

**Working Paper  
Volume 2023 Number 587**

# **Equitable Access and Public Attitudes to Vaccination for Internal Migrants in Vietnam**

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**Hoang Tu Anh, Pauline Oosterhoff, Le Lan Anh and  
Dinh Phuong Nga**

**February 2023**

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## Summary

This mixed methods participatory study explores equity and fairness in access to Vietnam's Covid-19 vaccination programme, when the Covid-19 vaccine was scarce, with a focus on internal migrant workers. At the beginning of the pandemic large numbers of Vietnamese migrants from rural areas lost their jobs. Migrants are vital to the Vietnamese economy. Many factories that produce goods for export employ internal migrants. Before the pandemic, these workers faced inequalities of access to available health services and nutritious food. Although the Vietnamese state aspires to universal access to health, internal migrant workers living outside their village do not have long-term household book registration, which is the key to access many public services including health care and prevention. We found that migrant workers, especially those working in the export zones where factories produce for export, did have access to vaccination. However, there are intersectional inequalities between internal migrants based on other characteristics such as (dis)ability. Policies that give priority to economic productivity disadvantage those who are not considered vital or essential from that perspective. The delegation of some of the vaccination access decisions to local authorities, for example village headmen, allowed for flexibility based on local contexts and needs. However, the capacity of implementers at grass-root level to respond to emerging situations was not identified clearly in implementing guidelines. This resulted in a lack of transparency in local decision-making. We recommend establishing an independent body with representatives from various groups to monitor policy implementation and decision-making for vaccination and emergency preparedness for future outbreaks. More research is needed to explore the social acceptability of medical technologies and medical interventions, especially in prolonged epidemics such as the Covid-19 pandemic.

## Keywords

Vietnam; Covid-19 vaccination; equity; fair; migrant; household registration.

## Authors

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# Executive Summary

## Background

According to statistics from the Ministry of Health, by the end of January 2023, over 11.5 million cases of Covid-19 infection and more than 43,000 deaths from Covid-19 had been recorded in Vietnam (Ministry of Health 2023). Although the '5Ks' (mask (*khẩu trang*), hygiene (*khử khuẩn*), distancing (*khoảng cách*), no gathering (*không tụ tập*), and health reporting (*khai báo y tế*)) remained the key measures to prevent the spread of the virus, the Vietnam government confirmed in early 2021 that vaccination was a key measure to curb the epidemic. A shortage of vaccines at the beginning of the vaccination campaign could have posed a great challenge to the equity principle of health care as well as social cohesion in Vietnam.

This research was conducted to capture the challenges in allocating Covid-19 vaccination to different population groups in the context of vaccine shortage. Vietnam, as a lower- and middle-income country with a population of almost 99 million, faced a vaccine shortage between early-2021 and the end of 2021. By 2022, vaccination was widely accessible in Vietnam. We studied equity and fairness in access to Covid-19 vaccine for internal migrant workers who move from rural to urban areas. Internal migrants are important for the Vietnamese economy. The key industrial zones in North, Central and South Vietnam depend on internal migrant work for the production of export goods.

## Methods

We used a mixed methods approach, combining primary and secondary qualitative data collected online and in person and a quantitative online survey. We reviewed Vietnamese vaccination policies during the period 2020–22, including Covid-19 vaccinations, paying specific attention to universal access. This review, combined with literature and experience from our previous research, informed semi-structured interviews conducted in Vietnamese. We selected a stratified sample of 60 people: professionals working in the public sector at different levels and functions in policymaking and policy implementation, and a wide range of subgroups of migrants, including: those working in the informal sector and small enterprises, people with disabilities, ethnic minorities, people who are not registered in the house registration scheme, homeless people, non-cisgender, and people who migrate for short-term or irregular periods of time. We also interviewed 14 professionals who were not directly involved in implementing the vaccination campaign but who had experienced vaccination themselves. The qualitative interviews informed an online survey. Although different strategies

were used to reach out to different populations, it was difficult to control for equal presentation of different migrant groups in the survey, as well as geographic location. We therefore did not use this data in our analysis.

## Findings

In response to the vaccine shortage, the government developed a pathway to scale-up vaccination based on the World Health Organization (WHO) Covid-19 vaccination guidelines and experiences from well-resourced countries. The policies aimed to establish an effective and equitable vaccination programme. However, interviews and data from the research show that while intentional exclusion of vulnerable groups such as migrant workers is not acceptable, in practice exclusion does occur because of multiple and layered intersectional inequalities, shortages of resources, and an outdated household registration system that discourages mobility in a country with high levels of internal migration.

The government made strategic decisions at the central level with limited consultation, especially with marginalised and vulnerable communities. The decision-making process and the strategy itself lost public support partly because the situation changed rapidly, partly because people close to the state or in the formal sector were prioritised first, and partly because the strategy lost its way during implementation.

Major factors that we found to influence access of people to vaccination are:

- Access to available vaccinations was not purely decided based on public health principles or medical criteria. Personal connections and economic criteria also played a major role in vaccination politics.
- Information about vaccines was widely available but often did not meet people's specific needs, such as people with disabilities, transgender people undergoing hormone therapy, people with chronic health problems, and so forth. This affected their willingness to get vaccinations.
- In the context of high vaccination coverage, there were still cases of people who wanted to be vaccinated but could not get access. These cases illustrate further how a combination of multiple social and economic characteristics and inequities can become unintended but real barriers for people in accessing vaccinations.

Main recommendations of the research are:

- There should be support groups or similar mechanisms to help vaccination implementers at grass-roots level to respond effectively and consistently with the complexity of vaccination eligibility.

- There should be an independent body, with representatives from various groups, including civil society, to monitor vaccination programmes and to take part in decision-making to minimise biases in the current public–private partnerships that could be dominated by (big) companies.
  - There should be a clear multidisciplinary research agenda and public engagement strategy, and the required budget, to support policy development and public dialogue.
  - More research is needed to explore the social acceptability of medical technologies and medical interventions, especially before the latter are implemented. This would improve the uptake and acceptability of some interventions but could also result in delays or the rejection of other medical technologies.
  - Intersectional gender issues in relation to the Covid-19 vaccination programme and other responses need further exploration – the roles of leaders at local level, such as the group head, in decision-making deserve more attention.
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On behalf of the research team,

Hoang Tu Anh

## Acronyms

COVAX	Covid-19 Vaccines Global Access
IDS	Institute of Development Studies
INGO	international non-governmental organisation
LGT	lesbian, gay, and transgender
NGO	non-governmental organisation
UK	United Kingdom
UN	United Nations
US	United States
WHO	World Health Organization

# 1. Introduction

Since the start of the fourth wave<sup>1</sup> of the Covid-19 pandemic in April 2021, by the end of January 2023, Vietnam had recorded more than 11.5 million cases of infection and 43,000 deaths (Ministry of Health 2023). With the evolution of the pandemic in the world and in the country, Vietnam's strategies to cope with it have also changed. Consistent throughout have been the '5Ks': mask (*khẩu trang*), hygiene (*khử khuẩn*), distancing (*khoảng cách*), no gathering (*không tụ tập*), and health reporting (*khai báo y tế*). During the first three waves of the pandemic, when cases of infection were mainly from outside the country, total cases of infection numbered in the thousands, and daily new cases in the dozens or less, tracing and strict isolation were considered effective measures to curb the spread of the virus. Vietnam's achievement in controlling the pandemic echoed the country's track record in emergency health responses and fighting outbreaks such as HIV, SARS, A(H5N1), A(H7N9), and avian influenza (Herington 2010; McKenna 2006). However, as with many other countries in the world, with the new variants in the fourth wave, the number of cases increased at a pace that was beyond the tracing system's capacity, and isolation was no longer relevant or effective. At a meeting on Covid-19 responses on 24 February 2021, the government confirmed that vaccination was a key measure to control the pandemic while maintaining the '5Ks'. The new strategy for the pandemic was '5Ks + vaccine' (Suc Khoe va Doi Song 2021).

Covid-19 vaccinations commenced in March 2021 in Vietnam. As reported on 25 March 2022, more than 200 million doses were given to 80 million people (84 per cent of the population), of whom 76.7 million were fully vaccinated (79.5 per cent of the population);<sup>2</sup> 46.9 million people had received a booster shot (48.7 per cent of the population) (VnExpress 2022). This achievement echoed Vietnam's previous success with the uptake of vaccinations for infectious diseases such as polio (Jit *et al.* 2015; Nguyen *et al.* 2019). Acceptance and willingness to pay for Covid-19 vaccination are high in Vietnam (Nguyen *et al.* 2021).

