Vietnam is in the centre of South-East Asia bordered by Laos and Cambodia in the West, China in the North and with the Pacific Ocean in the East and South. It is divided into five geographical regions: coastal regions, alluvial plains, middle region, low mountains and high mountains. It has tropical wet climate and the monsoons determine the wet and dry seasons. Two wide fertile alluvial deltas have great agricultural potential.

The population is nearly 70 million; 81% of whom live in rural areas. The growth rate of the population is 2.1%. Life expectancy at birth is 64 for men and 66 for women.

Children aged 0-16 are approximately half of the total population. The under-five mortality rate is 65 per 1,000 live births. The major causes of child mortality are acute respiratory infections, diarrhoea diseases, preventable transmissible diseases and malnutrition.

The administration is broken down into three levels: 54 provinces including 3 cities (Hanoi, Hai Phong and Ho Chi Minh); 555 districts and 9,611 communes. The local units have Provincial Councils and People's Committees.

Administrative Structures for Health
The two main tasks of the health services are Primary Health Care and improvements in the quality of health care. The concept of preventive medicine is emphasised as is the nationalisation and maximisation of local resources and maximising international assistance.

The national health policy fully endorses the Alma Ata definition of Primary Health Care with special emphasis on:

- the prevention and control of infectious diseases.
- the reduction of the population growth rate.
- the strengthening and development of the basic health services network at grassroots level.
- the development of self-sufficiency in essential drugs.
- the promotion of traditional medicine within the framework of the PHC system.
- the improvement of environmental sanitation and access to safe water.

Guidelines have recently been developed on the strengthening of district health systems, including staffing, equipment and supplies,
financing, supervision and training.

**Health Service Structures**

The Health Care infrastructure consists of an extensive network of health facilities at four main levels - central, provincial, district and commune - with Health Steering Committees, part of the People's Committees, at each level.

**Commune:** A Communal Health Station is built in each community with populations of around six thousand people on average. Primary Health Care (PHC) services provided by the station include immunization, prenatal examination, delivery, minor surgery and CBR. The station is staffed with an assistant physician, a nurse and a midwife but recently, there have been reductions of up to 30% in staffing at community level.

Community Health Workers, including Red Cross, operate at the village, hamlet or co-operative level.

Relatively new are the inter-communal Polyclinics at the level between district and commune, providing basic care for about five communes (around 30,000 people) and set up to support PHC activities especially in large, under-served areas.

**District:** At a district level, a general hospital provides treatment and covers around 125,000 people. In addition, hygiene and epidemiological brigades serve to control malaria and provide vaccination.

**Provincial:** At the provincial level, there are general and specialised hospitals, along with social disease dispensaries sanatoriums, maternal protection and family planning stations and rehabilitation departments.

The health facilities network in 1990 counted 174 provincial hospitals (82 general, 92 specialised hospitals), 505 district hospitals, 676 inter-community polyclinics and 9383 community health centres.

**Central:** The Ministry of Health is at the top of the PHC pyramid. Some specialised institutes are attached to the Ministry e.g. the Institute for the Protection of Children's Health, the National Institute of Nutrition, Institute of Hygiene and Epidemiology.

**Funding of Health Services**

Health spending accounts for 3.1% of the national budget. Salaries of
health staff at central and provincial levels, and part of those at district level, are paid from the national budget. All commune level salaries, however, are funded by the local People's Committee. The commune also finances the building of the community health centre and buys the essential drugs. Villagers contribute either in cash or in kind.

Disability Issues
Disability related issues are dealt with by the Ministry of Labour, Invalids and Social Affairs, the Ministry of Public Health and the Ministry of Education. The Ministry of Health is responsible for prevention and rehabilitation.

The Ministry of Labour, Invalids and Social Affairs is responsible for social welfare job replacement and it has eight rehabilitation centres and orthopaedic workshops in such major provinces as Hanoi, Ho Chi Minh and Hai Phong. There are three habilitation centres for children and one orthopaedic factory which produces semi-products to be completed as artificial limbs by the orthopaedic workshop. The factory also trains orthopaedic technicians.

In the Ministry of Education, the Special Education Section in the General Education Department administers the country's special schools. The Centre of Special Education for impaired children in the National Institute of Education and Science (NIES) conducts research on the education of disabled children and administers two schools for the blind in Hanoi and Ho Chi Minh, one school for the deaf in Hai Hung, one school for the mentally retarded in Hanoi and one school for those with speech difficulty in Hanoi.

Other special education schools and educational programmes of physically disabled children are under the Ministry of Labour, Invalids and Social Affairs. Vocational training is emphasised in education.

Disability in Vietnam
In 1983 a survey was conducted by the Ministry of Invalids and Social Affairs in co-operation with Ministry of Health and Department of General Statistics. A total of 1,485,000 disabled persons were identified; 2.7% of the population.

