

7 Viet Nam

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I. Summary of Main Results

Social and economic conditions in Viet Nam have improved considerably since the late 1980s: GDP per capita has risen, poverty rates have fallen, child and infant mortality rates have fallen, use of and advice on contraception is widely available as are ante-natal care and skilled assistance at deliveries, school enrolment rates have increased, and access to clean water and sanitation has risen. These changes occurred in both rural and urban areas, although most indicators remain significantly worse in the former. They are worse also among the ethnic minorities, who make up around 14% of the population.

Despite these achievements, the situation in the 1,870 most disadvantaged communes, which are mostly located in mountainous areas where ethnic minorities are concentrated, remains acute (relating to roads, classrooms, safe water, electricity, small-scale and irrigation works).

There is no concise definition of Social Protection (SP) in Viet Nam. The definition to be used for this study is: “The set of policies and programs that enable vulnerable groups¹ to reduce, mitigate and /or cope with the risks associated with their particular circumstances and that do not fall under activities normally associated with other sectors such as rural development, basic infrastructure, health and education, and that are both targeted at these groups and involve cash or in-kind transfers.”

¹ The primary target groups for social protection policies, which reflect ADB's definition of SP, are the unemployed/underemployed, the elderly, the sick, those affected by natural disasters, the poor, the disabled, and children with special needs.

A review of the major SP programs currently operating in Viet Nam, structured around the components and subcomponents of ADB's SP definition, includes a review of some area-wide integrated development projects and programs related to early child development that were considered not incorporated in the formulation of the Social Protection Index (SPI).

Statistical information on current SP activities in Viet Nam is synthesized and aggregated in Chapter V around the three proposed constituent elements of the SPI: (i) expenditure on SP programs, (ii) their coverage, and (iii) their distributional impact. This information is then used to derive indicators to be used in the eventual formulation of the SPI. The key indicators are presented in Table 1 below.

SP Expenditure. Data was obtained from the state budget allocation for "social subsidies" and the summation of the expenditures on individual SP programs (Table 5.2). The latter estimate is preferred for two reasons: firstly, the budget estimate could not be disaggregated and is known to include expenditure on general poverty alleviation programs that are excluded from the definition of SP; and secondly, it does not include some programs which do fall within the definition, e.g. those operated by national NGOs using nongovernment funds. Total SP expenditure in 2002/03 is estimated at around D19 trillion (\$1.2 billion), equivalent to 3.5% of GDP. Around 80% of this expenditure is on just two programs—Social Insurance and Social Assistance with the latter being principally going to war invalids and war contributors.

SP Coverage. This was assessed separately for seven target groups: the unemployed and underemployed, the elderly, the sick, the poor (separately for those receiving social assistance benefits and recipients of microcredit loans), the disabled, and children with special needs. To a large extent, these target groups are consistent with ADB's components of SP.² Estimates of the coverage of each of these target groups were derived by dividing the number of beneficiaries by two alternative reference populations: (i) narrow, which approximates the target group, e.g. for the poor; this is number of persons living below the poverty line; and (ii) wide, where the total population is used as the denominator (Table 5.5). Coverage rates (using the narrow reference population) in excess of 20% were obtained for programs related to the elderly, the sick, the poor, the disabled, and children. The advantages and disadvantages of using the narrow and wide reference

² Concerning ADB's definition of SP, see the forthcoming section Social Protection Index and Multi-Country Analysis of this book.

populations are discussed in the forthcoming section Social Protection Index and Multicountry Analysis of this book.

SP Distributional Impact. This element was assessed in two ways:

- (i) firstly by estimating the poverty targeting rate of individual SP programs (i.e. the percentage of the poor population who receive some SP assistance); and
- (ii) secondly, by estimating the per capita SP expenditure which goes to the poor and expressing this as a percentage of the poverty line income. The inclusion of this latter variable was deemed essential in order to “qualify” coverage rates that could give a misleading impression of the level of actual assistance provided.

In this context, it is important to note that despite a Poverty-Targeting Rate of just over 50%, SP expenditure per poor person amounts to below 12% of the poverty line income, rising to 22.7%, if only beneficiaries are considered. Table 1 provides a summary of the derived indicators.

II. Country Overview

This chapter presents a brief overview of the social and economic characteristics of Viet Nam that are considered of particular relevance to SP issues. The accompanying statistical tables are to be found at the end of the chapter.

A. Population

The population of Viet Nam increased from around 64 million in 1989 to 76 million in 1999 and an estimated 80 million in 2002. Average growth during the 1990s was 1.7% per annum, significantly lower than the rate (2.1% annually) prevailing during the 1980s. This resulted from a continuing decline in fertility—the Total Fertility Rate has more than halved since the late 1980s. Death rates have also decreased, but to a much lesser extent. The combination of these factors has led to a rapid ageing of the population, with only 30% of the population being under the age of 15 years compared with over 40% in 1989; 10% are now aged over 60 years compared with 7% previously. The most marked change, however, is in the zero to four age-group, where the number has actually decreased since 1989 indicating that pressures on the education system in terms of the physical provision of places are likely to decrease rather than increase in coming years.

Table 1. Summary of Preferred SP Indicators

SPI Component	Indicator	(%)	Viet Nam Estimate	(%)
Expenditure on SP	Total SP Expenditure as % of GDP			3.5
Coverage of SP The Unemployed/ Underemployed)	Reference population—narrow Beneficiaries as % of total of U/U	5.2	Reference population—wide As % of total labor force	1.7
The Elderly	Elderly receiving assistance as person of population aged 60+ years	34.0	As for “narrow” reference population	34.0
The Sick	% of population with health insurance or in receipt of subsidies	23.0	As for “narrow” reference population	23.0
The Poor/Social Assistance	% of poor population receiving some social assistance/welfare	26.0	% of total population	7.5
The Poor/Microcredit	% of population receiving loan	7.6	% of total population	2.2
The Disabled	Disabled beneficiaries as % of disabled population	35.0	As for “narrow” reference population	35.0
Children with Special Needs (CWSN)	CWSN receiving assistance as % of poor children aged 5-14 years	48.0	% of all children aged 5-14 years	14.0
Distributional Impact of SP				
Poverty-Targeting	% of poor population who receive some assistance SP expenditure per poor person as % of annual per capita poverty line income/expenditure			51.0 11.6
Impact of SP Transfers on Household Income	SP expenditure per poor beneficiary as % of annual per capita poverty line income/expenditure			22.7

Source: Chapter 5 Tables.

The other important feature of population change in Viet Nam is urbanization. The urban share of Viet Nam's population is now approaching a quarter, having increased from a fifth in 1989. In absolute terms, it has increased by almost 40%, from 13 to 18 million. The current urban growth rate, 3.4% annually, almost three times of that prevailing in rural areas, reflects the high rural-urban migration of recent years.

In 1999, there were 16.6 million households in the country with an average household size of 4.6, compared with 4.8 in 1989. The decline is due primarily to the marked reduction in fertility over the same period. The 2002 DHS reported a further decline in household size to 4.4 persons. There is an unusual little difference in average household size between urban and rural areas. In

Table 2.1. Population

Item	Population (000s)			Change 1989-1999		Estimates 2002
	1980	1989	1999	Growth Rate	No.	
Total Population	53,700	64,376	76,323	1.7%	11,947	80,000
Urban Population	12,919	18,077	3.4%	5,158		
Rural Population		51,457	58,246	1.2%	6,789	
% Urban		20%	24%			
Ethnic Minorities		8,369	10,527	2.3%	2,158	
% Ethnic Minorities		13%	14%			
By age		1989	1999	1989	1999	2002
0-4		8,892	7,173	14%	9%	7%
5-14		15,896	18,100	25%	24%	23%
15-24		13,295	15,147	21%	20%	18%
25-44		15,909	22,739	25%	30%	30%
45-59		5,804	7,028	9%	9%	11%
60+		4,580	6,136	7%	8%	10%
Total		64,376	76,323	100%	100%	100%
Households		13,400	16,662	2.2%		17,800
				annual		
				growth rate		
Average Household Size		4.8	4.6			4.5
Vital Rates (per 1000)	1980	1989	1999			
Crude Birth Rate	36	30	20			
Crude Death Rate	8	8	6			
Rate of Natural Increase	28	22	14			
Total Fertility Rate	1987-1989	1992-1996	1998-2002			
	3.9	2.7	1.9			
Life Expectancy at Birth	1990		2001			
Male	63		68			
Female	65		69			

Sources: 1999 Census; DHS. 2002.; UNDP. 2003.; World Bank. 2004.

1999, there were approximately 4 million and 12.6 million urban and rural households, respectively.

In order to derive current (2002) indicators for this study, the 1999 Census population and household figures were extrapolated by the observed intercensal growth rate. The resultant estimates of total population and total households in Viet Nam are, therefore, approximately 80 and 18 million, respectively.

B. The Economy

In recent years, Viet Nam has been one of the fast-growing economies in Asia. Between 1993 and 2003, real GDP per capita grew by an average of 5.9% per annum and in some years, GDP grew by more than 8% (ADB *et al.*, 2004). In 2003, the rate of growth of GDP was estimated to be just over 7% (CIME, 2004). Even in the years following the East Asian crisis, from which Viet Nam's economy was relatively insulated because of tight restrictions on the capital account, real economic growth was still in excess of 4% per annum (Poverty Working Group, 1999).

Different regions and sectors have benefited from this dramatic growth to varying degrees. The rapid growth of Viet Nam's economy has been accompanied by a gradual change in its sectoral composition. In 1993, agriculture, forestry and fisheries accounted for just 30% of GDP, while services accounted for 41%, and industry and construction accounted for 29% of GDP (GSO, 2002). By 2002, the agricultural sector's share in national income had dropped to 23%; services had declined slightly to 38%; and industry had boomed to 39%. The highest growth rates, sometimes exceeding 10% per annum, have been recorded in the industrial growth poles located in and around Ho Chi Minh City, Hanoi, Haiphong, and to a lesser extent, Danang, which have attracted the lion's share of foreign direct investment. Some agricultural areas, particularly the Mekong Delta, North Central Coast, and southern parts of the Central Highlands, have also experienced fast economic growth—largely due to Viet Nam's booming exports of rice, coffee, tea, spices, and other cash crops.

An unusual feature of Viet Nam's economy is the high concentration of economic activities in the hands of the State. In 2002, State companies accounted for 38% of GDP, compared with 35% by household and private enterprises, 14% by "foreign-invested" enterprises, and 4% for both collective and "mixed" enterprises. The state sector, which includes provincially as well as nationally owned enterprises, remained remarkably resilient in the face of huge inflows of FDI in the late 1990s.

In 2003, the State budget accounted for D158,020 billion or approximately 25%³ of GDP. Some D12,570 billion was to be spent on pensions and social relief, accounting for just below 8% of projected expenditures (GSO, 2003). A further 12.3% (D19,453 billion) of the budget was to be spent on education and training, with 3.1% (D4,860 billion) on health care.

In 2002, the last year for which there is data, Viet Nam received \$1,277 million in Official Development Assistance, down from \$1,453 million in 2001. This figure accounts for 3.6% of GNI, 16.2% of Central Government Expenditure and about \$16 for each person living in Viet Nam (World Bank, 2003). Viet Nam's major donors, in descending order of importance, are Japan, WB (IDA), ADB (ADF), and the IMF, followed by France, Denmark, and Germany (OECD, 2004). At the end of 2002, Viet Nam's debt stock stood at \$12,165 million, of which \$10,503 million was from official creditors. Of this \$7,635 million was from bilateral donors and \$2,868 million from multilateral donors, the vast majority of which was concessionary (ADB *et al.*, 2004). In 2002, public debt service was estimated to account for 3.3% of GDP, down from 4.9% in 1999.

Table 2.2. The Economy

Item	1995	1999	2002
GDP (billion dong, current)	140,258	399,942	536,098
GDP per capita growth	–	4.8%	7.0%
By Sector (% of GDP)			
Agriculture, Forestry and Fisheries	29.9	25.4	23.0
Industry and Construction	28.9	34.5	38.0
Services	41.2	40.1	28.0
By Ownership (% of GDP)			
State	40.2	38.8	38.3
Private	3.1	3.4	3.9
Household	36.0	32.9	31.4
Collective	10.1	8.8	8.0
Mixed	4.3	3.9	4.5
Foreign Enterprises	6.3	12.2	13.9
Foreign Direct Investment			
Number of Projects	370	311	754
Registered Capital	\$650.8	\$1,568.0	\$1,557.7
Aid as % of GDP	2.0%	5.0%	3.6%

Sources: GSO. 2002.; CIEM. 2004.; ADB *et al.*, 2004; World Bank. 2004.

³ In 1999, Central Government Expenditure was 29% of GDP, but this fell to 24.3% of GDP in 2001 (World Development Indicators, 2001 and 2004).

C. Employment and Labor Force

The labor force situation in Viet Nam changed in two important respects during the 1990s. In the first place, the previously mentioned changing population age structure has led to a reduction in the ratio between the inactive and the active populations, from 1.16 to 1.06. This change would have been greater, but for the increase in school enrolment ratios (see next paragraph), which is the primary reason why the overall participation rate (defined as the proportion of the over-15-year-old population is in the labor force and thus, classed as active) decreased from 77% to 73%. This probably also explains the decrease in women's share of total employment during the same period. Unemployment in urban areas has also decreased significantly to around 5.8% of the labor force compared with around 9% five years earlier; nationally, the unemployment stands at around 4%. Underemployment⁴ is, however, significant at around 12% of those employed; underemployment is lower in 1989 and slightly higher in rural areas. In all, around 5.6 million workers are either unemployed or underemployed.

Changes in the structure of employment reflect those that have taken place in the economy as a whole: service sector employment growth reached almost 6% annually, approximately double the overall rate of employment growth. As a result, this sector's share in total employment increased by one-third, from 12% to 16%, while that of agriculture declined. Agriculture, however, remains by far the most important sector accounting for around 59% of total employment. Manufacturing's share of total employment stayed much the same at 14–15%. The other major structural change is the dramatic shift from the state and collective sectors to the private sector, which now accounts for more than 60% of total employment, compared with only 27% in 1989.

Employment of children aged 13–14 years old decreased by 14% during the 1990s, but it is still significant at 16% of this age group. There are, however, pronounced differences between urban and rural areas, with the child employment rate in the latter being almost two times higher than in urban areas. This disparity is, nevertheless, substantially smaller than in 1989 when the rural child employment rate was five times greater than the urban rate. Reasons for this decrease are increased school enrolment in rural areas and increasing incomes.

⁴ Defined as those working under 16 hours (two days) per week. See Bales, 2000.

Table 2.3. Employment and Labor Force

Item	No. (000s)		Change 1989-1999		
	1989	1999	AGR	Increase	
Total Population	64,736	76,328	1.7%	11,592	
Population (15+ yrs)	39,151	50,766	2.6%	11,615	
Labor Force	30,026	37,034	2.1%	7,008	
Participation Rate	77%	73%			
Dependency Ratio	1.16	1.06			
Employed Population (15+ yrs)	26,974	35,847	2.9%	8,873	
Unemployment Rate*	4.9%	5.8%			
Female Employment (no.)	14,051	17,339	2.1%	3,288	
Female Employment (%)	52%	48%			
Urban Employment (no.)	4,627	7,721	5.3%	3,094	
Urban Employment (%)	17%	22%			
Educational Attainment	1989	1999	1989	1999	AGR
Primary	19,907	24,882	74%	69%	2.3%
Secondary	3,857	5,326	14%	15%	3.3%
Tertiary	3,210	5,639	12%	16%	5.8%
Ownership					
Government	4,179	3,503	15%	10%	(1.7%)
Collective	15,605	9,673	58%	27%	(4.7%)
Private	7,190	22,671	27%	63%	12.2%
Total 26,974	35,847	100%	100%	2.9%	
Child Employment (13-14 yrs)	1989	1999	Change		
Population (13-14 yrs)	2,969	3,708	25%		
Employed	681	584	(14%)		
Employment Rate (all)	23%	16%			
Urban	5%	7%			
Rural	27%	18%			

*As cited in GSO, 2002, p. 75, calculated rates differ markedly.

Sources: 1999 Census; GSO. 2002. *1999 Population and Housing Census: Labor Force and Employment in Vietnam*. Hanoi.

D. Education

The previous paragraph summarized major changes in labor force participation that occurred in Viet Nam during the 1990s. Several of these changes resulted from increased school enrolment. At primary school level, there has been relatively little change except among the ethnic minorities, where enrolment of primary school age children increased from 25% to 80%.

The improvements are most marked for lower and upper secondary schooling, where current national enrolment rates have reached 72% and 42% of the relevant age groups respectively, compared with 30% and 7% respectively in 1989. These changes have been most pronounced in rural areas and among ethnic minorities, although the latter still lag behind overall rural enrolment

rates. An important feature is that differences in enrolment rates between urban and rural areas and by gender are relatively minor.

Aside from the impact on the labor force, these changes now mean that literacy levels approach or exceed 95% for all ages from 10 to 49 years.

Table 2.4. Net Enrolment Rates, 1993 and 2002

Net Enrolment Rate	1993	2002	Change (%)
Primary —All Viet Nam	87*	91	4
Rural	85	89	4
Ethnic Minorities	64	80	16
Lower Secondary	30	72	42
Rural		26	70
44			
Ethnic Minorities	7	48	41
Upper Secondary	7	42	35
Rural	5	38	33
Ethnic Minorities	2	19	17
Literacy		1999	
10-14		96%	
15-19		95%	
20-49		93-95%	
50+		75%	
All		90%	
Urban		95%	
Rural		90%	
Male		94%	
Female		88%	

*As % of relevant age group.

Sources: ADB *et al.*, 2004; 1999 Census.

E. Health

I. General Health

In 2002, more than 80% of the population was served by a commune health center within 4 km (half were within 1.5–2 km) providing maternal and child health services. Of the communes, 77% were served by a health fieldworker providing basic services, including provision of basic medicines, vitamin A, ORS packets and other services. Virtually all communes received at least quarterly visits by a nonresident health worker. Several health education programs are in operation: general family planning (c. 90% of communes); immunization (c. 85%); sanitation; nutrition; diarrhea control; AIDS; drug abuse; and use of iodized salt and vitamin A (all 40–50%).

