VIET NAM

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Introduction

Viet Nam is the easternmost country of the Indochina Peninsula, covering an area of 331,210 km^2. The country has long coastline of 3,444 km and is mostly narrow from east to west. Mountains and tropical forests cover 40% and 42% respectively of the land area, and the mountainous areas are generally more remote and less developed than the Red River Delta in the north and Mekong River Delta in the south.

The population of Viet Nam in 2014 was 90 million - an increase of 4.2% from 2009 (General Statistics Office, 2014b) - and is projected to exceed 108 million by 2050. With a population density of 270 per km^2 Viet Nam is among the most densely populated countries in the world. 28.9 million people (32.3%) live in urban areas. The most densely populated regions in Viet Nam are the Red River Delta (20.4 million), and the Mekong River Delta (17.4 million) (General Statistics Office, 2014a). Viet Nam has established a population administration system, currently integrated in and managed by the health system, to take care of population administration and policy implementation.

Viet Nam's administrative system is organized into four levels -central, provincial (64 provinces), district (644 districts), and commune (11,161 communes) (General Statistics Office, 2014a). The governance model of Viet Nam has centralized and decentralized characteristics. The central government is responsible for establishing national laws, policies and plans, allocating budgets to provinces, and regulating the activities of provinces. Provincial governments have considerable autonomy in deciding the specific plans for socio-economic development and for budget allocation. In many sectors, including health, the national and subordinate governments have different clearly specified roles. For example, the central government, via the Ministry of Health, is responsible for, among other things, making national laws and regulations, issuing national health policy, establishing and disseminating standards, and supervising the operations of Provincial Departments of Health. However, the provincial governments are in charge of budget allocation and staff development in the health sector that they manage.

Since the re-unification of the country in 1975 Viet Nam has achieved substantial socio-economic development. The program of political and economic reform launched in 1986, referred to as *Doi Moi*, has lifted the country from the poorest category in the world to low-middle-income level in less than three decades. The GDP per capita in 2013 was approximately 1,800 US dollars, as compared with 580 US dollars in 2006 and less than 100 US dollars in 1986. In the last

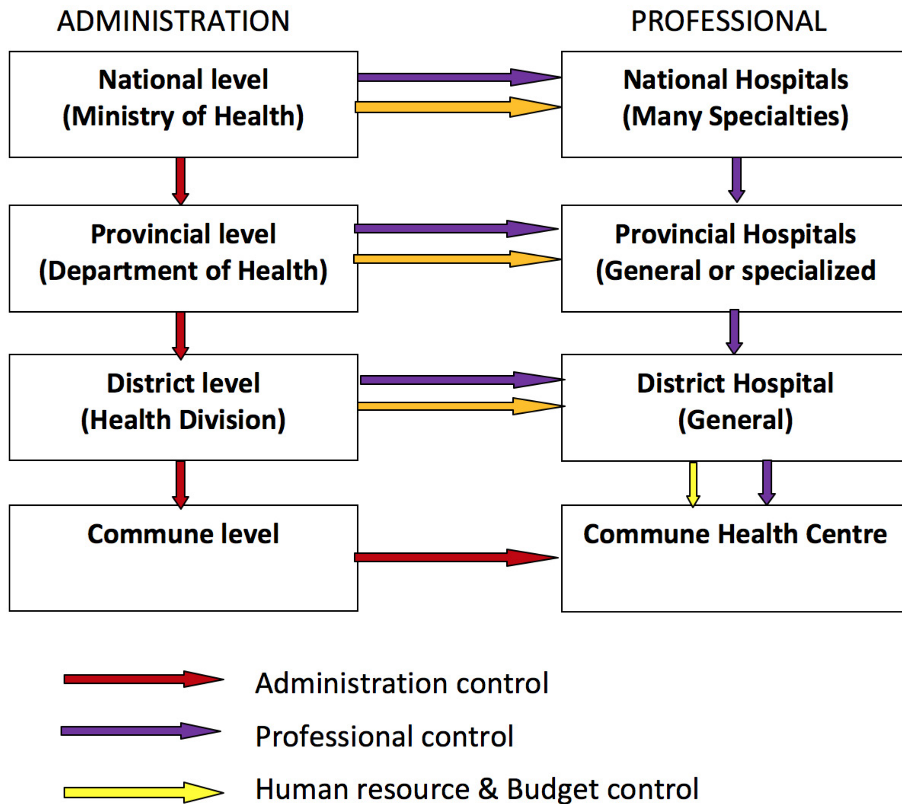
decade, the average annual economic growth has been 6.4%, yet the growth rate has recently slowed. The poverty rate was 9.8% in 2013, down from 15.5% in 2006. Viet Nam is about to move to the upper-middle income category. While six socio-economic regions (General Statistics Office, 2014a) have been designated by government, it is not clear that these regions have particular ecological, geographical, or economic criteria.