Of these, 55% had a motor disability, including 133,000 amputees and over one quarter of a million persons affected by polio. A further 34% had a sensory disability; including 235,000 visually impaired persons and 165,000 with a hearing impairment. An estimated 120,000 persons had a mental retardation and some 45,000 people had other types of disabilities.

It was estimated that nearly two-thirds of the people with disabilities were working. Of the remainder:

370,000 were capable of rehabilitation;
340,000 were dependent on assistance in daily life; 210,000 were unable to be independent. An analysis was made of all the children seen at the Institute for the Protection of Child Health in the period 1981-1993; a total in excess of 17,000. The largest proportion (26%) had motor and mental retardation, followed by those with cerebral palsy (25%) and polio (18%).

A follow-up of the latter children revealed that only 38% of the treated polio children showed some good results. For 41% no results were obtained and 21% children could not go on with their treatment.

Although the reasons for this may vary, a major factor is that parents could not afford the expense when they stay in Hanoi. The cost of 10 days in the capital might be equal to one year’s cost for their whole family in the countryside. That means, that parents who want to bring their child to the centre in Hanoi or Ho Chi Minh will have to do the equivalent of an extra year’s work to be able to spend another 10 days at the Centre. But what can a centre do for disabled children in only 10 days? Other studies have shown that follow up results of disabled person discharged from institutions is poor.

In another survey, the staff of the Rehabilitation Department of the Institute for the Protection of Child Health, contrasted the proportions of rehabilitation personnel to disabled people at four administrative levels. The results were as follows:

<table>
<thead>
<tr>
<th>Proportions of Disabled People</th>
<th>Level</th>
<th>Proportion of Rehab. Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5%</td>
<td>Central</td>
<td>70-80%</td>
</tr>
<tr>
<td>5-10%</td>
<td>Provincial</td>
<td>5-10%</td>
</tr>
<tr>
<td>10-15%</td>
<td>District</td>
<td>1%</td>
</tr>
<tr>
<td>75-80%</td>
<td>Community</td>
<td>0%</td>
</tr>
</tbody>
</table>

From the above figures, one can see very clearly the mal-distribution between the rehabilitation personnel and the numbers of disabled people. The training systems for rehabilitation personnel tended to train them to help people with disabilities in the urban and more developed areas only.

Finally, institutions are expensive to build and maintain and serve only a limited number of disabled persons. Further, they depend on staff that need high levels of training which are expensive to maintain.

Given all these considerations an alternative way of meeting the needs of Vietnamese people with disabilities had to be found.
Community Based Rehabilitation in Vietnam

In Vietnam the Community Based Rehabilitation Programme was begun in 1987; sponsored by Radda Barnen (Sweden) and started by their Consultant on CBR - Dr. Padmani Mendis. The programme now goes on with national experts.

The Ministry of Health (MoH) set up a Steering Committee chaired for the first three years by Prof. Nguyen Thu Nhan, Director of the Institute for Protection of Children's Health (IPCH). Afterwards a New Rehabilitation Committee was founded in the MoH chaired by the director(s) of the Department for Health Management. Steering Committees were also set up at provincial, district and communal level with involvement of People's Committees, mass organisations, Health Services, Education and Social affairs.

The CBR Development Project started in six communes of Tien Giang province and one commune in Ho Chi Minh City. The following objectives were formulated:

1. To gain experience in integrating CBR within the PHC system.
2. To assess the delivery system and manpower needs of CBR.
3. To assess the effectiveness of CBR technology as described in the manual "Training Disabled People in the Community" (WHO, 1990) and to determine the adaptations necessary for Vietnam.
4. To evaluate the impact of CBR on the lives of people with handicaps, their families and communities.
5. To assess and develop a system for recording, reporting, monitoring and evaluating rehabilitation.
6. To develop a provincial/regional teaching and demonstration area for rehabilitation.

Introductory seminars were first held at regional and provincial levels followed by a one month training course for selected project staff during which the objectives of the project were decided. A plan of action was designed for project development for the 12 month period from March, 1987. A reporting/monitoring and evaluation system was proposed and targets were set.

The seven pilot communes were selected by the CBR Steering Committees which were part of the PHC Committee. Three categories of communes were chosen.

1. Commune(s) with very well developed PHC networks and a strong commitment from the community, whose representatives were members of the Steering Committees.
2. Communes with moderately developed PHC networks and the capital per head below 600kg rice per year.
3. Communes with the least developed PHC networks and very
poor conditions.

Why three types of communes? Experiences from other programmes had shown that when the pilot areas were selected from only the 'best ones', people from poorer communes would say: "these areas are the best, we are not in that category, so we cannot follow the model they have done".

