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Improving Public Health Outcomes for Minorities in Vietnam

Located in Southeastern Asia, the country of Vietnam is expected to have one of the fastest growing economies in the coming decade. Vietnam is a country with a rich history and culture that has displayed resilience in the face of challenges, including country occupations, internal conflicts, and political instability. Although Vietnam has experienced tremendous improvements in industrialization and its trade economy in recent years, it is necessary to assess its developmental progress using the Sustainable Development Goals (SDGs). SDGs are a set of 17 goals created by the United Nations (UN) in 2012 to address the urgent environmental, political, and economic challenges that countries worldwide face to encourage world peace and prosperity. SDG #3 addresses good health and wellbeing to boost countries’ population health, reduce suffering from preventable diseases, and prolong lives through quality interventions. The widening poverty gap between ethnic groups in Vietnam is a threat to achievement of SDG #3 that can be resolved through increasing access to primary education, adapting to rising cases of non-communicable diseases, and strengthening of programs that address infectious disease outbreaks.

Vietnam’s economic, political, and social background have all contributed to its status regarding achievement of SDG #3. Vietnam is a lower-middle income country located in Southeastern Asia, bordering the Gulf of Thailand, Gulf of Tonkin, and South China Sea, as well as China, Laos, and Cambodia (The World Factbook, 2023). The official language of the county is Vietnamese, followed by English as a secondary language. Vietnam has a rich ethnic makeup, with 54 ethnic groups being recognized by the Vietnamese government. However, between 85-90% of Vietnam’s population is ethnically Vietnamese, or Kinh. Several groups constitute the remaining 10-15% of the population, including Tay, Thai, Muong, Khmer, Mong, and Nung groups (The World Factbook, 2023). The healthcare system in Vietnam is two-tiered, consisting of private and public options. The Ministry of Health and local health departments across the country manage public healthcare in the country. Traditional medicine is often used alongside Western medicine, and many citizens prefer a combination of the two treatments. Vietnam’s history with colonization illustrates how the current divisions in healthcare access have developed over time between ethnic groups. Vietnam fought colonial rule of Japan in 1940, followed by France during the French Indochina War that ended in 1954, when French forces were ultimately defeated by Ho Chi Minh’s communist forces (The World Factbook, 2023). However, during the French colonial period many changes were introduced to Vietnam’s education and healthcare systems. Like other colonial powers at the time, the French viewed medicalization in Vietnam as an avenue to win support from a new subject population and established social medicine in the country to restructure and “modernize” Indochina (Trang, 2020). As such, although the French were superficially invested in healthcare outcomes of the Vietnamese, this investment was secondary to their desire to westernize and dominate the non-European world. In 1905, the establishment of Indigenous Medical Assistance (AMI) took place in Indochina (Trang, 2020). This initiative was initiated by the French authorities, who recognized the imperative of curbing the spread of infectious diseases among indigenous populations before the health of their own soldiers became compromised. However, the lack of financial resources and unfair distribution of resources across ethnic groups continued even after these foundations were created. Indigenous doctors were only permitted to work underneath French doctors and were officially deemed subordinate in 1913 (Trang, 2020). The French administration may have favored certain regions and ethnicities during their colonization of Indochina, leading to uneven development in Vietnam. After the end of French colonization and the Vietnam War, North and South Vietnam were reunited and the Doi Moi reforms were enacted. Doi Moi shifted the developmental model of Vietnam from centrally planned to market-oriented, which brought general economic prosperity to the country (Le, 2022). Public health outcomes improved generally with the reforms due to large-scale campaigns such as the Expanded Program of Immunization and the National Target Programs on Health (Malqvist, 2013). However, the rapid urbanization of the country during Doi Moi catalyzed several divides in healthcare access for ethnic minorities. In the shift from government-financed health systems to a market-oriented approach, private healthcare providers increased unchecked, providing lower-quality care for higher prices (Malqvist, 2013). Ethnic minorities, often residing in rural areas, continue to face challenges to accessing healthcare due to residual effects of colonialism, geographical remoteness, cost of care, and cultural differences. As a public health agency, prioritizing investments in primary care accessibility and comprehensive campaigns addressing both non-communicable and infectious diseases is crucial to enhance healthcare outcomes specifically for ethnic minorities in Vietnam.