Viet Nam has achieved impressive progress in many of the Millennium Development Goals (MDGs). Targets have been achieved for MDG1 (reduction of extreme poverty and hunger eradication), MDG2 (universal primary education) and MDG3 (gender equality promotion and empowerment of women). Significant progress has also been made towards achieving the targets set for the other MDGs. There has been modest improvement of human development index, from 0.641 in 2010 to 0.665 in 2013 (Ministry of Planning and Investment, 2013).

General Health System

The state health system of Viet Nam is organized in accordance with the overall state governance structure. The health system consists of four levels - central, provincial, district, and commune. The Ministry of Health is the central administrative body, carrying out a range of state management functions related to different aspects of health and wellbeing (Viet Nam Government, 2012b). The Ministry of Health is organized into ministerial departments responsible for specific tasks. For example, the Medical Services Administration is primarily in charge of management of curative and palliative care, rehabilitation, and forensic medicine services. The Ministry of Health also organizes and manages central-level institutions covering different areas of treatment, disease prevention, research, and higher education. At the provincial level, the Departments of Health represent the provincial governments on state management of health care activities (Ministry of Health and Ministry of Internal Affairs, 2008). As noted above, Provincial Departments of Health manage the provincial health budget and human resources, under the direction and supervision of the national Ministry of Health which establishes national policy and regulations and directs technical and professional issues. Similar to the central level, there are a number of province-level organizations under the direct management of Provincial Departments of Health, including, for example, provincial general and specialized hospitals, centres for preventive medicine, and secondary schools of medicine. Figure 10.1 gives an overview of the organization of the national health system.

Figure 10.1: Health system organization



There have been considerable changes in organizational structure at district level. Before 2004, the majority of districts had only one institution, a district health centre, responsible for management of health care and implementation of curative and preventive activities in the area. Beginning in 2005, the implementation of a policy on local state management of health (Ministry of Health and Ministry of Internal Affairs, 2005) resulted in many, though not all, centres splitting into district general hospitals, focusing on medical practice, and district preventive health centres, working more extensively on preventive health. Another type of district-level health agency, the health bureau, is more involved with state management functions, including the administration of commune health stations. Recently, however, there have been initiatives to re-integrate the district health care facilities and their functions. Together with district-level institutions, commune health stations – the primary health care facilities – are responsible for primary or grassroots health care. The commune health stations are the first formal contact point of people with the public health care system and

provide basic health care services (Viet Nam Government, 2014). They also are responsible for recruiting and supervising village health workers, who assist in the provision of basic primary health care services at village level, including, for example, health communication, epidemic surveillance and reporting, pregnancy management, maternal and child health care, and first aid. The governance of health care at both district and commune levels follows a similar pattern to that at the provincial level, in which facilities work under the management of local governments and higher level health institutions.

