INDEPTH Training and Research Centres of Excellence (INTREC)

Vietnam Country Report

October 2012

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Acknowledgements

The research leading to these results has received funding from the European Union's Seventh Framework Programme (FP7/2007-2013) under the grant agreement 282605.

We would also like to express our sincere thanks to Dr. Nguyen Thanh Huong, Deputy Dean of Ha Noi School of Public Health (HSPH), and to Dr. Hoang Van Minh, Institute for Preventive Medicine and Public Health & Center for Health System Research, Hanoi Medical University, for their support in accessing invaluable materials for this study.

The authors would also like to thank all respondents who are leaders, policy makers for reserving their precious time for the interviews. The information gathered from the interviews is very important to this study.

For administrative support, we are grateful for the services of Lena Mustonen.

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Executive Summary

Viet Nam is a South-east Asia country, sharing borders with China, Laos and Cambodia, and with a population of over 85 million people. Since 1987 with Doi Moi (Renovation) policy, Viet Nam has made significant achievements, including GDP increase, higher life expectancy, better health care and education. However, together with country development, the health of Vietnamese people is influenced by many factors, and the inequity in health in different groups of society in Viet Nam is clear. With support from INTREC (INDEPTH Training and Research Centres of Excellence), a situation analysis study on social determinants of health (SDH) was conducted in Viet Nam. The aims of this study were to learn about the most important social determinants health in Viet Nam, current SHD teaching and training, knowledge and awareness of SDH among a variety of stakeholders, as well as to identify the gaps in training needs, and suggest recommendations for addressing the social determinants of health.

Methods: The situation analysis is a multi-method study including (i) Country profile review; (ii) Curricular review on ongoing social determinants of health-related training courses in Viet Nam and the training gaps that INTREC can fill; (iii) Literature review on the core social determinants of health, the main actors in the country and the relevant SDH policies and; (iv) Interviews with leaders and policy makers from different sectors in Vietnam, including the health sector. Based on the specific objectives of each part, different methods were applied to gather and to analyze information. Internet search, telephone conversations, face-to-face discussions, and semi-structured interviews with open-ended questions were applied as methods for this situation analysis.

Results: Results part of this report presents extensive findings from different parts of the situation analysis study.

The country profile review reveals that while Viet Nam's health indices have improved substantially in recent years, the country is now facing a host of relatively new health problems, including rising incidences of non-communicable or lifestyle-related diseases, and an escalating HIV/AIDS epidemic. Data for four main non-communicable-diseases (NCDs) suggest that the prevalence of certain NCDs, such as diabetes and CVD is high. Decline in death rates from communicable diseases, together with population aging, leads to a higher incidence and prevalence of NCDs. Tobacco, alcohol, physical activity and nutrition were cited as risk factors for NCDs.

In regard to *SDH Curricular review*, results from reviewing the information gathered on relevant SDH training courses in Viet Nam indicates that relevant SDH training is taught as a part of the

Master of Public Health Program, Master of Preventive Medicine, Specialty 1 and Specialty 2[1] Programs organized by the Ha Noi School of Public Health and Public health departments of the Ha Noi Medical University, Hue Medical University and HoChiMinh City Medical University. However, there is no separate course teaching SDH in these training institutions. Instead, SDH teaching curriculum was condensed and integrated into other subjects/units. It is noted that all the above mentioned master programs are designed and conducted in a face to face format. E-learning and self-studying were designed to support the program only. Given this fact, it is necessary to have a separate SDH subject or training course in these institutions. The development of the SDH curriculum should be based on the current one with emphasis on the country's economic development, environmental health, and the healthcare system as the main determinants of health in Viet Nam.

Findings from the *literature review* show that there is still a high and persistent degree of inequality in Viet Nam, including health inequality in maternal and child mortality, inequality between men and women, lifestyle, chronic disease and injury, as well as mortality inequality in different socioeconomic groups. The findings also reveal that socioeconomic, education and geographical issues are associated with inequality, disfavoring the poor, women, ethnic minorities and people with low education. Based on existing literature, it seems that the concern (especially from the government) on specifically bringing about equity in the uptake of health care services is more than the concern about health equity in general. Relevant SDH policies have been implemented, including health insurance supported by government, free health care for children under 6 years old, health care for the poor and near-poor, helmet law, and the goal to achieve universal health insurance coverage by 2014.

Interviews with policy makers and leaders from different sectors in Vietnam including health sector reveal that respondents' knowledge on SDH is limited and biased, depending on their occupation and the sectors they belong to. While decision makers thought that SDH was mostly related to policies and regulations relevant to their work, researchers/post-graduate lecturers in the field of Public Health in Vietnam understand this term more generally since they use it in their teaching or research. There were many SDH identified by the respondents; however, the most important ones were: Policy factors, Environment conditions, Living conditions, Rapid economic development and Urbanization, Transport injuries, and Poor health care services. Overall, there is a big gap in knowledge and action about SDH in Vietnam and still, the issue is not receiving enough attention.

[1] *This kind of course is post -graduate training in medical schools in Viet Nam. Specialty 2 is higher level than Specialty 1. Both of these are lower than Master level*

Conclusion and Recommendation: In conclusion, there is still important and persistent degree of inequality in Viet Nam, disfavoring the poor, women, ethnic minorities and people with low education. The issue of Social determinants of health is still new in Vietnam and has not received the attention it deserves. Knowledge on SDH among respondents (leaders, policy makers) is limited and bias depends on their occupation and the sectors they belong to. Policy factors, Environmental conditions, Living conditions, Rapid economic development and Urbanization, Transport-Injury and Poor health care services were identified as the most important social determinants of health in Viet Nam.

The Recommendations that can be brought up from this study focus on (i) How to fill the gaps in knowledge and awareness about Social Determinants of Health of decision makers, policy makers, and Vietnamese people; (ii) How to bridge the gap between researchers and decision makers; and (iii) As a training and academic institution, how to participate in the actions addressing social determinants of health in the country.

For (i), *Filling the gaps in knowledge and awareness about SDH*, the recommendations are: Providing training for policy makers. To do this, collaboration with National Political and Administrative Academy Ho Chi Minh (NPAA) is recommended. Other alternatives of Vietnamese partners to conduct SDH training are: Ha Noi School of Public Health, WHO, and Ha Noi Medical University. It is also important to collaborate with civil society to implement communication programs or specific raising awareness projects in the communities.

For (ii), *Bridging the gap between researchers and decisions makers*, the recommendations are: Co-operating with other organization such as civil societies, institutions, leading government organizations in the field; Conducting further specific research on the most important SHD that need to be addressed in Viet Nam and identifying and contacting relevant sectors/departments and individuals before implementing any relevant study, and; Integrating the research work into policy formulation process from the onset.

For the (iii), *Training and academic institutions to participate in actions on SDH*, the recommendations: Understanding on Vietnamese political structure, the policy process and policy development needs, and a good approach strategy; Collaborating with a partner in Viet Nam to find the avenue for social determinants of health to reach decision makers and the government; Partnering with civil societies in Viet Nam to conduct trainings and research on SDH in the community; Collaborating with others Vietnamese potential partners including: NPAA, HSPH, WHO, HMU for the training for leaders, policy makers and other academic trainings.

2. Introduction

The WHO's Commission on Social Determinants of Health was concerned with the dramatic differences in health status that exist between and within countries [2]. It compared, for example, the lifetime risk of maternal death in Afghanistan (1 in 8), to the lifetime risk in Sweden (1 in 17,400)[3]. It also highlighted the fact that maternal mortality is three to four times higher among the poor compared to the rich in Indonesia [4]. The Commission argued that these disparities, and innumerable similar ones across the globe, are intimately linked with social disadvantage, and that they are both unjust and preventable.

Addressing health inequities is therefore a moral imperative, but it is also essential for reasons of global self-interest: a more inequitable society is inherently a less stable one. But the Commission recognised the challenges that face steps to strengthen health equity, and, critically, that it requires going beyond the current prevailing focus on the immediate causes of disease. Rather, it is necessary to identify and act upon the 'causes of the causes': "*the fundamental global and national structures of social hierarchy and the socially determined conditions that these create, and in which people grow, live, work, and age*" [2].

To this end, three broad Principles of Action on these social determinants of health (SDH) were identified in the Commission Report, that together could, it was argued, 'close the gap' of health inequities within a generation [2]. These Principles of Action were:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

A wide range of actors is required if these Principles are to be effectively implemented. The Commission identified the core actors as the multi-lateral agencies (especially WHO), national and local governments, civil society, the private sector, and research institutions.

This report is concerned with the third of the three Principles of Action – the production of a strong SDH evidence base – and also with the people who are going to produce and then use that evidence base: those working in research institutions, and those with decision-making authority in governments. Current capacity to produce setting-specific, timely, and actionable evidence on the relationship between SDH and health outcomes is limited, and especially so in low- and middle-

income countries (LMICs). Likewise, with limited awareness of SDH among decision makers, and a general global culture that under-utilizes evidence within the policy process, there is an urgent need for capacity-building activities to promote informed decision-making that aims at reducing health inequities. As the Report points out, "*Knowledge – of what the health situation is, globally, regionally, nationally, and locally; of what can be done about that situation; and of what works effectively to alter health inequity through the social determinants of health – is at the heart of the Commission and underpins all its recommendations*" [2].

INTREC (INDEPTH Training and Research Centres of Excellence) was established with precisely this concern in mind. INTREC's two main aims are (i) providing SDH-related training for INDEPTH researchers in Africa and Asia, thereby allowing the production of evidence on associations between SDH and health outcomes; and (ii) enabling the sharing of this information through facilitating links between researchers and decision makers in these countries, and by ensuring that research findings are presented to decision makers in an actionable, policy-relevant manner.

The INTREC consortium consists of six institutions. The one around which most of the work revolves is INDEPTH – the International Network for the Demographic Evaluation of Populations and Their Health in Low- and Middle-Income Countries. With its secretariat in Accra, Ghana, INDEPTH is an expanding global network, currently with 44 Health and Demographic Surveillance Systems (HDSSs) from 20 countries in Africa, Asia and Oceania. Each HDSS conducts longitudinal health and demographic evaluation of rural and/or urban populations. INDEPTH aims to strengthen the capacity of HDSSs, and to mount multi-site research to guide health priorities and policies in LMICs, based on up-to-date evidence [5]. The other five members of the INTREC consortium are all universities, which bring their own respective technical expertise to particular components of the work. These universities are Umeå University in Sweden; Gadjah Mada University in Indonesia; Heidelberg University in Germany; the University of Amsterdam in the Netherlands; and Harvard University in the USA.

The work of INTREC will build on the pre-existing INDEPTH network, and is primarily focused on seven countries. In Africa, these include Ghana, Tanzania, and South Africa; and in Asia, Indonesia, India, Vietnam, and Bangladesh are taking part. Starting in 2013, each continent will be served respectively by regional training centres in Ghana and Indonesia. These centres will act as focal points for research and training on SDH for the INTREC countries and, in due course, other low- and middle-income countries. See www.intrec.info for more details.

This report constitutes the very first step in the work of INTREC in Viet Nam, by providing a situation analysis, conducted by an in-country social scientist and with the support of members of the consortium, that addresses three areas of concern:

1. Current SDH-related training in Viet Nam, and gaps identified, as a baseline for INTREC to build on;
2. The core SDH issues of concern in the country;
3. Ongoing SDH-related work in Viet Nam, both in terms of government policies and programmes, and in terms of efforts made by non-governmental organizations.

The report ends with a series of recommendations for action, directed at decision makers, programme implementers, as well as at INTREC itself. Based on the comprehensive, empirical background material included in the report, these recommendations will prove to be an invaluable guide for the future development of INTREC, as the programme works towards reducing health inequities in Viet Nam, and also in other low- and middle-income countries.

3. Methods

This situation analysis is a multi-method study including (i) Country profile of Vietnam; (ii) Curricula review on ongoing social determinants of health-related training courses in Viet Nam and the training gaps that INTREC can fill; (iii) Literature review on the core social determinants of health, the main actors in the country and the relevant SDH policies; and (iv) Interviews with leaders and policy makers from different sectors in Vietnam, including health sector. Based on the specific objectives of each part, different methods were applied to gather and to analyze information. The details are as follows:

a) Country profile

Relevant databases pertaining to Vietnam were identified via the internet. Criteria for selection included the likely reliability of a given database (e.g. WHO was considered as highly reliable), and the degree to which the information given was up to date. Databases such as Wikipedia, and unofficial or private websites were not referenced in this report.

The internet search for data and material included keywords or acronyms, such as “Vietnam”, “fact sheet”, “country information”, “World Bank”, “WHO” (World Health Organization). More specific key words or acronyms were employed for different sub-sections, including “demography”, “geography”, “MDGs” (Millennium Development Goals), “NCDs” (non-communicable diseases), “HIV/AIDS”, “tobacco”, etc.

Cross-references were made where more than one database was available, to synthesize a comprehensive description of the situation. In some instances, WHO databases were the primary sources of information; in others, relevant journal articles were sought to give greater depth to an issue. The data were then presented along with a commentary on the statistical patterns and public health challenges that the country faces.

b) Curricular review

Public health training in Viet Nam has developed rapidly in the last decade, with the establishment and development of the Ha Noi School of Public Health (HSPH). This school is the first and the only university of public health in Viet Nam so far. To search for the training courses related to “Social Determinants of Health” in Viet Nam, the INTREC Social Scientist (ISS) for Viet Nam – TBP, the first author of this report – applied “a multi-stage approach”. In the first step, ISS Viet Nam, as a public health expert who witnessed the development of the public health field in Viet Nam over the last 15 years, has developed a list of public health schools and public health departments in Viet Nam. Next, a pre-formatted table was sent to these departments and schools regarding relevant SDH training courses being used in their training programs, after ISS Viet Nam had contacted them by telephone or by face to face discussions. The discussions with the leaders of the schools of public

health/departments of public health focused on the relevant SDH training courses/sections being taught in their institutions and other SDH training courses outside that they may know.

In the second step, ISS Viet Nam followed-up to she received the completed table from the contacts, and conducted a further review on the core course literature, and on policy changes relevant to the SDH trainings. In this step, ISS Viet Nam searched for relevant SHD training courses through the Internet. The key words included "SDH training", "Determinants of Disease trainings", "Socioeconomic determinants of health", "Master of Public Health Curricular", "Public Health + Social Determinants" etc. The information gathered on ongoing SDH courses was summarized in a table *Annex 1 – Curricular Review*

c) Literature review

Literature review methods consist two main parts: search through the Internet, and contact directly with authors of the relevant articles/reports. The sources for literature review include reports and documents from NGOs and International agencies such as WHO/UNICEF/Donors; reports and legal documents from Vietnamese government and ministries; articles from the INDEPTH site at FilaBavi, and via different science journals and databases; and newspaper reports.

To search for relevant documents through the Internet, the keywords to search for were not only "social determinants of health" but also "health inequalities", "health inequities", "health determinants', "determinants of disease" etc. The search focused on reports and documents from 2005 to 2012.

