, Ha Nhi: 53.8 km, Chut: 48 km, La Hu: 39.2 km; Besides, there are about 24 ethnic minority groups whose distance from home to hospital is 20 km to less than 40 km.

The remote health facilities are one of the reasons why ethnic minority groups enjoy many difficulties and limitations in benefiting the right to access health services. Ethnic groups such as Mang, Lo Lo, Cong, La Hu, O Du, La Ha, and Hmong have limited access to special health services. The collected data shows that, in some extremely difficult communes of the Northern mountainous region, Thanh Hoa - Nghe An, the Central Highlands Region, the distance from residence to medical facilities is quite far, the quality of traffic road is poor, and unsafe, vehicles are mainly motorbikes, even walking in some communes. This situation generates anxiety, especially ethnic minority women. The Hmong or Ha Nhi ethnic women think that they may not be able to get to the medical facilities in time and are afraid of giving birth along the way they are traveling. (UNFPA & MOH, 2017)

Regarding the human rights in the field of health care, the obligation to fully implement requires the State not to refer to economic difficulties and resources to refuse to improve access to geography with health services of ethnic minorities in Vietnam. It may not be possible to achieve the expected results in a short time (obligation of results), but the requirement of equity in access health services required, challenges of geographical access need be identified and reflected in the policies of the Government, ministries, branches and local governments. The ambitious goal of this issue in recent Government of Vietnam's policies can be difficult to achieve due to the financial resource allocation mechanism and local enforcement and oversight.

Thirdly, access to health services of mothers and children

According to the Ministry of Health's report on maternal and child health (2011), the percentage of ethnic minority women giving birth at home in the Northern mountainous provinces is very high, accounting for 40% -60% of all births deliver, while most Kinh women and women living in the lowlands deliver in medical facilities. (Committee for Ethnic Minority Affairs, 2019) The results of the survey 2015 of the Committee for Ethnic Minority Affairs on the socio-economic situation of 53

ethnic minority groups still showed a same situation, slow to change that the proportion of women going to medical facilities for antenatal care is not high. The practice of giving birth at home is still common among many ethnic minority groups. (Table 02 on the number and percentage of women attending medical facilities giving birth and giving birth at home) (Committee for Ethnic Minority Affairs, 2015)

In all ethnic minority groups, 63.6% of all births are in medical facilities, while 36.3% of women give birth at home. Among the 53 ethnic minority groups, there are 25 ethnic minority groups whose percentage of women giving birth at home is 50% higher, including those with a very high percentage of women having children at home such as: Si La (88.85%); Lu (86.95%); Array (86.3%); La Ha (88.2%); Ha Nhi (82.4%), etc. In many upland villages and hamlets where ethnic minorities live, with the low literacy level, many women of reproductive age are not fluent in the Vietnamese language; while the hamlets and villages are far from the health stations, thus people do not go for prenatal check-ups, give birth at the commune health stations, easily resulting in maternal and child mortality. Up to now, the people here, although, have had many changes in this practice due to the improved literacy level and the development of the hamlet and village health care network, some ethnic minority groups still maintain the practice in giving births at home with a high proportion such as: the Thai ethnic people in the West Thanh Hoa, Nghe An; Mong ethnic people; Xo Dang people; Gia Rai people; Kho Mu people; Hre people; Ha Nhi people; La Chi people, etc.

Regarding the cause of this situation, according to the research by the United Nations Population Fund (UNFPA) and Ministry of Health (2017) on barriers to access to health services, the elements such as ethnicity, household economy and education all have an impact on the use of antenatal and intrapartum care services delivered by skilled health workers. These elements are closely related, however, the ethnicity has a greater influence than the other two elements. Compared to the national average, ethnic minority women from poor households are three times more likely to be unable to access antenatal care and not being given births by qualified health workers at birth-giving time that is six times higher. These results also show that the ethnicity is a significant social element affecting the use of maternal health care services in Vietnam, and it is clear that ethnic minority women are a very disadvantaged group. The data available also show that the use of maternal health services by women of many ethnic minority communities and women living in remote areas is low. (UNFPA & MOH, 2017)

In addition, there is still a large disparity in health indicators of people across regions, areas and ethnic groups. The proportion of children falling in stunting is still high, especially in rural areas, the Central Highlands Region, the Northern Midlands and Mountains, while the proportion of overweight and obesity among children is increasing in urban areas. (Vietnam Ministry of Health, 2017) Child mortality remains high and the slowest decrease is in mountainous, upland and ethnic minority areas.