Partly as a result of these efforts, key indicators of the health situation in Viet Nam show substantial improvements in recent years. Rates for infant mortality, child (under five years old) mortality, and maternal mortality have all fallen by between a third and a half since the late 1980s. Two thirds of children are now fully immunized against tuberculosis, measles, diphtheria and polio, with less than 5% having received no immunizations at all. Of the pregnant women, 87% received some ante-natal care; and 85% of births are now attended by skilled personnel (compared with 77% in the mid-1990s). Just under 80% of married women use some form of contraception. In general, rural values for the above indicators tend to be a couple of percentage points worse than the national average with urban values being considerably better.

Malnutrition. Although the proportion of undernourished people has fallen from 27% in 1990 to 18% by 2000, the extent of malnutrition is still high, especially among children. In 2002, it was reported that 28% of children under five years old were moderately or severely underweight.

HIV/AIDS. More than 154,000 people are currently infected and this is expected to increase to between 300,000 and 350,000 in the next five years; the associated sero-positive rates are just under 190 (per 100,000 population) today, potentially rising to 440 in five years' time. There are currently 6,500 children affected with HIV/AIDS, while 28,000 children are living with adults with HIV/AIDS.

2. Disability

Viet Nam currently has about 5.1 million disabled persons, accounting for 6.3% of the total population. There are 1.8 million with severe disabilities; of these, 150,000 are aged 15-20; 510,000 are aged 20-49; and the remaining around 1.1 million are aged over 50. Disability rates are substantially higher among men and in rural areas.

The MOLISA/UNICEF survey of child disability estimated that 2.8% of children aged up to 17 years had some disability, with half that proportion having severe disabilities.⁵ This is probably the most reliable data other than the census. Taken together, these surveys imply that there are around 840,000 children with some disability, of whom about 420,000 are severely disabled. Of these, approximately 135,000 are completely incapacitated.

Among children, 55–60% of disabilities are congenital, 30% result from disease/illness, 7% result from war legacies (unexploded ordnance) with the

⁵ Cited in Yoder, 2003.

remainder being due to accidents and other causes. The number of people currently affected with Agent Orange (which is still producing congenital birth defects and is now affecting third generation children) is 174,000 (MOLISA estimate). The cumulative number of persons affected with Agent Orange since the end of the war could exceed one million.

Table 2.5. Health Indicators

Indicator	Unit	1980	1987- 1992	1993- 1997	1998- 2002	Ratio 2002/ 1990	Source
Infant Mortality Rate	Per 1000	57	35.7	29.6	18.2	0.51	UN/WB
Under 5 Mortality Rate	live births		47.4	39.5	23.6	0.50	UN
Maternal Mortality Rate	Per 100,000 live births		160.0		100.0	0.63	WB/UNDP
Use of Contraception by Married Women	%				79.0		DHS
Antenatal Care	% of pregnancies				87.0		DHS
Births Attended by Skilled Person	% of births			77.0	85.0		DHS
Immunization							
BCG	% of children				93.0		DHS
Measles					83 (97)		DHS (UN)
Polio			85.0		93-76**		
Diphtheria					88-72		
All					67		

**Rates are for first and third vaccinations.

Sources: DHS. 2002; UNDP. 2003; World Bank. 2004.

F. Housing and Physical Infrastructure

Access to clean water and hygienic sanitation has increased considerably since the early 1990s. In 2002, just less than half of households had access to clean water, compared with around a quarter of households in 1993. The proportions of households with hygienic sanitation increased from 10% to 25% in the same period. Improvements occurred in urban and rural areas, although the situation remains severely deficient in rural areas with under 40% of rural households having access to clean water and less than 12% hygienic latrines. The values for ethnic minorities are worse, with only 13% and 4% having access to good water or sanitation.

General housing conditions have almost certainly improved, along with other social and economic indicators during the 1990s. A key indicator is that the number of persons per sleeping room decreased from 3.3 to 2.9 (13%) in only four years, from 1998 to 2002. Electricity is now almost universal in urban areas and reaches more than 70% of rural households.

Table 2.6. Housing Conditions

Item	Location	1993	1998	2002
Safe Water	Viet Nam	26*	41	49
	Urban	59	77	76
	Rural	18	29	40
	Minorities	5	10	13
Improved Sanitation	Viet Nam	10	17	25
	Urban	45	60	68
	Rural	2	3	12
	Minorities	1	1	4
Electricity	Viet Nam		78	
	Urban		96	
	Rural		72	
Persons per sleeping room	Viet Nam		3.3	2.9

*Percent of households.

Source: 1999 Census.

G. Poverty and Inequality

Viet Nam's record of poverty reduction during the 1990s and early 2000s has been remarkable. Although, several different definitions of poverty and several difference poverty lines are in common usage in Viet Nam, all show dramatic and sustained decreases in poverty since the *doi moi* (renovation) reforms of the late early 1980s. For example, the expenditure poverty line developed by the General Statistics Office and WB for use with the Viet Nam (Household) Living Standards Surveys,⁶ shows poverty falling from 58% in 1993 to 37% in 1998 and 29% in 2002 (ADB *et al.*, 2004). This would mean that more than 20 million people, almost a third of Viet Nam's total population, were lifted out of poverty in less than a decade. During the same period, the percentage of the population below the food poverty line dropped from 25% in 1993 to around 11% in 2002. According to the same surveys, the depth of poverty fell by almost two-thirds (from 18.5% to 6.9%) between 1993 and 2002. Data

⁶ In 2002, the food poverty line was D1.38 million per capita (D115,000 per month) and the general poverty line was D1.93 million (D160,000 per month) (ADB *et al.* 2004. [p. 19]). In comparison, mean per capita expenditure was around D250,000 per month.

using MOLISA's poverty line based on rice equivalent income⁷ reveal a similar trend with poverty declining from 30% in 1991 to 17% in 2000 and around 11% in 2003; the poverty rate in rural areas is now under 15%. When the "international poverty line" of \$1/day that is used to monitor Goal 1 of the Millennium Development Goals is applied, poverty is shown to have fallen by four-fifths: from 50.8% in 1990 to 10.6% (ADB *et al.*, 2004). Viet Nam's remarkable success in reducing poverty, no matter how it is defined and measured, is mirrored in the changes in other social indicators described elsewhere in this chapter.

Despite these remarkable successes, poverty is still severe and persistent in certain regions of Viet Nam. Both the 1999 Census and the 2002 Vietnam Household Living Standards Survey show that poverty in Viet Nam has a strong spatial characteristic, with the highest poverty rates being found in the upland areas of the North West Mountains and Central Highlands, where the poverty rate exceeds 50% (Minot, Baulch and Epprecht, 2003; General Statistics Office, 2004). These two regions accounted for 20% and 10% of poor people (according to the GSO/WB expenditure poverty line) in 2002, and are also the regions where most of Viet Nam's disadvantaged ethnic minorities live (ADB *et al.*, 2004). Despite their relatively low poverty rates, many poor people also live in the densely populated Red River and Mekong deltas, which each accounted for 17% of national poverty in 2002.

Poverty in Viet Nam is also concentrated among certain types of peoples and occupation groups. Among the ethnic minorities, poverty remains stubbornly high: the poverty rate among the non-Kinh and non-Chinese fell from 86% to 69% between 1993 and 2002, and still exceeds 80% among the Central Highland minorities and the Hmong (ADB *et al.*, 2004). On average, per capita expenditure among the ethnic minorities was 13% lower than for the Kinh and Chinese. The Participatory Poverty Assessments conducted in 16 of Viet Nam's 61 provinces in 1999 and 2003 show that poverty in urban areas is also heavily concentrated among recent migrants, particularly those without permits to live in the Viet Nam's booming cities. Urban migrants without registration permits are excluded from the benefits to which the rest of the urban poor are entitled to, such as exemptions from school fees and health care cards; and they face difficulties in accessing other public services (Poverty Working Group 1999: ADB *et al.*, 2004). Both ethnic minorities and urban migrants tend to share many of the other features that characterize the

⁷ MOLISA has adopted different poverty lines for different areas: approximately D80,000 per month in island and mountainous areas; D100,000 in other rural areas; and D150,000 in urban areas.

poor in Viet Nam, such as a lack of education, poor housing, working in agriculture, and living/coming from large families with many dependents.

Inequality in Viet Nam remains modest by international standards—the Gini coefficient of per capita expenditures have risen from 0.34 in 1993 to 0.37 in 2002, while the ratio of the richest to poorest quintiles income share increased from 4.9 in 1993 to 8.4 in 2002. Much of the increase in inequality has been driven by differences in inequality between rural and urban areas, where inequality tends to be much more pronounced (Poverty Working Group, 1999). Despite the relatively small increase in recorded inequality, the “rich-poor” gap remains a serious concern for the Government of Viet Nam, and questions are asked periodically about the reliability of the GSO’s income and expenditure estimates (ADB *et al*, 2004).

Table 2.7. Poverty and Inequality

Poverty (%)	1993	1998	2000	2002
Poverty Headcount	58.1	37.4		28.9
Urban	25.1	9.2		6.6
Rural	66.4	45.5		35.6
Ethnic Minorities	86.4	75.2		69.3
Food Poverty Headcount	24.9	15.0		10.9
Urban	7.9	2.5		1.9
Rural	29.1	18.6		13.6
Ethnic Minorities	52.0	41.8		41.5
% of Households Living				
Below MOLISA Poverty Line*			17% (20%) **	13%***
Poverty Gap	18.5	9.5		6.9
Urban	6.4	1.7		1.3
Rural	21.5	11.8		8.7
Ethnic Minorities	34.7	24.2		22.8
Population Living on Less Than 1PPP\$ per day	39.9	16.4	15.2	13.6
Inequality				
Richest/Poorest Ratio	4.97	5.49		6.03
Gini Coefficient (per capita expenditures)	0.34	0.35		0.37

* MOLISA poverty line was changed in 2001; comparisons with previous periods are not, therefore, possible.

** Rural poverty

*** MOLISA estimate.

Source: ADB *et al*. 2004; CPRGS. 2002.

H. Summary

There can be little doubt that social and economic conditions in Viet Nam have improved considerably since the late 1980s: GDP per capita has risen; poverty rates have fallen; child and infant mortality rates have fallen; use of and advice on contraception is widely available as are ante-natal care and skilled assistance at deliveries; school enrolment rates have increased; and access to clean water and sanitation has risen. These changes occurred in both rural and urban areas, although most indicators remain significantly worse in the former. They are worse also among the ethnic minorities, who make up around 14% of the population.

These changes are encapsulated in the national Human Development Index, which increased from 0.58 in 1985 to 0.61 in 1995 and 0.68 in 2002. Viet Nam's international ranking has improved from 120 to 109 (out of 173 countries) since 1995—19 steps above its ranking based on GDP per capita alone.

Despite these achievements, the situation in the 1,870 most disadvantaged communes, which are mostly located in mountainous areas where ethnic minorities are concentrated, remains acute:

- (i) 20–30% do not have roads leading to commune centers;
- (ii) 40% do not have enough classrooms, 5% do not have any permanent health facilities, and 20% have no commune level markets;
- (iii) 55% do not have access to safe water and 40% have commune centers without electricity;
- (iv) 50% do not have enough small-scale irrigation works; and
- (v) every year 1–1.5 million people qualify for emergency relief in these communes.⁸

III. The Definition of Social Protection in Viet Nam

There is no formal definition of SP in Viet Nam that is as all-embracing as the ADB definition. This is not altogether surprising as the term “Social Protection” has only been adopted by IFIs in recent years; it is also not in common usage in many developed countries. The main ministry involved with SP activities is the Ministry of Labor, Invalids and Social Affairs (MOLISA). One of its

⁸ Socialist Republic of Vietnam. 2003. *The Comprehensive Poverty Reduction and Growth Strategy (CPGRS)*. (pp. 20–21). Hanoi.

constituent departments, the Department of Social Protection,⁹ is responsible for social assistance programs, disaster relief, child protection (but more restricted than ADB definition) and overall coordination of the major Hunger Eradication and Poverty Reduction Program (HEPR). Other MOLISA departments are responsible for social insurance policy, labor and employment policies, vocational training, and programs to reduce drug abuse and prostitution. Virtually all MOLISA's activities, therefore, come under ADB's definition of SP. However, some aspects of ADB's definition do not fall within MOLISA's remit, e.g. assistance with education and health costs, area-wide/microschemes, and some aspects of child protection.

In the Comprehensive Poverty Reduction and Growth Strategy (CPRGS),¹⁰ the relevant chapter is entitled "Development of Safety Nets for the Poor and for Victims of Natural Disasters." This chapter includes policies to:

- (i) provide subsidies/exemptions to the poor for their health and education costs;
- (ii) help disabled and vulnerable people to be more self-sufficient and integrated into mainstream society;
- (iii) expand the coverage of social insurance policies, including community-based schemes;
- (iv) expand SP and safety-net schemes for the poor, the hungry, and those unable to work and with no other means of support;
- (v) protect and educate vulnerable children and those with special needs (CWSN), e.g. orphans, child workers and street kids, disabled children (including victims of HIV/AIDS and Agent Orange);
- (vi) improve labor market access for the poor and the vulnerable;
- (vii) enhance the labor legislation to protect workers' rights and increase safety at work;
- (viii) develop an effective system of emergency social relief solutions; and
- (ix) expand the participation and role of nongovernmental organizations in developing and implementing safety net policies.

There is a high degree of concordance between the policies contained in this chapter and the ADB definition of SP. The main differences are the

⁹ It is understood that a more accurate translation of the Vietnamese name for this department, Bao Tro Xa Hooi, would be Social Assistance.

¹⁰ CPRGS, 6/2002.

exclusion from the CPRGS chapter of social funds (i.e. area-based schemes to improve basic community infrastructure), early child development, and adolescent reproductive and sexual health.

Overall, despite the absence of a formal definition, Vietnamese notions of SP approximate the more traditional view that SP should be seen as primarily consisting of direct assistance to poor and vulnerable households, as well as insurance and other schemes to reduce vulnerability to risks arising from unemployment, old age and disability.

In this context, it should be noted that IFIs operating in Viet Nam also tend to use a more restrictive definition of SP than the ADB. The UN/MOLISA report on Basic Social Services in Viet Nam (Hanoi, 1999) limited their chapter on SP to social insurance, social assistance, employment services, disaster relief, and programs for the disabled and children with special needs. The Poverty Task Force Consultation Document on Reducing Vulnerability and Providing Social Protection (Hanoi, 2002) widened their discussion to also include mention of informal household and community-based SP mechanisms, the Hunger Eradication and Poverty Reduction Program (HEPR), microfinance, crop insurance, subsidized access to health care, and agricultural extension. The 2004 Viet Nam Development Report—Poverty¹¹ finally uses the term “Social Safety Nets” to concentrate on the direct transfer of resources to households under the Hunger Eradication and Poverty Reduction Program and the SOE Retrenchment Program, which also involved household level transfers.

In general, the review of SP definitions used by the Vietnamese and IFIs operating in Viet Nam reveals a more restrictive approach to SP than the ADB definition. This is particularly the case in the ADB Area-based and Child Protection subcomponents and those related to social funds/area development and early child development. The ADB definition includes programs for small-scale community level infrastructure as well as nutrition, health education, immunization and pre-schooling that are not included in definitions currently prevailing in Viet Nam.

In other respects, there is a high degree of consistency between ADB and Vietnamese definitions. Thus, labor market activities, social assistance and social insurance programs, direct subsidies to households for educational and health costs, emergency relief, and programs targeted at children with special needs are considered to be part of SP irrespective of whose definition is adopted. Conversely, microfinance is generally seen as falling outside the definition of SP.

¹¹ ADB et al. 2004.

It seems to be essential to distinguish between SP programs and activities and those that fall logically into the more widely defined categories of overall poverty reduction, and social development. For example, poverty reduction activities include policies and programs to promote economic growth and to improve the physical infrastructure of a country that should not be considered to form part of SP. Similarly, social development includes general health and education programs designed to benefit a country's entire population and increase its development potential, which also fall outside the definition of SP. Yet some of ADB's SP components contain elements of all of these, e.g. vocational training, area development/social funds, early child development.

The definition of SP to be used for this study is: "The set of policies and programs that enable vulnerable groups¹² to reduce, mitigate and /or cope with the risks associated with their particular circumstances and that do not fall under activities normally associated with other sectors such as rural development, basic infrastructure, health and education, and that are both targeted at these groups and involve cash or in-kind transfers."

A detailed discussion of the definition including ADB's definition of SP can be found in the forthcoming section Social Protection Index and Multicountry Analysis of this book. Based on the above definition, Table 3 contains a schedule of the types of programs that are considered to fall within the above definition. The Table also indicates those programs falling within ADB's categorization of SP activities that will not be considered in this study. The latter primarily include programs that either involve the construction of physical or social infrastructure, and integrated community development schemes and programs that traditionally fall within the education and health sectors, e.g. primary and pre-school education, immunization, health and nutrition education, pre- and post-natal care.

¹² The primary target groups for SP policies, which reflect ADB's definition of SP, are the unemployed/underemployed, the elderly, the sick, those affected by natural disasters, the poor, the disabled, and children with special needs.