ISS Viet Nam contacted directly with the prominent authors of many relevant articles on INDEPTH site (FilaBavi) to ask for more information and get the full-text articles. Telephone conversations were also conducted to learn about SDH on-going activities and other SDH information in Viet Nam

Information gathered, including documents and articles was then summarized in two table templates entitled: *Annex 2 - Social Determinants Country Needs; Annex 3 - On-going work on Social Determinants of Health*

d) Stakeholder interviews

Design

Semi-structured interviews with key informants are an integral part of many qualitative studies focusing on social science, and so they are in this study. Due to the diversity of social determinants of health, interviews aimed at obtaining in-depth information on a particular issue from each individual respondent. Key informants can provide a detailed picture of, for example, the most important social determinants of health in Viet Nam or/and comments on addressing them.

A multi-sectoral approach was used in this research. ISS Viet Nam conducted interviews with twelve leaders not only from the health sector but also from other sectors in society. This was because focusing on Social Determinants of Health required a multi-sectorial approach since it involved all sectors in society, not only the health sector. Before conducting the interviews, ISS Viet Nam discussed with experts in relevant fields in Viet Nam to come up with a list of possible respondents.

	National	Provincial/region around the DSS
Decision makers in health sector (national)	1	2
Decision makers in other sectors	1	1
Researchers/post-graduate lecturers	1	
Donors	1	
NGOs/INGOs/civil society	3	1
WHO expert	1	
Total	**12**	

Table 1 – List of informants who were interviewed for this study

A potential list of respondents was developed which included twelve people from six different categories, as in the table above. Half of the respondents are leaders (decision makers) at national or provincial level, working in different sectors of the government. Four people belong to the civil society category including international, Vietnamese NGOs and mass organizations.

After the list of potential respondents was developed, ISS Viet Nam contacted each respondent to request for an interview. If the respondent asked for more information of the interview, then a brief project information sheet was sent. All the interviews were conducted in the respondent's office at an agreed time. ISS Viet Nam conducted all of the interviews. Each interview took about 40 minutes and the language used in the interview was Vietnamese. No telephone interviews were conducted.

Before the interview, the purpose of the research was explained to the respondent. ISS gave the timeline to the respondent and asked the opinion of the respondent regarding the timeline (whether they agreed or had other comments on this). The respondents also were informed that they could stop the interview at any time if they did not wish to continue. If they did not want their voice to be tape recorded, then the ISS would switch off the recorder. After conclusion of the interview, the interviewer requested permission for a follow up interview if necessary.

To collect the data, ISS Viet Nam conducted twelve semi-structured with open-ended questions interviews with leaders in the North, the South and the Central Region of Viet Nam. The purpose of this is to ensure that the voices of different actors in different regions of Viet Nam were heard.

Data analysis

i. Familiarisation with the data

Familiarisation with the data began during data collection, as the ISS Viet Nam first spoke to the interview respondents or read the documents. During data collection, ISS Viet Nam made notes, reflected on the process of data collection and noted any interesting themes, or any ideas that came to mind.

Transcriptions were made after the interviews finished as soon as possible to recall any other ideas and to take more notes. This helped the ISS draw from that experience to enhance the next interviews. When all the interviews were conducted and all transcripts were made, the ISS reviewed and checked again all the transcriptions in order to "clean" the data, and confirm the accuracy of transcription. To ensure the quality of the transcriptions, another Vietnamese was hired to check and proof read all the transcriptions. Interview information was recorded on the following items: name and sex of respondent, type of respondent, the workplace of respondent, time, date and place that the interview was conducted and name of interviewer.

Finally, transcriptions were reformatted and eliminated the marks (Vietnamese marks) before importing into the OpenCode software[6] for analyzing. The average number of pages for a transcript of the interviews was about 8 pages.

ii. Identifying a thematic framework

The thematic framework used for analysis was determined by considering and synthesizing two key factors:

- The key concepts and themes identified in the project's conceptual framework.
- The themes emerging from familiarization with the data.

iii. Quotations

Quotations are used in this report to illustrate how the findings were discussed by the respondents. Quotations, therefore, are illustrative outputs of the findings, but not the primary tool of the analysis.

Attention was paid to ensure that quotations from all types of actors were represented equitably in this report. Care was taken to ensure that any identifier information was removed in order to

maintain the anonymity of respondents. The quotation was indexed with type of respondent such as decision maker - health, NGO leader, researcher, etc.

iv. Translation

To facilitate the dissemination to a wider audience, and in compliance with project contract requirements, this report is written in English. However, the data were collected and analysis in Vietnamese. This was more appropriate for the language skills of the respondents and helped to preserve the meaning of concepts in Vietnamese.

v. Ethics

According to good academic practice, and as a legal requirement in the project contract, the research strictly abided by an ethical framework. The application for ethic approval was sent to the Institutional Review Board at the Hanoi School of Public Health. This study received the ethical approval from the Institutional Review Board at the Hanoi School of Public Health in May 2012.

- *Informed consent:* An informed consent statement was explained to, and agreed to by, all respondents.
- *Confidentiality:* All the information was used for scientific purposes only.
- *Anonymity:* The aim was to ensure that outputs arising from the research do not attribute information to any particular source unless prior agreement is given. For this research, this is a challenge, as the number and potential pool of respondents (e.g. health leader, donor, civil society, WHO expert) is small. The respondent was only coded in the quotation under type of respondent. No specific name of position of individual was reported.

4. Vietnam country profile

Viet Nam is considered a development success story. Political and economic reforms (Doi Moi) launched by its Government in 1986 have transformed Viet Nam from one of the poorest countries in the world, to a lower middle-income country within a quarter of a century. Viet Nam has already attained five of its ten original Millennium Development Goal targets, and is well on the way to attaining two more by 2015. It now is one of the most dynamic emerging countries in the South East Asia region [7].

Geography

Viet Nam is the 66th largest country in the world, encompassing an area of 331,210 square kilometers. It lies in south-eastern Asia, bordering with the Gulf of Thailand, Gulf of Tonkin, and South China Sea, as well as land borders with China, Laos, and Cambodia[8] .

Notably, the country extends 1,650 km north to south, but it is only 50 km across at its narrowest point. Viet Nam has a tropical climate in the south; and a monsoonal climate in the north, with a hot, rainy and a warm, dry season. Hanoi is the capital of Viet Nam and the country is administratively divided into 58 provinces and 5 municipalities[8]

Figure 1 – Map of Vietnam and surrounding countries

Demography

With an estimated 91.5 million inhabitants as of 2012, Vietnam is the world's 14th most populous country, and the eighth most populous Asian country [8].

In the 1999 Census, the population of Viet Nam stood at just over 76 million. From 1979 to 1999, nearly 20 million people were added to the country's population. But, despite the addition of over 1 million people per year, the rate of growth of Vietnam's population has been slowing dramatically. By the end of the 1990s, the growth rate declined to lowest at 1.4% per year in 2000[9].

Infant mortality rates (IMR) vary considerably throughout the country. In cities such as Hanoi and Ho Chi Minh City, IMR is low, approaching those of some European countries. But between the provinces, it ranges from 33.9 to 10.6 per 1000 live births. And, in some provinces, particularly in ethnic minority regions, rates are among some of the world's highest[8, 9]. This may be related to obstacles in health care delivery due to the difficult terrain and to larger family sizes.

Population density is a concern in Viet Nam, particularly in the Red River Delta (in the northeast) which is by far the most densely populated region with 1,136 people per square kilometer, in 1999, which makes it one of the most densely populated countries in Southeast Asia and in the world[8, 9].

The decline in fertility is one of the most important demographic changes of recent years in Viet Nam. The total fertility rate (TFR) declined to 2.3 by 1999[9] and to 1.89 children born/woman according to 2012 estimates[8]. The dramatic nature of the decline is evident when comparing the current TFR to that of 1979: nearly 5 children per woman[9].

Vietnam's age and sex distribution is presented in Figure 2 below, showing a remarkable decrease in fertility as the base of the pyramid is shrinking.

Socio-economic and political context

After gaining independence from France on September 2, 1945 the nation adopted its current constitution in April 1992. Its legal system reflects the European-style civil law.

Viet Nam is a densely-populated developing country that in the last 30 years had to recover from the ravages of war, the loss of financial support from the old Soviet Bloc, and the rigidities of a centrally-planned economy. After reunification in 1975, even though Viet Nam switched its focus to reconstruction and development but due to the severe damages caused by many years of war Vietnam's economy experienced a long period of crisis during the 1970s and 1980s. To overcome these difficulties, the Doi Moi (renovation) process was initiated in 1986. This focused on[10]:

- Shifting from a planned, centralized economy based on public ownership to a multi-sector economy based on the market;
- Democratizing social life by building a state on the basis of the rule of law;
- Strengthening external cooperation with other countries.

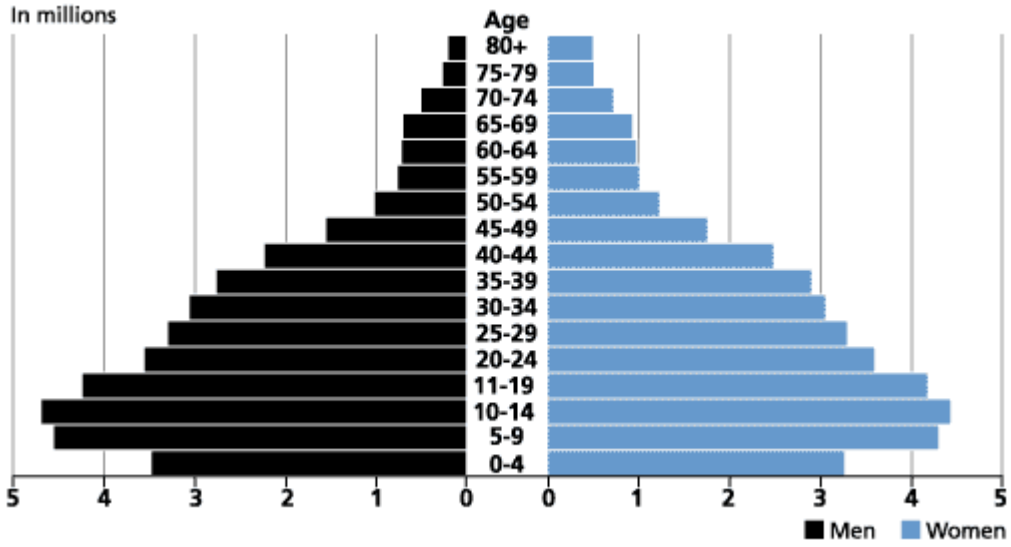

Figure 2 – population pyramid of Vietnam [Source: Ministry of Health, Vietnam, *Health Statistical Yearbook 2000* (PRB)]

Viet Nam maintained a very high economic growth rate throughout the 1990s. However, the benefits of the economic growth have not been distributed thorough society. Almost a decade ago, in 2002-2003, per capita income in urban areas was reported to be 2.2 times greater than that in rural areas, and also the income of the highest income quintile was 8.3 times greater than that of the lowest income quintile[10]. Currently, with average annual growth rate of about 7 percent, Viet Nam's economic output is predicted to double every 10 years.

Viet Nam has started the new Socio-Economic Development Strategy (SEDS) for 2011 – 2020. The previous two SEDS (1991-2000 and 2001-2010) helped Viet Nam advance from a largely poor, agricultural-based economy to a wealthier, market-based and rapidly developing one, increasingly integrated into the regional and global community. Vietnam joined the World Trade Organization in January 2007 following more than a decade-long negotiation process. Viet Nam aspires to enter middle income country status soon, and the new SEDS aims to establish the foundation for Viet Nam to become a modern, industrialized country by 2020[11].

Viet Nam has developed from per capita income below $100, in 1986, to a per capita income of $1,130 by the end of 2010. Over the past decade, the country's economy has grown rapidly, at an

average of 7% per year since 2000. If this level of economic growth continues, Viet Nam, a lower middle-income country, is expected to be reclassified as a middle-income country by 2012 [10].

Health and Development

According to the World Bank [4], Viet Nam is one of the best examples of successful poverty reduction. The ratio of population in poverty has fallen from 58 percent in 1993 to 14.5 percent in 2008, and most indicators of welfare have improved[10]. Viet Nam's remarkable achievements in poverty reduction in a very limited time owes to the government's strengthened capacity in measuring and monitoring poverty, and preparing policy interventions required to address the poverty. According to Oxfam International, Viet Nam's record equates to 6,000 people moving out of poverty every day for the past sixteen years[9].

Viet Nam has been applauded for the equity of its development, which has been better than most other countries in similar situations. One way of further appreciating this applause is by observing how rapidly health in Viet Nam has improved in recent years [10], presented in Table 1 as below.

Indicator	**1995**	**2000**	**2005**	**2010**
Life expectancy at birth	65y	67.8y	71.3y	75y
Crude death rate (per 1000 population)	6.0	5.6	5.3	5
Crude birth rate (per 1000 population)	22	20.5	18.6	17
Infant mortality rate (per 1000 live births)	45.1	36.7	17.8	-
Under-five mortality rate (per 1000 live births)	61.6	42	27.5	23
Maternal mortality ratio (per 100 000 live births)	110	95	80	-
Malnutrition rate among under-five children	44.9%	33.8%	25.2%	-
Poverty headcount ratio at poverty line (% of population)	**1998** 37.4%	**2002** 28.9%	**2006** 16.0%	**2008** 14.5%

Table 2 – Trends in key demographic and health indicators

The key demographic indicators indicate that Viet Nam has entered the third stage of demographic transition, where the population moves towards stability through a decline in the birth rate; as also seen in the population graph earlier. It can be said this transition, combined with rapid socioeconomic development and accelerating urbanization in the country, has contributed to major changes in the country's epidemiological patterns.

Millennium Development Goals

Viet Nam has made significant achievements in relation to achieving the MDGs, and is on track to achieve most of the targets set by the MDGs by 2015. However, an "unfinished agenda" remains in relation to several of the MDGs including maternal mortality and malnutrition, and water and sanitation[12]. Based on the Millennium Development Goals (MDGs) and the country's own aspirations, Viet Nam has also established its own 12 development goals (referred to as Viet Nam's Development Goals or VDGs), which include social and poverty reduction targets. The VDGs reflect the MDGs and at the same time take into account the specific development features of Viet Nam. The VDGs are integrated into the national socio-economic development strategies and are translated into specific targets.

The Government of Viet Nam has issued many documents to guide the implementation of the MDGs and the VDGs[12].

Disease Burden

While Viet Nam's health indices have improved substantially in recent years, the country is now facing a host of relatively new health problems, including rising incidences of non-communicable or lifestyle-related diseases, and an escalating HIV/AIDS epidemic. It faces a "double burden" of communicable and non-communicable disease. The overall incidence of communicable disease has fallen in recent decades; however there has been a significant increase over the last thirty years in the proportion of morbidity and mortality due to non-communicable diseases[13, 14].

Tuberculosis & HIV

Tuberculosis remains a major public health problem; WHO has classified 22 nations as High TB burden countries, of which Viet Nam ranks 13th. TB has been a national priority for more than 10 years, and the country has targets to reach 100% DOTS coverage and case detection. An average of more than 55,000 new respiratory TB patients has been reported each year for the last five years. The impact of the National TB Programme has been mitigated by the rapid spread of HIV since the early 1990s. According to 2010 estimates, of 42,356 TB patients with known HIV status, 3515 were HIV-positive[15].