Up to the end of May 2021, only 1 per cent of the population had been vaccinated with the first shot due to a shortage of vaccines (WHO 2021).

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<sup>1</sup> The Covid-19 pandemic in Vietnam: first wave, 23 January–24 July 2020: 415 cases (106 cases in the community and 309 cases among immigrants); second wave, 25 July 2020–27 January 2021: 1,136 cases (554 cases in the community and 582 cases among immigrants); third wave, 28 January 2021–26 April 2021: 1,301 cases (910 cases in the community and 391 cases among immigrants); fourth wave, 27 April 2021–present. Statistics for the fourth wave as of 31 January 2023: 11,523,645 cases (11,518,574 in the community and 5,071 cases among immigrants) (Ministry of Health 2023).

<sup>2</sup> Fully vaccinated: two doses of Moderna, Pfizer, AstraZeneca, Vero Cell; one dose of Johnson & Johnson; three doses of Abdala. In the context of this paper, the word 'vaccinated'/'vaccination' often means getting the first shot of vaccine.

According to a government report, by June 2021 Vietnam had received only 3 million doses of vaccine out of approximately 150 million doses needed to vaccinate its adult population (*Nguoi lao dong* 2021). These vaccine doses mainly came from the Covid-19 Vaccines Global Access (COVAX) mechanism<sup>3</sup> and donations. In other countries, including higher-income ones, the vaccine shortage caused public health and justice challenges regarding allocation of and access to Covid-19 vaccines. Although the World Health Organization (WHO) issued guidelines on allocating vaccines (WHO 2020) and prioritising population groups for vaccination (WHO 2022), these guidelines on practices are still being discussed (Rhodes 2021; Sekalala *et al.* 2021; Giubilini, Savulescu and Wilkinson 2021).

This research was conducted in Vietnam to document and analyse Vietnam's challenges in allocating Covid-19 vaccination to different population groups in the context of vaccine shortage. Although equity and fairness are high up in Vietnam's constitution and health policies, experience has shown that state efforts in controlling outbreaks and securing the national economy may overlook benefits for people with lower social status (Lockerbie and Herring 2009).

Research questions on equity and fairness in access to Covid-19 vaccine were studied using the case of internal migrant workers moving from rural to urban areas. We chose this group of people because of their increased vulnerabilities during the pandemic; not just in terms of health hazard, but also their risk of losing jobs and earning lower incomes, and their limited access to public health services due to the household registration system in Vietnam (for more on the household registration system, see section 5.2.1) (Bui *et al.* 2021). Freelance workers suffered more from the negative impact of the pandemic than workers in enterprises (Phạm, Phạm and Đình 2022). Measures to prevent the spread of Covid-19 such as social distancing, which prevented people from moving between provinces and in particular from leaving or entering important cities such as the capital, Hanoi, may affect the social and economic benefits of migrant workers more than those of other people, compared with the impact of unplanned lockdowns in other countries (Rather 2020; Tuoi Tre News 2021). Previous health system research on other diseases and illnesses showed structural inequalities in health status and access to services between migrant and non-migrant workers (Pham *et al.* 2019).

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<sup>3</sup> Co-led by the Coalition for Epidemic Preparedness Innovations; Gavi, the Vaccine Alliance; and WHO.

## 2. Research questions

This research looks at factors that influence the allocation of and access to Covid-19 vaccines. At the time of writing the proposal, we assumed that the shortage of vaccines and inherent inequity would put migrants and other vulnerable groups at risk of being excluded from the vaccination programme. During the eight months of research, we asked two broad questions:

- Is *de facto* exclusion of migrants or vulnerable people acceptable, and what are some of the rationales that people use to explain concrete unequal practices?
- What would a fair, transparent, and inclusive response to Covid-19 that includes rural migrants in the peri-urban and urban areas look like, starting with the capital?

When we started the fieldwork in August 2021, vaccine coverage was already high; thus, we wondered if our research questions were still relevant. We conducted a round of 12 interviews to explore possible exclusion and inequity in the vaccination programme. From that, we found that while vaccination coverage was high, some groups were unintentionally excluded, especially at the beginning of the vaccination campaign. Thus, we continued the research and interviewed migrant workers with intersecting vulnerabilities such as economic situation, occupation, ethnicity, disability, sexual orientation, and gender identity.

## 3. Methods

### 3.1 Research sites

The research was conducted in Hanoi – the capital and the cultural and political centre of Vietnam. It is the second-biggest city in the country, located on the Red River delta. Hanoi has a total population of more than 8 million people, with an urban population of 4.1 million. However, metropolitan Hanoi, or the Hanoi extension, covers a much larger area, with a population of almost 20 million. There are three large industrial zones in Hanoi, where the majority of workers are migrants. The first hotspots in the fourth wave of the pandemic in Vietnam occurred here.

### 3.2 Research methods

We used a mixed methods approach, combining primary and secondary qualitative data collected online and in person and a quantitative online survey.

#### 3.2.1 Secondary data analysis

We reviewed Vietnamese vaccination policies during the period 2020–22, including Covid-19 vaccinations. We paid specific attention to universal access among different groups under previous and current policies.

#### 3.2.2 Qualitative interviews

We conducted 60 semi-structured interviews with people in the following groups.

##### *Key informants*

Ten key professional governance informants, including experts in epidemiology, policy development and social protection; health communication professionals; and people involved in implementing the vaccination campaign at local level, such as group heads<sup>4</sup> and commune health workers, representatives of charity groups, and employers from small enterprises and in the informal sector.

The key informants were recruited based on their existing knowledge and relationship with the research team, which was the best way to reach people – cold calls are always hard, but especially in a pandemic. First, the research team brainstormed which sectors were involved in vaccination. Then, organisations and individuals were identified in each sector. The research team contacted these people using email, Facebook messages, and phone calls to get their

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<sup>4</sup> A 'group' in a city is similar to a village in a rural area. The administrative structure is province, district, commune/ward, then village/group.



agreement to be interviewed. For people at group and commune levels, the research team often reached them with the help of other colleagues and friends.

### ***Migrants***

In this research, we included a wide range of subgroups of migrants to help our in-depth understanding of exclusion and inequity, namely: those working in the informal sector and small enterprises, people with disabilities, ethnic minorities, people who are not registered in the house registration scheme, homeless people, non-cisgender, and people who migrate for short-term or irregular periods of time. Some 36 people who self-identified as migrants came from their provinces to stay in Hanoi for a certain period during the Covid-19 pandemic.

The research team contacted non-governmental organisations (NGOs) and community-based organisations to ask for help in recruiting migrant workers from their networks. Snowballing was also used in recruiting participants. The research team followed stories of research participants to identify new groups to be included in the research and to recruit new people. These people were identified during the course of the interviews. At first, the team contacted a few migrant workers in the industrial zones in Hanoi. Then, based on the interviews with them, key informants, and other people, the team continued to recruit migrants who were suggested in interviews as people who had (potentially) experienced exclusion or challenges in accessing Covid-19 vaccinations. These suggestions often did not identify specific people, although this was sometimes the case; rather, they indicated characteristics of migrant groups who may have been at higher risk of being excluded from the Covid-19 vaccination programme.

Characteristic vulnerabilities were: duration of stay in Hanoi (very short – several days or weeks; short – one or several months; and long – several months or years); purpose of migration (work, study, treatment, taking care of family members, etc.); employment sector (formal or informal); nature of labour (freelance, short- and long-term employees); nature of work (manual, intellectual, etc.); nature of business (corporate, company, family business, small enterprise, working group); housing situation (owned house, rented, or were homeless); disability status; nature of travel (periodic or daily travel to Hanoi); age (minor or adult); gender (woman, man, or transgender person); sexuality (heterosexual or homosexual); and ethnicity (ethnic Kinh or ethnic minority).

### ***Professionals from different socioeconomic backgrounds***

Fourteen people who were not directly involved in implementing the vaccination campaign but who had experienced vaccination themselves. These people's contact details were available to the research team, and they were willing and available to talk to the team. They were purposely selected to cover a wide range of professions such as journalists, trainers, policy advocates, artists, development workers and so forth.

Interviews were all conducted in the Vietnamese language by three Vietnamese researchers who have experience of working with different socioeconomic groups in Vietnam, including marginalised and vulnerable groups. The interviews were conducted until information saturation was reached.