The survey results on the socio-economic situation of 53 ethnic minority groups in 2015 showed that ethnic minorities are still far from completing the sustainable development goals of ethnic minorities. Still more than 60% of ethnic minority groups have not yet approached the target of 22% lower infant mortality rate under *the sustainable development goals to 2020* and more than 80% have not yet met the 19%o lower target according to *the Sustainable Development Goals to 2025*. Under-5 mortality rate is also difficult to reach the target when up to 80% of ethnic groups have mortality rates higher than 27% o (which is the target rate to 2020). The elements such as women's low educational attainment , birth habits at home, busy farming, long distance from health stations, poor sanitation, epidemics, etc. are all direct causes of ethnic minority children's high mortality rate. Attention to ethnic minority women and children is a requirement of ensuring human rights according to the international law, as they are a particularly vulnerable group in the healthcare sectors. Although Vietnam has made efforts to improve this situation, all levels of local authorities, and the health sector have not really paid attention to the issue of "gender-sensitive" and sometimes do not fully understand the meaning of "special temporary measures" as defined in Article 4 of *the Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW, 1979). (Vu, 2013)

Fourthly, the quality of health services

Over the years, Vietnam's health sector although, has made great efforts to improve the quality of health services in ethnic minority areas, the fact that there are still many existing shortcomings and limitations. In addition to the lack of many doctors, health workers in ethnic

minority areas, there is also the deterioration of infrastructure in many commune health stations, or a lack of medicines and medical equipment, suitable for many diverse groups such as women, children, the elderly, and HIV-infected people. In particular, the weak professional capacity and the poor service attitude of some medical staff, doctors and health workers are the big challenges today.

Sociological studies on the quality of health services in ethnic minority areas show that a huge number families are not assured about the quality, professional capacity and service spirit of the commune health station. They believed that local services are often not fully equipped with specialized medical equipment, poor infrastructure. The capacity to handle emergency cases and maternal health care remains limited. There are times when there is only one health worker on duty at the commune health station to monitor the patient, or there is no one in some cases. Therefore, it made them lose confidence in this grassroots medical system. Some commune health workers self-assessed that they are not confident in their ability to handle emergencies due to lack of expertise and lack of suitable medical equipment, including medications; or the quality of the commune health center has deteriorated. The Tay ethnic women have come to visit here and they found that there was no clean birth support equipment, so they decided to go to the district hospital.

Another issue related to the criterion of "suitability for the quality of health services" is the discriminatory attitude of a part of health workers and officials towards ethnic minority patients. Although this is a serious problem, it has not been fully analyzed in studies or reports of the health sector. Another limitation on the provision of public services (health and education) to ethnic minorities is that some localities do not really pay attention to the role of administrative and judicial procedures in protecting people to exercise procedural rights such as responding to and filing complaints against organizations and individuals providing health services. That health workers and officials do not know human rights about people's health are a fairly common problem in Vietnam today. This limitation will become more and more exacerbated if health workers and officials cannot overcome language and cultural barriers in ethnic minority areas.

There are several main reasons for limited quality in ethnic minority medical stations as follows:

(i) The medical organization model with hospital-centricity is the most basic cause. In the hospital-centricity medical system, commune health stations receive little attention and cannot meet the people's initial health care needs. The capacity of rural (mountainous and island) health facilities is limited. Health workers are often not professional enough, lack skills and training opportunities. The list of drugs allowed to be prescribed by the commune health worker is very limited... Due to the above reasons, patients have little confidence in the quality of services at primary health facilities and often choose to go to higher levels though they incur higher costs and much more troublesome procedures. (Vietnam Ministry of Health, 2011)

(ii) There are shortcomings in the governance mechanism to ensure accountability and supervision of organizations providing health services in ethnic minority areas, especially operations of hospitals, health centers, commune health stations. Over the past years, a number of International Development Partners have actively assisted Vietnam in this area. However, this issue is still delayed in innovation.