In 2007, an estimated 290 000 people were living with HIV in the country, a 12-fold increase since 1995; and HIV prevalence among injecting drug users and female sex workers is estimated as 33% and 3.5%, respectively. The average prevalence among pregnant women increased twelve-fold from 0.03% in 1994 to 0.37% in 2005, exceeding 1% in a number of provinces. The need for care and treatment of an HIV/AIDS patient has already become a challenge and is set to increase in the coming years. Approximately 67 000 people living with HIV in 2007 were in need of antiretroviral treatment, but only 1700 had access to it, and it is projected that the number in need of the treatment will increase rapidly in the next few years[13, 15].

Stigma and discrimination against people living with HIV, including from the health care setting, prevent patients and those in need from accessing prevention and treatment, but the government is increasingly working to confront this problem.

Malaria

Malaria control in Viet Nam in the last decade has also been extremely successful. Malaria cases and deaths have dropped by 60% and 97%, respectively, since 1996. Many localities have reported no malaria cases for the last few years. Very few malaria deaths have been reported since 2006[16].

Non-communicable disease overview

Increasing household income has changed dietary and eating habits, and these changing lifestyles have resulted in increasing physical inactivity, particularly in urban areas. These factors have all played an important role in the alarming increase of NCDs[10]. Men are more likely than women to be affected by NCD, and more likely to suffer from accidents or injuries. This is reflected in a lower life expectancy for men: 69 years, compared to 74 years for women[9, 10].

According to the WHO country profile resources[14], as of proportional mortality, NCDs are estimated to account for 75% of all deaths. And, remaining causes belong to communicable diseases at 16% and injuries at 9%[14].

Estimates from 2008, available at the WHO Viet Nam website[14], show the total number of deaths due to non-communicable diseases to be 208,000 among males and 222,000 among females. Out of this number, the percent of all deaths due to NCDs under age 60 is 26.4% in males and 19.4% in females. The disease specific age-standardized death rate per 100, 000 for four main NCDs is estimated in Table 3:

Age-standardized death rate per 100 000	***males***	***females***
All NCDs	687.2	508.2
Cancers	137.3	94.3
Chronic respiratory diseases	76.6	45.5
Cardiovascular diseases and diabetes	381.5	298.2

Table 3 – NCD Age-standardized death rate per 100 000

Risk factors

The WHO resources present risk factors for NCDs in two parts as the behavioral and metabolic risk factors. The figures for those estimates are provided in Table 4 [14]:

Behavioral risk factors			
2008 estimated prevalence %	***males***	***females***	***total***
Current daily tobacco smoking	40.4	1.0	20.1
Physical inactivity	14.2	15.6	14.9

Metabolic risk factors			
2008 estimated prevalence %	***males***	***females***	***total***
Raised blood pressure	36.0	30.0	33.0
Raised blood glucose	6.6	7.2	6.9
Overweight	9.5	10.9	10.2
Obesity	1.2	2.1	1.7
Raised Cholesterol	…	…	…

Table 4 - Behavioral and metabolic risk factors for NCDs

Tobacco

According to the Global Adult Tobacco Survey, 2010 prevalence of smoking among adults (15+) is reported to be 19.9% for current and 15.6% for daily smokers. The numbers increase to 23.8% for current and 19.5% for daily users of any smoked tobacco. In contrast, the prevalence of smokeless tobacco use is higher among females at 2.3%, whereas men account for only 0.3 % of smokeless tobacco use[17].

Viet Nam signed the WHO Framework Convention on Tobacco Control (WHO FCTC) in 2003 and ratified it in 2004. Despite legislations on smoke-free public places, very low compliance is reported for Viet Nam, receiving a score of only 3 out of 10 where score 0 is for low compliance. Further, there are no dedicated funds for enforcement of tobacco laws.

However, direct bans on media and publicity exist. The Government expenditure on tobacco control is also minimal, and there is no national agency or technical unit for tobacco control[17].

Alcohol

According to 2003 data[18], around 75.9% of the population aged 15+ both sexes, was reported to be abstainers (defined as ‘did not drink in the last 12 months’); out of whom 67.1% are lifetime abstainers.

Abstainers (15+ years), 2003 *Persons who did not drink in the last 12 months			
	Males	Females	Total
Lifetime Abstainers	38.5%	95.2%	67.1%
Former Drinkers	14.1%	3.5%	8.8%
Abstainers*	52.6%	98.7%	75.9%

Table 5 – Patterns of alcohol drinking, Vietnam

Taking into consideration the former drinkers figures, 3.5% females are reported to have consumed alcohol at some time and 1% used tobacco this reflects alcohol consumption to be more prevalent than tobacco use. This coincides with higher raised blood glucose, overweight and obesity and higher physical inactivity amongst females. Among males around 60 % of them consume alcohol, which contributes to the fact that NCDs account for 75%[14], of all deaths.

However, there is a lack of information in the resources used to write this review on alcohol policy or if any excise tax is levied on beer/wine/spirit [18]. 18 years of age is known to be the national legal minimum age for off-premise sales of alcoholic beverages selling or serving including restrictions on time of the days when such sales can undertake, but necessarily is being adhered to. No information is available on legally binding regulations on alcohol advertising and sponsorship[18].

Physical activity and Nutrition

As presented in the table earlier, 14.2 % males, and 15.6% females are known to be physically inactive. Nothing more can be said about these risk factors due to lack of information in the resources used[10, 14].

Country capacity to address NCDs

The chronic disease prevention and control can be said to be at its initial stages, as in most middle- and low-income countries. The Government is well aware of the rising trends in NCDs and the growing number of deaths and injuries due to causes such as traffic accidents, alcoholism and occupational hazards. It has initiated programs for four major NCDs (CVDs, cancer, chronic respiratory diseases and diabetes). An integrated policy and action plan has been formulated which is currently operational for the four main NCDs and their four main risk factors (alcohol, unhealthy diet, physical inactivity and tobacco). These focus on controlling and preventing diabetes cancer, cardiovascular diseases and mental disorders. However, resources for such

programs are limited, with little external funding, and the current national programs tend to be treatment-oriented rather than prevention- and community-focused.

A unit at Ministry of Health that is responsible for NCDs is working on such programs. Separate funding has been made available for treatment and control, prevention and health promotion and surveillance, monitoring and evaluation. A national health reporting system that includes NCD cause-specific mortality and morbidity, but that is not yet equipped for risk factors reporting, has been set up. However, a population-based cancer registry is still non-existent. Being chronic, these diseases are expensive to treat. As resources are limited, a public-health and prevention-oriented approach would be more cost effective and appropriate.

Overall, rapid urbanization presents many challenges for management of Viet Nam's progress. At the same time, major challenges to Viet Nam's development persist, and new ones have emerged in recent years. These include climate change and increasing social and economic disparities. Economic growth has been associated with an increase in inequality, particularly a widening rural-urban income gap. Poverty rates remain high, particularly among ethnic minorities, which comprise 14 per cent of the population and live mainly in these remote upland areas. About 90 per cent of the poor live in rural areas. Poverty still affects close to 15 per cent of Vietnamese people, including around 50 per cent of the ethnic minorities[12].

5. SDH Curricular review

a) Objective

The aims of curricular review were:

1. To identify ongoing social determinants of health-related training courses in Viet Nam
2. To establish gaps in training that INTREC can fill

b) Results

Results from reviewing the information gathered on relevant SDH training courses in Viet Nam indicates that relevant SDH training is taught as a part of the Master of Public Health Program, Master of Preventive Medicine, Specialty 1 and Specialty 2[2] Programs organized by the Ha Noi School of Public Health and Public health departments of the Ha Noi Medical University, Hue Medical University and HoChiMinh City Medical University. However, there is no separate course teaching SDH in these training institutions. In fact, prior to 2010, Social Determinants of Health was taught as a unit nested in a subject of the Master of Public Health Program. From 2010 to date, due to a policy from Vietnamese Ministry of Education, the Master Program was shortened from 24 months to 18 months. Thus some of the master program's subjects were cut and SDH was not taught as a separate unit. Instead, SDH teaching curriculum was condensed and integrated into other subjects/units. It is noted that all the above mentioned master programs are designed and conducted in a face to face format. E-learning and self-studying were designed to support the program only.

c) Available SDH relevant trainings

Closely examining the relevant curricular on SDH reveals that SDH trainings are scattered in different subjects of different master programs organized by different public health training institutions.

In Ha Noi School of Public Health (HSPH), the general concept of SDH and relevant information is provided within the Health Education and Promotion Subject. Useful information relevant to SDH is used and introduced, such as the Ottawa Charter from 1986 and the Bangkok Charter from 2005 regarding health promotion of WHO; WHO's Social determinants of Health; 10 solid facts and Development Trends 2005 software (source: www.gapmnder.org/human). The SDH teaching is a component supporting the learning objectives of the subject, in that the students are expected to understand social determinants of health and health promotion strategy; estimate and predict the possibility of behavior change and the solution to change behavior; analyze and choose appropriate approaches and solutions for health promotion programs.

[2] *This kind of course is post -graduate training in medical schools in Viet Nam. Specialty 2 is higher level than Specialty 1. Both of these are lower than Master level*

For the Master of Public Health Program provided by the Institute for Preventive Medicine and Public Health, Ha Noi Medical University (HMU), relevant SDH information is introduced within the Occupational Health Subject. In this subject, the social determinants of health are examined as "intermediate causes" from the angle of working environment such as noise, dust, and working hazard elements. In addition, relevant SDH information is also introduced in a selective subject entitled "Anthropology and sociology with medical problems and health subject". As the name of the subject could convey, SDH teaching in this subject is seen in connection with an anthropological approach. In some other parts, teaching content of the subject includes the cultural and social determinants of health: the role of inequality and social stratification, networks and social capital, gender issues and cultural characteristics of ethnic groups; influences of cultural and social development on health: the role of urbanization, and economic policies for social development; social structure etc. The book edited by Michael Marmot and Richard Wilkinson, entitled *Social Determinants of Health* (2nd edition, Oxford University Press, 2006) was listed among the textbooks introduced by the course. As mentioned above, prior to 2010, SDH was introduced as a separate subject of the MPH program organized by the HMU. Currently, SDH is introduced as a selective subject within the program.

Similar to the HSPH and the HMU, relevant training on SDH is integrated in Master of Public Health Program and Master of Preventive Medicine Programs organized by the HoChiMinhCity Medical University, Faculty of Public Health. Within the MPH program, relevant SDH training is introduced in the Environment Health Subject. Currently, the Faculty, with support from Queensland University of Technology (QUT), Australia, is working on revising and editing the textbook: "Environment Health, Occupational Health". The curricula of the programs focus on the environmental and occupational determinants to health. In others parts, the program contents include information on the Vietnamese Health Policies with emphasis on the equity in health care.
In the central region of Viet Nam, Faculty of Public Health of Hue Medical University was established in 2005. A few years later, it offered a Master of Public Health Program. Relevant SDH teaching was integrated and introduced in some subjects/units of the MPH program and Specialty 1 – Public Health and Specialty 2 - Preventive Medicine. The units are: Public health and Social Science in Health; Health Behavior Science; Violent abuse in family; Stress; Anthropology and Health and; Health Economics. SDH information is gathered and introduced in the Books and documents entitled: Social Science in Health and Public Health (in the introduction section); Social Determinants of Health and Health Promotion; Anthropology; Reproductive Health-Population-Health Planning and Health Economics. All of them are in Vietnamese.

d) Training gaps

Through reviewing the current SDH curricular and relevant SHD training courses in Viet Nam, it is suggested that there is a lot of room to improve the training on SDH in Viet Nam. Although Viet

Nam has achieved significant health development over the last two decades, it is now facing a lot of challenges that come with the economic development. The gap between the rich and the poor became large and health inequity is clear among different population groups in society. Given that relevant SDH training is nested and integrated within units/subjects of the Master and post-graduate programs offered by several public health schools in Viet Nam only, it is necessary to have a separate SDH subject or training course in these institutions. The SDH training course could be designed not only for the students in the public health schools, but also for the leaders of different sectors in Viet Nam. Information gathered from the interviews leaders and stakeholders in Viet Nam in the next step could provide further details on the needs for SDH training for the leaders and other stakeholders in Viet Nam.

In regards to the SDH training curriculum, the current SDH curriculum is relatively basic, and only provides some concepts of the SDH. It lacks discussion and connection of SDH to the real situation. Thus, the development of curriculum should be based on the current one with emphasis on the country's economic development, environmental health and the healthcare system as the main determinants of health in Viet Nam. The curriculum should be tailored for teaching at the academic institutions and for different training courses outside focusing on policy makers and decision makers, not only from health sectors but also from other sectors and on specific issues.

Health equity receives increasing attention from the Government of Viet Nam. Relevant policies and investments have been made to ensure the equity in healthcare among Vietnamese people. Thus, SDH training curriculum for policy and decision makers should focus on health equity and the concepts of social determinants of health rather than equality in access the health care system only. It is important that in the long term, the policy and decision makers not in the health sector need to understand this so that it could help their work.

6. Literature review

a) Background

This part of the report present the results of a review of the existing literature on (i) Core Social Determinants of Health in Viet Nam, (ii) On-going work on Social Determinants of Health that includes the main actors in the country and the relevant SDH policies, including identification of interested parties and any forthcoming policy reviews.

b) Core Social Determinants of Health in Viet Nam (SDH country needs)

i. Health inequality in maternal and child mortality

Health inequality in both maternal and child mortality is a concern in Viet Nam. UNICEF has conducted a situation analysis on maternal and child mortality[19]. This study mainly used the data from national household surveys: the 1992/1993 Vietnam Living Standards Survey (VLSS), the 2006 MICS II, the 2006 Vietnam Household Living Standards Survey (VHLSS), province-level data from the MOH Health Information System (HIS), and other sources. The study compares the early estimates for 1992/1993 and recent estimates for 2006 of inequality. In addition to the inequality estimates, the study analyzes the current situation of inequality focusing on maternal and child mortality. The analysis suggests that:

- There is a moderate degree of inequality in child mortality in Viet Nam disfavoring poorer women and their children that has persisted at least since 1992/93. The factors that contribute to the observed inequality in child mortality in both 1992/93 and 2006 include: schooling (both the highest level of schooling completed by any adult household member and, increasingly, the woman's own level of schooling), ethnicity, and the wealth index. In regards to the degree of inequality in maternal mortality in Viet Nam, the limited available data analyzed in the situation analysis suggest that maternal mortality is unequally distributed, favoring the rich, as is the case with child mortality.
- The schooling of adult household members is a consistently important contributor to the inequalities in child morbidity, as observed in 2006, while mother's schooling consistently reduces this influence.
- Province-level analysis of malaria morbidity (malaria incidence) in the general population found that there is a high degree of inequality in malaria morbidity disfavoring poorer provinces and that the main contributing factors to the observed inequality are household income and ethnicity.
- There was moderate inequality in malnutrition among children under 5 in 1992/93, which has increased substantially by 2006, even as average rates of child malnutrition have declined during the same period. Growing inequality in household incomes appears to have been the main factor contributing to the increased inequality in child malnutrition over time

- There have been impressive gains in women's average access to at least some antenatal care from a trained provider during the period 1992/93 to 2006, as well as reductions in the degree of inequality in this indicator.
- There is still considerable inequality in the distributions of most obstetric delivery care indicators, including "professionally assisted deliveries." Findings from key informant interviews confirm that geographic access to care, lack of knowledge of when care is needed, financial costs of medical care or of seeking care, and quality of reproductive services all contribute to inequalities in access to reproductive health services disfavoring the poor.
- There is still an important degree of inequality in immunization indicators, according to the available household survey data. On the demand side, income, ethnicity, and adult schooling still account for much of the observed inequality in key immunization indicators, while on the supply side, the situational analysis finds some evidence that physical access to health facilities and health providers is also important.