### ***Online survey***

Based on the qualitative interviews, people's main concerns about Covid-19 vaccines and vaccination, and perceptions on equity in the vaccination programme, were identified and verified with an online survey. The survey was conducted to suit the available resources and Covid-19 preventive measures. We used free software from KoBoToolbox to collect data from 480 survey participants. Although various strategies were used to reach out to different populations, it was difficult to control for equal presentation of the migrant groups in the survey, as well as geographic location. Thus, we have excluded this data from our analysis.

## **3.3 Limitations**

- Due to limited time and resources, the qualitative research was conducted only in Hanoi. A comparative study across different geographic areas would provide a more comprehensive picture of vaccination practices in Vietnam.
- Due to Covid-19 social-distancing measures, almost all of the interviews were conducted online using voice chat software. Interviewers could not see much of the interviewees' environments, which can provide valuable contextual information. It was also more difficult for the interviewers to interpret answers because they could not see the interviewees' facial and other non-verbal expressions. When the interviewees consented, we used video calls for greater interaction between the interviewers and interviewees.

## 4. Covid-19 vaccination programme

### 4.1 Navigating vaccination priorities

Similar to many other countries in the world, Vietnam struggled with a shortage of Covid-19 vaccines. To deal with the supply shortage, the state prioritised certain groups to meet vaccination targets. On 26 February 2021, the government issued resolution 21/2021 NQ-CP on purchasing and using vaccines. This policy determined nine priority groups for free vaccination (in order of priority) (see Box 4.1).

#### Box 4.1 Priority groups (February 2021)

1. Frontline workers (health workers, health volunteers, army forces, police);
2. Diplomatic and customs officials;
3. People working in supply chains of essential goods and services;
4. Teachers and people working in public administrative offices;
5. People over 65 years old and people with chronic diseases;
6. People living in locations with outbreaks of Covid-19;
7. Poor people and people receiving social welfare;
8. People assigned by the government to work or study abroad;
9. Other people identified by the Ministry of Health.

Source: Vietnam Government resolution 21/2021 NQ-CP

Considerations of health and economic development targets were seen in the priorities for vaccine allocation; for example, provinces and cities under the jurisdiction of the central level during the current pandemic and/or industrial zones and/or important transportation hubs.

Based on this resolution, on 5 March 2021 the Ministry of Health approved the 2021/22 vaccination plan with decision 1467/QĐ-BYT. The priority list of nine groups in resolution 21/2021 NQ-CP was used. However, the plan specified that only the first group – which included frontline health workers, people in community task forces, army forces, and police – would be included in the **first round** of vaccination, with 117,000 AstraZeneca vaccine doses from the first

batch that Vietnam received; 13 out of 61 provinces that were pandemic hotspots were included in this round.<sup>5</sup>

On 21 April 2021, the Ministry of Health issued two documents – 3141/BYT-DP and 3142/BYT-DP – on vaccinations for people at ministries, state agencies, units, corporations, multinational corporations, United Nations (UN) agencies, and international organisations based in Hanoi. According to these documents, people in groups 4 and 9 were already specified in resolution 21/2021 NQ-CP. People in these groups would be vaccinated in the **second round**, which would use about 12,000 out of the 20,000 vaccine doses that were allocated for Hanoi. Following these documents, on 7 May, the Ministry of Health issued document 3823/BYT-DP to assign tasks for five big hospitals in Hanoi to conduct vaccinations for the groups mentioned in 3141/BYT-DP and 3142/BYT-DP.

On 8 July, the Ministry of Health issued decision 3355/QĐ-BYT on the implementation of the 2021/22 vaccination plan (July 2021–April 2022) to rollout the programme in all communes in Vietnam to all adults who met the vaccination criteria indicated by vaccine companies. This document specified 16 priority groups (see Box 4.2). Compared with resolution 21/2021 NQ-CP, the newly added groups related to various outbreaks that had occurred before the issuance of the decision. Enterprises and workers from the private sector were also included.

## Box 4.2 Sixteen priority groups in decision 3355/QĐ-BYT (July 2021)

1. People working in health clinics and the health sector (public and private);
2. People taking part in pandemic prevention and control (members of Covid-19 taskforces at all levels; people working in quarantine camps, doing tracing work or conducting epidemiological surveys; community-based Covid-19 prevention and control groups, volunteers, journalists, etc.);
3. Armed forces;
4. Police;
5. Diplomatic officials serving on missions abroad and their family members; people working in diplomatic agencies, and consular and international organisations in Vietnam;
6. Customs officials; people working in immigration and export departments;

<sup>5</sup> The provinces included: Hà Nội, TP; Hồ Chí Minh; Hải Dương; Quảng Ninh; Hải Phòng; Bắc Ninh; Bắc Giang; Hưng Yên; Hòa Bình; Gia Lai; Bình Dương; and Điện Biên; and Hà Giang.

7. People providing essential services (airlines, transportation, tourism, electricity and water providers);
8. Teachers; people working in educational settings; pupils; students; young doctors; people working in administrative units; legal aid services; stock companies and bidding services; people who are in contact with many others;
9. People over 65 years old and people with chronic diseases;
10. People living in areas with Covid-19 outbreaks;
11. Poor people and people receiving social welfare;
12. People assigned by authorities to work abroad or people who want to go abroad to study;
13. Workers in enterprises\* and their family members (enterprises in industrial zones, production, transportation, credit, tourism, etc. and in essential services such as accommodation, food, banking, health care, pharmacy, medical equipment, retail and wholesale shops, markets, construction and tourism);
14. Religious leaders;
15. Freelance workers;
16. Other groups based on a decision of the Ministry of Health or head of provincial/city people's committee and proposed by organisations who carried out vaccinations for the Ministry of Health.

\* Including both private and public enterprises and businesses.

Source: Ministry of Health decision 3355/QĐ-BYT

## 4.2 Covid-19 vaccination campaign: 'Visit every alley, knock on every door'

Under the administrative system in Vietnam, villages in rural communes or resident groups (*tổ dân phố*) in urban wards are the lowest administrative level. In each village or resident group, a village head or group head (*tổ trưởng tổ dân phố*) is responsible for people's safety and the normal functioning of the village or group. This person should also make sure that people can participate in local decision-making (MOHA 2021).

During the Covid-19 vaccination campaign, group heads were among the key people to implement the campaign. To create a list of people living in an area to serve as the basis for inviting people for vaccination, the group heads went from house to house to collect information, including on long- or short-term household registrations, and scanned the area for homeless people: the vaccination

campaign slogan was ‘Visit every alley, knock on every door’. Based on the list and state guidance on who should be prioritised for vaccination, they composed a list of people and invited them for vaccination on specific days. If for any reason a person was not included on the list, they would not be able to be vaccinated.

## 5. Access to Covid-19 vaccinations for migrant workers and other vulnerable groups

### 5.1 Inclusion of migrant workers and vulnerable groups in vaccination policies

Migrants, though not explicitly included on the priority list for Covid-19 vaccinations, were also not explicitly excluded either. Many migrants could be in groups 13 (workers in enterprises and their family members), 7 (people providing essential services), and 15 (freelance workers) in the 16 priority groups. Group 13, especially, included people working in industrial zones, most of whom were migrants. Vulnerable people such as the poor, people living with HIV, and people with disabilities were included in group 11 (poor people and people receiving social welfare).