There has been steady growth in the total number, and in the number per 10,000 population, of health staff, growing from 241,498 in 2003 to 364,876 in 2009 and 424,237 in 2013. Although growth has occurred in all categories, including medical doctors, pharmacists, nurses, and midwives, the rates of increase differ across the professions. The number of pharmacists in the state sector has remained low for the past few years and has recently declined due to low enrolment in education programs (Nguyen et al., 2014). In 2013, the numbers per 10,000 population of doctors, nurses, and midwives were 7.6, 10.9, and 3.2 respectively, with each increasing from previous years (General Statistics Office, 2014a).

Viet Nam health policy prioritizes the extension of primary health services, with efforts made to increase the supply of health workers throughout the country. However, inequitable distributions of the health care workforce remain an issue. While more advantaged places such as urban and delta regions attract more health workers than rural and mountainous areas the ratios of health workers per 10,000 population were relatively even across six socio-economic regions.

As noted, primary health care, including district and commune health care facilities, plays a vital role in the health system. The focus on development of primary care has been a long-standing commitment from the time of national independence. As in other countries, substantial efforts and resources have been invested for the improvement of grassroots health care since the 1978 Alma-Ata Declaration and the country has achieved a great deal as a result of these efforts. These achievements include development of a legal framework for preventive medicine; strengthening of the preventive medicine network at central and local levels; and expansion and development of primary health care services. Examples of the positive progress in provision of primary health care include expanded immunization, control of communicable diseases such as HIV/AIDS and avian influenza, reduction of child malnutrition, and successful implementation of accident and injury prevention strategies. Strengthening the primary health network remains a major strategy for achieving Viet Nam's health policy goal of a sustainable health care system.

The whole population has access to secondary and tertiary care as required. Secondary and tertiary facilities include both public and private sector institutions and programs and include general hospitals, specialized hospitals, rehabilitation centres, and regional polyclinics. The majority of these facilities are under the management of the health sector, i.e. Ministry of Health or Provincial Departments of Health, yet several health institutions are established and managed by other sectors, such as military, social affairs, agriculture, or post and telecommunication. In 2013, Viet Nam had 1,069 hospitals, with the Ministry of Health directly managing 43 facilities, Departments of Health 1,000, and other sectors 26. The ratio of beds per 10,000 population was 25.0, an increase from 17.7 in 2005 (Ministry of Health, 2013).

The Viet Nam health system has a large number of priorities and responsibilities, and covering all of them is beyond the scope of this overview. There are, however, a few significant examples. Health system capacity is not sufficient to fully meet the needs and expectations of 90 million people, especially among the elderly, children, and marginalized groups. The health service delivery system lacks proper coordination between levels and between preventive and curative health care services. In addition, integration and continuity of care are not well implemented. Furthermore, the health care system is not sufficiently prepared for the rapid epidemiological and demographic transitions that Viet Nam is undergoing, particularly in relation to the emerging and increasingly dominant role of non-communicable diseases and the rapid aging of the population.

Mental Health Problems in the Community

Population-based surveys are the major sources of evidence of the epidemiology of mental disorders in Viet Nam. Studies of different scale, population sub-groups, and disorders have gradually revealed diverse aspects of mental health. At the country level, there has been only one nationally representative population-based study conducted across the six national socio-economic regions, conducted by the National Psychiatric Hospital No. 1 (NPHN1) in 2002(Nguyen et al., 2014). The key results from the survey, which examined 10 common mental disorders in the community, were that these disorders combined affected 14.9% of the surveyed sample. The highest prevalence disorders were alcohol abuse (5.3%), depression (2.8%), and anxiety (2.6%). The results from the second national epidemiological survey of mental disorders, completed by NPHN1 in 2012, have not yet been published. There has as yet been no study examining the prevalence of mental disorders among primary care attenders.

Little is known, on the national scale, about community awareness of, and attitudes towards, mental health and illness, including the extent of stigma and discrimination against the mentally ill. Yet there is some evidence, though modest, at sub-national level. For example, in a mixed-method survey in three provinces of 154 people, 11.7% of the sample reported never having heard of mental illness and only 19.5% perceived that there was no stigma and discrimination in their community against the mentally ill(Ly et al., 2014). From the policy perspective, increasing investment in, and diversifying approaches to communication and mental health education activities, have been the main strategies for improving community awareness(Cuong, 2015).

