Lessons from the Field

From research evidence to policy: mental health care in Viet Nam

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Problem The use of evidence-based policy is gaining attention in developing countries. Frameworks to analyse the process of developing policy and to assess whether evidence is likely to influence policy-makers are now available. However, the use of evidence in policies on caring for people with mental illness in developing countries has rarely been analysed.
Approach This case study from Viet Nam illustrates how evidence can be used to influence policy. We summarize evidence on the burden of mental illness in Viet Nam and describe attempts to influence policy-makers. We also interviewed key stakeholders to ascertain their views on how policy could be affected. We then applied an analytical framework to the case study; this framework included an assessment of the political context in which the policy was developed, the links between organizations needed to influence policy, external influences on policy-makers and the nature of evidence required to influence policy-makers.
Local setting The burden of mental illness among various population groups was large but there were few policies aimed at providing care for people with mental illness, apart from policies for providing hospital-based care for people with severe mental illness.
Relevant changes The national plan proposes to incorporate screening for mental illness among women and children in order to implement early detection and treatment.
Lessons learned Evidence on the burden of mental ill-health in Viet Nam is patchy and research in this area is still relatively undeveloped. Nonetheless the policy process was influenced by the evidence from research because key links between organizations and policy-makers were established at an early stage, the evidence was regarded as rigorous and the timing was opportune.

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Voir page 667 le résumé en français. En la página 667 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 668.

Background

The implementation of evidence-based policy is being encouraged in all public sectors, including health care, in many developed countries.[1] Although the use of evidence-based practice started in medicine its influence is now being seen in public health, especially in the delivery of health services. It is also influencing health policy more broadly. According to some practitioners: "Clinical practice in many countries is being transformed by evidence-based medicine, and a similar transformation in health systems is desperately needed".[2] In the United Kingdom and other developed countries much attention has been paid to the role evidence can have in improving health policy, but there is little research on the progress of evidence-based policy in developing countries. Additionally, the fields of public health and care for people with mental illness are rarely examined to ascertain the extent of the existence of evidence-based policy.

The theory of evidence-based policy has developed rapidly during the past decade. It is now recognized that the policy process (particularly the nature and role of stakeholders) must be understood[3] and that evidence needs to be credible and useful if it is to influence policy-makers. The policy process is not linear, flowing from problem identification through solution to policy-making, but it is iterative and interactive and involves a wide range of actors.[4] The analytical framework for this paper[5,6] considers four interrelated factors that determine whether evidence is likely to be adopted by policy-makers:

- the political context (the process of developing the policy including the role of civil society and power relations within society)
- the evidence itself (including its relevance, method of communication of the evidence, and its source)
- the links used to influence policy and disseminate evidence (including advocacy coalitions, knowledge communities and other networks)
- the external influences on the policy-makers (including donors).

We use this framework to analyse how and whether evidence was used to develop health-care policies for people with mental illness in Viet Nam.

Context, resources and key players

There is little published evidence about the extent and nature of mental health problems in Viet Nam. We briefly consider the evidence for different population groups. Only two prevalence

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studies of maternal mental health have been published. Fisher et al. found that 33% of women attending general health clinics in Ho Chi Minh City were depressed, and 19% explicitly acknowledged suicidal ideation.[7] These levels were much higher than those found in developed countries (where the level is typically 10–15%) and much higher than Vietnamese clinicians had anticipated: for sampling purposes the clinicians had estimated the prevalence to be 1%. This indicates that although Viet Nam may have a culture that proscribes the discussion of emotions or in which distress is associated with shame or stigma,[8] women were willing to reveal their level of distress to interviewers. Results from a nationwide survey of 2000 mothers of one-year-olds (in both rural and urban areas) found a 20% prevalence of depression or anxiety as measured by an instrument validated in Viet Nam.[9] The same study also measured mental health among children and found that 20% had poor mental health. McKelvey et al. emphasized that mental health services for children in Viet Nam were particularly limited due to the prioritization of other health problems, such as infectious diseases and malnutrition.[10]

A national community-based study of 5584 young people aged 14–25 years found that a quarter reported feeling so sad or helpless that they could no longer engage in their normal activities and they found it difficult to function.[11] This study included a slightly higher percentage of females than males; additionally, as many as 34% of girls from ethnic minority groups reported symptoms of depression. It is important to note that there are no community-based prevalence studies on the mental health of adult males.