### 5.2 Factors influencing migrant workers' access to vaccinations

#### 5.2.1 Household registration status

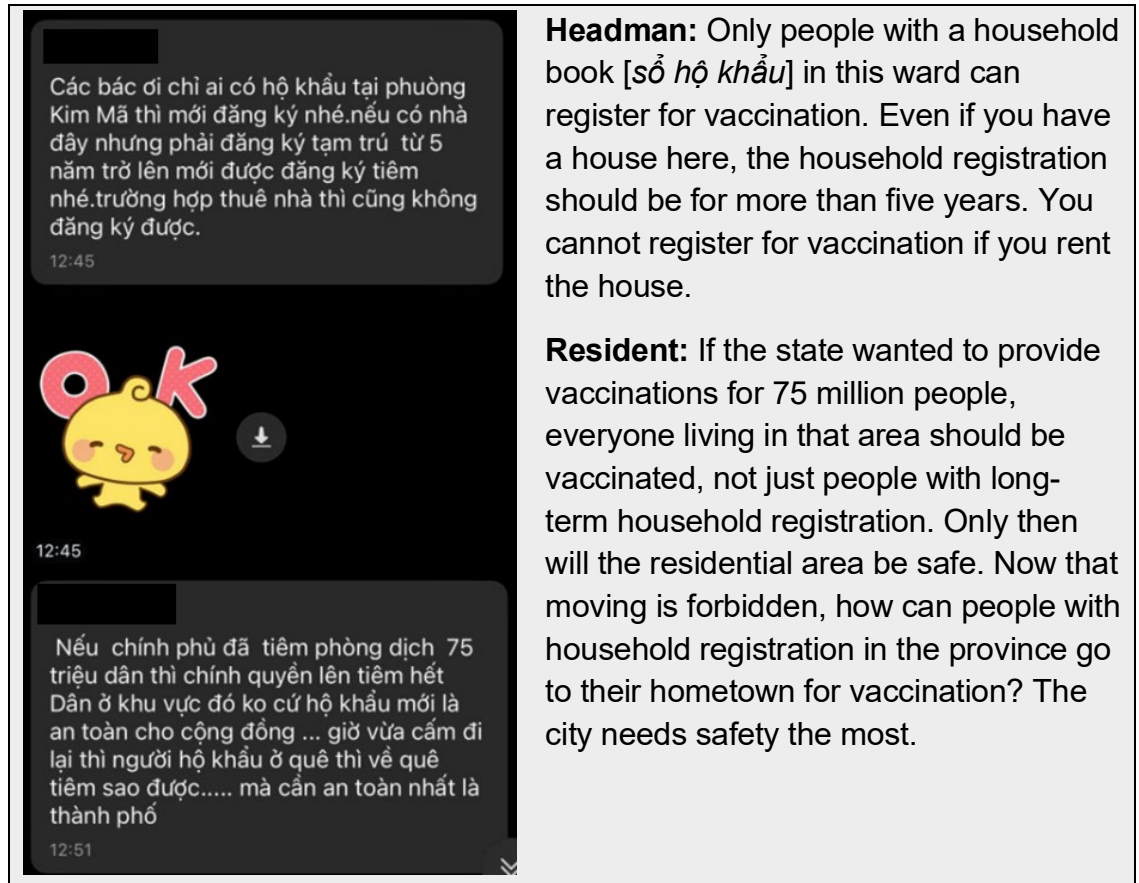
Established during the war with the United States (US)<sup>6</sup> in 1964 to manage internally displaced people, the household registration book (*sổ hộ khẩu*) was a tool for the state to control (internal) migration, among other things. In the past, people could only register in the place where they permanently resided. It was difficult for people to move from one province to another without facing sanctions (World Bank and VASS 2016). After the *đổi mới* economic reform in 1986, rules about *sổ hộ khẩu* were less strict. In addition to registration of a permanent household address (*đăng ký thường trú*), people could register as long-term temporary households (*đăng ký tạm trú dài hạn*) or short-term temporary households (*đăng ký tạm trú ngắn hạn*). *Sổ hộ khẩu* is associated with permanent household registration. A survey conducted by the World Bank in 2016 found that 'temporary registrants continue to face limitations in service access, particularly with regard to public schools, health insurance for young children, and basic procedures like registering a motorcycle' (*ibid.*: xi). The same survey showed that about 5.6 million people did not have *sổ hộ khẩu* at their place of residence, but temporary registration only. This group accounted for 18 per cent of the population in Hanoi and 36 per cent of the population in Ho Chi Minh City (*ibid.*).

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<sup>6</sup> 1 November 1955–30 April 1975.



## Figure 5.1 Zalo group messages



**Headman:** Only people with a household book [*sổ hộ khẩu*] in this ward can register for vaccination. Even if you have a house here, the household registration should be for more than five years. You cannot register for vaccination if you rent the house.

**Resident:** If the state wanted to provide vaccinations for 75 million people, everyone living in that area should be vaccinated, not just people with long-term household registration. Only then will the residential area be safe. Now that moving is forbidden, how can people with household registration in the province go to their hometown for vaccination? The city needs safety the most.

Note: The research team received the phone owner's permission to use this screenshot.

During the Covid-19 vaccination campaign, *sổ hộ khẩu* was not clearly mentioned as a condition for vaccination, but it was used in practice to screen and select eligible people. One key informant, who is a migrant himself, shared that at the beginning of the campaign, where he lives the village headman said that only people who had *sổ hộ khẩu* in that ward or had temporary registration for more than five years could be on the vaccination list. He migrated from Ho Chi Minh City to Hanoi for over two years, so he was invited for vaccination after those people with *sổ hộ khẩu* or people who had lived there for more than five years.

He also shared that his friend in Ho Chi Minh City had a similar experience. His friend came to the city to work and his landlord had not arranged a temporary household registration for him. The friend could not get vaccinated because he 'could not prove' that he 'actually' lived there. Below is the note from the friend's Facebook profile:


I have been so stressed about vaccination and I still did not receive a shot. After repeatedly registering more than a dozen times, sending messages to the hotline, calling the commune and district



health station (no answer), I received the invitation to get a Vero Cell vaccination yesterday. I went to the vaccine site but was sent back because I could not prove that I am living in the district. I am living here but I do not have a temporary household registration yet. There are many other people in a similar situation. I mean people who do not have a temporary household registration but are working in Saigon. I asked my landlord to urgently do it for me. I registered again and I'm waiting for my first shot. I just don't understand. The district authorities want to reach 100 per cent vaccination coverage but they do not accept people without household registration for vaccination. Then how can they get to the target of 100 per cent vaccination? Being refused for vaccination, I felt 'rejected' and very sad.

(Man, 28 years old, migrated from Hanoi to Ho Chi Minh City to work)

## Figure 5.2 Zalo group messages



The screenshot shows a Zalo group chat interface. At the top, the time is 17:39. The chat contains several messages:

- A message at 23:12: "Tất cả các phường đều tổ chức tiêm nên hộ khẩu ở đâu tiêm ở đó, vacxin phân đều về các phường mà!"
- A message: "Cậu xem chính sách của thành phố tôi gửi đây nó nói thế mà"
- A sticker with the text "Xin chào" and a blue cartoon character.
- A date separator: "07:05 05/08/2021"
- A message: "Đây là chủ trương của phường đưa xuống nên bọn em chỉ là người thực hiện thôi ạ!"
- A message: "Chủ trương chỉ đạo của quận Ba Đình xuống cho các phường thực hiện"

**Headman:** Every ward organised vaccination activities so people could be vaccinated where they have their household registration. Vaccines were allocated evenly for all the wards.

**Resident:** Please see the city policy that I just sent. It stated that [where people could be vaccinated did not depend on their household registration].

**Headman:** This is the ward policy. We are just the implementers.

**Local officer:** These are the instructions from the district for the wards.

Note: The research team received the phone owner's permission to use this screenshot.

## 5.2.2 Possession of an identity card

While household registration may not be compulsory for vaccination, possession of an identity card is essential. The identity number is needed to record a person's information in the vaccination registration system to create a Covid-19 vaccine passport later. Thus, it is difficult for people who do not have paperwork such as an identity card. During the research, we found that people who did not have an identity card could have problems accessing vaccinations. These included people who had lost their identity card or did not have one for various reasons. Although anyone who did not have an identity card could be prevented from getting a vaccination, migrants – especially short-term migrants – were at higher risk of being excluded than people who had lived in an area for a long time or permanently. Although an identity card number was needed to verify personal information and register the vaccination, people without an identity card were still accepted for vaccination if they were sponsored by a local official.

There were four people without identity cards in the research, including a man who had just finished a term in prison, a woman who came from a province to Hanoi to take care of her child in hospital, and two homeless men. Depending on their residential status, their access to vaccinations differed.

In the case of the man who had just got out of prison, his old identity card had expired and he could not get a new card yet. After finishing his term in prison, he had to move to a new house because his old house had been sold to pay his debts. His new house was too small, so he did not get a 'red book' (*sổ đỏ*) for the house (legalising the house, registering it under his name). Because he could not legalise the house, he could not formally register there and thus could not get a new identity card. However, he had been a resident of that area since childhood; everyone there knew him, including the group headman and local police. A local police officer certified the status of this man and accepted responsibility if anything went wrong. The man was vaccinated without difficulty.

Without residential status or knowing someone in the local administration or health authority, getting vaccinated could be much more difficult. For example, the woman who came to Hanoi to take care of her child in hospital could not get a vaccination because she had lost her identity card and had not got a new one. One of the homeless men did not have an identity card because he lost it. The group head took down his name and sent it to the vaccination site; however, he could not get in. The research team also tried to register him in two different wards but were also unable to get him into the site for vaccination.