Table 3. Inclusion/Exclusion of Social Protection Programs

Component/Subcomponent of Social Protection	Included/Excluded	Comments
Labor Market Programs		
Direct Employment-Generation (microenterprise development and public works)	Included	Includes loan-based programs to support small businesses, etc.
Labor Exchanges and Other Employment Services	Included	Includes retrenchment programs
Skills Development and Training	Excluded	Unless targeted at particular groups, such as the unemployed or disadvantaged children
Labor Legislation (including minimum age, wage levels, health, and safety, etc.)	Included	Not amenable to quantification
Social Insurance Programs		
Programs to cover the Risks Associated with Unemployment, Sickness, Maternity, Disability, Industrial Injury, and Old Age Health Insurance	Included	
	Included	
Social Assistance and Welfare Programs		
Welfare and Social Services (targeted at the Disabled, the Indigent, Those Affected by Disasters, and Other Vulnerable Groups)	Included	
Cash/In-kind Transfers (e.g. food stamps, health cost exemptions or subsidies)	Included	
Temporary Subsidies for Utilities, Housing, etc.	Included	Only if imposed in times of crisis and if targeted at particular vulnerable groups. General subsidies are excluded even if their rationale is to assist the poor
Micro and Area-based Schemes		
Microinsurance/Microfinance Schemes	Included	Microfinance seen as an important aspect of SP. Mainstream rural credit programs will be excluded.
Agricultural Insurance	Included	Agricultural insurance will rarely be affordable and therefore, targeted at the most vulnerable farmers
Social Funds	Excluded	Except where direct transfers to households occur
Disaster Preparedness and Management	Included	Reconstruction of physical infrastructure is excluded. De-mining programs included. Number of beneficiaries not amenable to quantification.
Child Protection		
Child Rights and Advocacy/Awareness Programs Against Child Abuse, Child Labor, etc	Included	Not amenable to quantification.
Early Child Development Activities	Excluded	Direct assistance for health and education would be included in following categories. Otherwise, these programs fall within basic health and education programs, which are excluded.
Educational Assistance (e.g. school feeding, scholarships, fee waivers)	Included	Will generally be included under social assistance
Health Assistance (e.g. health cost reduced fees/subsidized medicines for vulnerable groups)	Included	
Family Allowances	Included	Would not include transfers through the tax system
Street Children/Child Worker/ Orphan Initiatives	Included	

Source: Authors.

IV. Current Social Protection Activities and Programs

A. General

In this chapter, the main SP programs and activities that are currently operated by government agencies, IFIs, and national and international NGOs in Viet Nam are described. The objectives are twofold:

- (i) to present the main features of each program; and
- (ii) to provide the quantitative information needed to give the basis for the formulation of an SPI.

The key variables that are seen as the building blocks for the SPI¹³ are:

- (i) the cost/expenditure of SP programs;
- (ii) the coverage of the programs in terms of the number of beneficiaries; and
- (iii) the impact of these programs on the poor in terms of the proportion of program beneficiaries who are categorized as poor, using the current national poverty line.

Sections B to F of this chapter are structured around the components and subcomponents of the ADB's definition of SP listed in Table 3.

Unless otherwise stated:

- (i) Information on government programs comes from interviews with agency officials;
- (ii) Data on IFI projects comes from the Viet Nam Cooperation Report (UNDP, 2003), the NGO Directory (NGO Resource Centre, 2003), publicity material/handouts of selected INGOs, and IFI websites;
- (iii) Poverty levels are based on the GSO poverty line, including food and nonfood expenditures. It should be noted though that SP programs targeted at the poor use the MOLISA poverty line as the criterion (see section II.G).

B. Labor Market Programs

I. Labor Legislation and Standards

General. The current Viet Nam Labor Code¹⁴ has been developed since labor legislation was first enacted following the 1945 August Revolution. In its own words, the Labor Code “protects the rights to work, interests and

¹³ For details, see the forthcoming section Social Protection Index and Multi-Country Analysis of this book.

¹⁴ Socialist Republic of Vietnam. 2002.

other rights of workers and, at the same time, the lawful rights and interests of employers thereby creating conditions for a harmonious and stable labor relationship.” It contains 17 chapters and 196 articles. The Labor Code is comprehensive in its coverage of labor issues in that it includes provisions relating to aspects such as vocational training and social insurance that are often dealt with in separate legislation. In terms of this study, the most important provisions are:

Chapter I: General Provisions. The Code applies to all enterprises employing workers under a labor contract (Art. 2) (30% of employment in Viet Nam falls into this category); establishes the right to work independent of “sex, race, social class, beliefs or religion” (Art. 5); establishes a minimum wage (Art. 7); provides employees’ rights “to form, join and participate in (trade) union activities ... in order to protect his legal rights and benefits ... and to participate in the management of the business” (ibid.); allows for collective bargaining and the involvement of Trade Unions in discussions relating to labor relations (Art. 8); encourages share ownership and capital investment by workers (Art. 11); provides for Trade Unions to work with State bodies and other organizations (Art. 12).

Chapter II: Employment. This provides for the State to formulate policies to increase job creation and investment and to increase the employment of ethnic minority workers (Art. 14); establishes a national employment program and a National Employment Fund (Art. 15); provides for retrenchment payments (one month’s wages per year of employment) and retraining (Art. 16); establishes employment exchanges (Art. 17).

Chapter III: Vocational Training. This contains various provisions relating to the establishment and regulation of vocational training establishments (responsibility for vocational training lies with MOLISA and not the Ministry of Education).

Chapter IV: Labor Contract. This comprises of requirements and conditions relating to labor contracts (compulsory for all employees of registered enterprises) including conditions of work, remuneration, sick pay/leave, termination etc.

Chapter V: Collective Labor Agreements. This provides for and sets down conditions for collective labor agreements that “must” include provisions relating to working hours, wages/bonuses, occupational safety, and social insurance (Art. 47).

Chapter VI: Wages. This establishes the State's right to set a minimum wage in consultation with Trade Union and employers' representatives (Art. 56) (minimum wage raised from D210,000 a month in 2002 to D290,000 in 2003); makes bonuses mandatory subject to a firm's profitability and its workforce's productivity (Art. 64).

Chapter VII: Time of Work-Time of Rest. This contains provisions relating to working hours, payment for bank holidays, annual leave, and compassionate leave.

Chapter VIII: Occupational Safety and Hygiene. This has key provisions: "An employer shall be responsible for providing adequate means of protection to the employees ensuring occupational safety and hygiene for the employees (Art. 95). The Government shall establish a national program on labor protection, occupational safety and hygiene including (in consultation with the Vietnam General Confederation of Labor) technical research and promulgation of laws and regulations." (ibid.) Other provisions cover the duty of employers to provide a safe working environment, provide protective devices and warnings for dangerous machinery (Art. 97/8); health care and first aid (Art. 103); payment of compensation in case of industrial injury or death (Art. 107).

Chapter IX: Separate Provisions Concerning Female Employees. This contains policies to improve training and employment of female workers (Art.110); maternity leave (with benefits as included in the Social Insurance scheme) (Art. 114).

Chapter X: Separate Provisions Concerning Junior Workers and Other Categories of Worker. This contains prohibition, except in certain defined situations, of children under the age of 15 (Art. 120) and restrictions on the employment of children aged 15–17 years (Art. 121); preferential treatment for the training and employment of disabled workers, including the establishment of a quota for disabled workers¹⁵ (Art. 125–8) (see also 2 below).

Chapter XI: Social Insurance. This establishes the framework and contents of the Social Security system (see C.1 below for details).

¹⁵ Currently 2–3% of the workforce (see Hong, 2002).

Chapter XII: Trade Unions. This establishes the mandatory setting up of Trade Unions (Art. 153) and the provision of in-house facilities for the operation of the Trade Union (Art. 155).

Chapter XIII: Labor Disputes. This has procedures for resolving collective and individual labor disputes.

Chapter XIV: Labor Inspections. This contains functions and responsibilities of the State Labor Inspection office.

There are two IFI-funded programs to strengthen the implementation of the Vietnam Labor Code:

- (i) UNDP is assisting MOLISA to enhance its administrative capacity to implement effectively the Labor Code of Vietnam—c. \$1.6 million over five years; and
- (ii) the ILO, with German government finance, has a project to strengthen the labor inspection system through training and modernization—c. \$100,000 per annum.

Relating to Disabled Persons. The 1998 Ordinance on Disabled Persons contains the most important statement of national policy towards the disabled: “The State encourages and creates favorable conditions for disabled persons to exercise their right to on an equal basis their political, economic, cultural and social rights and develop their abilities to stabilize their life, integrate themselves into the community and take part in social activities” (Chapter 1, Article 3).

Other legislation ranging from the Labor Code (see above), laws, decrees, and circulars, seek to enshrine the rights of the disabled and to ensure that their needs and aspirations are taken into account in as many areas of government responsibility as possible. The Ministry of Health in 1997 issued a Plan for the Development of Rehabilitation 2000-2020. This plan, while concentrating on the physical rather than vocational rehabilitation, made the statement that declares “every disabled (person is) guaranteed on their education, economic status, job opportunity and improvement of quality of life.”

2. Direct Employment Creation

Viet Nam does not have any significant public works program, but does operate a revolving credit fund that makes small loans to small and household enterprises expressly for the purpose of job creation. The National Employment

Promotion Fund (NEPF, also known as Program 120) makes advances of approximately D200 billion per annum, which is divided among Viet Nam's 61 provinces, with an view to making small loans to assist job creation (about D10 million minimum for one work place to about D300 million maximum per entrepreneur). The NEPF was established in 1992 and has loaned a cumulative total of D21,000 billion. In 2001, under Decision 143, the NEPF was merged with the HEPR into the HEPR-EC.¹⁶

NEPF statistics from 1997 indicate that nearly 1.5 million people had found jobs on NEPF-approved projects. Fraser (1997) comments that if these statistics are credible (which he clearly does not believe them to be), they would be a very impressive achievement involving the creation of more than 300,000 jobs per annum for five years.¹⁷ The latest MOLISA estimates, from 2003, are that around 350,000 jobs a year are created by the HEPR-EC. The Employment Service Centers (ESCs) administered by mass organizations report equally impressive statistical results.

If the statistical and other evidence presented to this and other missions is accurate, there is a potential for the HEPC-EC program to generate up to 300,000 jobs per annum at minimal cost to the national budget. As Fraser (1997) comments with reference to the NETP, this could constitute a "very strong case for putting a lot more cash into the Fund." At the same time, he cautions that a major increase in the size of the NEPF would require a major increase in the capacity to administer it. In this case, MOLISA's ESCs network would be the obvious choice as the enhanced administrative arm of the HEPC-EC. However, until MOLISA and other mass organizations' estimates of the number of jobs created by the NETP/HEPR-EC can be verified, most donors view funding of the program with caution. In terms of expenditure, the total projected value of the fund for 2001-2005 is around D3,000 billion. In 2003, disbursements were estimated at D972 billion with repayments of D734 billion; outstanding and nonperforming loans amounted to D211 billion.¹⁸

3. Employment Service Centres

Following participation by MOLISA staff in an ILO conference on employment and training in 1987, Viet Nam was one of the first countries in the world to

¹⁶ The same decision renamed the Viet Nam Bank for the Poor as the Viet Nam Bank for Social Policy.

¹⁷ Frasers add that MOLISA stated rate of job creation is "even more remarkable" when two other factors are considered. First, that the repayment rate on loans is 96%. Second, that the NEPF administrators believe that for every project approved there are another six projects that could be approved, if funds were available.

¹⁸ VBSP unpublished data received through personal communication.

establish Employment Service Centres (ESCs) in its major urban centers. ESCs in Viet Nam operate as a loose confederation of several networks rather than a single network. The major network is under the jurisdiction of MOLISA (who operates 61 centers, one in each province) with other ESC networks operated by a range of other government and mass organizations (e.g. trades union, women's union, youth union). A key point to note is that, in contrast to ESCs in most developed countries, ESCs in Viet Nam operate as both job brokers and centers for skills upgrading.

According to Fraser (1997), a typical ESC in Viet Nam undertakes most, although probably not all, of the following functions:

- (i) providing counseling and advice concerning job opportunities and training options to job seekers;
- (ii) registering job seekers and trying to assist them to find work;
- (iii) assisting employers (especially public, joint venture and foreign employers) to find suitable workers;
- (iv) collecting information about the operations of the labor market;
- (v) operating vocational training centers that provide short-term employment-oriented training for skills in demand (both for paid jobs and for self-employment);
- (vi) operating small productions centers that both provide jobs for a few people and provide a bridge of experience between training and obtaining a job in the wider labor market;
- (vii) operating skill-training centers for disabled people, primarily with the aim of helping them to become at least partly self-supporting; and
- (viii) administer applications for credit and provide skill training for migrant workers returning from overseas.

Before 2002, about two thirds of the ESC placements were to employers in public sector enterprises and joint ventures, and to foreign employers. The 2002 Amendment to the Labor Code allowed foreign enterprises to recruit workers directly and since then, more than 1,000 small private employment agencies have been established. However, like the ESCs, all private employment agencies are urban-based and mostly concentrate on serving the needs of skilled workers and those workers wishing to work overseas—according to MOLISA (2004), approximately 360,000 Vietnamese workers went overseas.

Over the period 1993–1996, returns from ESCs indicate that about 430,000 people obtained training and 800,000 were assisted to find work (Fraser, 1997). In 2003, there were 176 ESCs in Viet Nam, which trained 100,000 workers and assisted 280,000 job seekers. Anecdotal evidence suggests

that most ESC networks do very little by way of systematic contact with either employers or school leavers, with most ESCs' focus being on the government and joint venture that "used to be based on them" to recruit their workers. Furthermore, there is evidence to suggest that the range of MOLISA and mass organization CES offices in any one province are located without any attempt to either make it easy for job seekers to find them, get to them or even know of their existence. There is also no apparent attempt to coordinate their employer contacts or services. These serious operational problems are being addressed by a three-year project between MOLISA and the US Department of Labor-funded project, which is working with 10 ESCs operated by MOLISA, the Viet Nam General Confederation of Labor and the Viet Nam Cooperative Alliance to develop new models to be "rolled out" to the other 166 ESCs in Viet Nam. The models under development focus on enhancing the capacity of the ESCs to promote employment through staff development (including employer outreach, job interviewing skills, vocational counseling, cooperation with other training institutions, and personnel/human resource management) and the provision of new equipment and job matching software (Aurora Associations International, 2003).

4. Skills Development and Training

Since 1999, MOLISA has taken over all responsibility for vocational training from the Ministry of Education. There are currently 213 state-funded vocational training schools, 82 privately funded training schools and 44 training school belonging to state-owned enterprises. In addition, there are 160 government-funded training centers and 137 vocational secondary schools. MOLISA's Department of Vocational Training estimates that 55% of the costs of vocational training schools are met by trainees, with the State budget contributing a further 26% of their costs, SOEs contributing 15% and international donors about 3%. The number of persons trained by the vocational schools in 2003 was 1,074,000 with total government expenditure of around D1,000 billion in 2002. It should be noted that there are conceptual issues about how much, if any, of these establishments should be considered to form part of SP. In particular, vocational training for school leavers would appear to be more logically included as part of other forms of further education, e.g. universities, teacher training colleges, etc.

Table 4.1 summarizes the information on training programs that are targeted towards particular vulnerable groups.

The ESCs are also involved in vocational training. Most of their vocational training courses are of relatively short duration (2 weeks to 1 month) and are offered on a fee-for-service basis. About 100,000 workers per annum are trained by the ESCs.

Table 4.1. Targeted Components of Vocational Training, 2002/03

Program	2002			2003		
	Number of Beneficiaries	Expenditure (D million)		Number of Beneficiaries	Expenditure (D million)	
		Total	Per Trainee		Total	Per Trainee
Children of War Invalids	9,496		0.90	10,102	9,280	0.92
Children of Poor Households	17,973	8,537	0.87	19,750	18,090	0.92
Ethnic Minorities Children	14,299	15,557	0.97	15,052	14,630	0.97
Total	41,768	37,992	0.91	44,904	42,000	0.94

Source: Estimates by the General Training Department.

Since both the vocational training schools and ESCs charge fees to their trainees and operate mainly in urban areas, they should be regarded as self-targeting SP programs with little impact among the poor (who make up less than 9% of the population of urban areas).

5. SOE Equitization (Retrenchment) Program

In mid-2002, the Social Safety Net Fund was established to assist workers made redundant from SOEs as a result of the latter's restructuring. This Fund, in its first year, provided an average of D28.8 million to 14,500 workers laid off from 374 SOEs,¹⁹ indicating a total expenditure of D416 billion. In all, SOE restructuring could lead to 250,00 redundancies by 2005.

C. Social and Health Insurance²⁰

Viet Nam's social security system contains two formal contributory nationwide scheme—Viet Nam Social Insurance (VSI) and Viet Nam Health Insurance (VHI)—plus a number of smaller area-based microinsurance schemes. In 2002, it was announced that the social insurance and health insurance were to be merged. However, the two schemes currently still operate as distinct entities and remain under the direction of two different Ministries (MOLISA and the MoH) and thus, are discussed separately.

¹⁹ ADB et al. 2004. (pp. 90–91)

²⁰ The material in this section is drawn from agency interviews and the following sources: Von Hauff, 2003; Mekong Economics, 2003. Poverty Task Force, 2002; and UN, 2003.

I. Viet Nam Social Insurance

Viet Nam's Social Insurance scheme was separated in 1996 to provide both short- and long-term benefits to public sector workers, military personnel, employees of state-owned enterprises, and waged employees of registered private companies. Short-term benefits include maternity leave, sickness benefits, employment injury, and redundancy pay, but unemployment benefits are specifically excluded. Long-term benefits include old age pensions and invalidity benefits for workers and their spouses. Contribution levels are 5% of salary for employees and 15% for employers. Until April 2003, membership of the VSI was compulsory only for enterprises with 10 or more employees, but since then it has applied to every registered company and enterprises. Nonetheless, the majority of workers in the informal economy do not participate in the voluntary social insurance scheme. Overall, it is estimated that 5.9 million workers are covered by social insurance out of a potential nine million wage employees.

The VSI's total expenditure in 2002 was D8,551,998 million, with the number of beneficiaries totalling 3,029,504. Table 4.2 gives a breakdown by category of beneficiary. In theory, the social insurance fund is autonomous of the state budget, but until 1999 the State was still the single largest source of social insurance financing. As shown in the table, the state budget still accounted for the majority of both beneficiaries and expenditures for pensions, death benefits, and professional diseases and accidents.

Table 4.2. Social Insurance Beneficiaries and Expenditure, 2002

Type of Benefit	Number of Beneficiaries		Expenditure (D million)	
All	Total	3,029,504	Total	8,551,998
Pensions	State budget	1,074,518	State budget	5,646,296
	VSI fund	196,165	VSI fund	1,281,206
Assistance to Families of Deceased	State budget	151,786	State budget	154,346
	VSI fund	33,665	VSI fund	34,218
Invalidity Benefit		311,813		922,567
Sickness Benefit		1,107,821		163,746
Pregnancy Benefit		114,971		316,171
Professional Diseases and Accidents	State budget	12,286	State budget	18,191
	VSI fund	11,022	VSI fund	15,257

Source: Department of Social Insurance, MOLISA

The level of benefits received by individuals cannot be ascertained with any accuracy, but table 4.3 shows the full benefit/compensation rates payable in 2003.