Together these studies, although few in number, point to a large burden of mental illness. This burden may affect productivity as well as reproductive and community roles.

The key actors in determining mental health policy in Viet Nam are the National Assembly, which approves and monitors policy; the Communist Party's Central Commission for Science and Education, which directs the development of health policy; the Department of Curative Medicine (within the Ministry of Health), which has responsibility for developing policies relating to mental health, including prevention policies; the Health Strategy and Policy Institute (within the Ministry of Health), which promotes itself as providing an evidence base for policy formulation; and the National Committee for Population, Families and Children (referred to as the National Committee), which is a government body that deals with all sectors that have an impact on families and children. In terms of international agencies, WHO and international universities have provided regular support.[12]

Until 2004 mental health policy was characterized by a national plan of action that focused on the treatment of schizophrenia and epilepsy in hospitals. There were no mental health promotion or mental illness prevention strategies nor were there any community-based or primary-care policies addressing mental health.

The process of change: from results to policy

In late 2004 a local nongovernmental organization (NGO), the Research and Training Centre for Community Development, presented its findings on mental illness to a regular meeting of the National Assembly's Parliamentary Commission for Social Affairs. About 60 people attended, including parliamentary senators and their counterparts from 22 of the 64 provinces. It should be noted that this NGO does not solely address mental health issues and this may have worked to its advantage in presenting its data: the results were not perceived as advancing its own agenda. The NGO described mental illness as a poverty-related issue, and this dovetailed with the senators' agenda. The meeting was purposely convened outside the capital to guarantee that attendees could not easily miss the meeting to return to their regular duties. Politicians and senior civil servants from key ministries attended, and the Deputy Minister of the Ministry of Education spoke at the meeting.

Feedback from politicians, which was collected by the NGO immediately after the meeting, indicated that they particularly appreciated being able to focus on a single issue for a whole day. They suggested that the knowledge they had gained would enable them to monitor the implementation of policies more effectively.

Soon after that event, the NGO presented to the National Committee its findings and a plan of action to provide mental-health care to mothers and children; about 80 people attended this event. This event was timed to feed into the Committee's process of developing its 5-year plan of action (2006–10).

The NGO also published an article on mental health among mothers and children in the national daily newspaper immediately after the event. The article was carefully worded to avoid stigmatizing those who might have a mental illness.

Prior to presenting its evidence on mental illness, the NGO had established credibility with this part of the government by providing data on malnutrition in children and iron deficiency in women and children, and this data had influenced policy at the time. Links with the Committee had also been developed by recruiting one of its senior members to the NGO's advisory panel. This long-term engagement with the government resulted in the prevalence statistics on mental illness among mothers and children being cited in the national plan of action. Additionally, the plan proposes to screen pregnant women and children for mental illness in order to implement early detection and treatment policies. Education about mental health is to be incorporated into early childhood development programmes, and a community-based intervention programme to treat people with mental illness is to be piloted. The relatively high profile afforded to mental health promotion and the prevention of mental illness as well as to community-based mental health activities (promotion and treatment) represent a significant change in policy.

Information from stakeholders

We interviewed four key stakeholders working in the area of mental health in late 2005 to assess: to what extent mental health was on any policy agenda and, if it was present, the stimulus that had prompted its inclusion; whether they knew of any evidence on mental health and whether it had influenced policy-makers; and what future evidence or action would be required to put mental health issues onto policy agendas. The respondents included a representative from the National Committee, a senior member of the Policy Institute of the Ministry of Health (a government health-policy specialist), a WHO spokesperson (representing the perspective of international health donors) and a

psychiatric researcher from the National Institute of Mental Health with 30 years' experience.