The inherent and mixed interests make these reports lack objectivity and honesty. In a number of reports on human rights such as: The Universal Periodic Review (UPR) Report, Report on the Implementation of International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1965) (Vu, 2013) also fail to meet the supervision and accountability requirements in the ethnic minority health sector. This is really a serious problem in governance and public administration. Obviously, there should be strong changes in awareness and measures for these activities, in order to clarify the responsibilities of leaders and managers of health service providers at local and grassroots levels.

(iii) Ineffective performance in the health sector of administrative and judicial mechanisms such as legal aid organizations, courts, procuracies, inspection and examination agencies. It does not meet the general standards of ensuring human rights, including the right to access health services of ethnic minorities.

(iv) Learning opportunities, remuneration for medical officers, doctors, physicians, health workers are still unreasonable, inappropriate with low salaries and allowances, which leads to a lack of real motivation for ensuring the right of ethnic minorities to access health services and health care, especially in difficult working environments and conditions as mountainous areas and remote

areas.

Fifthly, affordability for health services.

Despite the fact that health spending is no longer a major problem for some ethnic minority well-off households and they are even willing to pay high costs to access quality health services with modern techniques and attentive care, most ethnic minority households, especially poor households with few income opportunities, consider payments for health services a barrier to full access to health services. This is a real burden for many households and health expense even increases the proportion of poor households among ethnic minorities in many cases.

State health insurance policies and local support measures have increased health insurance coverage and reduced medical costs for many ethnic minority households. However, there are still many shortcomings, for example, the issue of health insurance payment. For ethnic minority groups with high usage of health insurance cards in medical examination and treatment, similar to that of Kinh people, the amount that the insurance agency actually has to pay is lower because they mainly use the grassroots service - where medical costs are lower. Although health expense is mostly paid by insurance agency, ethnic minorities still find it difficult to access better quality health services because the costs outside of health such as travel, meals and accommodation are very high. For example, a mother has to spend millions on taking care of and treating her child at the district hospital. In which, medical expenses are only from tens of thousands to several hundred thousand and are covered by insurance, most of the remaining costs are for meals and travel while taking care of the child but these expenses are not covered. Or for some of the most disadvantaged groups among ethnic minorities, the cost burden will increase because there is no understanding of the benefits and how to use health insurance cards. Thus, health insurance in these cases cannot reduce the financial risks for many ethnic minority households.

Sixthly, cultural barriers in accessing health services.

The cultural concept in this study covers the concepts, beliefs, languages, customs, habits and habits of ethnic minority groups participating in the process of selecting, accessing and using health service. While health service quality challenges involve subjects who are obliged to provide them, cultural challenges mainly arise from the beneficiaries of the health services. The cultural barriers and challenges in accessing health services among ethnic minorities in Vietnam are diverse and intertwined, especially for women. A lot of evidence have shown that many of the standards for equal rights of women in the health sector, as recognized in international law and national law, often conflict with some traditional cultural concepts.

Public health services in ethnic minority areas in Vietnam fundamentally disapprove of some ethnic minority groups' customs, practices and habits in health care, such as squatting during labor, holding a towel hanging from a rafters, taking a bath after giving birth, an herb healer performing rituals or family members present during delivery. The practice of giving birth at home is quite common among some ethnic groups that are closely related to cultural issues. In many cases, the husband's family, rather than the woman, plays a huge role in making decisions about using health services. For example, even though the health insurance pays all the costs of giving birth at a health facility, many ethnic women in the Central Highlands Region decided to give birth at home according to tradition. Sociological research on Hmong ethnic women shows that their perceptions of pregnancy and childbirth are normal and natural women's activities, so most of them give birth at home, except in difficult cases. Mothers and babies are bathed with warm herbal water after birth. Newborn mothers usually stay at home for one month after giving birth to recover their health and avoid contact with outsiders to avoid bringing misfortune to others. (UNFPA & MOH, 2017)