Table 4.3. Viet Nam Social Insurance Benefit/Compensation Rates, 2003

Type of Benefit	Rate(D)	Type of Benefit	Rate(D/month)
Military Pension	1,131,589/month	Professional Disease	2,647,285
Civil Service Pension	666,750/month	Professional Disease/Accident	174,450/month
Compensation for Death	5,015,246	Professional Accident Care	232,000/month
Burial Costs	2,320.000		
Sickness	152,733/month	Clause 28	3,131,870
Pregnancy	3,812,257/month	More than 30 working years	3,059,911
Retreat Leave	673.214/month	Commune Staff	3,343,286
		Commune/Ward Staff Allowance	242,000

Source: Department of Social Insurance, MOLISA.

In addition to the formal VSI, a number of informal social insurance schemes have been tried in Viet Nam in recent years. According to Von Hauff (2003), these schemes exist in the provinces of Bac Ninh, Hay Tay, and Nghe An; 265 villages and wards belonging to 29 districts; and cover approximately 200,000 rural laborers of whom 35,867 have received benefits. The operation of the main schemes in Bac Ninh, Hay Tay, and Nghe An can be summarized as follows:

- (i) **Bac Ninh.** Now-defunct provincial contributory pension scheme for farmers established in 1991. Farmers over 60 years of age received pensions of D10,000/month once they had contributed 100 kg of paddy to the scheme;
- (ii) **Hay Tay.** Now-defunct contributory pension fund for farmers established in the early 1980s. At its peak, about 42,000 farmers were members of the fund but it collapsed in 1988 following the hyperinflation of 1986-1987, which had eroded all most of its assets;
- (iii) **Nghe An.** Contributory pension fund first established in 1998 and covering five districts and approximately 74,000 farmers. Members are mostly farmers but also include agricultural laborers and other wage earners not covered by the VSI. Members participating in this scheme can choose between three contribution levels—D10,000; 20,000; and 30,000 per month—and are expected to pay contributions for at least 20 years. Notional benefits are D50,000, 100,000 and 150,000 per month at age 60 for men and 55 for women.

2. Health Insurance

Health insurance in Viet Nam started in 1993. It is administered by Viet Nam Health Insurance (VHI) under the umbrella of VSI. There are three main

health insurance schemes over and above the sickness and death benefits provided under the social security scheme:

- (i) the formal compulsory health insurance scheme,;
- (ii) voluntary health insurance, and
- (iii) health insurance for the poor.

Formal Health Insurance Scheme. This is compulsory for all formal sector employees, essentially those involved in wage labor in government and private enterprises employing more than 10 people.²¹ Employees contribute 1% of their earnings, while employers contribute 2%. Premiums are designed to cover 80% of all medical examination and treatment expenses with the insured paying the balance; hospital expenses are reimbursed directly. Social diseases, employment injury, and road accidents are not covered. About six million people²² are currently enrolled in the compulsory scheme. Of these, 60% are current employees (over 80% of these are public sector workers); the remainder are either pensioners or social-priority groups such as war veterans, invalids, the disabled, and orphans. Thus, despite its compulsory nature, coverage among workers outside the state sector is extremely low (Poverty Task Force, 2002).

Voluntary Health Insurance Scheme. This is mainly targeted at households not qualifying for either of the above programs. Annual premiums are D80–140,000 in urban areas and D60–100,000 in rural areas. Benefits are similar to those payable under the compulsory scheme. Uptake is low, however, due to the level of premiums and the high transaction costs incurred by local social security agencies. In 1998, only 124,000 people participated in this scheme.

There is also a policy of enrolling schoolchildren in this scheme. Parents pay annual premiums of D30–70,000 and D15–50,000 in urban and rural areas respectively. These premiums are generally collected by the school authorities at the same time as they collect school fees and other costs. The number of schoolchildren enrolled in the VHI has expanded considerably in recent years, from around three million in 1998 to more than eight million (approximately 45% of all schoolchildren) today. Benefits for schoolchildren will not be as extensive as those under the formal scheme.

²¹ It is understood that the scheme is in the process of being widened to include employees of all registered enterprises irrespective of the number of paid employees.

²² Estimates vary substantially from year to year: 6 million in 1998, 6.4 million in 2000, 5.8 million in 2002.

HEPR²³ has a major program to provide free health insurance cards and health certificates to poor households and those in mountainous areas forming part of Program 135. The program has been in operation since 1998. In 2002, Prime Ministerial Decision 139 made this program national and mandatory. This decision requires provinces to provide health insurance cards or to cover the medical costs of the following categories: (i) poor households as defined using the MOLISA poverty line; (ii) households in communes in particularly difficult conditions (Program 135); and (iii) ethnic minority households in the Central Highlands and six provinces in the Northern Mountains. Thus, the scheme is administered by the provinces that are constrained by lack of funds in many cases; and so are unable to issue cards/certificates to all eligible persons. Eligible households are identified at commune level by the People's Committees using a combination of the MOLISA poverty line and peer group identification.

The cards/certificates basically provide exemption for the first D30–50,000 of health expenditure and, in some cases, additional support to cover treatment costs in public hospitals. By 2002, around 4.4 million people in poor households²⁴ were registered and the annual expenditure was estimated to be around D70 billion. Coverage is estimated to be around 45% of all potentially eligible households.

The scheme is not without its problems. Recent PPA²⁵ reports in Dac Lak, Ha Giang, Ninh Thuan, and Quang Tri reported that Decision 139 had not yet been fully implemented due to delays in preparing the lists of eligible households, according to provincial officials. There are also problems of implementation; in some cases, quotas were imposed at provincial or district level that precluded some eligible persons from receiving them. Other problems relate to their usage: in two communes in Nghe An province, only just over half those with cards had used them; in the Ninh Thuan PPA, the percentage was just under two-thirds. A number of reasons were advanced for this fact—lack of cooperation by health staff; cards issued per person, not per household; cumbersome procedures (sometimes making it necessary to travel to district facilities and so incurring additional travel costs). This low usage probably explains the low average expenditure per card. In addition, it is uncertain to what extent health centers are reimbursed for the costs of treating people

²³ HEPR is a large multicomponent poverty reduction program. An overview of HEPR is to be found in section E.

²⁴ Around 40% have certificates and 60% have cards. Benefits are much the same irrespective whether certificates or insurance cards are held.

²⁵ See IOS/JICA, 2003; CRP, 2003; Long An Primary Health Care Centre, 2003; MOLISA-ILSSA, 2004; RDSC, 2003; Turk, 2004; Trinh et al., 2003.

with health cards, especially if these primarily involve consultations. In contrast, the Nghe An PPA does provide some examples of how the program has improved access to health services for some poor people.

Total coverage and expenditures of the three health insurance schemes are shown in Table 4.4. To this figure should be added another 1.7 million people who have health certificates that exempt them from the first D30–50,000 of their health expenditure. In total, 18.5 million Vietnamese (23% of the population) have some level of health insurance cover.

Table 4.4. Health Insurance Coverage and Expenditure

Year	Number of Participants		Amount Collected (D billion)	Amount Paid Out (D billion)
	Coverage (millions)	% of population		
1993	3.8	5.4	110.0	75.0
1994	4.3	5.9	256.0	189.9
1995	7.1	9.6	400.0	310.4
1996	8.9	11.8	520.0	489.0
1997	9.5	12.4	570.0	500.0
1998	9.8	12.5	669.0	522.0
1999	10.5	13.8	760.0	587.1
2000	10.6	13.9	943.8	650.6
2001	11.3	14.5	1,150.9	813.0
2002	13.2	17.0		
2003	16.8	20.7	1,625	
Formal	6		1,440	
Voluntary	8.1		116	
Free (HEPR)	2.7		69	

Source: Various, see footnote on previous page.

There are also three small area-based microinsurance schemes:²⁶

- (i) **Voluntary Health Insurance for Farmers.** The project was initiated in 2001 in Soc Son district, Hanoi Province and was targeted at farmers who qualified for neither the formal VHIS scheme nor the Health Insurance for the Poor program under HEPR. The scheme operated under the aegis of Hanoi Social Insurance (Voluntary Health Insurance Section) in cooperation with Hanoi People's Committee (HPC). Premiums were set at D50,000 per annum of which D15,000 was provided from the HPC budget; additional applicants from the same household paid reduced premiums.

²⁶ Information from Mekong Economics, Stocktaking Report on Social Security and Health Insurance Schemes in Viet Nam, for the Government of Germany, Hanoi, 2003.

Around 25,000 people signed up—17% of the population not covered by either of the above-mentioned schemes. Current status is not known, but it was observed that the level of premiums was difficult for many farmers and that health care services needed to be improved.

- (ii) **TYM fund of the Women's Union.** A microinsurance component was grafted on the existing TYM microcredit and savings scheme. Premiums are set at D200 per week (D10,000 per annum). Members are guaranteed one payout of D200,000 for illness or conditions that requires surgery or prolonged treatment. Benefits are also payable on death or diagnosis of cancer; all outstanding loans are also written off. The scheme operates in 15 TYM branches in seven provinces. The number of members is not known, but is probably around 15,000. Current plans are to expand this to 29,000 members by 2006.
- (iii) **Mutual Assistance Fund of Women under the Action Aid Microfinance Scheme in Uong Bi District, Quang Ninh Province.** As with the TYM fund, the Mutual Assistance Fund has “piggy-backed” on to an existing microcredit scheme. Premiums are D1,000 per month (D12,000 per annum). Benefits are D200,000 on death (D100,000 for other family members); D20,000 per consultation; and D200,000 per serious accident or illness. Mutual Assistance Funds have been established only in three out of the ten communes in the district where microcredit scheme operates. In the most active of these, over 400 people participate and the fund now stands at D18 million; around D3 million has been paid out. The level of premiums remains below the potential of many households and no more than half of those participating in the microcredit scheme have joined up. There are proposals to increase the payout per visit to D30,000 and extend the serious accident benefit to other family members but this may not be feasible given the current premium level.

Total coverage of these three schemes is, however, negligible in comparison with the VHI/HEPR schemes.

Several agencies are investigating the possibility of piloting informal insurance schemes among those falling outside the compulsory, voluntary, and free schemes, including ADB, GTZ, ILO, and WHO. These are, however, unlikely to make a significant impact in the near future given the problems encountered by the three microinsurance schemes described above.

D. Social Assistance²⁷

I. Welfare Programs (MOLISA)

MOLISA's Department of Social Protection operates a number of regular relief programs to provide support to the elderly on their own, the disabled, and the mentally ill.²⁸ These programs have been in existence for a number of years. In 2000, eligibility became mandatory and the system of allowances was simplified. Support is provided either through cash allowances or through residential care. Levels of support are broadly similar: cash allowances of D45–100,000 per month with the amount varying between rural and urban areas and between provinces; the average is around D60,000. The most destitute or those unable to be cared for in the community are provided with residential care in SPCs at a cost ranging from D150–300,000 per month.

Those qualifying are:

- (i) the elderly living on their own and with no source of income, and those aged 90+ years. Around 78,000 elderly persons receive this benefit of which about 6,000 receive residential care in SPCs; and
- (ii) Physically and mentally disabled persons. MOLISA's currently provides assistance to 120,500–10,500 of whom are cared for in SPCs.

MOLISA recognizes that funds are inadequate to meet demand, 90% of which are distributed by central government to provinces for local disbursement. This is apparent given that MOLISA estimates that around 363,000²⁹ people are severely disabled enough to merit inclusion in the program and that there are around 105,000 elderly people and 130,000 orphans living on their own. An evaluation of the program is scheduled for next year and is likely to examine this issue along with the fact that current allowances are well below the poverty line. As recent PPA respondents said, "Granting regular benefits does not help stabilize people's livelihood, but somewhat lessens their difficulties. This assistance cannot help people overcome their poverty"³⁰ and "(official support programs) only partly help people overcome their difficulties."

Total expenditure on these programs in 2003 was D150 billion with just over 250,000 people³¹ being assisted annually, representing between 40% and

²⁷ Programs primarily targeted at children are described under Child Protection, see below.

²⁸ MOLISA also provides support to orphans and street children. These are discussed under Child Protection in Section F below.

²⁹ This figure is not comparable to that contained in Table 2.6, which also includes war invalids.

³⁰ IOS/ JICA, 2003. (p. 66).

³¹ This figure includes persons resident in the SPCs.

45% of the eligible population. One fifth of this expenditure (D35 billion) goes to the SPCs, which cater to 18,000 vulnerable adults. There are around 240³² Social Protection Centers, although a number of these will cater primarily to children.³³ Health costs are also subsidized for SPC residents. Future policy is likely to involve a shift away from residential care to care in the community.

Another department of MOLISA, the Department for War Invalids and Heroes, operates a social assistance program for war veterans and their families. Allowances are based on a sliding scale of the extent of disability, ranging from those with 21% disability and above. Allowances are based on a proportion of the minimum wage, which recently increased from D210,000 to D290,000 per month. Allowances start at 40% of the minimum wage (D120,000 per month) for low levels of disability and rise to 160% (D450,000) for those with 90% or more disability. School costs for children of veterans with over 60% disabilities are also provided, while the most severely disabled receive full health care. Parents of war victims also receive allowances. Statistical data on this program proved hard to come by and only aggregate data could be obtained. In 2003, the number of beneficiaries was 1.38 million and total expenditure was D3,724 billion. There have been debates as to whether this program should be included as a bona fide SP program. Government officials are adamant that it should and, given that many of the benefits go to those with disabilities or to elderly parents, there is no justification for excluding it.

The Department for the Prevention of Social Evils operates programs to reduce drug abuse and prostitution. The Anti-Drug Action Plan for 2001–2005 is a National Targeting Program reflecting the importance attached to this issue by the Government. The program seeks to establish model detoxification and rehabilitation centers (these are separate facilities); and establish guidelines for the management and operation of these centers, including training, management courses, procedures and methods to identify, treat and rehabilitate drug users. Annual expenditure in 2002/03 averaged D135 billion of which around two-thirds was provided by central government and the remainder by provincial administrations. In 2003, 58,000 persons were being treated under this program representing just below half those “eligible.”

The 2001–2005 Anti-Prostitution Action Plan, which MOLISA coordinates with several other ministries and Provincial Peoples’ Committees, provides for the construction and operation of rehabilitation centers. In the

³² There are actually 300 SPCs, but 20% cater exclusively for drug addicts and prostitutes (see next subsection).

³³ Some deal exclusively with the mentally disabled, while one is for children with HIV/AIDS. Many of the remainder are mixed and cater to more than one vulnerable group.

last three years, 12 new centers have been constructed bringing the total in operation to 70 with a total capacity of 40,000. In Hanoi, the Action Plan is piloting programs to provide jobs and loans for prostitutes, so that they can be reintegrated into normal society. Publicity campaigns are also featured, especially at local level. Total annual expenditure is around D21 billion with around 12,500 being assisted in the last three years.

Nationally, there are around 600 production and business establishments that are dedicated to providing employment for the disabled.³⁴ Total employment in these establishments would be around 25,000, 78% of whom are disabled. Disabled employment in other enterprises was around 1%, lower than the 2–3% stipulated in the Labor Code and under-law documents. The Vietnam Association for Blind People has also used loans from the National Fund for Employment Promotion to create jobs for over 40,000 visually impaired people between 1992 and 2000. The total value of loans received exceeded D16 billion for 706 projects.

2. Social Welfare Programs (Other Agencies)

Vietnam Red Cross operated the “Assistance Fund for Victims of Agent Orange.” This fund, established in 1998, provides funding for health care, rehabilitation, vocational training, educational scholarships, and job creation to this target group. Around 220,000 people have been assisted in the last three years. Annual expenditure in 2003 was D34 billion.

Substantial social assistance is provided by the “Day for the Poor Fund,” which is operated by the Motherland (or Fatherland) Front. The total fund in 2003 was D230 billion, which was raised exclusively from public donations and has grown ten-fold since its launch in 2000. Funds are targeted at the poorest households (i.e. those below the food poverty line) based on lists established through participatory processes at the village level. Funds are used to improving housing, provide free health care, and assist with education costs, emergency food and production inputs. The existence of these forms of irregular relief is corroborated by some recent PPAs. Over 100,000 households benefited from this program in 2003.

Another “irregular” relief fund is provided by the “New Year Gifts to the Poor and Agent Orange Victims’ Movement,” operated by Vietnam Red Cross. This movement launches its activities nationwide once a year, one month before the New Year Festival (Tet) to raise cash and in-kind donations from the public to support the poor and Agent Orange victims with new year gifts. The gifts range from cash to sticky rice, clothes, blankets, mosquito nets,

³⁴ Grossed up from partial data cited in Hong, *op. cit.*

cakes etc. Beneficiary households received cash and in-kind donations of D200,000 and D100,000 respectively. Around 66,000 households benefited in 2003 compared with 41,000 in 2001. Total expenditure in 2003 was D20 billion.

Some villages also established local relief funds. In one village, D5 million had been collected which was topped by a grant of D2 million from the district. This was then distributed among the poorest families, based on a locally executed assessment, often during the Tet holiday. However, the amounts distributed were small and they were not seen as particularly effective because they were often unexpected and did not, therefore, provide anything other than a brief respite from severe poverty. Informal assistance can also be provided by neighbors and other residents to families who have fallen on particularly hard times, but there is no way of gauging the extent of this informal assistance or its prevalence.

3. Assistance with Educational and Health Costs

Educational subsidies and scholarship programs are discussed under child protection in Section F, while health insurance for the poor has been reviewed in Section C.