Viet Nam has implemented significant efforts to expand and improve access to mental health services in primary health facilities. The overall objectives have been to manage and provide services to patients at community level to reduce re-admissions, facilitate rehabilitation, and decrease medical costs. In practice, however, the provision of services at primary health care level has been limited. In general, provincial mental hospitals refer patients and supply medicines to district and commune health facilities, which are then responsible for continuing care, distribution of medicines and management of patients. The national mental health target program, commonly referred to as the community mental health program, has only covered schizophrenia and epilepsy, with recent pilot initiatives in the provinces of Bac Ninh and Hung Yen expanding the program to include depression. By 2014, approximately 9,330 (85%) and 6,633 (61%) out of the 11,162 communes in the country had implemented the program on schizophrenia and epilepsy respectively(Cuong, 2015).

The expansion of access to mental health services in Viet Nam is likely to face, and thus will need to address, certain impediments. Most importantly, Viet Nam has not established a comprehensive legal framework for the expanded provision of services at grassroots levels. In addition, the number of specialised mental health care staff is insufficient in terms of both quantity and quality, causing difficulties in the decentralization of services, which requires training lower-level health care staff and providing continuous supervision and training. The distribution of mental health human resources is also uneven across different geographical and economic areas. Another significant barrier involves the limited awareness among the population of mental health and illness, resulting in stigmatizing and discriminating attitudes and behaviours against the mentally ill.

Mental Health System

Mental Health Governance

While mental health services in Viet Nam are provided by both the health sector and social services sector we focus here on the health sector only. The governance of mental health care in Viet Nam has been organized in accordance with the general health system,with mental health laws, regulations, policies, institutions and services implemented at central, provincial, district, and commune levels. At the central level, the Ministry of Health is responsible for state management of national mental health care. Those management tasks are carried out by the Medical Services Administration Department of the Ministry of Health and central-level institutions, including two National Psychiatric Hospitals and the National Institute of Mental Health. National Psychiatric Hospital No. 1 (Hanoi) is the Ministry's authorized institution to implement mental health policy and generally supervise the professional activities of mental health all over the country, while it shares with National Psychiatric Hospital No. 2 (Bien Hoa) the responsibility for direct management of provincial psychiatric hospitals.

The provincial level is the most active place for implementing both curative and preventive mental health care. Many provincial facilities are involved in these activities, including provincial psychiatric hospitals, mental health departments in provincial general hospitals, mental health departments in provincial centres for social disease prevention, and provincial centres for preventive medicine.

Provincial psychiatric hospitals are the key organizations in providing inpatient services for the mentally ill and are also responsible for implementation of the community mental health programs by, for example, referring patients to commune health stations for continuing care, supplying psychotropic medicines, supervising the activities of those stations, and providing training for staff involved in mental health. Mental health care capacity is very little developed at the district level, and the majority of activities have involved outpatient services, mostly via district general hospitals. The linkage role of district level institutions that exists in other areas of health has not been developed in mental health. Commune health stations detect new cases, carry out initial assessment, and refer when appropriate to provincial psychiatric hospitals, and are in charge of receiving referred patients who have been discharged from provincial psychiatric hospitals, implement follow-up care with distribution of medicines and management, and carry out communication activities.

Mental Health Law and Policy

While Viet Nam has not issued a specific mental health law many general health and related laws and regulations are very relevant to mental health governance and mental health services. There has been sustained advocacy concerning the need for mental health law and working groups have been actively engaged in drafting such a law. On the other hand, many policies that directly address mental health or that are relevant to mental health have been issued. The primary mental health policy at the national level has been the Mental Health Protection for Community and Children Project, a part of the National Target Programs on Health. First issued in 1998, this government-funded project focused on schizophrenia and epilepsy and included several objectives, including early detection, management and treatment for people with these disorders; provision of continuing treatment with a focus on relapse prevention; and rehabilitation and reduction of chronic disability. The national mental health project has implemented a range of measures to achieve these objectives, including education communication, expansion of the mental health facility network, and training of both mental health care staff and primary health care staff.