According to the latest survey of the Committee for Ethnic Minority Affairs (2019), the rate of ethnic minorities speaking common language is not high (80.09%). Especially, there are ethnic minority groups whose literacy rate is very low, such as La Hu (46.9%); Mang (46.2%); Lu (49.7%); Mong (54.3%); Ha Nhi (60.7%) (Committee for Ethnic Minority Affairs, 2019) Compared to the Mekong River Delta Region, the Central Highlands Region and the Northern Midlands and Mountains Region, ethnic minorities in the North and South Central Coast regions have the lowest rates of Vietnamese speaking, typically Ta Oi people (74.8%). It has created a great barrier to access health services. (Committee for Ethnic Minority Affairs, 2019). To achieve the “culturally appropriate health services for ethnic minorities” criterion is placing greater responsibilities on ethnic minority health systems, especially the

grassroots level. The health services here are not only a place to implement pure technical measures, but also must be culturally sensitive. In addition, it is necessary to adapt, be patient, and harmonize with the diverse conceptions, practices, beliefs and habits of ethnic minority groups in Vietnam.

Some solutions to ensure substantially the right to access health services of ethnic minorities in Vietnam today

Equality and equity, opportunities or challenges in accessing health services of ethnic minorities all raise questions about the responsibilities of the state authorities in Vietnam today. Therefore, the following recommendations focus mainly on the obligations of competent state agencies to enforce laws and health policies, such as the Government, the Ministry of Health, and local governments and a number of related ministries and agencies, aiming to create a health system that can improve the way health services are delivered to the needs of the population and in accordance with the local context.

Firstly, improvements in geographic access and active support for the most disadvantageous groups among ethnic minorities to access health services.

Currently, these capabilities are facing many obstacles. Ethnic minority health priority investment policies are designed with ambitious goals, but are at odds with the delayed and unreasonable allocation of financial and human resources. At the provincial level, the results of group discussions of this study with leaders of the health sector (2018) in some provinces such as Thanh Hoa, Nghe An, Binh Thuan, Dak Nong have not shown any significant efforts to improve accessibility to geography, health infrastructure and travel in some poor, extremely difficult communes in the province as specified in Decision 2348/QĐ-TTg (The Government, 2016b) and Action Plan of Ministry of Health (No. 1379/CTr-BYT dated December 19, 2017) The outlook for improvement is dependent on equitable mobilization and allocation of financial resources and increased autonomy of the authorities and health sectors in ethnic minority areas. Currently, these agencies need to take advantage of the opportunities from the ‘priority investment policy” or the “basically do not use the state budget to build new medical facilities at higher levels” to implement projects on to build medical infrastructure for remote and ethnic minority areas. It needs to overcome the situation of spreading investment immediately; focus resources for key investment, meeting the following criteria: Focus on areas far from the center but convenient for people's travel; Areas are far from existing medical examination and treatment establishments; Place of dense population; Places where there is a real need; Assurance of staffing arrangements; The active fight against corruption and waste in public investment.

On the other hand, the difficulties faced by ethnic minorities are mixed, very diverse, and not the same in terms of development level between regions and ethnic groups. There are particularly difficult and most disadvantageous groups in accessing health services such as: La Hu, La Ha, Hmong, Mang, Kho Mu, Khang, Chut, Co Lao, Xinh Mun. It is recommended that these groups have special support policies, such as conditional direct financial assistance in some cases such as pregnancy, childbirth, accident and serious injury, treatment of dangerous infectious diseases. This approach is highly practical, suitable with the local context to prevent financial risks, reduce vulnerability, and improve access to health services among the most disadvantageous groups among ethnic minorities in Vietnam.

Secondly, improvement of the quality of commune health stations in ethnic minority areas.