4. Subsidy Programs

The only substantial direct subsidy program currently in operation is that operated by the Committee for Ethnic Minorities (CEM). Its overall aim is to support disadvantaged ethnic minority communities through subsidies on key production (e.g. seeds and fertilizer) and consumption (e.g. kerosene, salt) items to ensure that they pay the same prices for key production inputs and consumption items as people who live in mountainous towns. Subsidies cover transportation cost and some other cost from the town (or from the factory supplying the inputs) to inter-commune centres. Iodine salt is provided free of charge to poor households in extremely disadvantaged communes, subject to budget availability at the local level. Total value of these subsidies in 2003 was around D232.5 billion.³⁵ No information is available on the number of beneficiaries, although the total population in the Program 135 communes is around 10 million. Anecdotal evidence has also suggested that the impact of this program is diminished by the difficulty in ensuring that benefits accrue to the targeted communes and are not retained by traders and transporters. The total population theoretically benefiting from this scheme is around 20 million.³⁶

³⁵ Excluding D26 billion spent on providing free newspapers to these communities.

³⁶ From UN/MOLISA, 1999.

5. House Improvement Loans

Under the HEPR housing loan, poor households living in poor quality housing or in areas prone to natural disasters can access credit to improve their housing conditions. Consideration is being given to making all households eligible. The main targeted areas are the Mekong Delta and the Central highlands. In the former, applicants can borrow up to D17 million for construction of foundations, floor slabs, walls, and roofs. In the Central Highlands, up to D7 million is provided in-kind through the provision of materials. Loans are repayable over 10 years at 3% interest per annum; there is a five-year grace period.

Between 2001 and 2003, more than 196,000 households have obtained assistance for housing loan. A total of D850 billion has been disbursed in the three-year period.

6. Agricultural Tax Exemption

Since 2001, all poor (using the MOLISA definition) rural households are granted exemption from agricultural tax under HEPR. According to VLSS2002, 7.9% of all households, 11% of rural households (or about 1.4 million households in all) benefited from this exemption. Using the MOLISA poverty line, about 20% of rural households are classified as poor. While some of these will not own agricultural land, it appears that a significant number of poor rural households are not receiving this exemption. There is no estimate of the annual “value” of this exemption. An estimate can, however, be made by using the 1998 survey that contains a detailed breakdown of expenditures on land tax by quintile. These ranged from D84,000 in the lowest quintile to D170,000 in the richest. Applying these to the observed distribution of land tax exemptions by quintile in 2002 gives rise to an average payment of D98,000 per annum. Grossing this up using the 2002 estimate of 1.4 million households receiving this exemption, gives an estimated value of this exemption of around D134 billion.

7. Disaster Relief Assistance

MOLISA's coordinates the Contingency Relief Fund for Pre-Harvest Starvation and Disaster Relief with other government ministries and national NGOs, such as the Mother Front, Red Cross, the Youth Union and the Women's Union. The program is targeted at people affected by natural disasters and drought, such as Typhoon Lynda in 1996, flooding in the Central Region in 1999 and flooding in the Mekong Delta and land slides in the north in 2000. Assistance consists of one to three months of food aid; D1–2 million for each household losing a family member; D0.5–1 million for hospital fees; D1–3 million per

house damaged/destroyed; and D10–30 million per commune affected by drought.

The annual cost of this program inevitably fluctuates considerably from year to year. Annual expenditure in 2003 was around D280 billion (80% from central government funds, 20% from provinces) to assist around 900,000 people. Also distributed was 13,500 tons of rice; at the current price of D3,500 per kg, this is equivalent to an expenditure of D47 billion. In 1999 with large scale and severe natural disaster, the fund was mobilized through the Mother Front up to D128 billion.

In years where the problems are particularly serious, e.g. 2000-2001, emergency assistance is also received from IFIs and INGOs. Externally funded emergency relief (including food aid, house reconstruction, and infrastructure rehabilitation) averaged \$8.8 million (c. D140 billion) annually between 1998 and 2001. To put this figure in context, the government spent around D750 billion in 1999. Highest and lowest expenditures were in 2000 and 2001, when \$11.5 million and \$3 million (D180 and 50 billion) were spent respectively.

Much of the foreign emergency funds are not spent directly, but are channeled through organizations such as Red Cross Viet Nam, which has spent an average of D24 million in each of the last three years; around 70% of which comes from foreign donors, with the remainder being raised from local donations. Activities include fund raising, needs assessments, and the planning/implementation and monitoring of aid distribution. Relief provided to 25–30,000 households annually consists of emergency food, family tool kits (water tank, filter and kitchen accessories), reconstruction of houses and schools, life vests, and engine-operated boats.

8. Overseas Funded Projects

In general, IFIs fund few projects that can be construed as SP, apart from those that provide emergency relief or are targeted at children.³⁷ These programs fall into three main categories:³⁸ (i) programs to assist the disabled, (ii) the treatment and prevention of HIV/AIDS/STIs,³⁹ and (iii) drug abuse.

³⁷ See following sections for details of these programs.

³⁸ In this category programs and projects designed to promote human rights in general and to women in particular were excluded, e.g. more responsible and effective governance, enhanced local participation in democratic and decision-making process, and reforms to make the legal system more effective and responsive to the needs of the poor. These programs were seen as constituting a distinctive group of activities that could be categorized as “governance.”

³⁹ There are grounds for considering these programs to be part of the health sector rather than SP, particularly as other disease control programs (e.g. for leprosy, TB, and malaria) are not considered to be part of SP.

Table 4.2 lists the largest of these projects, i.e. those with a total commitment in excess of \$500,000 or an annual expenditure in excess of \$100,000.

Total annual expenditure on these projects in 2001 was around \$3.8 million (D60 billion).

NGOs are also active in the fields of disability and HIV/AIDS prevention. A recent report on disability identified 19 national and international NGOs working in this field. Projects are varied and include community-based rehabilitation, development of employment opportunities, advocacy and rights awareness, promotion of self-help groups, training for the care of the disabled, design and provision of prosthetics and hearing devices, and provision of loans to assist the visually impaired and partially sighted. In many cases, these NGOs will be the implementers of or the local partners for programs funded by the IFIs.

Similarly, around 18 INGOs are involved in HIV/AIDS/STI projects. Few details of these programs are available, although as with the disability programs, many will be subcomponents of the internationally funded programs contained in Table 4.5. As an example, Worldvision has:

- (i) trained more than 250 community volunteers among the vulnerable mobile population in Haiphong to publicize and reinforce behavior-change messages;
- (ii) trained volunteers to work with service providers along NH1 to reduce high-risk behavior;
- (iii) established an HIV/STI clinic at Doson, a popular recreation and resort area, as well as developed a network of peer educators to raise awareness and provide counseling care and support to people living with AIDS. Annual expenditure is around \$350,000.

Action Aid Viet Nam has developed HIV/AIDS components as part of its multisectoral programs involving raising awareness, establishing and training a network of program facilitators and communicators, and the preparation of training materials. The largest of these interventions was in HCMC, where 3,900 “at risk” people attended a major communication/training meeting and training to work with people living with HIV/AIDS.

E. Micro-/Area-Based Schemes

I. Microinsurance and Agricultural Insurance

There are currently insignificant agricultural insurance schemes operating in Viet Nam. The crop insurance scheme previously operated by BAOVIET has been discontinued. Three small microinsurance schemes do operate; these

Table 4.5. Internationally Funded Social Assistance Programs

Project	Type/Description	Funding Source	Period	Funding Total	Funding (\$ million) Annual
Assistance to the Disabled Social Work Support Program	Training of social workers	UNV	2000-2002	0.3	0.1
Disability Policy and Prosthetic and Rehabilitation Project	Policy-making and improvements to prosthetic services	USA	1998-2002	3.0	0.6
Vietnam Rehabilitation Project	To improve quality of rehabilitation services at provincial level and improve 'disability' training of medical personnel	USA	1998-2003	2.4	0.4
National Centre for Orthopedic Training and Care, Hanoi	Improve production of orthopedic aids*	Germany	1994-2006	6.4	0.5
Thermoplastic Orthotics Rehabilitation Program	Improvements in care of the disabled	USA	1998-2002	1.7	0.4
Development of National Programs on Mental Health	Institutional strengthening and policy-making	WHO	1996-2002	0.7	0.1
Drug Abuse and Prevention					
Support for the 2001-2010 National Drug Control	Capacity-building	Sweden, USA, Italy	2001-2003	0.4	0.13
Masterplan Formulation					
Song Ma Alternative Development Project	Promotion of viable alternatives to drug cultivation	USA	2002-2004	1.5	0.5
HIV/AIDS/STIs					
HIV/AIDS Capacity Training building for Policy Formulation, Management and Coordination of HIV/AIDS Prevention and Care Programs	Institutional strengthening at national and provincial levels	Australia, Sweden	1999-2003	0.9	0.2
STI, including HIV/AIDS	To improve treatment and immunization against STI	WHO	1998-2002	1.3	0.3
HIV/AIDS Community Clinics Network	Treatment and prevention of STIs through training of outreach workers and provision of equipment	Canada	2001-2007	3.1	0.7

*This is an important issue as a significant number (some estimated 68%) of the disabled have not received any orthopedic aids.

NB1. Table includes only projects with an annual expenditure in excess of \$100,000.

NB2. Table excludes programs completed by 2001 and those directed primarily at children; these are described in section F.

Source: UNDP. 2003. *Viet Nam Co-operation Report, 2003*. Hanoi.

have been described in section C. It is also understood that an ILO project that has the objective of developing a microinsurance program is currently in preparation.

2. Microcredit/ Finance (MCF)⁴⁰

Microcredit, in general, is not part of the ADB's definition of SP, although it can be included if MCF projects "include microinsurance, promote community self-help or other social protection policies." In Viet Nam, most MCF projects are directly targeted at the poor, often through NGOs, involve loans for as little as \$100, operate through small household credit groups, with interest rates (especially of the government schemes) often subsidized and requiring little or no collateral. MCF schemes form an important component of both government and foreign-funded integrated poverty-alleviation projects. They are also seen as being potentially effective in adding to the assets of poor households. Finally, they are programs directly targeted at poor households, which we see as being one of the important criteria for SP programs. For these reasons, we consider that they should be considered to fall within the definition of SP.⁴¹ The following paragraphs provide a brief summary of operating MCF programs in Viet Nam with emphasis on the quantitative aspects.

The principal provider of credit to rural households is the Viet Nam Bank for Agriculture and Rural Development (VBARD), which lends at commercial rates. Although its "social" lending functions were transferred to the Viet Nam Bank for the Poor (VBP, now Social Policy Bank) in 1996, VBARD still provides loans to low income households⁴² (LIHs) due, in part, to it having the most extensive nationwide network of branches. Much of its funds come from IFIs and, in particular, WB, ADB, and the German Bank for Reconstruction. It is estimated that by 2001, VBARD's customer base was around five million of which just less than half were LIHs. Much of its lending is channelled through mass organizations—Viet Nam Women's Union, Viet Nam Farmers' Association and the Viet Nam Youth Union. However, in some ways, VBARD operates as a commercial provider of rural credit, using commercial rates and insisting on the provision of collateral. On this basis, it definitely falls outside the ADB criterion for considering MCF schemes to be part of SP.

The main provider of microcredit to the poor is the Viet Nam Bank for Social Policy (VBSP formerly Viet Nam Bank for the Poor), which operates

⁴⁰ The information in this subsection comes from McCarty, 2001; SCUK, 2003; ADB, 2003; Save the Children Japan, 2003; Izumida, 2003.

⁴¹ Although Viet Nam is not a prime example, microcredit in some Asian countries (e.g. Bangladesh) is likely to be the most important means of directly assisting poor households.

⁴² Defined as 40% of households with the lowest incomes.

nationwide providing loans without collateral of up to D7 million (\$400–450); this ceiling may be raised to D10 million in the near future. The objective is to lend to the poor. In order to obtain a loan, applicants must appear on schedules of poor households drawn up at the commune-level based on a combination of the MOLISA poverty line and a community-level identification of poor households. Households deemed extremely poor (i.e. with negligible repayment capacity) are excluded. Interest rates are subsidized to the tune of 0.4 to 0.65% per month, giving cause for concern that this scheme is not sustainable in the long term. In this context, the HEPR budget allocation includes an annual subsidy of D150 billion for its loan component. In 1998, VBP had lent to 2.3 million poor households and it was estimated to have 1.3 million current customers. In 2003, VBSP planned to lend D2.1 trillion; thereby, increasing the number of households obtaining small loans to 2.7–2.8 million (16–17% total households) with the loan amount of D9,600 billion.

The third large provider of credit to the poor is the People's Credit Fund (PCF), which has branches in just below 900 communes. Local, self-managed credit and savings funds are established in participating communes. Interest rates are not subsidized; 66% of capital funds are mobilized from savings; much of the remainder come from ADB as part of its Rural Credit Project. There are no maximum loans; average loan size in 2001 was D4.1 million (although this fluctuates widely from province to province); repayment levels are reported to exceed 95%. To date, it has lent to 630,000 members (about 5% of all rural households); 2–3% of these were categorized as “very poor.”

Microcredit schemes have also been established by over 50 INGOs, with the oldest dating back to 1993. The number of exclusively poor households covered (around 164,000) is, however, relatively insignificant in comparison with the “formal” schemes—although these schemes are more likely to access the poorest households, who may not qualify for loans from the “formal” sector. These schemes operate through local partners, almost always the Women's Union, and invariably involve the formation of mutual guarantee household credit groups following the Grameen Bank model. Interest rates for these schemes, unlike the VBSP schemes, are generally not subsidized. NGO involvement includes providing the initial credit fund, training of scheme personnel and establishing the first credit groups. The longer-term objective is to hand the schemes over to the local partners and transfer resources to another area. Several of these schemes are now self-sufficient. Loans tend to be smaller than those from official sources—around D1.5 million compared to loans from other sources. Around 90% of loans are used for productive investment, mainly livestock, agriculture, and to a much lesser extent, small businesses.

A detailed evaluation of the long-running SCUUK scheme lists a number of measurable improvements in social and economic conditions in communes where microcredit has been introduced—reduced child malnutrition and poverty, improved school attendance, and general health. The majority of INGO microcredit schemes are operated as part of multisectoral projects (see below) so benefits directly related to the provision of microcredit cannot easily be identified. While official microcredit programs are designed to target the poor and evidence from the VLSS02 indicates that they are being at least partially successful, NGO-assisted programs are generally considered to be more effective at reaching the poorest households.

Data on MCF is available from household surveys as well as the cited reports. The data is not comparable, however, as the report data tends to refer to all customers, while the survey data provides a snapshot of households obtaining loans in the previous year. For the purposes of this project, the latter information is what will be used as the objective is to provide data on all SP activities in a single year. Table 4.6 summarizes accordingly the VHLSS02 data on loans obtained in the previous year together with the estimated total value of the loans. In total, 570,000 households took out loans in the previous year to a total value of just below D2 trillion.

It should be noted that while the figures for average loans look reasonable, the incidence of loan take-up appears to be on the low side, particularly for VBARD, which would be expected to be the most important source. As mentioned previously, there are, however, strong grounds for excluding VBARD activities as being mainstream rural lending programs rather than targeted microcredit operations.

3. Area-based Development Schemes/Social Funds

There are no social funds as such, although there is a large number of integrated rural and community development projects funded by government, IFI loans, bilateral grants, and NGOs. The great majority of these are multisectoral and include some or all of the following: irrigation improvement, agricultural extension services, water supply and sanitation, construction of local health centers and schools, local capacity-building, microcredit, health education, and other community services. Most also involve a high degree of community participation and involvement in their design and implementation. Total annual funding for all Area Development Programs in 2001 was around \$100 million (UNDP). International NGOs' expenditure on these types of program was around \$20 million in 2002, although much of this will have come from IFIs and be included in the UNDP total. Short descriptions of five such programs follow.

Table 4.6. Summary Data on Major Rural Finance Providers, 2001/02

Institution	Customers (000)	% Rural Households	Average Loan (D 000)	Total Value of Loans (D billion)
VBARD	178	1.0	4,361	776
VBSP	374	2.1	3,089	1,155
PCFs	18	0.1	2,202	40
Total	570	3.2		1,971

Source: Authors' analysis of VHLSS02.

Program 135. It is a government program that has operated since 1998. Its full name is “The Programme on Socio-Economic Development of Communes facing the Greatest Difficulties in Remote and Deep-lying Areas.”⁴³ Originally targeted at around 1,000 communes from an initial list of 1,750 almost all of which were situated in mountainous areas, the program in 2003 then targets 2,362 communes of which all bar 129 were allocated central government funds. The lead agency for program 135 is CE, which collaborates with all other relevant central government agencies. Its main components are:

- (i) construction of commune-level infrastructure: roads, health centers, primary schools, electrification, small-scale irrigation, improved water supply, markets, and land reclamation;
- (ii) construction of inter-commune facilities: roads, polyclinics, post offices, markets, etc;
- (iii) funding for the resettlement and sedentarization of ethnic minorities;
- (iv) improved agricultural extension services in extremely difficult communes; and
- (v) training of commune-level staff.

Program 135 funds are transferred to the provinces. In principle, D500 million (up from D400 million in 2002) is allocated to each targeted commune for commune-level infrastructure, with the remainder being allocated to other components. CEM guidelines do not specify whether districts or communes are to control the disbursement of funds at local level. The UNDP, PPAs, and VDR 2004 report widely differing practices with some communes exerting substantial control over the identification and disbursement of funds; whereas

⁴³ The following information comes from UNDP, 2004 and interviews with CEMMA.

in others, districts retain the majority of control. While the participatory nature of the program varies considerably across the country, the emphasis on small-scale community infrastructure justifies Program 135's inclusion under the ADB definition of social funds.

Achievements between 1999 and 2003 include: 70% of targeted communes have completed five project components—roads, power, school, irrigation, and health unit; 84% now have primary and 73% lower secondary schools; 93% can provide primary health care; 48% have marketplaces; 560 are linked by road to the commune centre; and 84% have electricity. CEMMA estimates that just below 10 million people have benefited in some way from the program.⁴⁴

Total expenditure in 2003 was around D1,450 billion, over 50% higher than in 2000. Around 80% of funds are allocated to commune-level projects, 18% to inter-commune infrastructure, and the remainder to training, agricultural/forestry extension and resettlement.