The findings of the situational analysis confirm that there is still an important and persistent degree of inequality in several maternal and child health outcomes. The factors contributing to the observed inequality include both demand-side factors (i.e., the household's "permanent income," adult schooling, and ethnicity) and supply-side factors (i.e., the accessibility and quality of locally available health services). A reasonable conclusion, therefore, is that an effective strategy to address the remaining inequalities in maternal and child mortality should include both demand-side and supply-side interventions targeted to the poor, many of whom are ethnic minorities residing in remote localities.

ii. Mortality inequality and the associations with socioeconomic factors

David et al [20], investigated the associations between socioeconomic variables and mortality among 41,000 adults in Northern Viet Nam in the period of rapid transition. The study was conducted using household survey data in Ba Vi District, where a field laboratory, Filabavi was established. The study investigates the relative importance of socioeconomic factors for explaining inequality in age-standardized mortality risk. The results confirm previously found negative associations between mortality and income and education, for both men and women in which, education variables have the expected gradient for both sexes, with highest hazards for those with lowest education. The study also found that marital status explains a large and growing part of the inequality. The hazards for singles are more than two and a half times as high than those for married, both for men and women. Together these results suggest that positive spillover effects of education exists, that is, you benefit not only from your own education but also from that of those around you.

iii. Health inequalities among men and women

Alternatively, health inequalities among men and women were also examined in a study conducted in eight different countries' HDSS sites within the INDEPTH Network[21] including Viet Nam. The study focuses on determining the extent to which demographic and socio-economic factors impact upon measures of health in the older population (aged 50 years and over), and to examine sex differences in health and further explain how these differences can be attributed to demographic and socio-economic determinants. The results show that in Viet Nam, older men have better health scores than women in all age groups. Also, there were large discrepancies in the proportion of the health score difference between men and women attributable to group differences in socio-economic and demographic characteristics, disfavoring women. This study confirmed the existence of sex differences in self-reported health in low and middle-income countries even after adjustments for differences in demographic and socioeconomic factors. The findings are consistent with results from Minh et al's study conducted in 2006, also in Fila Bavi, one of the two HDSS sites in Viet Nam on people aged 50 and over[22]. The study describes self-rated health (SRH) status among older adults and found that SRH status was reported to be better among: (i) men; (ii) younger people; (iii) people with higher education; (iv) people who were currently in marital a partnership; (v) those from wealthier households; and (vi) those who were living in riverside/island or highland areas compared to those of other categories of the same variable.

iv. Lifestyles of different population groups, their health and the associations with social factors.

The associations between social determinants and lifestyle were investigated in other studies [1, 23-25]. In general, education and low income were detected as strong determinants. Minh et al's study[24] revealed that lower physical functioning and psychological well-being were found in people with lower education, respondents from poorer household, women, and older people. In other studies, Minh et al[25] and Palipudi et al[1] found that increasing levels of knowledge on harmful effects of smoking has positive association with decreasing prevalence of tobacco use and that low income was found to be a significant predictor of becoming regular smokers in Vietnam. The findings confirm existing problems of inequality in health among older adults by sex, education, wealth status and place of residence. The finding highlights the importance of analyzing multiple dimensions of health status simultaneously in inequality investigations. For smoking prevention, intervention strategies should be comprehensive and their development should be based on knowledge of socio-economic determinants of the changes in smoking status. Priorities should be given to disadvantaged people e.g. low socio-economic groups and women.

v. Chronic diseases

In Vietnam, chronic diseases were shown to be leading causes of deaths, accounting for 66% of all deaths in 2002. The burdens caused by chronic disease morbidity and risk factors are also

substantial. From economic aspects, Minh et al [23] gathered available and relevant research findings in order to report and discuss current evidence on economic aspects of chronic disease in Viet Nam. The findings show that poorer people in Vietnam are more vulnerable to chronic diseases and their risk factors, other than being overweight, and that both population-wide and high-risk individual interventions against chronic disease were shown to be cost-effective in Viet Nam.

vi. Injury

Injury mortality rates are highly variable throughout Viet Nam. According to World Health Organization (WHO) [26], the majority of death and injuries on the roads are confined to the age group of 15 to 49 years – the group that makes up 56% of total population, and the most economically active group. WHO estimates that road traffic injuries are the leading cause of death for those aged 15-29 years in Viet Nam. Injury mortality annual rates are highly variable throughout Viet Nam. The highest (60.7 per 100,000 people) are found in the low socioeconomic areas of the Northern provinces. Provinces surrounding the two largest cities of Hanoi and Ho Chi Minh City have the lowest injury mortality rates with 38.4 and 36.8 deaths per 100,000 people respectively. There are many contributors and causes for road traffic injuries in Viet Nam. There is a strong association with the explosive growth in motorization, with more than 26.8 million registered vehicles as of December 2008, 95% of which are motorized two-wheelers.

c) On-going work on social determinants of health

Compared to neighboring countries, Vietnam has achieved an outstanding level of health considering its economic resources. Life expectancy at birth in 2005 was in the same magnitude (around 70) as in Thailand and China, even though Thailand has three times and China two times larger GDP per capita. Cambodia and Lao is approximately on the same GDP level as Vietnam but achieves 10 years less in life expectancy[27]. Other health indicators such as infant mortality rate and mortality rate among under-5s also decreased dramatically over the last two decades. The adaptation of different policies improving life conditions and health for Vietnamese people and their effectiveness contributed to this success. Recently, there are some social organizations and non-governmental organizations that have also implemented different activities to address SDH in the country. This section highlights some of the ongoing work on SDH in Viet Nam by identifying the main SDH actors in the country and SDH relevant policies.

i. Main SDH actors in the country

Within Vietnam, equity is clearly stated in the directions of the Party and State as an important goal for the development of its health care system. Based on existing literature, it seems that in Viet Nam, the concept of *equity in health care* is being used instead of health equity. The concern (especially from the government) on specifically bringing about equity in the uptake of health care services is more than the concern about health equity in generally[28]. Therefore, Central

Government, Ministry of Health, Ministry of Labor, Invalids and Social Affairs, Ministry of Finance and Health Insurance Sector are the main SDH actors in Viet Nam. Besides, there are other training institutions, civil societies, semi-civil societies or NGOs working on addressing the determinants of health. Examples of these works are:

- The Partnership for Action in Health Equity (PAHE). This group was formed by three Vietnamese non-governmental organizations to receive a grant from The Rockefeller Foundation for a project focusing on doing research for a publication entitled: "Health Equity in Viet Nam – A Civil Society Perspective". The publication consists of a numbers of reports that are quite informative on equity in health and equity in health care in Viet Nam, with the aim to raise a voice on health equity in Viet Nam. However, so far this group has received funding only from The Rockefeller Foundation for the above type of work and since the members of this partnership group (Vietnamese NGO) have other projects to do, the future existence of this partnership group and the SDH-related action will depend on both the finance they can get and their available human resources. SDH is still very new in Viet Nam and thus, this is a general situation for people interested in SDH.

- Forum for Social Determinants Network. This network was set up and nested in HoChiMinh City Institute of Hygiene and Public Health (IHPH). Relevant information on SDH was posted and introduced in this website [3]. The Institute has developed and tested the Urban Heart – A Health Equity Assessment and Response Tool in a number of provinces in southern Viet Nam. However, the effectiveness of the tool is still a subject for scrutiny.

- Hanoi School of Public Health (HSPH), in collaboration with Center for Disease Control and Prevention have been working to develop a short course on SDH for relevant participants (to be determined but they are likely the leaders and policy makers). HSPH plans that after this course, the school will develop it as an elective subject provided by the school.

ii. Relevant SDH policies, including identification of interested parties and any forthcoming policy reviews

In Viet Nam, health insurance was introduced in 1992 as a solution to help mobilize resources and create a more appropriate mechanism for payment of health care user fees. The health insurance

[3] http://www.ihph.org.vn/list_news.aspx?ncid=26

fund is run by the state to help Vietnamese people, and especially the poor, to access the health care service. Thus, it is a not-for-profit insurance company, a health insurance fund supported by the government. This health insurance fund will support from 80% of the cost of the health care treatment for the beneficiaries. For the compulsory health insurance, the beneficiaries are employed, students, pupils, retired people. For the people who are employed, the employers/governments *have to* contribute the main part to buy the health insurance for them (3.5% salary). The employees have to pay the rest (1% of their salary) for this health insurance cost. This is compulsory, such that all employers/employees must participate to ensure employees' right to access to health care services. For people who are unemployed or who are not students, pupils, and family members of those ensured under the compulsory plan[28], they do not have the health insurance. To support them to access the health care services when needed, the Vietnamese government also allows them to buy the government health insurance if they want (equivalent to 4.5% of the government basis salary, which is currently at 1.050.000 VND/month). This is called the voluntary health insurance and refers to the not-for-profit health insurance. People who volunteer to buy this health insurance have similar rights as people who have the compulsory health insurance. However, in order to participate to this voluntary health insurance, people need to contact with and have certification from the local governments where they live.

There is also other type of voluntary health insurance run by for-profit-health insurance companies. This type of health insurance is still new and mainly used in big cities in Viet Nam such as Ho Chi Minh City and Ha Noi, and for the middle income class and above. Nonetheless, this type of voluntary health insurance has not been popular since the cost for this health insurance is relatively high, and Vietnamese awareness regarding health insurance is still low.

In addition to these plans, there are also health insurance plans for the poor, near-poor and free health care plan for children under 6 years.

In order to establish poverty standards that serve as the basis for the implementation of social welfare policies and socio-economic policies, the Prime Minister has signed Decision No. 09/QD-TTg on promulgating the poor and near-poor households to apply for the period 2011 - 2015. Accordingly, the rural poor are households with an average income of 400,000 VND / person / month (from 4,800,000 VND / person / year) or less; urban poor households are households with average income from 500,000 VND / person / month (from 6,000,000 VND / person / year) or less; rural near-poor households are households with average income of 401,000 VND to 520,000 VND / person / month; near-poor households in urban households with average income of 501,000 VND to 650,000 VND / person / month. This poverty standard is applicable from 01/01/2011.

- *Free health care for children under 6 year olds (72 months)*

Decree 36/2005/ND-CP dated 17th March 2005[29] stipulates the detail for implementation of the 2004 Law on Child Protection, Care and Education. According to this Decree, since 2005, children under six have been entitled to free medical check-ups and treatment at public healthcare facilities. The Government has invested millions of dollars in this program, and as of June 2006, 8.5 million children under six (96 percent of all children under six nationwide) were granted free medical check-up cards[30]. Implementation actors of this decree include: Ministry of Health (national public healthcare system), Provincial Department of Health, Committee for Population, Family and Children of all levels, Provincial Department of Finance. Besides, the Decree declared to establish the "Child Protection Fund" aiming to mobilize the funding from other domestic and international institution. The Government of Viet Nam provides the seed money for this fund.

- *Policy on Healthcare for the poor*

Decision 139/2002/QD-TTg dated 15 October 2002 and the recent revised Decision 14/2012/QD-TTg dated 01 March 2012 on health care for the poor. According to these decisions, people from poor households (according to the Vietnamese standard), ethnic minority in disadvantaged areas (based on national poverty line), disadvantaged people, and people with illness that need costly and high technologies treatment such as cancer, heart operation, hemodialysis but have no ability to pay, will receive support (via health insurance) for treatment. The budget for this comes from the government budget (via health insurance), from the Health care Fund for the Poor which the government contributed about 75% upward and from other sources. This policy so far benefits a lot of poor people but there is a concern that it may create a burden and pressure for the insurance sector in the longer term. Vietnam's health insurance program faces a further challenge regarding the financial sustainability of the scheme: health insurance contributions are too low to cover the cost of the expanded package of services.

- *Health Insurance for the near-poor*

Recently, the Government of Viet Nam has directed Viet Nam Social Insurance to extend the support in buying health insurance for the near-poor households (based on national poverty line). The Official Letter from Viet Nam Social Insurance – 1584/BHXH-BT dated 26th April 2012 directs the implementation of this policy. According to this, health insurance will also cover people from near-poor households in which, government budget will support at least 70% for buying the health insurance for them. The rest will be contributed by the households themselves. This policy has been effective since 1st January 2012.

- *Universal health insurance coverage by 2014*

Vietnam is undertaking health financing reform in an attempt to achieve universal health insurance coverage by 2014. Changes in health insurance policies have doubled the overall coverage between 2004 and 2006. Coverage of health insurance in Vietnam has a fairly wide

population coverage (43.7% in 2008), but the funding from health insurance over the total health expenditure remains low (17.6% in 2008). The impact of health insurance on financial protection is still modest. In achieving universal coverage through effective health financing, Vietnam can adopt the model recommended by the WHO which reduce out-of-pocket payment step by step, and which increases the pre-payment mechanism.

- *Helmet Law*

In Vietnam, traffic accident has become one of the main causes of deaths and injuries and takes a large part in community's cost. 70% of the traffic accidents in Vietnam are related to motorcycle crashes, and 88% of motorcycle crash-related deaths were due to head trauma[31]. Since 2001, through Decrees, Resolutions, Instructions, Regulations, and especially the Road Traffic Law, the government has directed frequently and resolutely the policy of wearing helmets. However, the actual enforcement is different at different cities/provinces due to the difference in the area's determination and the people's awareness of traffic safety. After seven years, the Vietnamese Government passed the compulsory helmet law, and on 15th December 2007, the first day that the law in effective, the helmet compliance rate was almost 100%. Government policy, police, national and international NGOs are attributed to this success.

7. Stakeholder interviews

a) Objectives

The objectives of the interviews were:

1. To learn about respondents' knowledge of and attitudes towards SDH in their country / district
2. To identify the most important SDHs, and the most important related sectors (e.g. transport, justice, etc.), in each country/ district
3. To establish where there are gaps in knowledge and action about SDH in their country/ district
4. To establish means of addressing these gaps and identify the challenges inherent in tackling these
5. To validate and discuss findings from reviews (country profile, literature and curricula) on SDH and health inequities in their country

b) Findings

ISS Viet Nam conducted semi-structured interviews with twelve leaders, not only from the health sector but also from different sectors in society in different regions of Viet Nam. Qualitative analysis methodology was applied to analyze the data gathered from the interviews. Quotations were used to illustrate the analysis resulted presented below:

i. Respondents' Knowledge of and Attitudes towards SDH

In general, respondents' understanding on SDH is very limited and biased. None of them could briefly describe or mention all the five layers of the social determinants of health presented in the framework provided by Dahlgren and Whitehead (1991) that includes: age, sex and heredity factors, lifestyle factors, social and community networks, living and working conditions, and general socio-economic, cultural and environment conditions.