Currently, considering many criteria, the commune health station is the place with the most favorable and suitable conditions for meeting the basic and minimum criteria for ensuring the right to access health services of ethnic minorities, such as: easy to access, low cost, culturally appropriate, high connection with the community, favorable for monitoring, accountability and feedback activities of the people. Vietnam's recent health policy framework has made important changes in terms of 'improving the quality of grassroots health services (from the district level and lower) with many priorities given to regions with extremely difficult socio-economic conditions and ethnic minority areas. Example: Decision No. 2348/QĐ-TTg of the Prime Minister dated December 5, 2016 approving the Project of building and developing the grassroots health network in the new situation; In 2014, the Ministry of Health issued a set of national criteria for commune health in the period up to 2020... These policies have comprehensive content, the ability to cover, and overcome the status of promulgation in the “one

for all" style. However, the commune health station remains the weakest place in the Vietnamese health system, especially the commune health stations in ethnic minority areas. Presently, the opportunity for improving this situation should focus on the implementation of policies and laws of the Government, ministries, branches and local authorities, especially the health sector.

The bottleneck of the implementation of policies and laws lies in the rational financial allocation and independent policy evaluation, overcoming the domination of "interest groups", "credit-driven practice" or "term of office's concept (short-term thinking, perception, behavior, and short-term actions of those holding leadership and manager positions in a specified term in order to pursue immediate goals and benefits to gain get the most benefits both physically and mentally for themselves, interest groups or for a certain collective unit that ignores the medium and long-term goals and interests of the nation or nation)" in the public administration in Vietnam over time. In addition to standards for medical infrastructure and equipment, ready-to-serve medical officers and workers, ethnic minority commune health stations need to actively renew their management mechanisms and strengthen their ability to cope with emerging and re-emerging infectious diseases, such as Covid - 19 and viral hemorrhagic fever, leukemia; proactively apply information technology, take active measures to prepare e-health profiles for each citizen, improve cultural sensitivity, work and mobilize the participation of community organizations, village midwives; connect with households, encourage the use of folk remedies, useful treatments... to meet diverse health care needs of ethnic minority groups.

Thirdly, comprehensive training and improvement of preferential regimes for grassroots health workers and officers in ethnic minority areas.

The rights-based approach as analyzed above requires that ethnic minority ethnic minority officers, doctors, and grassroots health workers need to be comprehensively trained, linked with the following criteria: Understanding and meeting people's health needs, including the health of mothers and children; building awareness of protecting human rights in the field of health care such as the right to be free from discrimination, the right to be provided with information and to keep health information confidential, the right to complain...; respecting medical ethics; ability to communicate culturally with ethnic minority groups. Health agencies need to attach importance to on-site and continuous training, and training of ethnic minority health workers. On the other hand, in order to maintain motivation and encourage health officials, doctors and health workers to work in ethnic minority areas, it is necessary to improve the preferential regime and necessary financial support, career opportunities, for example, allowances reform, assistance with travel, housing, working conditions, rewards and learning opportunities, advancement.

Fourthly, promotion of education and communication on health and human rights for ethnic minorities.

This activity aims to meet the basic criteria of human rights in the health sector: "being able to access information on health and health" of ethnic minorities. In the immediate future, it is necessary to focus on contents such as: how to use health insurance cards; medical network, prevention of dangerous infectious diseases; prevention and control of non-communicable diseases; overcoming backward customs and practices that are harmful to health, especially the health of mothers and children; building a healthy lifestyle, performing tasks in immunization, preventive medicine and nutritional counseling. Special attention should be paid to ethnic groups residing in geographically divided areas with limited common language.

Ethnic minorities, on the other hand, have the right to know about their rights, including the right to access health services. However, the health sector's communication and education policies have not clearly demonstrated this approach in other studies. The lack of ethnic minorities in their limited understanding of their rights, and even an ethnic group in the "blind" status of human rights should be seen as a real barrier to the enjoyment of human rights in the medical and health sectors as well as in other fields.