The other big government-targeted poverty-reduction program is the Hunger Eradication and Poverty Reduction and Employment Creation Program (HEPREC),⁴⁵ which was established in 2001 and combines the pre-existing National Target HEPR and Employment Creation programs. Overall responsibility lies with a steering committee chaired by the Deputy Prime Minister with the minister of MOLISA as the standing vice chairperson and the vice ministers of all other relevant ministries as members. HEPR objectives are to reduce the number of poor households, provide basic infrastructure to all poor communes, provide jobs at the rate of 1.4 to 1.5 million annually until 2005, and reduce unemployment (urban areas) and underemployment (rural areas).

HEPR project components fall into four basic categories:

- (i) Direct support to the poor:⁴⁶ in terms of subsidies for education and health, and land tax exemptions. These are described in this chapter;
- (ii) General projects: State Bank of Vietnam subsidy to existing VBSP credit programs targeted at the poor—D150 billion annually (see preceding subsection on microcredit). The other two general

⁴⁴ In 2002, according to the VHLSS, around 15% of households (about 12 million people) resided in program 135 communes, of whom more than 55% were classed as poor using the GSO classification and 30% using the MOLISA definition. The discrepancy could result from the fact that some communes included in the program may not yet have received any direct benefits and/or conflation with similar components of HEPR.

⁴⁵ The majority of this information comes from UNDP, 2004 (op. cit.).

⁴⁶ Using the MOLISA definition, which is broadly equivalent to GSO's food poverty category.

- projects are increased agricultural extension services and the replication of HEPR development models in other areas (about D20 billion per annum each);
- (iii) Commune-targeted components: improvements to basic infrastructure; resettlement and sedentarization; training and development of non-agricultural enterprises. These are, to all intents and purposes, similar to the components of Program 135, but targeted at 700 poor communes not covered by Program 135. The average annual projected cost of these programs is around D740 billion in three year 2001-2003 from local budget. The sedentarization and resettlement are expected to result in the relocation/settlement of around 350,000 households; and
 - (iv) Job creation: this component and its constituent elements have been described in Section B above.

HEPR-EC essentially consists of a number of subprograms operated by different line ministries. Several of these are described in this chapter with only those directly targeted at communes falling within the definition of a social fund. The number of beneficiaries under this component are estimated over 20 million. Total annual expenditure was around D878 billion in 2003. This figure excludes agricultural tax exemptions, 500 billion as medical expenses free for the poor and 216 billion as free tuition for poor households children. In overall, it amounts to just below D1,600 billion. Contributions from the communities themselves were also significant, but cannot be estimated.

Community-Based Rural Infrastructure Project.⁴⁷ With \$103 million WB loan over six years, this will provide essential infrastructure to the 2.4 million people living in 540 poor communes in Viet Nam's north, central and southern coastal regions. This project directly compliments the Government's own program to assist poor remote and mountainous communes (Program 135). CBRIP is a community-driven participatory project that will provide small grants to poor communes to build, rehabilitate or replace degraded public infrastructure as identified through a consultative decision-making process by local communities. Eligible infrastructure includes transport infrastructure (such as improved road access, tracks, trails, bridges, and ferry crossings), schools and health centers, irrigation and flood protection works, drinking

⁴⁷ Almost certainly some communes targeted under this and other major overseas-funded integrated development projects and Program 135/ HEPR communes.

water systems and sanitation, markets, and sources of electricity. Sixty communes will be targeted in the first year.

Northern Mountains Poverty Reduction Project. With \$32.5 million over six years financed by WB/IDA loan (80%), by communes (15%), and by other donors (including DFID), it is a multisectoral, decentralized project that will help about one million rural poor (85% of whom are ethnic minorities) in over 1,700 communes through investments in rural roads and markets, irrigation and water supply, basic education and health, and community development. The main responsibility for planning and prioritization of specific project activities and works will rest with the Commune People's Committee, working with the Commune People's Council, the Fatherland Front and other mass organizations, including the Women's Union, Farmers' Association, Youth Union, and Veterans' Association. In preparing proposals for project support, the communes will solicit and screen proposals from village leaders as well as other officials and groups. Designs for projects "approved" by the commune would be reviewed and validated by technical staff of the District People's Committee (District governments typically include staff with sufficient technical training to capably review most of the small-scale activities and works of the project).

Improved Livelihoods for Mountainous Communities (ILMC) Project. It is funded by CIDA and implemented by CECI. The project seeks, over a five-year period and with around \$6 million funding, to improve the livelihoods of over 100,000 people in 276 communes in two districts in Thanh Hoa province. There are three main components: (i) income-generation (through improved agriculture and promotion of nonagricultural employment opportunities); (ii) social services development (through health education, investment in district and commune health centers and schools, and training); and (iii) institutional strengthening and capacity-building at district, commune, and hamlet levels to promote participation in poverty reduction activities.

Area Development Programs. Worldvision operates 18 of these programs in communities throughout Viet Nam. These are integrated programs designed to improve livelihoods (construction of tanks, dams, and canals), for social development (construction and equipping of classrooms and clinics, training of pre-school teachers and volunteers, health education, health checks on children, and surgical operations); and for community involvement (capacity-building of local partners and community participation). Worldvision's total annual funding is around \$7 million and an estimated 800,000 people have benefited from these and other Worldvision programs.

While these and many other programs are considered to fall into the definition of social funds, there are difficulties in including them within this study because:

- (i) They are multisectoral and frequently include components that fall outside the definition of SP: rural development, infrastructure construction, microcredit, basic health, and education services. They would, thus, appear to fall more logically into the definitions of overall poverty alleviation and social development than SP;
- (ii) A clearer definition is required as to the criteria for inclusion of area development programs that involve different levels of community impacts and involvement in decision-making;
- (iii) Costs are incurred over a number of years and the number of beneficiaries increases similarly. Yet, it is not realistic to limit the number of beneficiaries to those gaining in any one year. Benefits will persist throughout the economic life of buildings and physical infrastructure and as long as support in terms of teaching, health, and agricultural extension staff are provided (though this can be captured through depreciation);
- (iv) They rarely involve direct transfers of resources to individual households or significant social assistance or social insurance components;
- (v) The multiplicity of the programs makes the compilation of relevant information a daunting task, especially when it becomes necessary to estimate counterpart funding and to allow for communes benefiting from more than one project—there are almost certainly overlaps between 135 communes and IFI-funded programs;
- (vi) This review of Area-Development excludes forestry, fishery, and slum upgrading/relocation projects, which are all mentioned as SP projects by ADB in their progress report on the Social Protection Strategy.⁴⁸ Inclusion of these types of project would further widen the scope of this category of activity.

4. Disaster Preparedness and Management

Direct support to disaster victims has been described in Section D above. This section reviews programs that relate to the mitigation of natural disasters.

Based on UNDP statistics for 2001, just over \$2 million was disbursed by IFIs on disaster preparedness activities covering early warning and food information systems, relief planning, and institutional preparedness. Specific

⁴⁸ ADB, 2002, Appendix 3.

projects included establishing typhoon and flood warning systems and establishing a Disaster Management Unit and a Disaster Management Training Team—to provide training in disaster preparedness at all government levels, teaching children how to look after themselves and their families during floods or storms, developing longer-term measures to reduce the impact of flooding (especially in the Mekong delta), area-based physical (e.g. flood control) and institutional projects to reduce vulnerability to flooding in coastal areas. Some of these programs (e.g. AUSAID's North Dam Flood Control Project and CIDA/CECI's Capacity-building for Adaptation to Climate Change Project) are arguably more akin to Area Development Programs in that they include local participation, farm production, nutrition/health, and the design of local infrastructure and houses to be more resistant to flooding. Worldvision includes a disaster preparedness component in all its ADPs (see above) and its work on the Quang Tri Disaster Mitigation Project included construction/reinforcement of water courses, equipping rescue teams, and community-level awareness raising.

An important issue related to this item is whether expenditure on major flood control projects, e.g. the construction of flood protection barriers and dykes, should be included.

War Legacies. Based on NGO Resource Centre information, seven international NGOs are involved in de-mining and unexploded ordnance mapping and clearing. Total annual expenditure of those dealing exclusively with de-mining and providing assistance to persons handicapped by encounters with unexploded ordnance (e.g. Peace Trees, Clear Path International, Viet Nam Veterans Memorial Fund, and Viet Nam Veterans of America Foundation) is around \$3 million.⁴⁹ Total expenditure will be higher, but it is not possible to disaggregate war legacy expenditure from total expenditure of Oxfam Hong Kong and Australian Volunteers International.

F. Child Protection

I. Child Rights and Advocacy/Awareness Programs

Viet Nam ratified the Convention for the Rights of the Child (CRC) in 1990 and established the Committee for the Protection and Care of Children (CPCC) in 1991 with branches extending to district levels. At the same time, the Law on the Protection and Care and Education of Children was enacted and National Programme of Action (NPA) for Children was adopted.

⁴⁹ This total includes some expenditure on assistance to the disabled.

Achievements since then include:

- (i) development of local NPAs at district and commune level;
 - (ii) strengthening the capacity of the CPCC to carry out its mandated advocacy, coordinating, monitoring, and reporting functions;
 - (iii) holding of national seminars on child rights and many training courses and workshops;
 - (iv) the Young Pioneers Organization has established child rights clubs in selected cities and provinces;
 - (v) promulgation of around 100 legal instruments relating to children and moves towards the harmonizing of Viet Nam legislation with CRC requirements; and
 - (vi) improvements to the statistical database relating to children.
- Government efforts have been heavily supported by UNICEF. At present, the major ongoing project (Rights Promotion), with a five-year budget of \$4 million is designed to achieve further progress on the above-mentioned issues by creating the enabling process and environment needed to enhance human rights for children and women.

Although details are not available, most NGOs working with children will include advocacy and child rights components as part of their integrated projects, especially at district and commune level.

2. Early Childhood Development (ECD)

This subcomponent of SP is defined as including programs that “ensure the balanced psychomotive development of the child through basic nutrition, preventive health and educational programs.” The most important government programs that fall into this category are:⁵⁰

- (i) **Child Immunization.** There are national programs to provide immunization for all children against tuberculosis (BCG), measles, polio, and diphtheria, with the latter requiring three vaccinations each. Whereas immunization coverage is almost complete in urban areas, coverage rates in rural areas drops off significantly, especially for the second and third doses of the polio and diphtheria vaccines. Nevertheless, virtually all children have at least one of the

⁵⁰ The following information mostly comes from the report on the Demographic and Health Survey (DHS) 2002 published by GSO in 2003.

vaccinations and around two-thirds (over 90% in urban areas) have had all of them;

- (ii) **Nutritional Supplements.** Iodized salt is subsidized under the previously described CE program in poor and mountainous communes; although the DHS also found that it was available in under 15% of rural communes compared with 30% of urban communes. ORS packets, iron tablets, and vitamin A are much more widely available; and
- (iii) **Health Education Programs.** Clinics throughout the country operate preventive health campaigns covering the following topics: nutrition, breast-feeding, diarrhea control, immunization, vitamin A use, iodine deficiency, and sanitation. Coverage of these programs is widespread, but by no means universal. With the exception of immunization campaigns, which operated in over 80% of clinics, the coverage rate varied between 40% and 55% of communities.

There is a number of ECD programs operated by IFIs and NGOs. These include:

- (i) Save the Children UK (but often in collaboration with other SCFs and agencies) has been promoting ECD in minority areas for several years. By 2002, 47 classes for five year olds have been established in minority areas; support has mainly been in the form of teachers' salaries. SCUUK has also worked with MoET in three districts in Quang Ninh to establish a nine-month pre-school program for five year olds with a view to its wider adoption in the future. SCUUK is about to start a project to assist communities in establishing kindergartens, train teachers, and generally assist the development of preschool children. A new project to establish kindergartens, train teachers and provide community education on child development in 150 communes in three provinces has just been approved. Annual expenditure of about \$600, 000 is projected;
- (ii) Plan International operates two ECD programs. The first, the Poverty Alleviation and Nutrition Programme has two components: (i) bi-monthly weighing of all under five years old; and (ii) the Nutrition Education and Rehabilitation Program for underweight children, which provides advice and education on nutrition to their mothers, and provides money to purchase basic lunches for malnourished children for two weeks every month (D2,500 per

lunch per child). Around 22,000 children have participated in this program in the last three years. The second relevant program is the Pre-School Education Program, which has built and equipped 127 preschool classrooms in the last three years;⁵¹

- (iii) UNICEF's Early Childhood Care for Development Project is a five-year project with a total budget of around \$5 million. Operated through MOET, the project is targeted at 80% of preschool children in 35 poor districts. Its primary aim is to promote preschool education and stimulation through emphasis on family and community action;
- (iv) UNICEF also has a five-year Health and Nutrition Promotion project with an aim of consolidating the national goals on the reduction of child malnutrition, child mortality, and maternal malnutrition mortality and morbidity targeted at 66 districts. The program has an annual expenditure of around \$1.3 million and is operated through MoH; and
- (v) Worldvision placed a strong emphasis on ECCD in their 18 Area Development Programs (see above) through intensive training programs for teachers and volunteers. Children aged three to five years are targeted.

The above are examples of programs related to ECD operated by government and nongovernment agencies. Many other international NGOs operate in this field as part of holistic and integrated projects. It is not practical to identify and describe them all.

3. Assistance with Basic Education

The most important program falling into this category is the HEPR educational component, which provides exemption from lower secondary school fees for children in designated communes. Education costs are reduced for children in poor families (using the more restrictive MOLISA definition), orphans, children with over 20% assessed disability, and students of vocational schools for the disabled or catering for ethnic minority children. The following benefits are provided:

- (i) Exemption from lower secondary school fees (there are no fees for primary schools): 50% exemption for children of poor households except in communes in poor mountainous areas targeted by

⁵¹ Plan International is also heavily involved in constructing, equipping, and training personnel for community schools and health centres.

- Program 135 (see next section);
- (ii) Exemption of eligible primary school children from ancillary costs, e.g. school improvement, and parent association fees, and insurance costs. In some cases, free textbooks are provided;
 - (iii) Scholarships worth up to D120,000 per month to attend higher secondary school;
 - (iv) Additional financial monthly support of D60,000, D90,000 and D120,000 for preschool, primary, and secondary school pupils, respectively; and
 - (v) Support to 10 boarding schools for ethnic minority children in the 10 most difficult provinces.

It should be noted that application of these benefits varies considerably across the country and that by no means all children receive all these benefits. The nonfee costs of education can be substantial and among the poorest families, can act as a deterrent to poor families to keeping their children in school.⁵² Assistance is also greater for orphans and children with disabilities.

Total annual expenditure is in the order of D216 billion⁵³ with about 2.5 million children currently benefiting from the program out of an estimated 3.4 to 3.6 million who are theoretically eligible.

VBSP has now taken over the Education Fund previously operated by the Industrial and Commercial Bank of Viet Nam. This fund provides loans of up to D200,000 per month to students from poor and war invalid households. Guarantors are required for the loans, which are repayable in three to four years after completion of studies. However, repayment rates are poor. VBSP budgeted D38 billion to this fund in 2003, which would provide for around 20,000 students.

A large number of NGOs have education programs. These primarily involve the construction, rehabilitation and equipping of school facilities in poor areas, and teacher training. They rarely involve significant subsidies to poor/vulnerable households to increase school attendance, although some offer scholarships (Worldvision provided about 3,000 scholarships in 2003). Total NGO expenditure on education in 2002 was around \$15 million.

⁵² See for instance, IOS/JICA (2003), pp. 47-51.

⁵³ This figure almost certainly excludes school fee exemptions, which would not be "made up" by additional school revenues.

4. Assistance with Health Costs

Direct subsidies to allay the health costs of the poor and the vulnerable have been discussed in Section D above, while health insurance schemes were described in Section C.

As with education, there is considerable IFI and NGO involvement with the health sector and again, this involvement is primarily related to improving physical facilities, training, local capacity building, health education, and national health administration and budgeting rather than direct assistance to individual households. From discussions, the current trend is to improve access to facilities through the expansion of mobile services and publicity. Total grant expenditure on this sector amounted to around \$75 million in 2001. Total NGO expenditure in 2002 was around \$25 million; this figure also includes expenditure on preventing HIV/AIDS and caring for those affected by the disease.

5. Children with Special Needs (CWSN)

a. Orphans/Street Children

MOLISA's has a long-standing program of providing assistance to orphans, street children, and children with special needs (CWSN), such as the disabled and the mentally ill. Most of those assisted live in the community and are provided with allowances of D45–60,000 per month as well as free health care and school fee exemptions (see above). Total annual expenditure on orphans is about D30 billion and these programs cover approximately 43,500 orphans out of an estimated 128,000.

MOLISA estimated that there are around 200 residential centres being ran by other agencies, including the Red Cross, the Association of War Veterans, SOS village, Buddhist and Christian churches, and other INGOs in addition to the SPCs described previously. MOLISA staff considered that these homes would be smaller, in general, than the government SPCs with an average of around 100 children per home. On this basis, the number of children cared for in NGO run homes could be in the region of 20,000 (although some may cater for adults). An indicative estimate of annual expenditure is around D40 billion (assuming D200,000 per child per month).

MOLISA estimates that there are 20,000 street children in Viet Nam, mostly concentrated in Hanoi and HCMC. Initiatives to assist these children include:

- (i) MOLISA assists 2,000–3,000 street-children annually at a cost of around D3 billion. Assistance comes in the form of food and shelter

for up to two weeks before they are returned to their homes or put into care;⁵⁴

- (ii) Plan International provides basic and vocational education to street children (around 1,100 children) and has established counseling centers that have received visits by 7,000 children since their inception;
- (iii) Catholic Relief Services (CRS) has constructed a vocational center for street children in Danang at a cost of \$67,000, excluding counterpart funding;
- (iv) The European Union's (EU's) Disadvantaged Youth and Street Children in Hanoi and Hue projects work with local People's Committee to improve conditions of street children. Total expenditure in 2001 amounted to \$290,000; and
- (v) ActionAid is working with street children in HCMC and local residents and employers to provide more secure employment. Approximately 3,600 children are involved although not all will be street children.

b. Children with Disabilities (CWD)

"Programmes [*sic*] designed specifically for disabled children are limited but growing. The community-based rehabilitation program now operates in 30 out of 64 provinces."⁵⁵ In addition, pilot programs are being developed to enable 42,000 disabled children to attend regular school.