According to the policy of financial subsidy for the mentally ill people with persistent mental illness, receive a minimum of 270,000 Viet Nam Dong per month (approximately 14 USD as in 2015). In addition, people with mental illness who have been admitted to a social services facility (social protection centre) receive a monthly subsidy of 450,000 Viet Nam Dong. The provinces have also mobilized local sources to provide additional subsidy for these patients, which vary according to the financial capacity of different provinces (Nguyen et al., 2014).

Mental Health Facilities

The mental health system in Viet Nam has many types of facility across the four levels of the system. Under the management of Ministry of Health are the central-level institutions, including the two National Psychiatric Hospitals and the National Institute of Mental Health. In 2014 there were 36 provincial psychiatric hospitals, 24 departments of mental health in provincial centres for social disease protection or centres for preventive medicine, and 25 departments of mental health in provincial general hospitals. Mental health care at district and commune levels is integrated into general health care facilities, namely district general hospitals, and district health centres, and commune health stations at commune level (Cuong, 2015).

A recent survey (Cao, Tran, Ta, Dinh, & Nguyen, 2014) of capacity of mental health facilities in 49 provincial facilities of 31 provinces of northern Viet Nam showed that the total number of inpatient beds was 4,525. The average ratio of inpatient beds per 100,000 populations was 10.7, with very variable distribution across socio-economic regions. Three provinces had no inpatients beds, with patients with severe illness having to be referred to nearby provincial or central facilities. Available mental health facilities and beds are shown in Table 10.1.

Table 10.1: Availablity of mental health facilities and beds

	Total number of facilities/ beds	Rate per 100,000 population	Number of facilities/ beds reserved for children and adolescents	Rate per 100,000 Population
Mental health out patient facilities	59	0.07	UN	UN
Day treatment facilities	1	0.001	UN	UN
Psychiatric beds in general hospitals	300	0.34	UN	UN
Community residential facilities	UN	UN	UN	UN
Beds/places in community residential facilities	UN	UN	UN	UN
Mental hospitals	32	0.04	UN	UN
Beds in mental hospitals	16,000	17.97	UN	UN

UN: Unknown or unavailable
Source: World Health Organization, 2011

Mental Health Human Resources

While the health workforce, including health workers in the field of NCDs, has experienced steady growth, severe shortages exist in mental health. As reported in the survey of capacity of mental health facilities (Cao et al., 2014) there were only 530 psychiatrists in 31 surveyed provinces, 1.3 psychiatrists per 100,000 population. A matter of considerable concern is the fact that the number of psychiatrists has been declining in recent years. In the 31 northern provinces referred to above there were 650 psychiatrists in 2002 (Cao et al., 2014). The latest available national data available are from 2011 (Table 10.2).

Table 10.2: Workforce and training

Health professionals working in mental health services	Health professionals working in the mental health sector Rate per 100,000	Training of health professions in educational institutions Rate per 100,000
Psychiatrists	1.01	0.03
Medical doctors, not specialized in psychiatry	67.39	1.12
Nurses	75.34	UN
Psychologists	0.03	UN
Social workers	0.0	0.0
Occupational therapists	0.0	0.0
Other health workers	UN	NA

UN: Unknown or unavailable
Source: World Health Organization, 2011[15]

Financing

State budget, from both central and provincial sources, has played the dominant role in financing central, provincial and other hospital-based mental health care, and in curative and preventive activities in the community delivered via the national mental health project. However, this important source has been cut over the last few years and thus does not correspond with the increasing burden of mental disorders. In 2012, the total budget for the project was 75 billion Viet Nam dongs, which shrank to 74.2 billion in 2013 and sharply plummeted to 44 billion in 2014 (Cuong, 2015). This sudden reduction has brought serious challenges in maintaining the activities of the project. It was reported that the implementation of the project in 2014 was only 65-68% as compared with 2013. Health insurance is another important source of funding for mental health care. The list of drugs reimbursed by health insurance includes 38 drugs for treatment of mental illness (Ministry of Health, 2014). However, the current health insurance policy mainly focuses on reimbursing treatment services and does not generally cover preventive services, not only in mental health but also other fields.