**Training Manpower for CBR**

With the exception of the first two seminars and training courses conducted by Dr. Mendis, the remaining courses and seminars have been conducted by Dr. Hai and his staff along with other local specialists.

The following steps have been employed to establish the CBR Programme in a locality.

1. The National Steering Committee conducts a five day seminar at Provincial level to promote CBR among representatives of all relevant Ministries, the People's Committee and local organisations. A Steering Committee is set up at Provincial Level. The Vice-chairman of the People's Committee becomes the Chairman of the CBR Steering Committee.

2. The National Committee conducts a one month training course for provincial and district level rehabilitation doctors, therapists, assistant doctors and teachers from the regular school. The WHO manual is used in this training and training at other levels.

3. Those trained in the one month course return to their district and conduct a three day seminar to promote CBR at district and commune levels. A District Level Steering Committee is also set up.

4. The same personnel also conduct a two week course for the Brigade nurses, local teachers and volunteers, such as Red Cross members, who will implement CBR within the villages or hamlets.

5. Those trained in the two week courses conduct a house-to-house survey to identify disabled people in their respective villages.

6. Training begins for disabled people who need rehabilitation. Personnel who work at village level supervise the disabled people and their families in carrying out the training.

   In most instances trainers were family members - mothers as well as fathers, grandparents, brothers and sisters. In instances where family members were not available (e.g. elderly people living alone) the Primary Health Workers have taken the role of trainers. In such cases, the workers were often relatives or very close neighbours. In the future however, the Primary Health
Workers will delegate this role to others.

In all instances where technical aids were necessary for people with mobility handicaps, the family have made them using the Vietnamese training manual as a guide. Support was available from the Primary Health Workers and, if necessary, from the assistant doctors or physiotherapists.

7. Village level personnel report regularly to the staff at the Health Station. District level staff visit the community level for supervision every one or two weeks. Provincial level staff visit District level for supervision approximately every two weeks.

8. Records are kept at all levels so the progress of each person's rehabilitation programme can be monitored.

9. Supervision is done at each level by the appropriate steering committee.

This approach, provides coverage for a great number of disabled people in the community at a cost level that can be maintained by any community. The main goal throughout is to reinforce the family programmes for people with disabilities.

Training for Community-Level Workers

The two week training for the community level workers includes modules on the following topics:

- Objectives and orientation to the training.
- Facts on disabilities and identification of disabled persons in Vietnam and the world over.
- First-level prevention and referral pattern.
- Simple identification and rehabilitation of disabilities including moving, hearing, visual, mental and communication disorders, sensation loss, epilepsy.
- Communication and motivation techniques.
- Role of the community worker in the rehabilitation process.
- Role of the family, community and Steering Committee on CBR.
- When and how to refer disabled persons needing other services.
- Roles of other members of the rehabilitation team.

Training Methods: The methods of training generally fall into the following four main aspects:

1. Lectures, seminars, group discussion, peer learning, role-plays.
2. Use of audio-visual materials and manuals (see below).
3. Practical work in teaching rehabilitation through individual or group placements; and
4. Field study in the community.

Training for community-level workers emphasised a more practical, problem-orientated approach and encouraged the trainees' full participation. Role playing, case studies and group discussions proved to be especially effective methods.

**Training Materials:** From the first year up to the present, the WHO manual, *Training Disabled People in the Community* has been the most important tool for implementation of CBR. Without it, CBR could have not been successful. However, during the course of implementing CBR programmes, we found out that other materials were vital; in particular, Nancy Finnie's book, *Handling the Cerebral Palsy Child at Home* and David Werner's *Disabled Village Children*. Both these books have been translated into Vietnamese and they are used extensively for upgrading courses in all CBR programmes.

In order to help all intermediate workers to be able to teach CBR in their community, "A Guide for CBR" was written by Dr. Hai and others.

**Impact of the CBR Programmes**
Since the pilot phase, the CBR programmes has spread to some eleven provinces. The Table below summarises the activities of the CBR Programmes to date.

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provinces with CBR</td>
<td>11</td>
</tr>
<tr>
<td>Districts with CBR</td>
<td>23</td>
</tr>
<tr>
<td>Communities with CBR</td>
<td>208</td>
</tr>
<tr>
<td>Total population covered by CBR</td>
<td>1,643,347</td>
</tr>
<tr>
<td>Total population of Children 15 years and younger</td>
<td>642,381</td>
</tr>
<tr>
<td>Number of disabled children</td>
<td>7,649</td>
</tr>
<tr>
<td>Training courses conducted</td>
<td>231</td>
</tr>
<tr>
<td>Assistant Doctors trained in CBR</td>
<td>732</td>
</tr>
<tr>
<td>Physiotherapists trained in CBR</td>
<td>90</td>
</tr>
<tr>
<td>CBR workers trained</td>
<td>2,534</td>
</tr>
<tr>
<td>Teachers trained</td>
<td>70</td>
</tr>
<tr>
<td>Number of children with disabilities</td>
<td>1</td>
</tr>
<tr>
<td>attending school</td>
<td></td>
</tr>
</tbody>
</table>

**National Impact:** The CBR programmes are fully integrated into the
Primary Health Care system at all levels, both for referral and for services. This includes communal health stations; districts; province and central levels.