The task of human rights education for ethnic minorities is to explain to people about the rights they enjoy under the Constitution and the law and to raise awareness of state agencies, civil servants, public servants, social organizations, and businesses about the meaning and obligation to respect and ensure human rights of the ethnic minorities at the same time. In the field of medical and health sectors, it is necessary to disseminate information in appropriate forms on language, culture, and laws that are directly related, such as the Law on Examination and Treatment; Law on

Health Insurance; Social insurance law; Law on Access to Information; Law on Complaints; Denunciation Law; Law on Legal Aid, and guidelines for access to health services by competent authorities.

Fifthly, enhancement of support and training of the force of "commune, hamlet and village health workers who work part-time as village midwives".

There are different sociological statistics and assessments of the role of village midwives, for example, there is an opinion that their role is not recognized in local communities because they are too young, inexperienced, limited in education and expertise and do not have the necessary medical equipment for a clean delivery... The opposite opinion is that the model of "village midwives" has brought some positive results. However, there are the following reasons to support the "village midwife" model that has been implemented in many ethnic minority provinces over the past time (there are nearly 3,000 village midwives at this time):

(i) This is a community and villager initiative that comes from a local ethnic minority context and the village midwives have been trained for about 9 months in safe motherhood services. Some of their current limitations can be overcome through the active support of local authorities and the health sector.

(ii) Regarding cultural suitability: Village midwives are ethnic minorities who share the same culture, customs, practices and beliefs, so they can use the ethnic minority language to advocate for providing safe motherhood services in place. Therefore, their activities will contribute to meet the "cultural appropriateness" standard in a certain way and they can reconcile cultural conflicts with human rights in health care, particularly women's rights.

(iii) Practical context of grassroots healthcare in ethnic minority areas. With the permissible human resources of medical centers and medical stations in ethnic minority areas, it is difficult for them to regularly visit people and be close to people to perform some health care activities for mothers and children or communication on health for ethnic minorities. Therefore, village midwives can be seen as a practical solution to partially compensate for this shortage and expand access to local health care for ethnic minority communities. Currently, it is necessary to increase training, guidance, and improvement of required skills and other supports to help them complete their tasks, especially in extremely difficult, geographically divided communes, the customs of giving birth at home is maintained or the child mortality is high.

Sixthly, step up the administrative and judicial reform.

The issue on ensuring the access to health services of ethnic minorities emphasizes the role of administrative and judicial reform in these activities. Although this is a difficult issue, the current implementation of laws and policies shows that a number of activities should be deployed, such as:

(i) Strengthen supervision and accountability for activities of health service providers in ethnic minority areas.

Supervision and accountability is an inevitable component of the issue on ensuring human rights as well as improving equal access to health services. In Vietnam, the supervision mechanism and accountability are specified in a number of laws such as the Law on Examination and Treatment (2009); The Law on Health Insurance (2008) amended and supplemented in 2014. Of which, the Law on Examination and Treatment (2009) established a mechanism to allow patients to complain and provide feedback. According to this Law, patients have the right to choose a medical examination and treatment solution; to be provided with information about medical records and medical examination and treatment expenses. The mechanism under Chapter 7 of the Law provides for establishing a professional council to listen and consider complaints; to allow patients and their representatives to comment directly on medical examination and treatment of medical services, ... However, openness, transparency and accountability in providing medical services remains a major challenge that should be drastically improved in Vietnam.

In addition to the supervision of the National Assembly, the People's Council at all levels and the Health sector, it is necessary to develop a mechanism to allow for a certain independence in the supervision of social and professional organizations; facilitate the supervision by competent international organizations over activities of health service providers in ethnic minority areas; This mechanism may include supporting the development of in-depth reports and publications on ensuring rights in the health and healthcare sectors of ethnic minorities in Vietnam. In supervision, it is necessary to create a favorable mechanism for the participation of

ethnic minority communities.

(ii) Collect feedback and improve the access to administrative and judicial mechanisms.