The other homeless man did not have an identity card because his mother fled from hospital after she gave birth to him. Without verification of his birth from the hospital, this man could not get a birth certificate and so could not get an identity card. He had never had an identity card in his life. He said that he had suffered a lot of problems in education, with finding a job and so forth because he did not

possess an identity card. However, this man successfully got his vaccination because he gave a fake identity number on the registration form and the people at the vaccination site did not – or could not – check it:

*I do not have an identity card because when my mother gave birth to me, she took me and fled from the hospital as she could not afford the hospital fee. When I was 18 years old, I went to the local authority to get an identity card but the hospital did not keep my record after 18 years. Without an identity card, I faced many difficulties. I could only finish primary school. Without an identity card, I could not go to secondary school. I could not get an identity card because I do not have a birth certificate. I also could not open a bank account or buy a motorbike.*

*Most recently, it involved the Covid-19 vaccination. Because I do not have an identity card, people did not call me for vaccination. Because I am not vaccinated, I am worried that I may be infected. Travelling for work may also be difficult if I am not fully vaccinated with two doses.*

*I asked my brother to register me at a ward using his relationship with a local official. I received the vaccination form on which I should fill in my identity number. I just filled in random numbers. Twice for the vaccination, I used different numbers. However, because there was no identity check at the site, I got vaccinated successfully.*

*It was my parents' fault that I did not have an identity card and I feel very ashamed about my situation. I hope that the government will help homeless people to get identity cards to make our lives easier.*  
(Man, 21 years old, homeless, freelance worker in Hanoi)

### 5.2.3 Types of migration

In this research, we found that there were various types of migrants in a big city such as Hanoi. In addition to traditional types of migration, such as migrating to work in the city, other types have emerged there during the Covid-19 pandemic. People came to Hanoi for temporary reasons, such as medical treatment for themselves or family members in hospital, but had to stay in Hanoi and could not return home due to Covid-19 restrictions.

For example, the account below showed how a man had been in Hanoi for a few weeks to take care of his son, who was receiving treatment at the National Children's Hospital. His landlord had not registered him yet, so he could not get a

vaccination because his name was not in the household registration system for the local area:

*One time, I went out to buy food. Other women in the hospital told me to go to Ngọc Khánh ward, which is nearby, to be vaccinated. I took a motorbike ride. The women there said that I could get vaccinated without a temporary household registration – an identity card was enough. However, when I was there, the ward policemen told me that I should register with the ward first and I would need a household registration to get a vaccination. So, I went back to the hospital without getting vaccinated. I don't know when I can get a vaccination.*  
(Man, 26 years old, worker, taking care of his child at a hospital in Hanoi)

Many of these people had to stay in Hanoi for an extended period that was much longer than they had planned. Some of them could not return home due to lockdowns and the high cost of travel. They also had to pay for Covid-19 tests, which could cost them a fortune.<sup>7</sup> In addition to the challenge of *sổ hộ khẩu*, these people may not have been able to go to the vaccine site because they had to spend time in hospital and could not leave their sick child. Such cases mostly involved women who came to Hanoi to take care of their children in hospital while their husband stayed at home to work and to take care of other children:

*I have not got a vaccination because I am busy taking care of my child in the hospital. My landlord messaged me and called me to get a vaccination. However, I could not go out to get the vaccination because no one was helping me look after my child. Once, I was able to go out and I asked the landlord, but they said that there was no more vaccine. The group headman said that I should wait until the next call.*  
(Woman, 28 years old, housewife, taking care of her child at a hospital in Hanoi)

While these groups had difficulties with vaccinations, hospital patients were vaccinated early. For example, people with chronic diseases who had to stay in Hanoi for medical reasons; people who were undergoing treatment in hospital, such as people with kidney failure who had to stay in Hanoi for haemodialysis; and, similarly, people with cancers or other diseases. They formed small residential clusters called 'kidney villages' (*xóm thận*) or 'cancer villages' (*xóm ung thư*). Because they had to go to hospital often, these people were vaccinated early at the hospitals where they were being treated. Without a

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<sup>7</sup> At that time, a polymerase chain reaction (PCR) test cost VND750,000 (around 30 euros) and a quick test around VND250,000 (around ten euros).

vaccination, they had to pay high costs for Covid-19 tests every time they visited the hospital.

Another group included people who live in the suburbs of Hanoi or its neighbouring provinces. Before Covid-19, these people travelled to Hanoi every day to work and may not have identified themselves as migrants. During the Covid-19 pandemic, when Hanoi was in lockdown, they could not enter the city and thus could not be vaccinated even when they had been invited for a vaccination. In contrast, some people lived in Hanoi but travelled to work in nearby provinces every day. Due to Covid-19 preventive measures, they had to stay at their workplaces in the provinces and could not enter the city for vaccination. Information in the media said that people with vaccine appointments could enter the city; but, in practice, people could not get in (VietNamNet 2021). This made people very frustrated because the reality that they faced was different from the information that they received in the media. In fact, there was no formal regulation about these groups in the policies:

*I got a message from the office that I should go to the commune health station in my office area in Hanoi to get a vaccination. I live outside Hanoi. When I got to the bridge [at the entrance of Hanoi], even though I showed the vaccination message, the guard there did not let me pass. I read the city regulation; it said that people from outside Hanoi could enter for vaccination. However, in my case it did not work out.*

(Woman, 32 years old, accountant at a local NGO in Hanoi)

Similarly, when people lived in a pandemic hotspot, they could not get to vaccination appointments:

*I lived across the river in the neighbouring commune. I was not allowed to cross the river because there was a pandemic hotspot in my commune.<sup>8</sup>*

(Woman, 35 years old, worker in a factory in an industrial zone)

In contrast, some migrants who could not get onto a priority list in Hanoi were on the list in their hometown. However, due to lockdown, they could not return home to be vaccinated:

*I am from Lao Cai.<sup>9</sup> I am taking care of my child who has cancer. I saw people going to get a vaccination, but I could not go because I could not leave my child alone here. My family is among the poor, so*

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<sup>8</sup> At that time, Vietnam applied a strict lockdown to households, buildings, villages, and communes with cases of Covid-19; the lockdown lasted for 14 days or more.

<sup>9</sup> A province in the mountainous northern area of Vietnam, which is about 320km (200 miles) from Hanoi.

*we had already registered for vaccination a long time ago. My husband was already vaccinated, but am not because I am here. I got stuck in Hanoi. I could not get a vaccination here and also could not return to my province, even though they already called me there for a vaccination. In my province, in order, they gave priority to people working with government organisations, teachers, and then people who made great contributions to the country, and then poor people. I think the vaccine programme is not very equitable because [other] people have all got a vaccination but I have not. I come from a remote area and I do not have any family members or relatives here, so I do not have information on who I should contact to be vaccinated here to protect myself better.*

(Woman, 34 years old, freelance worker, taking care of her child at a hospital in Hanoi)

#### **5.2.4 Type of work: formal vs informal**

Although it was indicated clearly that the priority list covered not only people working in the public sector but also in the private sector, people working in the public sector may have received preferential treatment. Nine out of 16 groups on the list are exclusively or predominantly state run; 11 groups on the list mainly relate to formal rather than informal roles. The dominance of public and formal sectors on the priority list may have influenced migrants' access to vaccination as they occupy a higher proportion of roles in the private and informal sectors. A 2016 report by the General Statistics Office and the International Labour Organization on informal labour in Vietnam showed that 18 million Vietnamese people worked in the informal sector, estimated at 57.2 per cent of the non-agricultural labour force and three-quarters of total jobs in the economy (GSO and ILO 2016). Some occupations have high levels of informal workers, such as construction (90.2 per cent), family businesses (98.7 per cent), and accommodation and food services (80.7 per cent) (*ibid.*). Income from the informal sector makes up 15–27 per cent of Vietnam's gross domestic product (Nguyen 2019).