Generally, the term "social determinants of health" was understood as social factors that immediately affect or are associated with human health, and not "the causes of the causes of illness". Also, the effect of social factors was mentioned by respondents as the effect from single factors to human health, in that one's health could be affected by one or more factors. The effect of potential interactions between, for example, low income or adequate housing and human health, was generally not mentioned. The Concept of Social Determinant of Health was understood differently by different respondents in different sectors. Respondents' understanding on social determinants of health was also biased toward their occupation and sectors they belong to.

- *What Social Determinants of Health means to decision makers working for the government*

For respondents in the category of "decision makers" working for the government, social determinants of health mainly meant policies and regulations relevant to their work. For instance, for the respondents in the health sector, SDHs mean social factors that affect the access to the health care system, policies on health care service, policies on healthcare personnel, on hospital management, health insurance and health insurance for the poor.

> *"..social determinants of health are policies including recruitment policies, policies of preferential treatment, policies for sector management in general."*
>
> (Decision maker1 – Health)

Respondents' from other sectors beyond the health sector understand that health is influenced by many social factors, and in some ways, directly or indirectly, that their work may have impact on people's health. A respondent from another sector at national level thinks that the impact from his work (or his sector) to health mainly goes through developing relevant regulations and through implementation of government policies.

> *"..Although our work does not provide health care service directly, it influences health through policies, through training and education or through providing guidance for policy implementation."*
>
> (Decision maker – Other sector 2)

A respondent in a non-health sector at provincial level thinks that through attracting more collaboration projects to the province, not only with health sector but also with other sectors, his sector has influence on people's health:

> *"For example, a collaboration project to construct a kindergarten has influence on people's health in different ways (compared to the health care project)"*
>
> (Decision maker – Other sector 1)

- *What Social Determinants of Health means to respondents in civil society category*

Respondents from civil society – a category that includes mass organizations, international NGO and local NGOs – understand the term "social determinants of health" more broadly. According to the respondents, social determinants of health were understood as factors such as individual lifestyle factors, food safety, hygiene, nutrition, community awareness, economic development, health equity, or environmental pollution. To them, relevant policies addressing these problems are also social determinants of health. Depending on their organization's mission and their work, these above mentioned social factors were mentioned more or less by respondents. Social determinants of health are understood differently by different actors in this category:

> *"Actually, in theory, Social Determinants of Health consist of two main parts. The first part is about policies and health care system. The second part is related to living conditions, living environment and culture. "*

(NGO leader 2)

"I think health is influenced by many factors, such as social context, environment, living conditions, job, social prejudice, policies."

(A leader of a mass organization)

Nonetheless, these above factors were not mentioned systematically, as parts in the main determinants of health framework provided by Dahlgren and Whitehead, or linked with WHO's effort in addressing Social Determinants Health recently. To another respondent, social determinants of health and how to address them were mentioned as parts in the organization's programs where the respondents are working for.

"In general, it (SDH) is integrated in all our programs."

(NGO leader1)

"I think there are many social factors that influence health. As our organization working on gender issues, ..we have responsibility to educate and to raise awareness of the gender (we represent) so that they know how to take care of their health."

(A leader of a mass organization)

- *What Social Determinants of Health means to respondents working for WHO and donor organizations*

Interviews with a representative of a donor organization and a WHO expert revealed that they understand Social Determinants of Health, in general, quite broadly and similarly to respondents' in the civil society category. At the moment, both the donor organization and WHO Viet Nam do not have an SDH commissioner, SDH department or staff specifically assigned to be responsible for SDH issues. Respondents are high ranking staff, working on different programs, said to be knowledgeable on SDH. Through interviews, it is understood that up to the present, the donor organization and WHO Viet Nam have not had any specific project in this field. Although their understanding on social determinants of health is quite broad and less biased compared to other respondents in above categories, their understanding on SDH in general seems "general" and mainly comes from the actual situation in Viet Nam, and not much in connection with the global concept adopted by WHO or identified by other famous scientists in the field (e.g Dahlgren and Whitehead).

"I understand it (SDH) is the underlying cause of illness. Health influenced by direct causes and other causes originated from socio-economic factors."

(WHO expert)

"Besides direct clinical causes, health is also influenced by many other social factors such as environment, health policies, culture, dietary.."

(Donor representative)

- *What Social Determinants of Health means to respondents is a researcher/post-graduate lecturer*

Among all the respondents, the respondent who is a researcher and also a post-graduate lecturer has the broadest understanding of the social determinants of health. This is an exceptional case, since this respondent is a prominent researcher and lecturer in the field of public health in Viet Nam. Since in Viet Nam, SDH issue is still very new, ISS Viet Nam chose this respondent on purpose to learn about how an expert in similar field talks about Social Determinants of Health. Social determinants of health were mentioned according to the framework provided by Dahlgren and Whitehead

"I understand health is influenced by many factors. Normally, it is understood that health is influenced only by direct factors related to health care system or clinical issues. But in fact, health is also influenced by many other social factors such as employment, environmental conditions, social economic, gender, urbanization, transportation..".

(A researcher/post-graduate lecturer)

- *Use of the term Social Determinants of Health by the respondents*

The term Social Determinants of Health was used depending on the circumstances and specific purposes. In general this term was used in formal documents, in research reports and in academic teaching only. For example, this term was not usually used in the training programs in the community or communication programs. However, since the respondent' understanding on SDH is varied and quite specific, that the use of this term is appropriate or not is subject for scrutiny.

"I used it in teaching"

(A researcher/post-graduate lecturer)

"When we develop plan or decision, we use it but in daily conversation, if we use it, it is not practical"

(*Decision maker4 – Health)*

ii. The most important SDHs and the relevant sectors

Most of respondents think that currently, there are many important social determinants of health that need to be addressed in Viet Nam, and it is very difficult to know which social determinant of health is the most important. Also, a few respondents think that there is lack of evidence (data) in order to know which social determinant(s) of health is the most important.

"I think the social determinants of health issue is very broad including institutionalization, policy, socio-economic, environment… so it is hard to say what is the most important factor."

(NGO leader2)

"Actually, to answer this question is not easy since currently, we do not have any evidence to tell which social determinant of health is the most important.."

(A researcher/post-graduate lecturer)

However from observation and experience, respondents picked one or more social factors that they think are the most important in Viet Nam. Different respondents in different categories provided different factors. The following are some of the main factors that were considered as the important factors by respondents.

- *Policy factor*

Among SDHs, policy issues were cited as a SDH that plays a very important role in affecting the human health and that needs to be addressed. The term "policy" that the respondents used includes laws, decisions, regulations etc. It is said that in Viet Nam, many good policies related to social determinants of health have been adopted, but the implementation is very weak.

> *"Actually, there are quite enough health related policies such as law on medical examination and treatment, law on communicable disease prevention, law on health care etc.… However, how people implement them is still a question.."*
>
> (Decision maker1 – Health)

Another aspect related to policy, is that many current policies are not consistent with the whole legislation system and the development conditions in Viet Nam.

> *"I think policy issue still has problem… For example, policy development and improvement is the first factor that needs to be considered…"*
>
> (NGO leader 2)

In regards to policy, health insurance policy was considered as a most important social determinant of health

> *"Important social determinants of health (in Viet Nam) include not only one, but also a number of factors… In regards to policy, I think Health Insurance Policy, especially health insurance policy for the poor is an important change"*
>
> (NGO leader 3)

- *Environmental conditions*

Social determinants of health including socio-economic, cultural and environmental conditions are, more or less, identified by respondents as the most important social factor influencing health in Viet Nam at the moment. During the interviews, these factors were mentioned in connection to each other. It may come from the fact that in the last two decades, Vietnam's socio-economic situation has developed significantly, affecting the environmental conditions, and these in turn influence health. The effect could be positive and negative. However in this case, it was mentioned by respondents as a negative effect. Environmental pollution caused by industrial zones has been a problem in Viet Nam. Nevertheless, this problem was only reported once it became serious and people just know about it through mass media. In many cases, it is said that

the environmental impact assessment has been neglected under the pressure of economic development.

"One of the most important social determinants of health is environment issue. It needs to say that environment (in Viet Nam) has been influenced seriously".

(Donor representative)

"I think the most important factor influence the health is environment."

(*DecisionMaker3-Health)*

Also, in some provinces, especially in the provinces in the central region of Viet Nam, environmental pollution is considered as one of the most important social determinants of health. The major cause of this problem was originated outside of Viet Nam – during the American war. Bombs, mines, and other explosive materials still remaining underground killing and injuring people living there. In addition, the health of people is seriously affected by a lot of herbicides (e.g. Agent Orange) used during the war in the areas.

- *Living conditions*

Other social factors related to living conditions such as food safety, water and sanitation and health care services were also identified by the respondents as the most important social determinants of health in Viet Nam currently. Food safety is an alarming problem in Viet Nam now. Through mass media, it is known that high levels of chemical contaminated in many types of food, especially fruits and vegetables, could have a bad effect on human health. Many collective food poisonings in factories or industrial zones in Viet Nam have also been reported.

"I think the most important factor is environment factor. The environment here means food safety."

(DecisionMaker3- Health)

"In Viet Nam, food safety is the most important factor"

(Donor representative)

"I think the most important social determinant of health in Viet Nam now is living condition. For example bad sanitation, bad nutrition, living environment (dust, wastes) created bad effect to our health."

(NGO leader1)

Water and sanitation is another problem influencing the health of people:

"..in the Mekong Delta, clean water is a problem while in areas near industrial zones, it is the waste water".

(Donor representative)

- *Urbanization - Transport – Injury*

According to some respondents, rapid urbanization and other relevant social factors have been creating bad effects on people's health. Thus, they were identified as the most important current social determinants of health in Viet Nam. Parks, trees and traditional markets became fewer and fewer as more space was reserved for commercial buildings and residential areas. Rapid urban growth created pressure for the infrastructure of many cities. In Viet Nam, transport became a serious problem and injury and death due to traffic are major problems. Poorly planned urbanization was attributed as the main cause of the problem. The transport sector and the government paid great attention to this, and many solutions and measures were implemented. However, transportation and injury remain as a big problem in Viet Nam, directly influencing people's health.

> *"If I have to choose which one is the most important social determinant of health, I think about injury and relevant factors since it (injury) have great association with transportation and urbanization as well as people's behavior."*
>
> *(*A researcher/post-graduate lecturer)

Significant economic development in the last two decades has make the gaps between the rich and the poor become wider and this issue was identified by respondent as an important social factor influencing health and is the cause of health inequity in the country.

> *"The gap between the rich and the poor, the adverse side of the market economy, is getting wider and is affecting people's health… For example, the poor has more difficult in accessing the health care services"*
>
> (WHO expert)

- *Poor Health Care Services*

Patient overload at the hospitals in the cities have been a pressing issue in Viet Nam. The public health system in Vietnam, including central, provincial, district and commune (village) levels, has been established for a long time and has made some great achievements in the past in preventing certain communicable diseases such as trachoma, dengue fever, diarrhea etc. However, with economic development, disease patterns change, and infectious diseases declined while that of non-communicable diseases is increasing. The health care facilities at all levels (district, commune, and sometimes provincial) do not meet the health care needs of the people due to the lack of good doctors, essential equipment, and facilities degradation. As a result, patients from different provinces rushed to hospitals in big cities seeking for better medical services. The private health system has been formed in the last decade but this system is not enough to meet the health care needs of the people, again because of the lack of qualified medical doctors (who mostly come from public hospitals). Moreover, the cost of health care in private facilities is very high compared to the income of general Vietnamese people. Therefore, medical services have a serious and direct impact on Vietnamese people's health today.

iii. Gaps in knowledge and action about SDH in the country

The document review and results from the interviews with leaders of different sector in society revealed that social determinants of health in Viet Nam are still new and have not received appropriate attention as they deserve. Generally, knowledge on social determinants of health of the respondents is limited and biased. It is perceived that since the issue is human health, it is the job of the health sector to take care of things.

> *"In conclusion, the biggest obstacle is the awareness of the decision makers regarding social determinants of health. They normally think that health is the responsibility of the health sector, and they do not know that health is also strongly influenced by many other sectors."*
>
> *(*A researcher/post-graduate lecturer)

Meanwhile, people in health sector mainly focus on issues related to the health care system and the access to health care services.

> *"In general, the most important social determinants of health is ..health insurance, and the most important actor is the health sector. Health sector is active to take care of people's health*
>
> (DecisionMaker4-Health)
>
> *"The most important social determinant of health is health policies. It is very important"*
>
> (DecisionMaker1-Health)

To answer the question "*Do you think that the social determinants of health are seen as politically important here*", most of the respondents think social determinants of health have not been seen as politically important in Viet Nam. People (government officials or government in general) might do a lot of work and implementing big programs that are relevant to addressing the social determinants of health, such as hunger elimination, poverty reduction, and universal education. But they did those with other purposes, for example, to fulfill their duty in implementing the government policies, or to improve the life of poor people toward achieving social justice, and they did not think that these programs may also help address social determinants of health.

> *"No, most of them do not know that what they do influences the health. They do it for other purposes"*
>
> *"..people can see the unemployment, urbanization.. but do not link those with health"*
>
> (WHO expert)
>
> *"Actually, I think it is not. Each factor may be considered as politically important. For example, people see urbanization, land, transport.. as politically important factors, but they did not link them with health. Instead, they link them with other problems under pressure from society"*
>
> *(*A researcher/post-graduate lecturer)

In general, Vietnamese people lack awareness in regard to the social factors influencing their health. In a number of cases, people (including government officials) living near industrial zones know that waste water is not good for their health but did not report it, even if they have the chance. The government at those areas may also know about the environmental pollution, but since the industrial zones bring jobs and investment to that province/district, and since they think that the pollution is not serious, they did not do anything about it.

".. People did not participate (in addressing the environment pollution). Instead, they let it pass. It is because that they see the benefit in short term. This is an obstacle and this obstacle is due to lack of knowledge"

(DecisionMaker3- Health)

Currently, there are not so many studies on social determinants of health in Viet Nam. For example, studies such as "assessing the impact of urbanization and traffic to the health of different population groups in society" is still rare. Information from available relevant studies did not meet or suitable with the need of policy development in Viet Nam. Besides, findings from the available research on social determinants of health have not been brought to the decision makers and policy makers. One of the reasons was that there was lack of or no connection or discussion between the researchers and policy makers to find out the evidence and data needed before undertaking research. On the other hand, it seems that in many cases, the purpose of doing research and writing articles was simply to publish them in relevant science journals or to use them in academic teaching. Therefore, the findings were not used as evidence for policy development. Also, in some cases, policies were developed not based on evidence. Instead, they were developed according to the understanding of the policy makers.

"The policy makers develop and adopt policies but do not base much on evidence"

(WHO expert)

"Now people use the term "evidence-based policy" a lot, but in fact, it isn't so.."

(NGO leader 2)

"Actually, there is no obstacle. The important thing is that researchers need to provide the evidence that managers need.."

"In many cases, we do not know about things (evidence) done in the world or things done by researchers.."