The senior member of the National Committee suggested that the novelty of the data had attracted attention and that this had led to a growing consensus that there was a problem. The fact that mental health issues converged with the current priorities of his department (focusing on early childhood development, child abuse and street children) enabled him to incorporate mental health issues into long-term plans. He suggested that in order to put mental health firmly onto policy agendas a senior member of the Central Communist Party would need to champion it.

The psychiatric researcher felt that the presentation of research results had made policy-makers more interested in depression (as opposed to only severe mental illness, such as schizophrenia). However, she believed that researchers in Viet Nam had no role in influencing the process of developing policy: "We are just scientists, we do the research. How to change policy: it's up to the government".

The health-policy specialist stated that there was a gap between research findings and the formulation of policy and that getting the ministry to think about preventing and promoting mental health and community-based approaches would be particularly challenging because mental health policy covers only treatment for patients with severe mental illnesses in hospitals. He emphasized the need for training for professionals as well as raising public awareness of the extent, nature and treatment of common mental illnesses.

The WHO spokesperson predicted that 2006 would see the development of guidelines for a national mental health programme (to coincide with the General Assembly's mental health legislation) and emphasized that in Viet Nam, the terms policy, guidelines, strategy and action plan were used interchangeably.

Table 1. **Factors required to encourage policy-makers to act on evidence and their application to the situation in Viet Nam**

Factor	Application in Viet Nam
Political context	Timing of release of evidence opportune because it coincided with planning cycle
	Different levels of government engaged with researchers (provincial and national)
	Role of civil society in Viet Nam is limited so has no influence
	Not yet broad-based support for policy change (limited engagement with Ministry of Health, no Communist Party champion)
	No legal framework for mental health services
Evidence	Methodologically rigorous
	Limited number of studies; no conflicting findings
	Multiple methods used to communicate results, including mass media
Links	Researchers forged links with policy-makers before results available
	Existence of National Committee assists cross-sectoral approach
External influences	Overseas universities and international agencies involved

Analysing change

How can the framework be applied to the process described above? Table 1 identifies the characteristics of the process according to the four factors required to encourage policy-makers to act on evidence.

Evidence is more likely to contribute to policy if:[5]

- it fits within political limits and pressures and resonates with policy-makers' assumptions or if sufficient pressure is exerted to challenge politicians;
- the evidence is convincing, practical and well packaged;
- researchers and policy-makers are in the same network (that is, they see each other regularly) and trust one another.

In Viet Nam, using evidence to present mental illness as a "new problem" seems to have had some resonance in terms of shaping policy. Changes in policy in Viet Nam are unlikely to come from political pressure but are more likely to result from long-term positive engagement. This engagement between researchers and policy-makers has begun.

Although the evidence on mental illness is limited, it seems to have been perceived as convincing. Its impact in some quarters has been minimal (for example, in the Ministry of Health) and perhaps it needs to be packaged differently for them.

Networks of key stakeholders (that is, of researchers and policy-makers) have been established and are active. Additionally, despite the fact that the idea of local NGOs undertaking research is a new phenomenon in Viet Nam, the NGOs understand the need for early engagement with policy-makers.

There are criteria available for evaluating policy recommendations.[13] If these criteria are applied to the emerging policy described above, the main gaps identified are the lack of knowledge about the feasibility and cost of any intervention. Thus there is a need for intervention studies that examine the cost effectiveness of interventions. The main challenge is thus policy implementation rather than formulation.