There are also less than 100 training centers that cater exclusively for the disabled. Total annual out-turn is 5,000–6,000 trained workers with disabilities. Two of the largest of these are vocational centers for young people with disabilities in Ha Tay and Thu Duc. Together, these two schools cater to 1,200 students every year. Courses are provided in tailoring, electronics, electrical work, carpentry, mechanics, and information technology. Subventions of D5.4 million per student are provided, implying an annual expenditure of an amount of about D6.5 billion. Extrapolating from this data, total annual expenditure on training for the disabled would, therefore, be about D25 billion.

Important internationally funded projects targeted at children with disabilities are:

- (i) UNICEF's Child Protection project, with annual funding of around \$1.2 million, is designed to assist the Government to reduce the

⁵⁴ Estimated from 1996-1999 data as current information is not available due to local administration of the program and imperfect report. The data comes from MOLISA, Statistics on Social Safety Nets in Vietnam, p. 171-2, Hanoi, 1999.

⁵⁵ UNICEF, 2000.

prevalence of children in need of special protection both through pilot projects (see above) and at national level, to further increase awareness and continue implementing policy and legislative reforms;

- (ii) USAID has four major programs: (i) HCMC Assistance to Children with Disability, (ii) Expansion of Community Support for Children with Disabilities (CWD), (iii) Inclusive Education for Hearing Impaired and Deaf Children in Viet Nam, and (iv) The Adaptive Vocational Training Programme for Adolescents with Disabilities. Objectives of these programs (which had a combined expenditure in 2001 of around \$1.3 million) are to improve educational opportunities for CWD, improve the ability of teachers to address the needs of CWD, raise community awareness of CWD, develop models for the community-based rehabilitation and acceptance of CWD, and provide adaptive training programs. A fifth, much smaller program is designed to reduce accidents that result in the death or injury of adolescents;
- (iii) The Czech Government is financing the construction of a specialized rehabilitation and orthopedic center for disabled youth at Thai Nguyen. The project includes training and operation for 10 years at a total investment of \$1.5 million; and
- (iv) World Concern runs a program for disabled adolescents in several provinces in the country teaching similar courses to those provided at the government-run training schools. Annual expenditure is around \$450,000.

A number of other local and international NGOs work with children with disabilities, both through direct involvement and capacity building and policy-making. These programs/organizations are either much smaller or have been mentioned previously under the Social Assistance Programs.

c. Youth Programs

MOLISA has no targeted youth programs, although programs described previously relating to disability, orphans, street children, vocational training, drug abuse, and prostitution will all involve a significant number of teenagers and young adults.

There is also heavy involvement of aid agencies in programs to combat drug abuse, especially, and prostitution/child trafficking. Those programs not specifically targeted at children are summarized in Table 4.3 above. The US government, working with MOET, has a project to develop and pilot drug-

prevention education modules for schools with associated teacher training (annual expenditure in 2001 is \$42,000).

The ILO with DFID finance has initiated the Viet Nam Project to Combat Trafficking in Children and Women with interventions consisting of awareness raising, advocacy, capacity-building, and direct assistance at community level involving pilot projects that increase employment and income-generating opportunities in vulnerable communities. As with many other projects, other issues such as HIV/AIDS, literacy, family planning, and gender equality are included. Local partners include MOLISA, the Border Guard Command, VWU, and the CPFC. The project is targeted at the border regions along the Mekong and is part of similar projects in southern China, Laos, Cambodia, and Thailand. ActionAid Vietnam and SCUK are also involved in this project (expenditure not known).

SCUK (with EU funding) is carrying out the Child Focused HIV/AIDS Intervention and Management Project to increase awareness among children in Haiphong and HCMC in order to reduce their vulnerability to HIV infection and reduce the impact of the AIDS epidemic on children in Viet Nam. This program, which has a four-year funding of \$640,000, is notable for the high degree of children participating in the project. To date, around 28,000 school children and 11,000 out-of-school young persons have benefited. A similar but larger project, Healthy Living and Life Skills for Young Children and Adolescents, is being ran by MOET in selected communes with funding of about \$450,000 per annum. This project is taking place in several communes and covers life skills and training in healthy living as well as HIV/AIDS. Both these projects essentially involve health education. USAID is running the community-based Awareness-raising and Behavioral Change for Viet Nam Youth Project to improve the ability of the Viet Nam Youth Union to deliver community-based HIV/AIDS activities through publicity campaigns, education courses and training. Total expenditure is about \$0.9 million over a five-year period.

The EU is funding projects at a national level and in Hanoi and Hue designed to improve adolescent reproductive and sexual health. Annual expenditure for all three programs is around \$850,000. CARE international is involved in the capacity-building of local institutions to deal with similar issues; funding in 2001 was \$164,000.

There are some programs to improve employment opportunities for adolescents (over and above those targeted at children with special needs). The ILO and the Dutch Government are collaborating in a project (Promoting More and Better Jobs for Young Women: the Transition from School to Work) to strengthen the capacity of employment service centers to cater to this group and to run courses in basic and life skills. The total budget is \$215,000 over

three years. A similar project—Strengthening the Capacity of the Hoa Sua Vocational Training School for Disadvantaged Girls (funded by UN Volunteers)—is designed to increase opportunities for girls from orphanages and poor families; funding in 2001 was \$128,000.

Although bonded child labor is largely absent in Viet Nam, a significant proportion of children work, particularly in rural areas. Child employment also appears to be on the increase in urban areas despite the fact that it is illegal to employ children under the age of 15 years. The ILO (with Dutch Government funding) is developing a national strategy for the prevention and reduction of child labor in the country. The program involves a combination of institutional development and direct action, including research, advocacy, and awareness-raising, capacity-building and training, and pilot projects to improve conditions of or withdraw children working in nonagricultural sectors. The program is expected to address directly the needs of 1,500 child workers. Total expenditure is around \$550,000 over three years.

d. Children with Special Needs—Summary Information

Data on the number of CWSN in Viet Nam is incomplete and open to debate. What exists is summarized in Table 4.7. Child Protection—Methodological Issues.

This review of programs and activities related to Child Protection has revealed that there are a large number of programs operated/funded by the Government, IFIs, and NGOs relating to Child Protection. A number of issues theoretical and practical issues emerge.

The key theoretical questions are:

- (i) Whether health programs targeted at young children (e.g. immunization, child and mother nutrition, health education) should be considered to fall under the SP umbrella. These traditionally are seen as part of the health sector. Is it logical to include programs targeted to mothers and children and exclude ante-natal care and family planning? Why should immunization programs be included but not programs to control other diseases? These other diseases include TB and malaria, for which there is considerable WHO funding;
- (ii) On preschool education, this is a nascent concern in rural Viet Nam. In urban areas, most women work and child care is provided by a combination of family members, and kindergartens/crèches provided by private operators or work units. Is it logical to consider pre-school education as part of SP when primary education is specifically excluded? Arguably, SP should only embrace

educational issues where they involve the types of targeted subsidies or school-cost exemptions such as those described above; and

- (iii) On youth programs, should reproductive and sexual health programs be considered as part of SP or part of the health sector?

The practical issues, several of which have already been raised in connection with other SP components, are:

- (i) The multiplicity of NGO programs that are wholly or partly directed at assistance to children in general, or those with special needs in particular. PACCOM information identifies more than 250 programs related to education and over 480 related to health, with a combined annual expenditure of \$40 million (in 2002);
- (ii) The general absence of program-by-program information on expenditures and beneficiaries, and the multisectoral nature of many of the programs that, as with Area Development Schemes, makes it virtually impossible to disentangle Child Protection expenditure (and beneficiaries) from total program expenditure, even where this is available;
- (iii) How to assess beneficiary numbers when the major components of projects are advocacy, promotion of child rights, legislative reforms, training, capacity-building, physical construction and equipment? All of these will lead to benefits long after the formal completion of the project; and
- (iv) On the inter-relationship between the Government, IFI, and NGO expenditures, most IFI expenditure is channeled through government agencies; but it is also channeled through NGOs (especially international ones), leading to substantial potential for double counting.

V. Synthesis of Results

In this chapter the information obtained from the review of current SP activities in Viet Nam is synthesized in order to derive indicators that can be used in the formulation of an SPI. In accordance with the methodology proposed, this information concentrates on the following items:

- (i) annual expenditure on SP;
- (ii) the coverage of SP programs and activities, i.e. the number of beneficiaries; and
- (iii) the distributional impact of SP activities.

Table 4.7. Children with Special Needs

Category	Number	Source	No. Assisted	Source/Comments
Orphans	128,000	MOLISA	63,500*	MOLISA
Street Children	20,000	MOLISA	10,000	Indicative based on MOLISA, NGOs, and consultants
Children with HIV/AIDS	34,500	Incl. Kids living with adults with IV/AIDS	Estimated 90%	A number of NGOs work in this field
Child Workers	584,000	1999 Census—working 13/14 year olds	Very few	ILO project has just started
Children with Disabilities				
Very severely disabled	125,000	Classified as invalids in the 1999 Census.	42,000 CWD attend regular school; 5,000-6,000 CWD trained every year	Several NGOs run projects for CWD. There are also some major IFI-funded projects. But data on the number of beneficiaries are almost completely lacking.
Severely disabled	275,000	By subtraction	Many hearing and visually impaired children have received assistance	A number of CWD will be provided with residential care in children's homes (see above under orphans).
Partially disabled	400,000	MOLISA/ UNICEF	Many amputees have been fitted with prosthetics	Many CWD will be assisted as part of programs targeted at the disabled in general.
Sub-total	800,000⁵⁶	MOLISA/ UNICEF	Estimated 30%	
All CWSN	1,566,500		345,000	

*Including an unknown number with disabilities who are not orphans.

NB. There are unavoidably overlaps between the categories in both totals and those assisted. Source: See table.

⁵⁶ There is considerable uncertainty about the number of disabled children. MOLISA also gives an estimate of 1–1.2 million (including up to 200,000 affected by Agent Orange (The Viet Nam Economic Outlook [March 2004 edition] also gave an estimate of 74,000 persons affected by this abomination).

For details concerning the methodology, see the section Social Protection Index and Multicountry Analysis of this book.

A. Social Protection Expenditure

There are two potential approaches to deriving information on SP expenditure: the “top-down” and the “bottom-up” approach.

Ideally, total expenditure on SP should be capable of derivation from the Government budget and other “top level” information. In 2001 and 2002, expenditure on social subsidies averaged D13 trillion (\$840 million), but was projected to increase to D17 trillion (c. \$1.1 billion) in 2003. Further investigation revealed that this budget includes the following items: (i) financial support to social assistance centers; (ii) financial support to social assistance outside these centers (i.e. in communities); (iii) other social programs such as anti-drug and anti-prostitution; and (iv) poverty-targeting programs—HEPR, program 135.⁵⁷ It proved impossible to obtain further disaggregation of the overall social subsidies’ budget into these more detailed categories. By the same token, no breakdown of the budgets for other line items was available that enabled the identification of SP components of these budgets, e.g. education/training or health. Total projected spending in 2003 on these sectors was D29 trillion.

Aggregate information on IFI-funded projects is provided in the annual Vietnam Cooperation Report.⁵⁸ However, it is not possible to identify SP expenditure directly as the sectoral breakdown used results in SP programs occurring in several different categories. In any case: (i) the great majority of this funding is channeled through government organizations and would thus be included in the budget estimate for social subsidies; and (ii) IFI funding of SP programs is relatively modest compared with the funds devoted to other sectors.

Total annual INGO expenditure was just below \$100 million (around D1.6 trillion) in 2002. Of this \$21 million (around D300 billion) was devoted to almost 500 projects targeted at the disabled, vulnerable children, and people trafficking, all of which fall within the definition of SP. There are also other SP projects classified under education (e.g. scholarships), economic development (microfinance) or health (HIV/AIDS prevention) that cannot be identified separately. In any case, INGO expenditure is insignificant in terms of total government expenditure on SP— about 2%, if INGO “social” sector projects only are included. It should also be pointed out that a substantial

⁵⁷ Ministry of Finance and World Bank.

⁵⁸ UNDP, 2003.

proportion of INGO funding comes from IFIs and therefore, care must be taken to avoid double counting.

Given these shortcomings in the aggregate data on SP, reliance had to be placed on the “bottom-up” approach, whereby expenditures on SP were identified from data on individual SP activities and were then aggregated. This information is presented in Table 5.1 by SP subcomponent, while Table 5.2 contains a summary of this information by SP subcomponent. The majority of the information presented is based on information obtained directly from discussions with agency representatives and data gleaned from a multiplicity of reports, published and unpublished; in some cases, it has been necessary to derive estimates that can only be considered as indicative. The fact that so little of this information was available in easily accessible published reports made the compilation of Tables 5.1 a painstaking task.

We do not, however, consider that there are any major omissions. We also have no reason to believe that the cited expenditure on the largest programs is incorrect and we are consequently confident that the overall magnitude of SP expenditure, which is broadly comparable to that derived directly from the national budget, is also correct. Omissions mainly concern the institutional/advocacy aspects related to the application of the labor code, and NGO projects dealing with the disabled and vulnerable children, which only make up a small proportion of total SP expenditure.

Table 5.2 shows that expenditure on SP in Viet Nam is dominated by the expenditure on social/health insurance and social assistance; together, these two components accounted for over 70% of Viet Nam’s total SP expenditure of just under D19 trillion. Within these categories, VSIF and assistance to war invalids and heroes accounted for over 60% of total expenditure. In terms of individual programs, the largest single program in terms of expenditure; expenditure on health insurance accounted for another 9%.

Indicators that could be used as a component of SPI are:

- (i) total SP expenditure as a percentage of GDP: 3.5%; and
- (ii) total SP expenditure as a percentage of government expenditure: 11.7%.

Only the first of these should be retained. GDP already includes government expenditure. Using government expenditure as the denominator would reduce comparability as different countries would have different levels of government participation in the overall economy. Furthermore, when a combination of the two indicators was suggested, the weight assigned to SP expenditure as percentage of government expenditure was only 20%, which is considered too low to significantly affect the overall indicator. Finally, using one indicator reduces the complexity of the overall SPI.

Table 5.1. Annual Expenditure on Social Protection Programs by Subcomponent

SP Component/Program	Funding/ Year	Annual Cost (D billion)	Comments
Labor Market Programs			
Employment Service Centers	Govt./ MOLISA	28	Essentially self-financing
HEPR-EC—Job-creation program (loans to businesses)	Govt./ MOLISA	972	2003 disbursements
SOE Equitization Program	Govt./ WB	418	VDR 2004
Vocational and Technical Training	Govt./ MOLISA	42	Targeted training only
Subtotal		1,461	
Social Insurance			
VSIF	Govt. VSIF	8,552	
Contributory Health Insurance (VHI)	Govt. VHI	1,440	
Voluntary Health Insurance	Govt. VHI	117	
Health Insurance for the Poor	Govt./ MOH	69	
Subtotal		10,178	
Social Assistance			
War Invalids and Contributors	Govt./ MOLISA	3,724	
Disabled	Govt./ MOLISA	83	
Elderly on Their Own	Govt./ MOLISA	47	Social assistance only
Social Protection Centers	Govt./ MOLISA	24	
Drug Addiction	Govt./ MOLISA	135	
Prostitution	Govt./ MOLISA	21	
Land Tax Exemptions (HEPR)	Govt.	191*	Extrapolated from survey data
House Improvement Loans (HEPR)	Govt.	200	
Day of the Poor Fund (Motherland Front) Orange	Public	230	
New Year Gifts to the Poor and Agent	Public	20	
Victims Movement (VRC)			
Assistance Fund for Agent Orange Victims	Public/ NGOs	34	

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Table 5.1. Annual Expenditure on Social Protection Programs by Subcomponent (continued)

SP Component/Program	Funding/ Year	Annual Cost (D billion)	Comments
Subsidies on Key Goods in Mountainous Areas			
Emergency Relief (MOLISA)	Govt. CEMMA	230	
Emergency Relief (CEMIMA)	MOLISA	327	
Emergency Relief (Red Cross Vietnam)	CEMMA	71	
Emergency Relief (overseas funding)	Public/ Foreign	24	
Miscellaneous Social Assistance Programs	Foreign	26	
	Foreign	61	E.g. disability, HIV/AIDS
Subtotal		5,314	
Micro/Area-Wide Programs			
Microcredit (PCFs, VBP, INGO schemes)	All	1,195	VHLS502; excl. VBARD
Disaster Protection and Emergency Relief	IFIs/ INGOs	32	
War Legacies	INGOs	50*	Indicative estimate only
Subtotal		1,277	
Child Protection			
Child Rights and Advocacy	Foreign	20*	Indicative estimate only
Educational Subsidies (HEPR)	Govt. MOET	216	
Orphans	Govt. MOLISA	30	
Street Children	Govt./ Foreign	15*	Indicative estimate only
Nongovernment Children's Homes	All NGOs	60*	Indicative estimate only
Training for the Disabled	Govt. MOLISA	25*	Indicative estimate only
Assistance to Disabled Children	Foreign	55*	Indicative estimate only
HIV/AIDS Youth Programs	Foreign	26	
Protection/Prevention of Child Labor	Foreign	3*	Indicative estimate only
Subtotal		450	
Grand Total		18,680	

NB. IFI- and INGO-funded projects have only been included where we are confident that they are not already included in government-funded programs. Source: Chapter 4 and authors' estimates(*).

Table 5.2. Summary of Annual Social Protection Expenditure and Indicators

SP Component	Expenditure (D billion)	(%)
Labor Market Programs	1,461	7.8
Social Insurance	10,178	54.5
Social Assistance	5,314	28.4
Micro/Area-wide Programs	1,277	6.8
Child Protection	450	2.4
Total	18,680	100.0
Indicators of Social Protection Expenditure		
As % of GDP	3.5%	
As % of Government Expenditure	11.7%	

Source: Table 5.1; Consultants' estimates.