Among those workers, many are migrants from rural areas who lost their jobs and suffered social and economic consequences due to the pandemic (Mnet 2020; Lam and Hoang 2020). Many of these rural migrants are relatively poor and live in crowded, shared housing (Hoang, Truong and Dinh 2013; IOM 2020) in urban and peri-urban settings, which increases their risk of catching Covid-19. Many internal migrants work in small companies or in the informal sector, which is where most employment (82 per cent) in Vietnam is generated (Cling, Razafindrakoto and Roubaud 2011). Most companies in Vietnam are relatively small, domestic, family-owned enterprises, though the estimated number of enterprises varies widely (OECD 2021). The proportion of internal migrants



employed in these different kinds and sizes of companies is difficult to know. Even in large industrial zones, not all jobs are formal or in big factories. To reduce labour cost, many companies outsource work to smaller companies. In turn, these smaller companies outsource work to family businesses or individuals. People who work in smaller companies, family businesses, or as individuals do not receive the same benefits as people working in big factories. Thus, even if people all live and work in the same industrial zone, only the workers in big factories benefit from being in category 13 on the priority list:

*There is serious hierarchy in the industrial zone. There are big companies with big factories, but there are also many small collectives and family businesses in the supply chain that make products for these big companies. When getting to vaccination, these big companies only gave the vaccine to people working officially in their factories, not people in the supply chain outside the factories... You know, for the companies to provide vaccine for their workers, they had to contribute resources in different forms. Small companies or family businesses could not afford this. Sometimes, they may also not care.*

(Woman, 42 years old, researcher at a local NGO in Hanoi)

### **5.2.5 Individuals handle vaccination procedures at grass-roots level**

The priority list served as a guideline for people in charge to implement the vaccination campaign. However, as shown above, many groups and subgroups were not mentioned on the list, such as people who did not have a household registration, people who are temporarily trapped in cities due to preventive measures, people who have lost their identity card, and so forth. It seemed that local officials at grass-roots level had not been provided with the details to respond to these emerging situations; but it was up to them to handle the cases.

For example, health staff at one hospital showed their concern over vaccinating children's caregivers who came from other provinces and had to stay in the hospital during the pandemic. The hospital where the children were being treated was in fact a vaccination site. The government had assigned it to conduct vaccinations for corporations and organisations. Patients' family members, however, could not be vaccinated there, even though some parents were staying at the hospital's guest house to take care of their children:

*There were about 30 mothers and fathers staying here to take care of their children. I thought that they could get vaccine here as our hospital is also a vaccination site. I registered them on a list and submitted it to the hospital manager for approval. However, I could not get approval. My manager said that these women were not in the*

*categories of people that our hospital vaccinates. So, these women asked the landlord where they rented a room to register them on the local list.*

(Woman, 28 years old, nurse at a hospital in Hanoi)

In cases of people who did not have a household registration or identity card, as described above, we also found that local officials decided whether to accept cases or not. During the research, the team supported research participants who did not have a household registration to get vaccinated. If someone was unsuccessful in one place, we sent them to another site where the team informed the group head in the residential area in advance and asked for help.

The interviews also showed that vaccination policy could vary from location to location. Some wards differentiated between long- and short-term household registrations; others did not. However, we were not sure if this was a temporary policy wards had made to deal with vaccine shortages or a policy change in Hanoi, as it was difficult to track. Some research participants complained that their local officials were passive and not flexible. When they made a complaint or requested further explanation about an official announcement, village heads would tell them they were just following instructions from the ward, the next level up.

## 5.3 Other minority and vulnerable groups' access to vaccinations

In the earlier stages of the pandemic, the Vietnamese government was seen to respond to what Ivic (2020) calls the third generation of human rights<sup>10</sup> and ethical standards, as they are based on collective benefit and taking care of vulnerable people (*ibid.*). However, at the beginning of the vaccination campaign, vaccine shortage posed a great challenge for the government in ensuring vulnerable groups' access.

### 5.3.1 People with disabilities

It was estimated in 2018 that 31.7 per cent of 8 million people with disabilities were in the labour force (GSO 2018). The government had a special programme to provide vaccinations for people with disabilities, implemented by the Ministry of Investment and Planning and Ministry of Labour, Invalids and Social Affairs. Under this programme, people with disabilities were called early to get vaccinated. However, this programme reached only a few people who were

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<sup>10</sup> Human rights have developed over the years. Civil and political rights are first-generation rights; the second generation emerged after the Second World War and are related to equality. They are fundamentally economic, social, and cultural in nature. The third generation is usually labelled as group and collective rights.



leaders of or active in non-governmental and community-based organisations for people with disabilities. Other people with disabilities, who often worked individually or in small enterprises, did not know they had priority status and were not called by local officials, perhaps unintentionally, because many disabilities are not visible. Employers of people with disabilities also did not know that some employees were entitled to special benefits.

An interview with the owner of a hair salon with deaf employees showed that he was not aware of any special programme for his employees. In addition to being disabled, some of his employees were below 18 years of age – a group that was also not eligible for vaccination in the early stages of the pandemic. During lockdown, the owner had to close his shop. His employees returned to their hometowns. After the lockdown was lifted, the owner reopened his shop and his employees returned to work. However, they were not included on the vaccination list as they were not registered. So, in this case, the deaf workers could not get vaccinated due to a triple barrier: because they were migrants without a household registration; because they were people with disabilities; and because they worked in the informal sector.

### 5.3.2 Lesbian, gay, and transgender people

Most lesbian, gay, and transgender (LGT) people said that they did not have any difficulty in accessing vaccinations. LGT people who were also migrant workers faced difficulties related to household registration at the beginning of the vaccination campaign, as mentioned above; they were vaccinated in the later stages of the vaccination campaign. In the case of transwomen and transmen, though their appearance may have been different on their identity cards, they were invited for vaccination because they had already lived in a particular area for a long time and were recognised by local authorities, such as the village headman, community health workers, and so on.

However, among the research participants, we met people who did not want to be vaccinated. According to these people – who, for example, might be transgender people undergoing hormone therapy or with specific health conditions – there was not enough information about Covid-19 vaccines or it did not meet their specific needs:

*I still have not been vaccinated, though they called me several times. I am not sure if the vaccine is safe for me. I am using hormones and I also have other health problems. I have looked for information from different sources, including finding information from international documents and translating them. I also asked doctors who I know, but I am still not sure.*

(Transgender man, 25 years old)

### 5.3.3 Homeless people

In general, homeless people were vaccinated because they would be registered on the list by local officials in their efforts to ‘visit every alley and knock on every door’. However, if they could not meet other criteria, such as possessing an identity card, they may have faced difficulty in getting vaccinated, as described above.

### 5.3.4 Out-of-school children

Vietnam implemented a vaccine programme for children aged 12–17 years old. However, this programme was implemented in schools; so, out-of-school children, who might be street children or working, could not get vaccinations. According to the Labour Code (2019), people over 15 years old in Vietnam can work legally. About 39 per cent of adolescents aged 15–19 years old have joined the labour force in Vietnam (MOHA 2015):

*I’m supporting 11 children [who are] 11–18 years old for vaccination. I could register five children at school, but only three of them were vaccinated because there was not enough vaccine. Three out-of-school children were registered in the ward. They were not vaccinated because the vaccines were prioritised for schools first. (Woman, 24 years old, working for an NGO that supports street children and survivors of trafficking)*

*These kids rent houses in different places, so I had to contact different wards to register them for vaccination. In these wards, they all requested a sponsored letter from the organisation. To date, I have already registered ten kids. The group head said that he would call me when vaccine was available, but I have not received any message so far, so I don’t know when they will be vaccinated. There are 20 more kids – I do not know how to register them because I do not know their group headman. (Man, 32 years old, working for an NGO that supports street children)*

People who provided support for marginalised and vulnerable people also complained about equity in the vaccination programme:

*I saw that the commune health workers were not supportive and sincere when we contacted them. We were, in fact, very concerned that the children had not been vaccinated because they had a high risk of being infected. They were all living together in one place. However, when I called, the commune health workers did not have a nice attitude. They said to me, ‘Why do you call so much! We have*

*not called you because there is no new announcement. You should not call us so much like that.'*

*According to my observation, children at school get much better access to services. Children who are also 12–18 years old but are out of school may also get access to vaccination, but not so well as children in school.*

*I think that [access to] vaccination is not equal for every child. The children who are in school are more privileged. I think the wards should work with the schools to make sure that all children can access vaccinations to ensure their health.*

*(Woman, 24 years old, supports children who are trafficking survivors)*

## 6. Perceptions about a just and equitable vaccination programme

Interviews during the research showed that people share a common view on a just and equitable vaccination programme with the following characteristics:

- ‘Good’ vaccine is accessible to all.
- Prioritising people whose health is most at risk.
- People’s personal sacrifices are acknowledged.
- The programme is strategic and evidence-based.
- The programme is transparent and participatory.

### 6.1 ‘Good’ vaccine is accessible to all

The government made ensuring people’s safety and health its number one principle, followed by social and economic development objectives, in the country’s efforts to contain the pandemic (Government of Vietnam 2021). In the above-mentioned policies, the objective of the vaccination programme was to ‘actively prevent Covid-19 pandemic by vaccinating people at risk and the community’. Equal access to vaccination was also mentioned as a key principle in vaccine distribution and planning the rollout of the vaccination programme.