To combat wealth disparities seen between ethnic groups in Vietnam, it is important to understand the reforms needed in the education system and to make investments towards increasing primary care access. There is evidence that education can provide solutions to combat poverty, and the government of Vietnam has invested historically in ethnic minority education. Vietnam’s ethnic minorities continue to have lower net enrollment rates at both the primary and secondary school level. As stated in a review by Trieu et al. conducted in 2019, primary completion rate for Kinh students was 86%, and the rate for ethnic minority children was only 61%. Mountainous areas of north and central Vietnam show particularly large discrepancies in timely primary school completion, with less than half of all ethnic minority children attending lower secondary school at the right age (Trieu et al., 2014). Without successful or timely completion of primary education, ethnic minorities will face more barriers to entering high schools and receiving the necessary scores to attend university, which is pivotal to securing a livable income. Community engagement, cultural sensitivity training, and language support programs are interventions that could be employed to reduce barriers to instruction that children outside of the Kinh ethnicity face to completing primary school (Malqvist, 2013). Introducing scholarship programs for minority families also reduces the financial burden that accompanies enrollment in privatized institutions (Malqvist, 2013). In addition, better data reporting on primary education outcomes should be initiated by public health agencies to properly gauge the effectiveness of interventions. Currently, vital registration data includes ethnicity as a variable, but there is much left unanswered about educational discrepancies among minorities (Trieu et al., 2014). Increasing primary education access and introducing more reliable registry data collection are both recommendations that would aid in reducing wealth disparity among minorities in Vietnam.

In addition to education, reducing costs associated with prevention and treatment of noncommunicable diseases is another important measure to reduce health disparities between Vietnamese ethnic groups. Although Vietnam has advanced significantly in its economic sector in recent years, noncommunicable diseases pose a threat to achievement of SDG #3 particularly for ethnic minorities. Lack of prevention programs and a high cost for treatment constitute a significant burden particularly for disadvantaged minority groups. For example, prevalence of diabetes mellitus in Vietnam has rapidly increased in recent years due to a shift in dietary patterns towards higher consumption of processed foods as urbanization continues (Ton et al., 2020). Although incidence of diabetes has been well-reported for the urbanized northern and southern regions in Vietnam, fewer studies have investigated the rural center of the country, home to Montagnard ethnic groups residing in the Central Highlands. However, a study by Nguyen et al. in 2019 found that barriers to accessing screening programs and lack of awareness of diabetic consequences led to higher proportions of prediabetes and undiagnosed diabetes in these regions. People living in the mountainous central highlands are more vulnerable to noncommunicable diseases in general due to low education levels, low socioeconomic status, and geographic barriers to healthcare (Thi Le, 2022). Public health interventions should involve more than warning about risk factors; they have demonstrated efficacy, particularly in mountainous regions, through the active engagement of community health workers (Thi Le, 2022). This successful approach holds promise for broader implementation by agencies in the future.

Finally, addressing infectious disease outbreaks is paramount in advocating for better health outcomes for ethnic minorities in Vietnam. One example of an infectious disease that has high prevalence modernly in Vietnam is tuberculosis (TB). The World Health Organization (WHO) estimated in 2015 that 130,000 cases of tuberculosis occurred in Vietnam in 2013, or 144 cases per 100,00 members of the population. In addition, an estimated 5,000 multidrug-resistant TB (MDR-TB) cases occurred in 2013 in Vietnam (WHO, 2015). These statistics culminate to make Vietnam the 10th highest burden TB country in the world with less than 60% of people receiving treatment (Gould et al., 2014). TB concentrates in vulnerable populations, such as minorities, children, older people, and the poor (WHO, 2015). Detecting these cases can be more difficult than in the general population. Government funding is often inadequate for supporting prevention and treatment of the disease in rural areas with higher poverty rates. TB, along with other infectious agents such as HIV and malaria, do not receive the publicity or funding necessary to improve health outcomes for disadvantaged populations (Gould et al., 2014). They are considered “neglected diseases” that require a consistent public health effort through implementation of health education programs, regular screenings in areas with a high prevalence of minorities, and conduction of anti-stigma campaigns. These inventions will ease the burden of infectious disease in minority groups in Vietnam to promote better health outcomes.

In Vietnam, enhancing access to primary education, reducing non-communicable disease treatment costs, and controlling infectious disease outbreaks, are key factors for achieving SDG#3 (Good Health and Well-Being) The cumulative goal of these recommendations is to reduce the poverty gap among ethnic minorities, especially those residing in remote regions of the country. Focusing on community-based, evidence informed approaches through direct communication with these groups will allow the recommendations of our public health agency to make an impact on health outcomes across communities in Vietnam.

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