Services

Psychiatric diagnosis, psychotropic drug prescribing, and inpatient mental health care may only be done at provincial and central levels – essentially in the central and provincial psychiatric hospitals. Primary health care is responsible

for receiving and referring patients, distributing medicines, and other relevant management tasks. The grassroots health service network does not have the capacity to provide essential mental health services. Despite the fact that there are 11,000 commune health stations and 600 district hospitals, which have made a remarkable contribution to Viet Nam's achievements in general health, these facilities have very limited capacity to respond effectively to the needs of the growing number of patients with mental illness. This may be attributed to several factors, including lack of mental health law, insufficient political commitment, insufficient skills and knowledge of health workers at district and commune levels, lack of necessary drugs and equipment at health facilities, inappropriate health insurance reimbursement policies, lack of linkages and integration between preventive and curative care, and fragmentation in health service delivery that prevents comprehensive and continuous care (Nguyen et al., 2014). In addition, the current policy and investment have not yet prioritized decentralization of mental health services, and commitments to build additional provincial psychiatric hospitals further limit the resources available for effective mental health services at the primary health care level. Access to inpatient and community care is shown in Table 10.3.

Table 10.3: Access to care

	Rates per 100,000 population	Females (%)	Under age 18 (%)
Persons treated in mental health out patient facilities	370.57	UN	UN
Persons treated in mental health day treatment facilities	1.68	UN	UN
Admissions to psychiatric beds in general hospitals	UN	UN	UN
Persons staying in community residential facilities at the end of the year	UN	UN	UN
Admissions to mental hospitals	UN	UN	UN

UN: Unknown or unavailable

Source: World Health Organization, 2011

Medicines

Viet Nam has an essential drug list and a health insurance drug formulary that includes most drugs that may be needed treatment of mental illness - the

updated formulary of essential drugs of the Ministry of Health (Ministry of Health, 2014) lists 38 medicines for mental disorders. These include six anxiolytics (e.g. diazepam), 12 antipsychotics (e.g. haloperidol) and 10 antidepressants (e.g. amitriptyline), together with other types of medicines. The National Psychiatric Hospital No. 1 is responsible for supervising the purchase of medicines by provinces. State budget from the national mental health project is disbursed to provinces for purchasing medicines, which may be done by provincial psychiatric hospitals or People's Committees. District and commune levels are not authorized to purchase medicines. Instead, they receive supplies from provincial level institutions and distribute the medicines that have been prescribed, usually and provincial psychiatric hospital level, for patients. Provinces can also use local sources of funding to supplement their stocks with new generation medicines.

Methadone replacement therapy for opiate dependence was fist piloted in 2008 and formally regulated by the government in 2012 (Viet Nam Government, 2012a). However, the major source of methadone supply comes from international donors. While it is expected that this source of funding will largely cease by 2015 steps have recently been taken to continue to provide methadone, possibly with funds from the National Target Program on HIV/AIDS Prevention, or by mobilizing social contributions.

There are no data available on national expenditure for psychotropic medicines.

Human Rights

Violation of human rights of people with mental illness can occur in many forms, of which the most severe is restraint by chaining or by locking in a confined space. Other forms of human rights violation include stigma and discrimination, prolonged involuntary hospitalization, and restriction of civil rights. However, there is little systematic evidence concerning the human rights of people with mental illness in Viet Nam. Viet Nam ratified the Convention on the Rights of Persons with Disabilities in December 2014 and protection of human rights will be a core feature of the National Mental Health Strategy that is currently being developed.