(DecisionMaker1-Health)

Coordination among different sectors is vital in addressing social problems requiring the involvement from many sectors. According to the respondents, the coordination in Viet Nam in addressing specific diseases or social problems is still weak and ineffective. In Viet Nam, in order to address HIV/AIDS, a steering committee with members from relevant ministries (sectors) such as health, transportation, policy, social affair, education, etc. was established, and the health

sector is the leading agency. However, HIV/AIDS is still a problem, and the coordination has not been very effective. Another example is about injury. Injury, especially injury due to transportation, is considered as a leading killer, a serious health problem now in Viet Nam. However, there is still no coordination committee[32].

"It is needed to find a unit or an agency acting as leading agency to coordinate or educate people on social factors influencing health "

*(*A researcher/post-graduate lecturer)

"It is needed to have a qualified competent body to do this (SDH)

(DecisionMaker3- Health)

"Not only the health sector, but also other sectors want to collaborate to avoid overlap.."

(DecisionMaker1-Health)

Currently, there is no SDH Department or specific staff assigned for this work at WHO Viet Nam office or within other Civil Societies in Viet Nam (or elsewhere in Viet Nam). This reflects the lack of attention and understanding toward SDH in Viet Nam. There is also a difficulty in raising awareness of Vietnamese leaders regarding Social Determinants of Health, and there is no good linkage between the SDH researchers and the Vietnamese policy makers.

In summary, respondents' knowledge on SDH is very limited and bias depends on their occupation and the sectors they belong to. While decision makers thought that SDH was mostly related to policies and regulations relevant to their work, researchers/post-graduate lecturers in the field of Public Health in Vietnam understand this term more generally since they use it in their teaching or research. Lack of studies assessing the impacts of social problems on Vietnamese' health and weak coordination in addressing them were also identified as the gaps in action about SDH in the country. There were many SDH identified by the respondents; however, the most important ones were: Policy factor, Environment conditions, Living condition, Urbanization-Transport-Injury and Poor health care services. Overall, there is a big gap in knowledge and action about SDH in Vietnam and still, it is not getting enough attention.

8. Conclusions and recommendations

In conclusion, the findings from the literature review show that there is still an important and persistent degree of inequality in Viet Nam, including morbidity and mortality inequalities between different socioeconomic groups, health inequality in maternal and child mortality, inequality among men and women, lifestyle, chronic disease, and injury. Policy factors, environmental conditions, living conditions, rapid economic development and urbanization, transport injury, and poor health care services were identified as the most important social determinants of health in Vietnam.

In Vietnam, SDH requires involvement from multi-sectors. A lot of parties play an important part in action on SDH such as Central Government, Ministry of Health, Ministry of Labor, Invalids and Social Affairs, Ministry of Finance, Health Insurance sector as well as civil society organization and NGOs. Though the concept of SDH has not been clear in Vietnam, there is some SDH work on-going in this field. Relevant SDH policies have been implemented, such as health insurance supported by the Government, free health care for children under 6 years old, health care for the poor and near-poor, helmet law, and the goal to achieve universal health insurance coverage by 2014. However, there is still a big gap in training, knowledge and action on SDH in Vietnam.

Generally, knowledge on social determinants of health of the respondents is limited and biased and SDH is not taught as a separate subject in public health schools. Coordination among different sectors is vital in addressing social problems requiring the involvement from many sectors. However, according to the respondents, coordinating issues in Viet Nam in addressing specific disease or social problems is still weak and not effective.

This final section brings up some recommendations based on the findings from this study on how to address the gaps in knowledge and action about SDH in Vietnam. In order to address social determinants of health, many measures and activities are needed. Since the Commission on Social Determinants of Health was established within WHO, there have been a lot of good guidance for different countries to address SDH. Big and small conferences have also been organized throughout the world to discuss about SDH issues. In the scope of this report, ISS Viet Nam will focus on proposing recommendations on how to address the SDH gaps in Viet Nam, as presented above. Specifically, recommendations will focus on the main parts as follows:

- How to fill the gaps in knowledge and awareness about Social Determinants of Health of decision makers, policy maker and Vietnamese people
- How to bridge the gap between researchers and decision maker
- As a training and academic institution, how to participate in the actions addressing social determinants of health in the country.

In addition, ISS Viet Nam will also present some potential challenges when tackling these gaps. The recommendations are provided based on the ISS's personal understanding after reviewing relevant documents and analyzing the interviews.

i. How to fill the gaps in knowledge and awareness about SDH of decision makers, policy makers and Vietnamese people?

In this section, several gaps were identified:

- The Concept of Social Determinant of Health was understood differently by different respondents (leaders and policy makers) in different sectors. Respondents' understanding on social determinants of health was limited and also biased by their occupation and the sectors they belong to.
- In general, Vietnamese people lack awareness in regard to the social factors influencing their health

To address these gaps, the following recommendations are proposed:

Improve knowledge and awareness about SDH of Vietnamese decision makers

In general, training is needed to improve knowledge. However, improving knowledge of Vietnamese leaders on social determinants of health is not just about providing training. It is because SDH is very much relevant to policies, and that the potential trainers are decision makers or policy makers. Thus in order to provide training to them, the training institution has to have good understanding on Vietnamese political structure, the policy process and policy development needs, and a good approach strategy. Only by doing so, the training could be effective and sustainable.

The approach strategy requires that the training institution needs to have good "legal" status in Viet Nam, and is eligible to work or to provide training on SDH, especially for the leaders. For foreign agencies such as International Non-Governmental Organizations or foreign training institutions, good legal status requires them to have a representative office or project office in Viet Nam, or even more important than that, they need to have a partner in Viet Nam working on a specific project. Specifically, in the field of training on social determinants for Vietnamese leaders, the best Vietnamese partner for a foreign training institution is National Political and Administrative Academy Ho Chi Minh (NPAA).

The National Political and Administrative Academy Ho Chi Minh (NPAA) is one of the country's leading research and teaching institutions. With its network of political schools on the national and provincial level, almost every public or political official undergoes training at the NPAA. The

academy has collaborated with local NGOs and UNDP for projects to train for leaders of Viet Nam on, for example, HIV/AIDS or public management. Similarly, SDH training institution could have collaboration with the Academy on specific training. The advantage of this approach is that the training projects could be implemented throughout the country and many leaders will attend the trainings.

Ha Noi School of Public Health (HSPH) could also be a good Vietnamese partner. Although it is entitled as "school" in English, in Viet Nam, it is a university. It was established in 2001 and is the first and the only public health university in Viet Nam so far. As a public health university, it is eligible enough to provide training on SDH. Since curriculum on SDH is still very limited, supporting HSPH to develop a proper and good SDH curriculum could be a good project. Once the curriculum is ready, HSPH could use it to organize different SDH courses for students or decision makers. Nonetheless, whether the trainees (leaders) will attend the training or not is a question. Similarly, Institute for Preventive Medicine and Public Health (belong to Ha Noi Medical University) could also be a good partner for SDH training.

Although the WHO Viet Nam office has not had a separate SDH department, contacting them and discussing the issue of training on SDH in Viet Nam is necessary. WHO has a good reputation in Viet Nam and has "power" to work with Vietnamese leaders and sectors. However, for most of the health-related projects in Viet Nam, WHO just provides technical support in the field, and does not act as an implementing agency. They also need a Vietnamese partner who actually implements the projects. Also, since WHO Viet Nam does not have SDH department and staff assigned for SDH, the importance they attach to this field is unknown.

Besides training, conferences or workshops on social determinants of health should be organized to raise awareness of Vietnamese decision makers. The workshops and conferences are the chances to provide to the leaders and other participants with the concepts of social determinants of health, and listen to them on the social factors and relevant problems influencing Vietnamese health. In order to organizing such conferences and workshops, training institutions should collaborate with local partners.

Raising awareness among Vietnamese people on social determinants of health

In Viet Nam, raising awareness for the population is normally done though communication programs or specific raising awareness projects in the communities. In regard to raise awareness on SDH, it should be focused on the areas where social factors are likely to influence people's health the most. For example, programs should focus on urbanization – transport injuries in big cities, or environmental pollution in the Mekong Delta or in areas near industrial zones. Civil society is an essential partner in doing this type of work.

In summary, in order to fill the gaps in knowledge and awareness about Social Determinants of Health of decision makers, policy maker and Vietnamese people, there is a need for:

- Providing training for policy makers. To do this, collaboration with National Political and Administrative Academy Ho Chi Minh (NPAA) is recommended. Other alternatives Vietnamese partners to conduct SDH training are: HSPH, WHO, HMU.
- Collaborating with civil societies to implement communication programs or specific raising awareness projects in the communities.

ii. How to bridge the gap between researchers and decision maker?

Linking researchers and decision maker needs a sound understanding on the process of policy formulation. In Viet Nam, key policy issues are identified and overall directions are set largely by Party agencies. In each five-year legislative period, the key Government documents – the Resolutions of the Party National Congress – sets the framework for policy directions, in the form of Resolutions and Instructions. The National Assembly approves major legislation, in the form of Laws, and Resolutions. The Prime Minister and the Government will assign the sector ministers and functional departments of the ministries to draft the legislative documents.

The drafting of legislation involves i) advice and consultation with ministries and local departments and ii) the establishment of a committee of editors (mostly experts from ministries and other state bodies) for the drafting and criteria setting of the legislation. Pursuant to ratification by the National Assembly, the Government and Prime Minister will then issue decrees, decisions and instructions, and the sector ministers issue specific decisions and circulars to put them into action. However, the real impact of new legislation usually does not lie in the overall or original policy statement, but in these follow-up guidelines and instructions. After the issuance of the original policy documents, the follow-up legislation is through inter-ministerial circulars that give detail, for instance, to the planning guidelines and financing strategies[33]

The above policy formulation process reveals that depending on the specific subjects (or SDH), researchers should make contact with the relevant sectors (ministries). It is also clear that research work should include policy makers in the process from the onset. Experience shows that researchers should not contact decision makers individually, but rather that the evidence should

be provided to decision makers by an organization such as civil society, research institutions, or ideally, the leading government organization in the field. Before conducting any SDH research, research institutions need to stick to the real life and the daily happenings of the social problems influencing the health to determine the specific SDH they want to address. Once the social problem is determined, they need to establish which sectors, departments or even individuals have responsibility in developing the relevant policies, as mentioned above. After that, it is very important that the research institution makes contact to discuss with relevant individuals, departments and sectors on the collaboration opportunities in the research process. Research institutions need to establish and maintain relationships with people in these sectors and departments. By doing all these activities, it is much more likely that the evidence (the research findings) will contribute to the policy development.

In summary, in order to bridge the gap between researchers and policy makers, there is a need for;

- Co-operating with other organization such as civil societies, institutions, leading government organizations in the field
- Conducting further specific research on the most important SHD need to be addressed in Viet Nam and identifying and contacting relevant sectors/departments and individuals before actual implementing any relevant study.
- Integrating the research work into policy formulation process from the onset

iii. As a training and academic institution, how to participate in the actions addressing social determinants of health in the country?

Actions addressing SDHs in the country involve different sectors and institutions. There are several ways for training and academic institution to participate in these actions. However, one important thing is that any foreign training institution should collaborate with a partner in Viet Nam in order to find the avenue for social determinants of health to reach decision makers and the government. Besides the potential Vietnamese partners identified above (NPAA, HSPH, WHO, HMU etc), civil society organizations could also be very good partners to help training and academic institutions in addressing the social determinants of health in the country. The information below illustrates the roles and may suggest opportunities for any SDH training institution to participate in actions to addressing social determinants of health in the country.

In Vietnam, the term "civil society organization" is understood to cover three different types of organizations: (1) mass organizations, such as Vietnam Fatherland Front, the Youth Union, the Women's Union, the Farmers' Association, etc.; (2) Professional associations, such as Vietnam Public Health Association, Vietnam Family Planning Union, etc. and (3) Vietnamese and international NGOs. Mass organizations have historically served as avenues for the government to communicate with key social sectors in Vietnam. The mass organizations are considered part of the political system, as mediators between the grassroots and the political center. They have direct formal dialogue with the government and direct influence in the National Assembly. However, due to the close alliance of mass organizations with the Government, their autonomy to challenge Government policies is limited.

In the context of Vietnam, NGOs are identified as one of the institutions or components of civil society. They are divided into two categories: Vietnamese and international. International NGOs are focusing their programs on poverty alleviation and capacity building. They support local mass organizations and often target the grassroots level. Although the role of these NGOs is increasingly important in service delivery, their voices are heard only in public meetings or through local politicians.

Vietnamese local NGOs belong to independent networks and are relatively new to Viet Nam. Many Vietnamese NGOs work on poverty reduction and health care. Their impact on social policy may often be indirect and fairly limited. However, there have been good connections between Vietnamese NGOs and government/party agencies. This helps them to overcome bureaucratic processes.

Since few civil society organizations in Viet Nam have separate SDH departments (and in fact SDH department has not been existing anywhere in Viet Nam), there has not been any project specifically on SDH. Nonetheless, based on their roles, their program focus and as said by a NGO leader, *"In general, it (SDHs) integrated in all our programs.."* there are potential rooms for SDH research training institution to collaborate with them in conducting research or assessment on specific social factor(s) influencing people's health.

The following is an example of a successful participation from a local NGO in policy development. The development of the National Plan for Safe Motherhood took place in 2003. Funding for this process was granted by the Royal Netherlands Embassy. According to formal government policy procedures, the technical policy should be developed by a technical agency. Therefore, the Reproductive Health Department was assigned by the MOH to take the lead in this process. During the development phase, a field assessment on safe motherhood was conducted in health facilities at provincial, district and commune levels in seven selected provinces representing seven ecological regions of Vietnam. Results were disseminated and utilized for developing strategies in

the National Plan for Safe Motherhood by the Reproductive Health Department policymakers. This survey was implemented by a Vietnamese NGO whose representative had extensive experiences in the safe motherhood field in Viet Nam. The survey was designed and its results were analyzed in the light of WHO guidelines on "Needs Assessments for Safe Motherhood" and lessons learnt from some other surveys on health services in Vietnam. The results were presented in three regional workshops and revealed the poor service delivery of safe motherhood services in the country, particularly in remote areas. Different respondents confirmed that the study was utilized to develop the National Plan for Safe Motherhood. [33]

According to the Reproductive Health Department policymakers and the researchers, the field assessment study was credible. The credibility was supported by its use of WHO guidelines, lessons learnt from other studies in Vietnam and high representativeness of different regions in Vietnam. Furthermore, the results were believed to be reliable since the study received MOH supervision during implementation. These were the main reasons to explain why the results were used for development of the National Plan for Safe Motherhood.

Successful participation of the Vietnamese NGO in developing the National Plan for Safe Motherhood again confirm that: (i) there are potential opportunities for SDH research and training in Viet Nam; (ii) research should be a part in the policy formulation process from the onset and (iii) the collaboration between the research institution (for example a local NGO), WHO (provide technical guidance), and the assigned government department is very important in any policy-related development project.

In summary, for a training and academic institution to participate in the actions addressing social determinants of health in the country, there is a need for;

- Understanding on Vietnamese political structure, the policy process and policy development needs, and a good approach strategy.
- Collaborating with a partner in Viet Nam to find the avenue for social determinants of health to reach decision makers and the government.
- Partnering with civil societies in Viet Nam to conduct trainings and research on SDH in the community. Collaborating with others Vietnamese potential partners include: NPAA, HSPH, WHO, HMU for the training for leaders, policy makers and other academic trainings.

iv. Challenges:

There are a number of potential challenges can be seen in tackling the gaps in knowledge and actions about SDH in Viet Nam presented above.