Most of the CBR workers and intermediate level workers belong to existing primary health networks which are well co-ordinated in the horizontal and vertical programmes; covering topics such as nutrition, leprosy and mental illness.

CBR has had a marked impact on Primary Health Care services as it checks up and stimulates other PHC programmes such as nutrition, education, family planning and the detection of polio.

CBR has also had an impact on the rehabilitation services. One of the most important achievements is the adoption of new curriculum for training rehabilitation technicians (formerly called physiotherapists) in three National schools (Hai Hung, Danang, Hoi Chi Minh city). Moreover, two out of the three rehabilitation schools have had major repairs carried out.

Also in medical colleges in Hanoi and Hoi Chi Minh City a new curricula in rehabilitation training has been established that is orientated mainly towards CBR.

Thanks to CBR, 77 communal health stations have been upgraded with basic equipment. This provides better working environments for the assistant doctors whose aim is the prevention of disabilities.

Sixteen rehabilitation departments in 16 districts with CBR programmes have been set up and equipped with locally made basic rehabilitation equipment.

The Rehabilitation Department in the Institute for the Protection of Child Health (IPCH) has become the co-ordinating and training resource centre for CBR in the whole county.

A major effort has gone into the production of training materials. The WHO Manual, Training in the Community for People with Disabilities (1989) was translated into Vietnamese and over 5,000 copies were issued for CBR in the whole country. Also 1,500 copies of the Vietnamese version of Werner's Disabled Village Children were printed as were 5,000 copies of the locally produced manual, Guide for CBR, which is used in teaching the management of CBR programmes.

Five video programmes made by Vietnamese Television on CBR have been broadcast nationally.

VINAREHA (Vietnam Rehabilitation Association) was founded in 1990 with the primary aim of promoting and developing CBR.

**International Impact:** CBR experiences of Vietnam have been shared in both regional and international conferences held in the Philippines, Thailand, Laos, India and Holland.

WHO Headquarters sent four Mongolian doctors to be trained on
CBR by Dr. Hai for 2 months. A further four people from Kampuchia were also trained.

**Changing Attitudes:** In practice, this has been one of the most important difficulties and it has been a continuing problem. Attitudes need to change among disabled people themselves as well as among the able-bodied.

There are a lot of resource persons within the community, who, if mobilised, can contribute to education and changing of attitudes. For instance, traditional healers who have experienced success already in the rehabilitation or treatment of different types of disabled people. Especially important are those healers endowed by their ancestors with a high reputation in the community.

Other important allies in changing attitudes are family members with disabled people themselves who have cared and treated them for years and gained precious experiences in many aspects of dealing with disabled people.

Many disabled people themselves have overcome their disability; including the war invalid, some people with polio, those with hearing and speech problems. They can share very practical living experiences in overcoming their own disabilities.

**Five Conditions Required for CBR**

In summary then, we have found that there are five conditions required to start and maintain CBR programmes in Vietnam. These are:

1. **Community Involvement, support and motivation from leadership (that is the People's Committee) through CBR Steering Committees which are integrated into Primary Health Care systems.** Links need to be made with: People's Committees, Health section, Social affairs, Education, Mass organisations (Women's Union, Youth), Red Cross and Finance

2. **Manpower is required to implement techniques of rehabilitation in CBR services.** This includes:
   - Disabled persons
   - Family members
   - CBR workers (Trained PHC workers, brigade nurses, Red Cross members, teachers).
   - Physiotherapists, rehabilitation specialists.

3. **Referral system need to be established at various levels:**
Linking with Primary Health Care Services

- Communal Health Station
- Rehabilitation Unit in District Hospital
- Rehabilitation Department of Provincial Hospital
- Rehabilitation Centres nationally.

4. Training materials need to be produced:
   - Materials for making appropriate technical aids
   - Manuals for training.

5. Funds must be available to support the programmes. These have come from: Radda Barnen and from local resources.

Dr. Tran Trong Hai is Head of the Rehabilitation Department of the Institute for the Protection of Children's Health (IPCH) in Hanoi. He has worked extensively in the area of CBR throughout Vietnam over a number of years.

Professor Nguyen Thu Nhan is the Director of the Rehabilitation Department at Bach Mai Hospital in Hanoi. Along with Dr. Hai, she is a key member of VINAREA, the NGO which manages the CBR Programme in Vietnam.

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