Mental Health Information System

The application of information technology has been improved in psychiatric hospitals but is still insufficient for diverse management tasks. Recently the National Psychiatric Hospital No. 1 has led a project to build an application for managing and reporting the activities of the national mental health project. This health information system initiative is expected to connect, and facilitate

collaboration across, facilities at different levels, improve the quality of data and reporting, keep track of organizational aspects of mental health facilities, and improve leadership and governance in the mental health sector (Cuong, 2015). Currently, the national mental health project requires regular reports from lower to higher levels but the information collected does not comprehensively cover all relevant clinical and organizational domains. The application that is being developed is expected to fill this gap.

The data collected through the routine national health information system are shown in Table 10.4.

Table 10.4: Data collected through the routine national health information system

	Data on number of people/ activities are collected and reported	Data on age and gender are collected and reported	Data on patient's diagnosis are collected and reported
Persons with mental disorders treated in primary health care	Yes	No	Yes
Interventions (psychopharmacological and psychosocial) delivered in primary health care for people with mental disorders	Yes	No	Yes
Persons treated in mental health out patient facilities	Yes	No	Yes
Contacts in mental health out patient facilities	No	No	No
Persons treated in mental health day treatment facilities	Yes	No	No
Admissions in general hospitals with psychiatric beds	No	No	No
Admissions in mental hospitals	Yes	No	Yes
Days spent in mental hospitals	Yes	No	Yes
Admissions in community residential facilities	No	No	No

UN: Unknown or unavailable
Source: World Health Organization, 2011

Integrating Mental Health into the National Health System

Significant efforts have been made by the Viet Nam health system, in collaboration with international collaborators, to improve the integration of mental health into the national health system. Stakeholders are in the process of identifying the best options for the treatment and care of people with mental disorders at different levels of care. Rather than adopting an existing model, the specific way in which mental health should be integrated into primary heath care in Viet Nam will be influenced by the current function, status and strengths of primary, secondary and tertiary care levels taking into account the conditions of the health system as well as the community and cultural context.

Community Empowerment

There has been modest progress in community empowerment in mental health. Development of community-based organizations, such as those established by and for people with mental illness and their families, has not been a priority and has been slow. An exception is in the area of illicit drug use, where the development of community groups has been more likely to originate from the field of HIV/AIDS prevention. Even the number of non-governmental organizations working in mental health is limited. However, health facilities have maintained practical coordination with political and social organizations in mental health care activities, such as the youth unions and women's union. These organizations can contribute to the process of care and rehabilitation for people with mental illness.

Priorities, Challenges and Opportunities

Given the current situation of mental health in Viet Nam many priorities, many of them urgent, can be identified. Developing the legislative framework, particularly adopting a specific mental health law, is among the most important priorities. It is also important to specify how mental health services are to be more closely

integrated with the national health system. Successful implementation of new legislation, integration of services, and other important initiatives will require capacity building for the mental health system (including both facilities and human resources), at all levels, to be prepared for the increasing demands and expanding provision of mental health care. Among the most important challenges in the continuing strengthening of the mental health system is the very limited state funding allocated to mental health, resulting in both limited coverage and quality of mental health services. Changing this lack of priority for mental health will require substantial efforts to build consensus among relevant stakeholders concerning the goals and methods of mental health system reform. As well as impediments, there are many opportunities for progress. Political commitment and support is without doubt growing, largely due to the increasing understanding of the importance of mental health for social and economic development, and of the very substantial economic and social costs of not attending to population mental health. As part of this it is also better appreciated that good governance and effective leadership are central to any process of reform and to building sustainability. Another opportunity involves the extensive availability and development of grassroots level health care system. Although the potential of this network has not been fully realised for mental health it is a very strong platform on which to build a community-focused mental health service delivery system.

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