- Viet Nam has achieved significant economic development in the last two decades and just became lower-middle income country. The government and people are now striving hard to keep the pace of that economic development. Therefore, social determinants of health such as the environment sometimes receive less attention than economic development.

- SDH is very broad and need the involvement from many different sectors (if not all), and addressing it needs a lot of time and resources while in Viet Nam, there are many problems in priority. Implementing any SDH work also means creating more work and responsibility for sectors and for government officials. Thus, this may not receive "real" support from them. Maybe, for some reasons such as to follow directions from the higher government, they have to do it, but it is questionable whether they will do it properly.

- There is a lack of qualified human resources in the Vietnamese government organizations. Thus, assignment of suitable official to work mainly on SDH project is difficult. In government organizations, a qualified official has a lot of responsibilities. This could cause delays in developing and implementing SDH projects.

- In Viet Nam, in most cases, disease prevention is only implemented once the problems occur, and disease prevention work is just to prevent the spread of disease. For example, when food poisoning occurs, food safety issues are discussed. This is a habit and a common perception of people and of a lot of decision makers. Hence, it can cause difficulties in the implementation of cooperation projects in the field of SDH with Vietnamese agencies.

- SDH documents are very scarce in Viet Nam. Document review and interview revealed that currently, there is only one Social Determinants of Health document used in teaching at the HSPH. This document is actually a curriculum unit (belong to the health promotion subject) composed by lecturers at the HSPH based on foreign documents on SDH. This might be an opportunity for a SDH training and research institution to collaborate with the HSPH in developing SDH curriculum, but it could be a disadvantage since it may take a lot of time and resources in order to implement any SDH training courses at this university (or even in Viet Nam).

- There is no SDH committee within WHO in Viet Nam. Since SDHs are very much related to policy, if even WHO has not paid appropriate attention on this issue, it would be very difficult to approach high ranking officials in Viet Nam on this issue.

- As with other work, starting to do work on social determinants of health may take a lot of time and resources, especially in Viet Nam, where bureaucracy in government organization is considered still high.

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Annex 1 – Curricular Review on SDH training in Vietnam (Post Graduate)

Name of Partner	Name of SDH-related course	Format of course (e.g. face-to-face; online, self-study, etc)	Name and contact details of course organizer	Topics covered in the course	Core course literature
Ha Noi School of Public Health					
• **Faculty of social Science, Behavior and Health Education**	Master of Public Health Program Subject: Health Education and promotion	Face to face	Dr Truong Quang Tien Emai: tqt@hsph.edu.vn Office tel : (844) 6266 2321	Learning objectives: • Understand the core concepts relevant to health promotion. • Could analyze determinants of health and health promotion strategy. • Could apply the theories of change to analyze, estimate, predict the possibility of behavior change and the solution to change behavior • Could analyze and choose appropriate approaches, solutions for health promotion programs. • Could develop indicators to evaluate health promotion program. Contents of the course: • Introduction	**Text books:** • Information book – HSPH • Social Science and Health Promotion • Ottawa chapter 1986 and Bangkok chapter 2005 regarding Health Promotion of WHO • Determinants of Health (this document is selected translated from foreign language books) Readings: • David Armstrong (2003). *Outline for application sociological approach on health*. • Development Trends 2005 sofware (source: www.gapminder.org/Human) • Jenie Naidoo, Jane Wills (2000), *Health Promotion- Foundations*

				• Theories of change • Health Promotion Approach • Health Promotion Strategy • Develop plan for health promotion programs • Practice, exercise	*for practice.* • Karen Glanz et all (2008). *Health Behavior and Health Education*. Theory, Research and Practice, 4th ed, published by Jossey-Bass. • National Academy of Sciences (2001). *Health and Behavior*: The Interplay of Biological, Behavioral, and Societal Influences. PDF version at http://www.nap.edu/catalog/9838.html • Nutbeam, D. and Harris, E., (2004). *Theory in a Nutshell,* A Practical Guide to Health Promotion Theories. Mc Graw – Hill Australia Pty Ltd. • WHO(2006), Health Promotion – Book regarding health promotion in primary health care. (Book already translated into Vietnamese) • VicHealth (2003). Integrated Health Promotion resource kit. • WHO (2003). *Social determinants of health*: *10 solid facts*.
Ha Noi Medical University					
Institute for Preventive Medicine and	Master of Public Health	Face to face	Head of the Institute: Dr. Truong Viet Dzung Vien Y hoc du phong va Y		

Public Health			te cong cong Add: Số 1 Tôn Thất Tùng - Đống Đa - Hà nội Điện thoại : 84.4.8523798 - Fax 84.4.8525115 Email: daihocyhn@hmu.edu.vn		
•	• Subject: Occupational Health	• Face to face	• Occupational Health Department	• Health care strategy for worker • Working environment and solutions to control • Noise and occupational deaftness • Dust in working environment and silicosis • Management of hazards that are chemical elements • Management of hazards that are biochemical factors • Management of chemical plant protection and agricultural labor • Physical and mental issues in working environment	• Occupational Health, Medical Publishing House 1998 (postgraduate curriculum: CKI, Higher Education, Preventive Medicine) • Occupational health, Medical Publishing House 1978 (university curriculum) • Occupational Disease, Volume 1.2 - Medical Publishing House 1982 • Epidemiology of medical workers, document translation • Manual labor clinical medicine. Translated documents • Regular Technical regulations - Labor Medicine - Sanitation - School Health - Medicine Publisher 2002 • Mc Donald, J.C. (ed) (1981) Recent Advances in Occupational Health, Churchill Livingstone, Edinrbergh. • Phoon, W.O (1973) (ed) Manual

					on Occupational Health and Safety, National Safety First Council, Singapore. • Phoon, W.O and Chen.P.C.Y (1996). Textbook of community Medicine in South-East Asia.
	Subject: Anthropology and sociology with medical problems and health (This is a selective subject)	Face to face	Medical ethics and medical sociology Department	• Outline the of anthropology and sociology with medical problems and health: some basic concepts in anthropology and sociology • The relationship between anthropology and sociology and public health approach (epidemiology) • The cultural and social determinants of health; the role of inequality and social stratification, networks and social capital, gender issue and cultural characteristics of ethnic groups • Influences of cultural and social development on health: the role of urbanization and migration, globalization, and economic policies for social development • Expose to disease and illness from the perspective of anthropology: power, beliefs, political economy and health-	• Hanne O. Mogensen et al. Enter the subject of social anthropology in the context of Vietnam: A study on gender and reproductive health in coastal areas north central part. Statistics Publishing House: Hanoi. 2005 • Hanoi Medical University. Medical Sociology, Medical Publishing House: Hanoi. 2002 • Peter Conrad (ed). The Sociology of health and illness: critical perspectives. 8th edition. Worth Publishers: New York. 2009 • Michael Marmot and Richard Wilkinson (eds). Social determinants of health. 2nd edition. Oxford University Press. 2006 • Robert Hahn. Sickness and healing: an Anthropological perspective. Yale University Press: New Haven. 1996 • Peter Brown and Ron Barrett. Understanding and applying the medical anthropology. 2nd

				seeking behavior • Social structure features of medical and health care • Social structure features of medical and health care: physician and socialization of medicine in the West and the East • Research methods in medical anthropology and sociology (social epidemiology)	edition. McGraw-Hill Publication: New York. 2009 • J. Michael Oakes and Jay S. Kaufman (eds). Methods in social epidemiology. Joessey-Bas Publisher: San Francisco. 2006
	Subject: Social Determinant of Health (Since the Master program is shorten from 2 years to 18 months (according to the Ministry of Education), this subject may have to be integrated with other subject. However, currently, it is still a selective subject)	Face to face	Environment health Department	• Methods of analysis problems. Pattern of Social Determinants of Health • Factors of peace, justice and sustainable development • Elements of health services • Cultural and social factors, lifestyle • The involvement of communities in health care • Health promotion • Environmental factors	• Ann Linstrand, Staffan Bergstrom, Hans Rosling (2008). Global Health. Karolinska Institute. Sweden. • Michael Marmot, Richard Wilkinson (1999). Social determinant of health. Oxford University Press • Ministry of Health (2008). General overview report of the health sector in 2007. Medical Publishing House • Dao Ngoc Phong (1997). Lecture on environmental health oriented. Medical publishers.
HCMC Medical University					
• **Faculty of Public Health**	Master degree Specialty 1 – Public	Face to face	HCM City Medical and Pharmaceutical University	**Master Degree** Epidemiology	- Family Planning: A global handbooks for providers

	Health (*) Specialty 2 – Health Management (*) (This kind of course is post -graduate training in medical schools in Viet Nam. Specialty 2 is higher level than specialty 1)		Faculty of Public Health 159 Hưng Phú, Phường 8, Quận 8, TP.HCM Tel: (84 8) - 38559714 - 39540034 Fax: (84 8) - 38597965 Email: vanphongkhoaytcc@ump.edu.vn	Bio-statistic Health Promotion National Health Programs Environment Health Health Management Demography Public Health Health Economics Preventive Medicine Public Health Research Methodologies **Specialty 1 – Public Health** Biostatistic Demography Health Promotion Microbiology, Parasite Epidemiology Information technology Applications Health Economics National Health Programs Environment health Health Management Preventive Medicine Public Health **Specialty 2 – Health Management** Advanced Biostatistic Biostatistic Demography Health Promotion Microbiology, Parasite	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs and World Health Organization. Published 2007 - Full Report: UNDP in Action 2009/2010: Delivering on Commitments - Manage and Organize the Health System (Vietnamese book) - Regional Analysis Sex ratio - Environment Health - Revision documents on Manage and Organize the Health System - Manage, organize and Health Policies - Vietnam Population General Census 2009 - Sex Ratio in Viet Nam in recent years - 2009 - USA life tables 2004 - Women and Health 2009 - World Population data sheet 2010

				Advanced Epidemiology Advanced Information technology Applications Health Economics Nutition and food Preventive Medicine National Health Programs Environment health – occupational health Health Management Public Health Methods for research healthcare system.	
Hue Medical School					
• **Faculty of Public Health**	**Master Degree** Specialty 1 – Public Health (*) Specialty 2 – Preventive Medicine (*) (This kind of courses is post -graduate training in medical schools in Viet Nam. Specialty 2 is higher level than specialty 1) **Subject:** • Health Promotion and Psychology in Health Education	Face to face	A/Prof. Vo Van Thang M.D., M.P.H., Ph.D Head of Dept. Biostatistics, DemographyReproductive Health Dean, Faculty of Public Health Hue College of Medicine and Pharmacy 06 Ngo Quyen Street, Hue city Thua Thien Hue province, Vietnam Fax: 00-84-54-3826019 Office tel: 84-54-3883711	- Public Health and Social Science in Health - Health behavior Science - Violent abuse in family - Stress - Anthropology and health - Health Economics	Books and documents: Introduction - Social Science in Health and Public Health (Vietnameses) Social Determinants of Health and Health Promotion (Vietnamese) Anthropology Reproductive Health – Population – Health Planning and Health Economics

	• Demography – Reproductive Health • Nutrition Health Management				

Annex 2 - Social Determinants Country Needs

No.	Reference/title of article	Name of contact details of first (or other main) author	Objective of study	Methods	Findings	Recommendations
[19]	**Health equity in Vietnam – A situational analysis focused on maternal and child mortality**	http://www.unicef.org/vietnam/resources_12860.html	This situational analysis provides estimates of the degree of inequality in both maternal and child mortality and other high-level maternal and child health outcomes causally related to maternal and child mortality, including child morbidity, children's nutritional status and fertility	The main data sources used in the situational analysis include three household surveys, i.e., the 1992/93 Vietnam Living Standards Survey (VLSS), the 2006 MICS III and the 2006 Viet Nam Household Living Standards Survey (VHLSS), and province-level data from the MOH Health Information System (HIS) and other sources. Both early estimates for 1992/93 and recent estimates for 2006 of inequality are presented and compared. In addition to inequality estimates, the situational analysis presents the results of regression analysis used to identify the underlying factors, such as age, sex, education, income,	The findings of the situational analysis confirm that there is still an important and persistent degree of inequality in several high-level maternal and child health outcomes and that these inequalities are matched (or even exceeded in some cases) by the degree of inequality in several causally related intermediate outcomes (for example, immunization). The factors contributing to the observed inequality include both demand-side factors (i.e., the household's "permanent income," adult schooling, and ethnicity) and supply-side factors (i.e.,the accessibility and quality of locally available health services).	An effective strategy to address the remaining inequalities in maternal and child mortality should include both demand-side and supply-side interventions targeted to the poor, many of whom are ethnic minorities residing in remote localities.

				urbanization and ethnicity that are most closely associated with these outcomes. The observed inequalities are also decomposed in order to quantify the contributions made by the various underlying factors to the observed inequality		
[28]	**Health Equity in Viet Nam: A Civil Society Perspective** **Content of the report includes:** - **Introduction** - **Int'l Definitions and Health Equity Indicators in Viet Nam** - **Assessing Equity in Health Financing in Viet Nam** - **Equity in Health Care: Patient Perspectives** - **Promoting Health Equity in Viet Nam; The roles of Civil Society**	• Hannah Olson – Independent Consultant. Email: hannahcreeklson@gmail.com • Hoang Tu Anh – Center for Creative in Health and Population. Email: tuanh@ccihp.org • Hoang Van Minh – Ha Noi Medical University. Email: hvminh71@yahoo.com • Le Bach Duong • Le Minh Giang • Mai Khanh Linh • Nguyen Mai Huong • Tran Hung Minh • Tran Thanh Huong	To do research that inform policies and programs.	This report consists of a number of sections. Therefore, it employed different methodologies	The report's finding is varies since it focuses on different critical issues. Please see the report for details	The report based on extensive consultations between PAHE (Partnership for Action on Health Equity) with health system stakeholders. Although the report is very informative and some of the authors are prominent in the field of community development in Viet Nam, it reflects the views of the authors only. Please see the report for details

		(Please see the hard copy report for contact details).				
[20]	**Inequality in mortality in Viet Nam during a period of rapid transition**	Nguyen Thi Kim Chuc, Faculty of Public Health, Hanoi Medical University, Viet Nam	In this paper, the associations between socioeconomic variables and mortality for 41,000 adults in Northern Vietnam followed from January 1999 to March 2008 are estimated using Cox's proportionally hazard models.	The authors use decomposition techniques to investigate the relative importance of socioeconomic factors for explaining inequality in age-standardized mortality risk.	The results confirm previously found negative associations between mortality and income and education, for both men and women. The paper also found that marital status, at least for men, explain a large and growing part of the inequality. Together these results suggest that positive spillover effects of education exists, that is, you benefit not only from your own education but also from that of those around you.	This research's results warrant further research, however, since only two of these hazard ratios are significantly different from unity at conventional levels.
[1]	**Social Determinants of Health and Tobacco Use in Thirteen Low and Middle Income Countries: Evidence from Global Adult Tobacco Survey**	Krishna M. Palipudi, Centers for Disease Control and Prevention, Atlanta, Georgia, United States of America, E-mail: kpalipudi@cdc.gov (There is no Vietnamese author listed in the list of authors in this study)	The objective of this study is to examine the role of social determinants on current tobacco use in thirteen low-and-middle income countries	The study used nationally representative data from the Global Adult Tobacco Survey (GATS) conducted during 2008–2010 in 13 low-and-middle income countries: Bangladesh, China, Egypt, India, Mexico, Philippines, Poland, Russian Federation, Thailand, Turkey, Ukraine,	For educational level, the trend was significant in Bangladesh, Egypt, India, Philippines and Thailand demonstrating decreasing prevalence of tobacco use with increasing levels of education. For wealth index, the trend of decreasing prevalence of tobacco use with increasing wealth was significant for Bangladesh,	These findings demonstrate a significant but varied role of social determinants on current tobacco use within and across countries