Although we have argued that mental health policy in developing countries is rarely driven by evidence we should not be naive about the process in developed countries. Several commentators have described the difficulty of promoting evidence-based mental health

Box 1. **Lessons learned**

- There are analytical frameworks available that enable researchers to examine how and why policy-makers use certain evidence.
- They have rarely been applied to mental health policies in developing countries.
- Although evidence on common mental illnesses in Viet Nam is limited, it gained the attention of policy-makers because the researchers engaged with key stakeholders at an early stage of their research, the data were regarded as rigorous and the timing of the release of the data was opportune in that it coincided with a 5-year planning cycle.

policy in the United Kingdom.[14] Cooper showed that although evidence-based health care is now being promulgated as a rational basis for planning mental health services in the United Kingdom, its contributions to those services have been limited.[15]

The case study presented here emphasizes the idea that "evidence is not static, but rather, is characterised by its emergent and provisional nature, being inevitably incomplete and inconclusive".[4] Evidence on the burden of mental illness in Viet Nam is limited. Nonetheless the process of developing policy was influenced by the evidence because links between stakeholders were established at an early stage, the evidence was regarded as rigorous and the timing was opportune (Box 1). ■

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Résumé

Des résultats de recherche à l'élaboration d'une politique : soins de santé mentale au Viêt Nam

Situation La mise en œuvre de politiques élaborées à partir d'une base factuelle suscite un intérêt grandissant dans les pays en développement. Des cadres permettant d'analyser le processus d'élaboration des politiques et d'évaluer dans quelle mesure ces résultats peuvent influencer les décideurs sont maintenant disponibles. Cependant, l'utilisation de bases factuelles dans la définition des politiques de prise en charge des personnes atteintes de troubles mentaux dans les pays en développement a rarement été analysée.

Démarche La présente étude de cas menée au Viêt Nam montre comment l'on peut utiliser des éléments factuels pour influer sur les politiques. Les données disponibles sur la charge de troubles mentaux au Viêt Nam ont été récapitulées et les tentatives pour influer à travers elles sur les décideurs ont été décrites. Des intervenants importants dans les politiques ont été interrogés pour évaluer leur opinion quant à la possibilité d'influer sur leurs décisions. Un cadre analytique a ensuite été appliqué à cette étude de cas. Ce cadre comprenait une évaluation du contexte politique dans lequel les politiques seraient mises au point, des liens entre organismes nécessaires pour influer sur elles, des influences externes sur les décisions et de la nature des données nécessaires pour exercer une influence.

Contexte local La charge de troubles mentaux parmi les divers groupes de population était importante, mais il existait peu de politiques de prise en charge des personnes souffrant de troubles mentaux en dehors des politiques de prestation de soins hospitaliers à l'intention des malades atteints de troubles graves.

Modifications intéressantes Le plan national propose d'intégrer le dépistage des troubles mentaux chez les femmes et les enfants afin de permettre leur détection et leur traitement à un stade précoce.

Enseignements tirés Les données concernant les troubles mentaux au Viêt Nam sont parcellaires et la recherche dans ce domaine est relativement peu développée. Néanmoins, le processus d'élaboration des politiques a subi l'influence des résultats de la recherche car des liens entre les organismes et les décideurs politiques ont été établis à un stade précoce, les données ont été considérées comme solides et elles ont été disponibles à un moment opportun.

Resumen

Influencia de la investigación en las políticas: la atención de salud mental en Viet Nam

Problema En los países en desarrollo se está prestando una creciente atención a la aplicación de políticas basadas en la evidencia. Se dispone ya de sistemas para analizar el proceso de formulación de políticas y evaluar si la evidencia obtenida tiene alguna probabilidad de influir en las instancias normativas. Sin embargo, rara vez se ha analizado la aplicación de la evidencia a las políticas de atención a las personas con enfermedades mentales en los países en desarrollo.