According to the guidance of the World Health Organization (WHO), the quality of health services is linked with the criterion "ability to understand and satisfy the needs of treatment and health care" of the people. Therefore, regardless of which model is applied in providing health services in ethnic minority areas in Vietnam, the responsible bodies must develop mechanisms and measures to receive feedback from people regarding their needs, expectations as well as their satisfaction with health services,then on such base, adjust the operation of health services to meet the needs of the people and communities that it serves. On the other hand, in order to gradually improve the legal capacity and citizenship status of ethnic minorities, it is necessary to promote initiatives of administrative and judicial reform, facilitate for them to access more favorably these mechanisms in protecting equal rights as well as legal and legitimate interests when participating in the process of using health services.

Conclusion

In the health sector, ensuring ethnic minorities' right to access health services is a consistent view of the State of Vietnam. Considering a number of popular criteria, Vietnam has achieved positive results in ensuring the right to access health services of ethnic minorities. However, the above analysis shows that the inequality in receiving this right still exists. Most ethnic minority groups in Vietnam have a lower average than national average in terms of equal access to health services. The health network has covered most of the communes in ethnic minority areas, but the consolidation, improvement and maintenance for the quality of health services here are facing many disadvantages due to the impacts of the economic circumstance, financial resources, geographic area and specific cultural factors. Due to limited information and medical reports, the article only focuses on highlighting the most essential aspects that should be satisfied in ensuring this right. Focusing on issues such as: the availability, health insurance, affordability, quality of health services, access to healthcare services for ethnic minority mothers and children, is consistent with the prevailing international criteria in ensuring this right in the context of ethnic minorities in Vietnam.

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Table 1. **Number and rate of people in 10 ethnic minorities using health insurance cards in 2015 (VCEMA, 2015)**

No.	Name of the ethnic group	Number of ethnic minority people using health insurance cards for medical examination (person)	Rate of ethnic minority people using health insurance cards for medical examination (%)	No.	Name of the ethnic group	Number of ethnic minority people using health insurance cards for medical examination (person)	Rate of ethnic minority people using health insurance cards for medical examination (%)
1	Si La	687	92.5	6	La Ha	2,157	23.3
2	O Đu	347	88.3	7	Xtieng	13,192	27.9
2	Cong	2,025	80.7	8	Ngai	153	28.6
3	Chu Ru	14,249	75.0	9	Xin Mun	8,454	31.8
5	Ro Mam	307	73.1	10	Muong	391,807	32.0

* Percentage does not include unspecified cases.

Table 2. **Ethnic groups have a rate of over 50 percent of women giving birth at home (VCEMA, 2015)**

No.	Name of ethnic groups	Number of women going to health facilities for giving birth (person)	Number of women giving birth at home (person)	Percentage of women going to health facilities for giving birth (%)	Percentage of women giving birth at home (%)
Ethnic minority people according to the investigation on the ethnic minority in 2015		1,621,782	925,065	63,6	36.3
1	Thai	160,229	215,494	42.6	57.3
2	Hmong	51,040	176,096	22.4	77.4
3	Gia Rai	41,027	45,466	47.2	52.3
4	Ba Na	20,209	26,374	43.3	56.5
5	Xo Dang	10,494	22,414	31.8	68.0
6	Hre	10,594	20,129	34.3	65.2
7	Kho Mu	4,368	12,019	26.6	73.3
8	Co	2,489	4,393	36.0	63.5
9	Xinh Mun	1,275	4,386	22.5	77.4
10	Ha Nhi	775	3,655	17.5	82.4
11	Lao	884	2,531	25.9	74.1
12	La Chi	903	1,764	33.8	66.0
13	Khang	702	2,494	22.0	78.0
14	Phu La	1,169	1,329	46.7	53.2
15	La Hu	86	1,816	4.5	95.1
16	La Ha	230	1,742	11.6	88.2
17	Lu	180	1,206	13.0	86.9
18	Chut	403	674	37.4	62.6
19	Lo Lo	290	526	35.4	64.3
20	Mang	94	591	13.7	86.3
21	Co Lao	123	336	26.8	73.2
22	Cong	104	415	19.9	79.6
23	Si La	15	122	11.2	88.8
24	Ro Mam	44	50	46.4	53.6
25	O Du	21	54	28.3	71.7

* Percentage does not include unspecified cases.