				Uruguay, and Viet Nam. These surveys provided information on 209,027 respondent's aged 15 years and above and the country datasets were analyzed individually for estimating current tobacco use across various socio-demographic factors (gender, age, place of residence, education, wealth index, and knowledge on harmful effects of smoking).	India, Philippines, Thailand, Turkey, Ukraine, Uruguay and Viet Nam. The trend of decreasing prevalence with increasing levels of knowledge on harmful effects of smoking was significant in China, India, Philippines, Poland, Russian Federation, Thailand, Ukraine and Viet Nam.	
[34]	**Social Determinants of Health in Viet Nam**	Le Hoang Ninh – Editor Institute of Hygiene and Public Health 159 Hưng Phu, P.8, Q8, TP.HoChiMinh Tel: (84-8) 8559503 - 8559719 Fax: (84-4) 8563164	The objective of this study is to review relevant social determinants of health in Viet Nam	All national and international papers related to social determinants of health from textbooks, journals, internets were collected and documents were classified and reviewed by topic.	Although Viet Nam is poor, its vital health indicators are comparable to those of middle-income countries. Linear regression analysis shows that there was a relationship between GNP per capita and the life expectancy at birth, infant mortality rate. There are positive relationship between life expectancy and GNP per capita and negative relationship between IMR and average income per person/ per month. There is	The study explores the relationships between social determinants and health status of population. To improve the health of Vietnamese, we need to take into account not only health determinants but also social determinants of health, especially economic development, education, housing, employment, and

					a strong relationship between mother's education and children mortality. Those mothers with no education will have a higher mortality rate of their children. Health insurance scheme affects population health, especially the poor. Urbanization is also an important social determinant. Lifestyle is an essential social determinant. Tobacco use, alcohol and drug abuse, traffic accident injuries, violence, suicide, and mental health impacted on population health. Indirectly, transportation, education, housing, environment, employment rate, and social support are all contributing to the overall health status of the population.	environment.
[21]	**Health inequalities among older men and women in Africa and Asia**	Hoang Van Minh, Faculty of Public Health, Ha Noi Medical University, Ha Noi, Viet Nam Email: hvminh71@yahoo.com	To determine the extent to which demographic and socio-economic factors impact upon measures of health in older populations in Africa	A total of 46,269 individuals aged 50 years and over in eight Health and Demographic Surveillance System (HDSS) sites within the INDEPTH Network were	Older men have better self-reported health than older women. Differences in household socio-economic levels, age, education levels, marital status and living	This study confirmed the existence of sex differences in self-reported health in low- and middle-income countries even after adjustments for

			and Asia; to examine sex differences in health and further explain how these differences can be attributed to demographic and socio-economic determinants	studied during 20062007 using an abbreviated version of the WHO Study on global AGEing and adult health (SAGE) Wave I instrument. The survey data were then linked to longitudinal HDSS background information. A health score was calculated based on self-reported health derived from eight health domains. Multivariable regression and post-regression decomposition provide ways of measuring and explaining the health score gap between men and women.	arrangements explained from about 82% and 71% of the gaps in health score observed between men and women in South Africa and Kenya, respectively, to almost nothing in Bangladesh. Different health domains contributed differently to the overall health scores for men and women in each country	differences in demographic and socio-economic factors. A decomposition analysis suggested that sex differences in health differed across the HDSS sites, with the greatest level of inequality found in Bangladesh. The analysis showed considerable variation in how differences in socio-demographic and economic characteristics explained the gaps in self-reported health observed between older men and women in African and Asian settings. The overall health score was a robust indicator of health, with two domains, pain and sleep/energy, contributing consistently across the HDSS sites. Further studies are

						warranted to understand other significant individual and contextual determinants to which these sex differences in health can be attributed. This will lay a foundation for a more evidence-based approach to resource allocation, and to developing health promotion programmes for older men and women in these settings
[24]	**Multilevel analysis of covariation in socioeconomic predictors of physical functioning and psychological well-being among older people in rural Vietnam**	Hoang Van Minh, Faculty of Public Health, Ha Noi Medical University, Ha Noi, Viet Nam Email: hvminh71@yahoo.com	This papers aims to 1) examine the effects of different socio-economic factors on physical functioning and psychological well-being among older adults in a rural community in northern Vietnam; and 2) investigate the extent to which the two outcomes variables co-vary within individuals	Data from the WHO/INDEPTH study on global ageing and adult health conducted on 8535 people aged 50 years old and over in Bavi district of Vietnam in 2006 were analysed. A multivariate response model was constructed to answer our research questions. The model treats the individual as a level two unit and the multiple measurements	Lower physical functioning and psychological well-being were found in 1) women; 2) older people; 3) people with lower education level; 4) people who were currently single; 5) respondents from poorer household; and 6) mountainous dwellers compared to that in those of other category(ies) of the same variable. Socioeconomic factors accounted for about 24% and 7% of variation in	The present study shows that there exist problems of inequality in health among older adults in the study setting. This finding highlights the importance of analyzing multiple dimensions of health status simultaneously in inequality investigations.

				observed within an individual as a level one unit.	physical functioning and psychological well-being scores, respectively. The adjusted correlation coefficient (0.35) indicates that physical functioning and psychological well-being did not strongly co-vary.	
[22]	**Multilevel analysis of effects of individual characteristics and household factors on self-rated health among older adults in rural Vietnam**	Hoang Van Minh, Faculty of Public Health, Ha Noi Medical University, Ha Noi, Viet Nam Email: hvminh71@yahoo.com	This paper aims in a rural community of Vietnam, and examine individual and household-level factors associated with good health rating among the study populations	The study was carried out in the Bavi district, a rural community located 60 km west of Hanoi, the capital, within the Epidemiological Field Laboratory of Bavi (FilaBavi) in Vietnam in 2006. All people aged 50 years and over who lived within the district were surveyed. Face-to-face household interviews were conducted by trained surveyors using standard WHO/INDEPTH network questionnaire - summary version. A logistic multilevel modeling approach was applied to analyze the association between SRH and both individual and household-level factors.	The proportion of people aged 50 years and older in FilaBavi reported having good/very good health and poor/very poor health was 15.1%and 24.8%, respectively. SRH status was reported to be better among: (i) men; (ii) younger people; (iii) people with higher education; (iv) people who were currently in marital a partnership; (v) those from wealthier households; and (vi) those who were living in riverside/island or highland areas compared to those of other categories of the same variable.	The findings reveal that there exist problems of inequality in health among older adults in the study setting by sex, age, education, wealth status and place of residence. We also found a considerable contribution of the household-level factors to SRH of the study populations.

[23]	**Economic aspects of chronic diseases in Vietnam**	Hoang Van Minh, Faculty of Public Health, Ha Noi Medical University, Ha Noi, Viet Nam Email: hvminh71@yahoo.com	This paper, by gathering available and relevant research findings, aims to report and discuss current evidence on economic aspects of chronic diseases in Vietnam. Data used in this paper were obtained from various information sources: international and national journal articles and studies, government documents and publications, web-based statistics and fact sheets	Data used in this paper were obtained from various information sources: international and national journal articles and studies, government documents and publications, web-based statistics and fact sheets.	In Vietnam, chronic diseases were shown to be leading causes of deaths, accounting for 66% of all deaths in 2002. The burdens caused by chronic disease morbidity and risk factors are also substantial. Poorer people in Vietnam are more vulnerable to chronic diseases and their risk factors, other than being overweight. The estimated economic loss caused by chronic diseases for Vietnam in 2005 was about US$20 million (0.033% of annual national GDP). Chronic diseases were also shown to cause economic losses for families and individuals in Vietnam. Both population-wide and high-risk individual interventions against chronic disease were shown to be cost-effective in Vietnam.	Given the evidence from this study, actions to prevent chronic diseases in Vietnam are clearly urgent. Further research findings are required to give greater insights into economic aspects of chronic diseases in Vietnam.
[35]	**Health Care fund for the poor in Viet Nam: How evidence and Politics came together**	Nguyen Hoang Long Tong Thi Song Huong Dang Boi Huong Tran Thi Mai Oanh Sarah Bales Nguyen Thi Kim	This paper describes the evidence for and process that led to the issuance of Prime Minister's Decision No. 139/2002/QD-TTg on	Data used in this paper were obtained from various information sources: legal documents, observation, process	The draft of a revision of Decision 139 has been submitted to the Government and is waiting to be approved. The revision will allow the HCFP to	

		Phuong Henrik Axelson Institute of Hygiene and Public Health 159 Hưng Phu, P.8, Q8, TP.HoChiMinh Tel: (84-8) 8559503 - 8559719 Fax: (84-4) 8563164	the health care for the poor in Viet Nam. According to the Decision, known as Decision 139 and issued on 15 October 2002, all people identified as poor (based on the national poverty line), are entitled to free health care at public health care facilities and their health care cost is covered by a Health Care Fund for the Poor (HCFP) that is to be established in every province/city and financed by the state budget.	documentations..	reimburse private providers supplying health care to the poor, as long as that they are selected and contracted by a health insurance agency. The original Decision allowed reimbursement of only public providers, which resulted in a shift in health-care seeking by the poor, away from private providers and towards the already overcrowded public sector. There was political pressure to create a level playing field for private providers, and expanding the private sector is seen as a way to reduce the burden of increased use of public sector services	
[36]	**Dynamics of health insurance ownership in Vietnam, 2004-06**	Trong-Ha NGUYEN Research School of Economics, Australian National University, Crisp Building (# 26), Australian National University, Canberra, ACT, 0200 Australia. Email: ha.trong@anu.edu.au. Tel: +61 2 61258109. Fax: +61 2 6125 0182	Vietnam is undertaking health financing reform in an attempt to achieve universal health insurance coverage by 2014. Changes in health insurance policies have doubled the overall coverage between 2004 and 2006. However, close	This paper uses longitudinal data from VHLSS 2004 and 2006 The authors model the static and dynamic health insurance choices allowing for heterogeneity of choices	The results from both static and dynamic models highlight the importance of income and education in determining the movement in or out of a particular scheme. The results from the static models of health insurance determinants show significant adverse selection in the current health insurance system	Some policy implications to increase coverage and to maintain financial sustainability of the health insurance system are drawn

			examination of Vietnam Living Standard Surveys during this period reveals that about one fifth of the insured in 2004 dropped out of the health insurance system by 2006. This paper investigates the characteristics of those who joined and those who left the health insurance system.		where individuals with bad health are more likely to be insured. The findings from the dynamic models of health insurance ownership also suggest that the current health insurance system entails significant adverse selection where people with worse health are more likely to join or stay in and less likely to move out of the system	
[25]	**Smoking Epidemics And Socio-Economic Predictors Of Regular Use And Cessation: Findings From WHO STEPS Risk Factor Surveys In Vietnam And Indonesia**	Hoang Van Minh, Faculty of Public Health, Ha Noi Medical University, Ha Noi, Viet Nam Email: hvminh71@yahoo.com	to characterize smoking epidemics in rural communities of Vietnam and Indonesia by identifying associations between socio-economic status and changes in smoking status among adult populations	A population-based surveys were carried out in two demographic surveillance sites (DSSs) in Vietnam and Indonesia using the WHO STEPS approach to surveillance of non-communicable disease risk factors	The paper reveals that the prevalence of smoking among people aged 25-64 years was higher in Indonesia than in Vietnam. Indonesian men started smoking regularly earlier and ceased less than Vietnamese men. While low income was found to be a significant predictor of becoming regular smokers in Vietnam, old birth cohort and low education significantly increased the probability of being a regular smoker in Indonesia. Economic status was also found to be a significant predictor of	Given the results of this study, the actions to curb the smoking epidemic need to be strengthened in both countries, especially in Indonesia. Lessons learnt from initial successes in controlling tobacco in Vietnam should be documented, shared and further developed. Intervention strategies should be comprehensive and their development should be based on knowledge of socio-

					smoking cessation in Vietnam while education and occupation played an important role in Indonesia.	economic determinants of the changes in smoking status. Priorities should be given to disadvantaged people e.g. low socio-economic groups and women.

Annex 3 - On-going work on Social Determinants of Health

No.	Name of group/institution/actor	Web address, and name and contact details of key person/people	Mission of group/institution	Core area of work, and possible alliances	Accomplishments, future aims
1	Partnership for Action in Health Equity (PAHE)	Currently, this group is cared of the Institute for Social Development Studies (ISDS) that can be accessed from the following link: http://www.isds.org.vn/index.php?option=com_content&view=article&id=140%3Ahealth-equity-in-vietnam&catid=35%3Afeatured-projects&Itemid=55&lang=en Dr. Khuat Thu Hong, Co-Director of Institute for Social Development Studies, Mr. Nguyen Mai Huong – Director, Center for Community Health Research and Development – Email: maihuong@ccrdvn.org	To build and advocate for constructive voices of the civil society on critical issues regarding health equity that the Vietnam health system encounter in the country's rapidly changing context	Health equity in Viet Nam, possible alliances including Civil Society Organization such as my center (HealthCD – Center for Health and Community Development), Ha Noi School of Public Health, Ha Noi Medical University, Rockefeller Foundation and other foundations	Report entitled: "Health Equity in Viet Nam – A Civil Society Perspective" – (There is no soft copy of this report. However, I send you the scan of the hard copy) PAHE plans to produce a series of report on critical issues that affect the status of health equity in Vietnam. The focus of these reports will vary yearly and be based on extensive consultations between PAHE with health system stakeholders
2	Ho Chi Minh City Institute of Hygiene and Public Health (IHPH)	HoChiMinh City Institute for Hygiene and Public Helath http://www.ihph.org.vn/view_news.aspx?nid=146 Le Hoang Ninh – Editor Ho Chi Minh City Institute of Hygiene and Public Health 159 Hưng Phu, P.8, Q8, TP.HoChiMinh Tel: (84-8) 8559503 - 8559719 Fax: (84-4) 8563164	The mission of the institute is to improve the health of Vietnamese people	Hygiene, Public Health, Social Determinants of Health. Possible alliances: WHO, academic institutions such as the Ha Noi School of Public Health, Provincial Health Departments, MOH .v.v	The Institute has set up a Forum for Social Determinants Network (link below) http://www.ihph.org.vn/list_news.aspx?ncid=26 Develop and test the Urban Heart – A Health Equity Assessment and Response Tool in a number of provinces in southern Viet Nam.