Métodos Este estudio de casos realizado en Viet Nam demuestra cómo puede usarse la evidencia para influir en las políticas. Resumimos la evidencia disponible sobre la carga de enfermedades mentales en Viet Nam y describimos los intentos de influir en las instancias normativas. Además entrevistamos a partes interesadas importantes a fin de conocer su opinión sobre la manera de influir en las políticas. A continuación aplicamos al estudio de casos un marco analítico que comprendía una evaluación del contexto político del desarrollo normativo, los vínculos entre organizaciones necesarios para influir en la política, las influencias externas en las instancias normativas, y la naturaleza de la evidencia requerida para influir en esas instancias.

Entorno local La carga de enfermedades mentales entre los diversos grupos de población era elevada, pero eran pocas las políticas orientadas a proporcionar atención a los afectados por esas enfermedades, aparte de las políticas destinadas a dispensar atención hospitalaria a las personas con enfermedades mentales graves.

Cambios importantes El plan nacional propone incorporar el cribado de las enfermedades mentales entre las mujeres y los niños a fin de implementar la detección y el tratamiento tempranos.

Lecciones aprendidas La evidencia disponible sobre la carga de morbilidad mental en Viet Nam es irregular, y las investigaciones en ese terreno están aún relativamente poco desarrolladas. Sin embargo, el proceso de formulación de las políticas se vio influido por la evidencia aportada por las investigaciones, debido a que en una fase temprana ya se establecieron vínculos entre las organizaciones y las instancias decisorias y a que la evidencia era rigurosa, y el momento, oportuno.

ملخص

من بيِّنات البحوث إلى التطبيق: رعاية الصحة النفسية في فييتنام

المشكلة: يتزايد الاهتمام بالسياسات المسندة بالبيِّنات في البلدان النامية. وتتوافر في الوقت الحاضر أُطُر العمل لتحليل عملية إعداد السياسات وتقييم ما إذا كانت البيِّنات قد تؤثِّر على أصحاب القرار السياسي. إلا أن استخدام البيِّنات في سياسات رعاية المصابين باعتلال نفسي في البلدان النامية لم يحلَّل إلا نادراً.

الأسلوب: توضِّح دراسة الحالة هذه من فييتنام كيف يمكن للبيِّنات أن تستخدم في التأثير على السياسات، فقد لخصنا البينات حول عبء الاعتلالات النفسية في فييتنام ووصفنا محاولات تأثيرها على أصحاب القرار السياسي. وأجرينا مقابلات مع كبار المعنيين للتعرف على آرائهم حول الكيفية التي قد تتأثر السياسات بها. ثم طبقنا إطار عمل تحليلي على الحالة المدروسة، ويشتمل إطار العمل هذا على تقييم السياق السياسي الذي رسمت السياسات فيه، والتأثيرات الخارجية على أصحاب القرار السياسي وطبيعة البيِّنات اللازمة للتأثير على أصحاب القرار السياسي.

المواقع المحلية: لقد كان عبء الاعتلال النفسي بين مختلف المجموعات السكانية كبيراً، إلا أنه كان هناك عدد قليل من السياسات التي تستهدف إيتاء الرعاية للمصابين بمرض نفسي، وذلك إلى جانب السياسات التي تستهدف إيتاء الرعاية المرتكزة على المستشفيات للمصابين باعتلال نفسي وخيم.

التغيرات الملائمة: تقترح الخطة الوطنية إدماج تحرِّي الاعتلالات النفسية لدى النساء والأطفال تمهيداً لتنفيذ المعالجة والكشف الباكرين.

الدروس المستفادة: إن البيِّنات حول عبء الاعتلال في الصحة النفسية في فييتنام غير مكتملة، وتعاني البحوث في هذا المجال من نقص في الإعداد، إلا أن العملية السياسية تتأثر بالبيِّنات المستمدة من البحوث، إذ أن الروابط الرئيسية بين المنظمات وأصحاب القرار السياسي قد ترسَّخت في مرحلة باكرة، فالبيِّنات قوية والتوقيت يعد فرصة مواتية.

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