In general, research participants greatly appreciated the government’s efforts to mobilise a large quantity of vaccine in a short time. That Vietnam had achieved high vaccine coverage by the end of 2021 and vaccine was provided for free was an important factor for people in their perception of the vaccination programme as being just and equitable. People in marginalised groups such as mobile migrant workers, homeless people and so forth were happy and grateful that they had been vaccinated:

*I’m so grateful to the government and to the party for trying very hard to have enough vaccine so I could be vaccinated. If I had to pay for this, I don’t know if I could afford it.*

(Man, 34 years old, resident in boat village)

*I do not even live here. I do not have a household registration here. I could not believe that I had a vaccination. The group head got our names and sent us an invitation for vaccination.*

(Man, 45 years old, migrant construction worker)

It was not just an issue of access to the vaccination programme, but also the choice of vaccine. Vietnam approved nine Covid-19 vaccines. The most common ones were Pfizer (US), Moderna (Canada), AstraZeneca (UK), and Vero Cell (China). Participants in the research shared common opinions on the quality of different Covid-19 vaccines. Pfizer and Moderna were viewed as ‘the best’ vaccines and thought that these vaccines were only available to and accessible for people in elite groups. AstraZeneca was seen as ‘average’ and the vaccine that was provided to the wider population. Vero Cell was seen as ‘not very good’ and provided to anyone at grass-roots level. Although participants thought that access to the vaccination programme was equitable – because everyone could get vaccinated and it was free – they did not think access to different vaccines was equitable:

*I think there is inequity with the kind of vaccine that we got. Some people got Pfizer and Moderna, some got AstraZeneca and others got Chinese vaccine [Vero Cell]. There were few doses of Pfizer and Moderna. You had to be in a special position or have special relationship to have it. AstraZeneca is for more normal people and Chinese vaccine is for anyone. At first, I did not notice. I thought that in my local area there were only AstraZeneca or Chinese vaccines. However, when people were called for the second shot, I heard they called people with the first shot of Pfizer and Moderna also. It means that these vaccines were available in my commune for the first shot, but it was not announced so nobody knew about it.*

(Transgender man, 25 years old)

## 6.2 Prioritising people whose health is most at risk

In 2021, WHO experts developed a values framework for effective and just allocation of vaccines and prioritisation of Covid-19 vaccinations, which emphasises that policymakers should not use pandemic and economic factors alone to decide vaccination priority (WHO 2020). The framework provides a guideline rather than a tool for direct application, and policymakers and practitioners were, at the time of the research, still struggling to choose between groups that were at higher risk of severe illness and death by infection (Sekalala *et al.* 2021) and groups that were at higher risk of infection (Rhodes 2021). Balancing epidemiological and non-epidemiological factors is another consideration for a just Covid-19 vaccination policy (Kohns Vasconcelos 2021).

While prioritisation has varied across countries and is still being debated, interviews in this study showed that people seemed not to be aware about the variations and dilemmas in vaccination strategies. Research participants

endorsed strategies that prioritised people at high risk of mortality, such as elderly people and people with health problems, including those applied in the US, UK, and other higher-income countries in the West. Interviewees saw these strategies as the gold standard when reviewing the strategy applied in Vietnam, as shown in the interviews below. According to the research participants, targeting the most adversely affected health groups was important. Many research participants expressed their frustration that elderly people and people with chronic health problems were not at the top of the priority list and were vaccinated after other people in their communes:

*I felt so frustrated that elderly people were very much down the priority list. They should be the top priority. This is what we see in other countries in the world. In Hanoi, they even excluded elderly people and people with underlying health conditions from vaccination. I do not know why they made that decision.*

(Woman, 42 years old, working for an airline)

Some research participants studied the government policies on vaccination carefully. They found that the term 'people at risk', as it was used in the objectives of the vaccination programme, did not make clear if it meant risk of death, infection, or transmission. For them, risk of death or of being left in a serious condition should have been the priority rather than risk of infection.

The research participants were not convinced that certain groups belonged on the priority list. For example, people from ministries, state agencies, units, corporations, UN agencies, and international organisations. They questioned the grounds on which these people were prioritised and included in the second round of vaccinations:

*I was angry that people at international organisations such as the UN and INGOs [international non-governmental organisations] received the shot early. How come people at INGOs are at higher risk than local NGOs? I am even more upset because they accepted this arrangement. They always highlighted equity and rights as principles of their work, but they kept silent and complicit with this unjust arrangement.*

(Woman, 42 years old, researcher)

Prioritising teachers and people working in the education system was also questioned. Teachers and people working in educational settings were being vaccinated when children were studying online and there was no plan to vaccinate children.

The inclusion of young workers in the industrial zones was also questioned:<sup>11</sup>

*What I found bitter was that young workers in companies such as FPT Software were among the first to get vaccine. You know, when the outbreaks occurred, these workers worked from home most of the time. However, because FPT Software is located inside the industrial zone, they became a priority. These workers were not even in their office. They were at home. They were IT people, so they could work at home. But they were identified as high risk, so they got vaccinated first.*  
(Man, 30 years old, lawyer)

### 6.3 People's personal sacrifices are acknowledged

There was a high degree of consensus among research participants on prioritising groups such as frontline health workers, police, people in the armed forces, (health) volunteers, and members of Covid-19 community task forces (*tổ Covid-19 cộng đồng*)<sup>12</sup> – the first four groups on the priority list. These groups were prioritised not only because of their high risk of infection, but also because of their sacrifice for the community. In addition to health workers, armed forces and police were widely mobilised for Covid-19 prevention and response activities. These forces were especially used in quarantine activities and to organise testing and vaccination when these activities were implemented at large scale.

During the lockdown in Ho Chi Minh City, the army delivered groceries to people in lockdown areas. At the peak of the fourth wave in the city, when rates of infection and death were high, the army was mobilised to handle dead bodies and send people's ashes to their families. It is important to note that during the pandemic, images of people such as health workers, police and people in the armed forces were shown almost daily on television. They were called 'heroes' and praised by the country's leaders for their sacrifice and contribution during the pandemic (Viet Nam News 2021). War metaphors have been used by the leaders of Vietnam to motivate and mobilise people's solidarity (Ivic 2020). Sacrifice, a concept rooted in the war against the US, was highlighted in the efforts to combat Covid-19.

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<sup>11</sup> In May 2021, shortly after the start of the fourth wave of Covid-19 in Vietnam, there were large outbreaks in industrial zones in Bac Ninh and Bac Giang, the two provinces next to Hanoi. Later that month and at the start of July, outbreaks occurred in Binh Duong and Dong Nai, industrial zones in the south. At that time, workers in industrial zones were not included in the 11 priority groups, though people in areas with outbreaks were on the list. At a meeting in July 2021, the vice-prime minister ordered the prioritisation of this group: all workers in industrial zones were to be vaccinated before August 2021 if there was enough vaccine. On 11 June 2021, the Central Cabinet passed decision 07/KL/TW to vaccinate workers and other people in the industrial zones.

<sup>12</sup> In all residential areas, local authorities established local Covid-19 community taskforces to monitor infected cases, including tracking related cases, quarantine and social distancing, and organising testing and vaccination activities.



## 6.4 The programme is strategic and evidence-based

Interviews with key informants showed that they were not clear on what grounds vaccine prioritisation was decided. Public health experts wondered if the policies were based on research and if they had been well designed in consultation with public health experts:

*I think the decisions were not evidence-based. I do not know what research was conducted in Vietnam to form these decisions. It was not clear at all. I was especially concerned about the quality of research. I had the opportunity to see research presented at a Covid-19 taskforce meeting. The quality was very poor. Extremely poor. I'm very worried this kind of research is used for policy development. The research, if conducted, was not disseminated outside, so researchers could not have the opportunity for critique to improve the research. I think the Covid-19 pandemic is very new. As you see in many other countries, they had to do a lot of research to understand it and to develop policies. I have not seen that practice here.*

(Man, 60 years old, epidemiologist)

People supported the adaptability of government policy illustrated by the quick addition of higher-risk groups to the list when these risks were identified in the field. For example: people working in immigration and export departments and custom officials (group 6); people providing essential services (group 7); religious leaders (group 14); and freelance workers (group 15). However, these frequent changes made people think that responses were *ad hoc* and 'following' the situation rather than 'strategic' and 'proactive'.

## 6.5 The programme is transparent and participatory

Transparent and participatory approaches were listed as important for justice in the Covid-19 vaccination programme (Sekalala *et al.* 2021). Though the government priority list served as a guideline, making decisions in actual situations was much harder. In the research, most of the people interviewed were not clear about how local officials selected people to be invited for vaccination on specific days. They also wondered if priority was given to people who held positions in the local area such as head of building, head of floor and so forth, or people with social relationships with decision makers, or people with a lot of money. Transparency is key in rolling out vaccination programmes (Dela Cruz *et al.* 2021; Cohen *et al.* 2020; Zhang *et al.* 2020). Thus, the lack of



transparency may have reduced people's trust in the programme and compromised its achievements in the long term.

Key informants involved in the research also questioned the nature of the participation of researchers or other public health experts in government meetings to discuss Covid-19 policies. They wondered if and how research and recommendations from researchers and experts were used in policy development:

*Since the start of the pandemic, my institute has been conducting research about Covid-19. I think we are among the few doing this. However, our work did not catch the government's attention until after I wrote a lot for the media, such as popular newspapers. They quoted our work. They asked us for information. Then I was invited to the taskforce meetings. However, it was not clear to me how much our research results were used in policy development.*

(Woman, 48 years old, public health expert)

People also complained about transparency in information about the pandemic and vaccination campaign. People said that while the government made a great effort to provide information widely and via different channels, it was often hard for people – including professionals such as researchers and public health professionals – to follow and to have a comprehensive knowledge of the situation.

*Information has been provided on channels such as Zalo and Facebook to make it easy for people to receive information. However, information presented on these channels could not help people chase the pandemic or vaccination through the timeline. Information should be presented on a hub on formal website of the Ministry of Health.*

(Man, preventive medicine specialist)

## 7. Conclusions

We aimed to understand whether *de facto* exclusion of migrants or vulnerable people is acceptable in Vietnam and what the reasons could be if that were the case. We also wanted to determine what a just, transparent, and inclusive response to Covid-19 would look like.

We found that *de facto* exclusion is not acceptable. Exclusion does occur because of staggered and aggregated intersectional inequalities, shortages of resources, and an outdated household registration system that discourages mobility in a country with high levels of internal migration.

To untangle how unintended exclusion takes place, it is useful to distinguish between individual intersectional factors, such as sex, age, ability, educational level, and structural political economic factors such as the delegation of authority to headmen, the organisation of the health system at provincial level. The individual and the system interact and shape each other, but the power and authority of the state is different in many ways from that of the individual.

Both individual and structural factors play a role in being included or excluded, willingly and unwillingly. One should not assume that all people with a disability are vulnerable: intersectionality – in terms of gender, class, and level of education – also plays a role in people's ability to participate in public life. And there are many kinds of disabilities. For example, disability might have been a reason why some people were excluded, yet people with certain kinds of disability were prioritised.

The government – and companies or NGOs for that matter – have to make difficult decisions about how scarce resources, such as vaccines, are allocated. It is realistic to assume that there will always be some people who are and feel disadvantaged. To deal with this reality it is important to have policies that are made based on principles. Although policies should be clear they still have to be implemented and, given the diversity of the human experience, it is unlikely that all staff will possess the knowledge to be able to judge difficult cases. Most cases might be easy to decide, but there should be room for human judgement. Replacing human judgement with many different detailed policies, to avoid errors, will make the life of staff harder and less efficient, and even then will not guarantee that all cases will be covered. Having a small pool of highly trained competent people in the system who can help with hard cases could help. And regular monitoring and meaningful participation through public consultation, and meaningful participation, to solve bottlenecks, could help the responsiveness and fairness of the system.

Although Vietnam is a diverse country with many differences, there is a widespread and strong public belief in the state health system. This is not surprising given the strong and internationally respected track record of that system to improve the population's health status even when resources are limited. However, trust in the state is precious and maintaining it should be a priority for reasons of public health, human rights, and pragmatic governance. Several additional key findings and observations are presented below:

- The Vietnamese government considers vaccination a strategic measure to flatten the pandemic, together with other preventive measures such as wearing masks, washing hands, and social distancing. To achieve the objectives of vaccine coverage and cope with the vaccine supply shortage, which was severe at the beginning of the pandemic, the state laid out a pathway for vaccination, with priority groups to be vaccinated earlier than others. This strategy was inspired by the WHO Covid-19 vaccination guidelines and well-resourced countries. However, this did not convince everyone, partly because the situation changed rapidly, partly because people close to the state or in the formal sector were prioritised first, and partly because the strategy lost its way during implementation. To access vaccination, citizens needed to be registered. The state used a household registration system that dated back to the 1960s and was developed for a different purpose, although rationing of various goods and controlling the population's movements were also important during the war.
- In the context of high vaccination coverage, there were still cases of people who wanted to be vaccinated but could not get access to Covid-19 vaccinations even at the time of interview. In these cases, migration intersected with other factors resulting in exclusion. They illustrated further how a combination of multiple social and economic characteristics and inequities can become unintended but real barriers for people in accessing vaccinations.
- The government made decisions at central level with limited consultation. Ordinary people and scientists did not appear to be convinced by some of the reasoning behind choices for priority groups. One criticism was the lack of evidence and argumentation of the state to support these centralised decisions.
- Despite criticism about prioritisation by the state, vaccination acceptance among the population was high. Although people had – and still have – questions and concerns regarding the short- and long-term effects and side effects of Covid-19 vaccines and vaccination, so-called 'anti-vaxxers' are not influential. Almost everyone accepts and complies with state requirements around vaccination.

- Access to available vaccinations was not only decided based on public health principles or medical criteria. While these criteria provided guidance, personal connections – either through online platforms or in real life with local authorities – played a role in getting access to vaccinations through residential channels. Economic criteria also played a major role, as was clear in the prioritisation of workers – who were often relatively young – in large companies in the formal sector. However, in Vietnam most people are employed by small companies and in the informal sector.
  - Information about vaccines was widely available but often could not meet the requirements of all people with specific needs, such as people with disabilities, transgender people undergoing hormone therapy, people with chronic health problems, and so forth. This affected their willingness to get vaccinations.
  - The research could not look into gender analysis in depth. However, initial findings showed that gender could be an issue that prevented some people from accessing vaccination; for example, in terms of workload, such as (unpaid) caring duties, which are disproportionately done by women.
  - Migrant workers and people with special needs faced more difficulties in accessing vaccination, especially in the first stage of vaccination when vaccine supply was limited. There were three reasons for this:
    - **Administrative issues:** household registration (*sổ hộ khẩu*) and identity cards using a paper-based rather than a digital system, so it was difficult for people who for any reason did not have their papers. The Covid-19 vaccination programme was among the rare cases where household registration was not used as the basis for prioritisation; however, other personal documents such as identity cards were still used to identify people to be included in the programme. While this was important and was needed to establish the vaccination database, the programme did not consider the needs of people who did not possess these papers for various reasons and who therefore could not be vaccinated easily. Because there were no detailed guidelines to deal with these situations, local responses depended on individuals.
    - **Policy gaps:** the policies did not explicitly cover minority groups that were affected by preventive measures, such as daily migrants and short-term migrants who could not return to their provinces due to Covid-19 restrictions.
    - **Infrastructure:** people with disabilities may experience difficulty getting to vaccination sites, including those with mobility or mental health problems, and people who are blind or deaf.
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## 8. Where to next?

### 8.1 Implications for future policies and practices

- There should be support groups or similar mechanisms to help headmen and other local officials to deal with cases that fall outside the system (and there are always such cases). While these people were privileged by their powers during the Covid-19 vaccination programme, they were also burdened. They faced the complexity of dealing with the individual cases of people in their community and did not get enough guidance or resources from higher levels to help them deal effectively with these differences.
- There should be an independent body, with representatives from various groups, including civil society, to monitor vaccination programmes and to take part in decision-making to minimise biases in the current public–private partnerships that could be dominated by (big) companies.
- There should be a clear multidisciplinary research agenda and public engagement strategy, and the required budget, to support policy development and public dialogue.

### 8.2 Implications for future research

- More research is needed to explore the social acceptability of medical technologies and medical interventions, especially before the latter are implemented. This would improve the uptake and acceptability of some interventions but could also result in delays or the rejection of other medical technologies. The use of force, especially in the context of lack of communication, is risky, as it could affect public trust in the health system, which has been and still is high in Vietnam.
- Intersectional gender issues in relation to the Covid-19 vaccination programme and other responses need further exploration – the roles of leaders at local level, such as the group head, in decision-making deserve more attention.

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