B. Coverage of Social Protection Programs

The second proposed component of a Social Protection Index is the coverage of SP programs. Table 5.3 presents available information on the number of beneficiaries⁵⁹ of the SP programs listed in Table 5.1. Although data is missing for some of the smaller programs, particularly those that are foreign-funded programs and targeted at the disabled and children, data is available or can be estimated for virtually all the largest programs.

There are three important points to make about the information contained in Table 5.3:

- (i) Quantification of the number of beneficiaries is not possible for those programs dealing primarily with capacity-building/training, awareness-raising, and institutional/legislative reform;
- (ii) Some programs have multiple target groups, especially those targeted at children; and
- (iii) Some programs target the same people, e.g. land tax exemptions and educational subsidies both target poor households (as do several others). Conversely, other programs may target different groups—some HIV/AIDS programs will target children and adults.

Table 5.4 shows the relationship between the categories of SP programs, the corresponding target groups, and the reference population. It also defines the “reference” populations that will be used to derive the coverage indicators. Table 5.4 presents two definitions of the reference population: the “narrow”

⁵⁹ In most cases, the number of beneficiaries = the number of people actually receiving benefits. The main exception are health insurance schemes, where it is more appropriate to use scheme membership, i.e. the number of persons who are covered by the scheme even if they do not receive any benefit from it.

Table 5.3. Beneficiaries of Social Protection Programs

SP Component/Program	Beneficiaries (000s)		Reference Population (potential target group)		Comment
	People	Hholds	Description	People	
Labor Market Programs					
Employment Service Centers	280		Unemployed/underemployed	5,600	Beneficiaries = no. of job seekers assisted
Job-Creation Program	300				Govt. estimate that has not been independently verified
SOE Retrenchment Program	29		SOE unempl		
Vocational and Technical Training	45		Total labor force entrants and unemployed/underemployed	7,600	Definition of target population is not clear
Social Insurance					cut
VSIF	3,029		Wage employees	9,000	
Health Insurance—All Schemes	18,500		Total Pop.	80,000	5.9 million people are covered
Social Assistance					Persons covered
War invalids, Veterans, and Martyrs	1,380		War veterans	1,380	
Disabled	121		Severely disabled; appears low.	1,800	Census estimate excludes c. 3.2 million partially disabled
Elderly on Their Own	78		Single elderly	121	
Drug Addiction	58		Drug addicts	125	
Prostitution	4		Prostitutes	14	MOLISA estimate but incapable of verification
Land Tax Exemptions		1,460	MOLISA poor	2,600hh	Beneficiaries from VHLSS 2002
House Improvement Loans		141	MOLISA poor	9,600hh	Annual beneficiaries based on a 3 year period
Day of the Poor Fund	460		Severely poor	10,400	Pop.living below food poverty line
New Year Gifts to the Poor and Agent	66		Severely poor	10,400	Provided to those not receiving assistance from elsewhere
Orange Victims Movement					

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Table 5.3. Beneficiaries of Social Protection Programs (continued)

SP Component/Program	Beneficiaries (000s)		Reference Population (potential target group)		Comment
	People	Holds	Description	People	
Assistance Fund for Agent Orange Victims	82		Agent Orange Victims	100	Using lower MOLISA estimate Impact highly uncertain; pop. of 1,000 mountainous districts
Subsidies on Key Goods in Mountainous Areas	10,000		135 communes	10,000	
Emergency Relief (MOLISA)	900		Disaster/pre-harvest/ drought victims	900	Assumed assistance provided to all needy Very poor in 135 communes
Emergency Relief (CEM)			Disaster victims		
Emergency Relief (Red Cross Vietnam)		25	Disaster victims		Varies year by year. All needy persons likely to receive assistance.
Emergency Relief (overseas funding)					Majority of projects do not directly assist target groups as they involve capacity-building and training. No beneficiary information on those that do bring direct benefits, e.g production of prosthetics, assistance to HIV/AIDS sufferers.
Miscellaneous Social Assistance Programs					
Micro/Area-wide programs					Beneficiary calculations are not applicable
Microcredit					
Disaster Protection and Emergency Relief					Beneficiary calculations are not applicable
War Legacies					
Child Protection					Beneficiary calculations are not applicable
Child Rights and Advocacy					
Educational Subsidies (HEPR)	2,500		Children in poor hhs	3,500	MOLISA/ MOET estimate
Orphans	4		Orphans	128	
Street children	10		Street children	20	MOLISA estimate
Non-government Children's homes	10		Children in difficulties	128	MOLISA estimate
Training for the Disabled	6		Disabled kids	400	No. of orphans
Assistance to Disabled Children	42		Beneficiary information either not known or not applicable, i.e. programs do not always provide direct assistance.		Excl. partially disabled (Table 4.5)
HIV/AIDS Youth Programs					Projected out-turn of ILO project
Protection/Prevention of child labor	2		Child workers	584	

* Excluding VBARD.

Sources: Various, see Chapter 4.

Table 5.4. Categories of Social Protection Programs and Primary Target Groups

Target Group	Types of SP program	Reference Population— Narrowly Defined*	Reference Population— Widely Defined
The Unemployed and Underemployed	All labor market programs (relevant training and job-creation through SME support); food for work programs; targeted public works programs	The unemployed and underemployed	Total labor force/active population
The Elderly	Pensions Social assistance to the elderly	Population aged 60+ years	Population aged 60+ years
The Sick	Formal health insurance Microinsurance Subsidized health costs or exemptions Senior citizen treatment allowance	Total population	Total population
The Poor (especially the severely poor and disadvantaged)	All recipients of basic social welfare/assistance payments Allowances to senior citizens, widows, conflict-hit persons Social welfare centers, old age homes, but excluding education and health programs as well as those for the disabled . Microfinance/credit	Poor population	Total population
The Disabled	All forms of assistance programs for the disabled (including recipients of social assistance, training programs)	Poor population The disabled population	Total population The disabled population
Children with Special Needs (CWSN)	Educational programs (e.g. fee exemptions, scholarships, school feeding programs, etc.) All other identified child protection programs	Poor children aged 5-14 years	All children aged 5-14 years

*These groups are broadly similar to those identified in PTF (2002), They also recur, with some variation, in most PPAs undertaken in Viet Nam, Turk (2004), and in many poverty assessments undertaken throughout the world.

NB. Victims of natural disasters have been excluded for two reasons. Firstly, this group varies dramatically from year to year with the occurrence or non-occurrence of natural disasters. Secondly, there is no convincing way of assessing the target population in order to derive a coverage indicator for emergency relief assistance.

Source: Consultants.

definition of the reference population attempts to approximate the target population, while the “wide” definition includes the total population who could receive benefits from each category of program.

The next step is to relate the information on SP programs contained in Table 5.3 to the target groups shown in Table 5.4. The results are presented in Table 5.5. It is important to note that some of the information presented may not be completely accurate, since the exact numbers of program beneficiaries were not always available. In these cases, the authors either used estimates based on discussions with the relevant officials or especially where no published data existed, derived their own estimates. In Viet Nam however, this potential problem was reduced by the availability of data on the coverage of some SP programs from VHLSS02.

Table 5.5 presents coverage rates for both the narrow and wide reference populations. In interpreting the information presented in Table 5.5, it should be remembered that beneficiaries from some programs can appear under more than one target group. In estimating the total number of beneficiaries within each target group, major overlaps have been allowed for. There are bound to be some remaining minor overlaps, but it is considered that these overlaps will have a negligible impact on the calculated coverage rates.

Table 5.5 reveals coverage rates, using the narrow reference population, between 23% and 48% for the majority of target groups: the elderly, the sick, the poor, the disabled, and children with special needs. These rates reflect the wide range of SP programs operated by the Vietnamese Government. Some of these programs have existed for many years (social insurance and relief to war invalids), while the others have been developed since the late 1990s as part of the Government’s major objective of reducing poverty.

Furthermore, analysis of VHLSS02 reveals that 37.3% of all households were in receipt of some SP benefits in 2002. This is much higher than the equivalent proportion in 1998 which was 24%. The reasons are the following:

- (i) coverage of certain programs has increased since 1998, e.g. educational subsidies; and
- (ii) a number of assistance programs have come into operation since 1998—health insurance, land tax exemptions, irregular relief mobilized by national NGOs.

Unlike the information on cost, which consisted of just one indicator, the coverage component involves seven indicators. In the section Social Protection Index and Multicountry Analysis of this book, the seven indicators of coverage will be combined into a single indicator for the SP coverage component.

Table 5.5. Coverage of Major SP Programs by Priority Target Group

Target Group	Applicable Programs (these should be specified for each country)	Beneficiaries (000s)		Reference Population ^a		Coverage (%)	
		Program	Total	Narrow	Wide	Narrow	Wide
The Unemployed and Underemployed	ESCs, SOE retrenchment	310	660	12,600 ^b	39,400	5.2	1.7
	NEPF/targeted training Food for work, public works programs	350 Do not exist					
The Elderly ^d	War invalids and heroes ^c Pensioners receiving SI benefits The elderly on their own	1,380 1,270 78	2,728	8,000	8,000	34	34
	(receiving social assistance) Formal Health Insurance Schemes (VSIF) Schoolchildren Subsidized treatment costs/health cards Microinsurance negligible	6,100 8,000 4,400					
The Sick	Land tax exemptions	5,360	6,000 ^e	23,200	80,000	26	7.5
	Regular social assistance House improvement loans Day for the Poor New Year gifts to the Poor	250 620 460 66					
The Poor	VBSP	1,683	6,000 ^e	23,200	80,000	7.6	2.2
	PCFs	81					
The Poor/Microcredit Programs ^f	War invalids and heroes ^g SI invalidity beneficiaries	1,380 312	1,764 1,960	5,670	80,000 5,670	35	35
	Regular social assistance to the disabled Agent Orange victims	120 148					
Children with Special Needs (CSWN)	HEPR education component Street kids; orphans; disabled children (incl. children receiving direct social assistance)	2,500 132.5	2,633	5,450	18,800	48	14

^a See Table 5.4 for definition. Figures are in 000s.

^b Based on 5.8% unemployment and 26% under-employment (working <25 hours per week)

^c Assumes all recipients are elderly and no overlaps with pension recipients; no more data available.

^d Indicator designed to indicate what proportion of the elderly currently has pensions or other assistance.

^e Overlaps are likely to be significant in this category.

^f VBARD excluded as being a general rural credit program using commercial rates and conditions, i.e. it is not targeted and has no real SP component.

^g Assumes all beneficiaries are disabled; no other data available. Source: Authors' estimates derived from preceding tables using VHLSS02, interviews, and reports.

C. The Distributional Impact of SPI Programs

This is the third proposed component of the SPI. It can be assessed in two complementary ways:

- (i) by estimating the extent to which SP programs target the poor, i.e. the poverty-targeting rate, which is defined as the proportion of the poor population (i.e. with incomes below the poverty line) who are beneficiaries of SP programs; and
- (ii) by examining the impact of SP expenditure on the incomes of the poor, i.e. the Income Impact.

While the poverty-targeting rate provides an indication of the coverage of the poor population by SP programs, the Income Impact gives some idea of the effectiveness of these programs in raising the income of poor households.

I. The Poverty-Targeting Rate

There are two basic steps in the derivation of the overall poverty-targeting rate:

- (i) estimating the number of poor beneficiaries for each of the identified SP programs; and
- (ii) estimating the overlaps between schemes so as to avoid double counting.

The base data for deriving this indicator is the information on SP programs and their beneficiaries from Tables 5.3 and 5.5. The required information on the Poverty Targeting of these programs can either be obtained on an *ad hoc* basis from knowledge of the targeting of each program - e.g. programs such as the relief and social assistance funds can be assumed to exclusively benefit the poor whereas social insurance schemes that only benefit government or formal sector employment can be assumed to have few, if any, poor beneficiaries - or through the analysis of household survey data. The second approach is likely to yield more robust results:

- (i) Institutions responsible for executing the major SP programs rarely maintain data disaggregated by poor and nonpoor households; and
- (ii) Household survey information also permits the identification of overlaps between programs (i.e. households receiving benefits from more than one program).

Fortunately, the VHLSS02 has a substantial amount of information on the poverty-targeting of the most important SP programs. Table 5.6 presents this information; the main findings are:

- (i) Of the beneficiaries from the HEPR health insurance, microcredit loans, agricultural tax exemptions, education subsidy, and housing assistance programs, 56-76% are poor; 30-46% are very poor. As these programs are explicitly targeted at the poor, these proportions indicate that the targeting is generally successful;
- (ii) Although the targeting of most of these programs is good, inclusion rates remain low. Only the agricultural tax exemptions and education assistance reach more than 20% of the poor; the social allowances and health assistance (insurance or certificates) are the other programs whose coverage exceeds 10% of the poor population. It should, however, be noted that targeting for these programs is based on a combination of MOLISA's poverty line, which is lower than GSO's,⁶⁰ and self-identification by the communities; additionally, unofficial quota systems also operate. In consequence, these programs would not be expected to have targeting rates that cover very high proportions of the 'GSO' poor population; and
- (iii) The war invalid program, SI pensions, and insurances are not targeted at the poor; this is shown by the high percentage (70-85%) of not poor beneficiaries.

If there were no overlaps between programs, 102% of the poor population (the sum of the last column) receives SP assistance; this is clearly implausible. The overlap between the programs listed in Table 5.6 can, however, be obtained from VHLSS02 by identifying poor households that received benefits from at least one of the above programs. On the basis of this analysis, it was found that just under half the poor population (49.6%) in Viet Nam, around 2.55 million households, received assistance from at least one of the programs listed in Table 5.6.

While VHLSS02 covers most of the important SP programs, it does not cover them all. It is, therefore, necessary to estimate the poverty-targeting rates and overlaps between the programs listed in Table 5.6 and other SP programs. This procedure is shown in Table 5.7. There were two steps—estimating the poverty-targeting rates and then the likelihood of overlaps with the major SP programs. These estimates were made based on discussions with officials involved in the programs and the authors' own knowledge.

⁶⁰ The MOLISA poverty line is closer to the GSO's food poverty line, both of which give headcount poverty rates under that derived using the standard GSO poverty line (see Table 2.7 and Section 2.G).

Table 5.6. Poverty-Targeting of SP Programs, 2002

Program	Households That Benefit	Beneficiaries (%)		Poverty- Targeting—Poor
	(%)	Nonpoor	Poor***	Beneficiaries as % of the Poor Population
Pensions	13.0	81.6	18.4	8.3
Social Allowance	10.2	51.6	48.4	17.1
The Invalid, Heroic	7.4	70	30	7.7
The Elderly/ Disabled	1.2	51.5	48.5	2.0
Insurances	2.1	84.5	15.5	1.1
Health Insurance*	5.1	35.6	64.4	11.4
VBSP	2.2	31.6	68.4	5.2
PCF	0.1	43.4	56.6	0.2
Agricultural Tax Exemption	8.2	26.7	73.3	20.8
Education Assistance	13.8	44.0	56.0	26.7
Housing Assistance	0.5	24.3	75.7	1.3

* Health insurance cards or fee exemption certificates.

*** Using GSO poverty line which is not always used for the targeting of these programs (see text).

Number = poor beneficiaries / poor population * 100

Source: Consultants' analysis of VHLSS02.

From Table 5.7, the “best estimate” poverty-targeting rate is 51%,⁶¹ indicating that just over half the poor population of the country receives some form of SP assistance in 2002. It also is only slightly higher than the 49.6% obtained from VHLSS02; thereby, confirming that VHLSS02 “captures” all the major Vietnamese SP programs. This poverty-targeting rate is also much higher than the 1998 figure of 19% (obtained from a similar analysis by the consultants of VLSS98), even if this figure took into account fewer programs.

2. Impact of SP Programs on Household Expenditures

While the poverty-targeting rate provides an indication of the extent to which SP programs reach their target populations, it gives no information on the magnitude of the assistance provided. This is a crucial issue and any SPI developed without taking this aspect into consideration would be deficient.

The ideal method for estimating the impact of SP assistance on household incomes is to analyze survey data on the income received from SP programs. In the great majority of cases, this approach is not, however, considered to be feasible, due to the following:

⁶¹ It is noteworthy that a very similar “best estimate,” 49% was obtained by the authors using their own estimates of poverty-targeting rates, i.e. independently of the VHLSS02 data. This, to a considerable degree, demonstrates that the ad hoc approach to poverty-targeting can be adopted with some confidence where no survey data is available, based on professional judgement.

Table 5.7. Poverty-Targeting of Social Protection Programs

Target Group	SP Program	Beneficiaries (000s)	Poverty-Targeting	Comments	Poor Benefits	Overlap	Comments	Poor Benefits
SP Programs Covered by VHLS02 All	Pensions, SI, health insurance, educational assistance, land tax exemptions, regular social assistance, etc.	310	15%	Focused on urban areas where poverty rate is under 7%	11,500	0%	From VHLS02, 49.5% of the poor population (see Table 5.6 and text)	11,500
					46.5	25%	Most SP programs are unlikely to target the urban unemployed	35
SP Programs Not Covered by VHLS02 The Unemployed and Underemployed	NEPF Targeted training programs	305	15%	National poverty level	45.8	25%	Groups targeted are the same as for major SP programs	34
	Residents of Social Protection Centers	45	29%		13.1	100%	These beneficiaries are unlikely to be affected by other programs	0
The Poor and Vulnerable	Prostitutes and drug addicts Day for the poor	27	100%	Very high	27	0%	These beneficiaries are unlikely to be affected by other programs	27
					62	0%	Many likely to receive health cards and/or tax exemptions and also overlaps between these 2 programs.	62
Disability Programs	New Year gifts to the poor	460	100%	Estimate Very high	460	75%	Overlap with other SA programs and Day for the poor	115
					66	75%	Overlap with other SA programs and Day for the poor	17
Child Protection	Agent Orange victims(excluding Day for the Poor)	141	80%	High	41	75%	Likely to overlap with education, Health subsidies	10
					113	25%	Some overlap with health educational programs	85
All Poor Beneficiaries Poor Population Poverty-Targeting				No overlaps	12,374		Excluding overlaps	11,883
					23,200	53%	Best Estimate	23,200

Source: Tables 5.3, 5.5, 5.7 and Consultants' Estimates.

- (i) The household survey database will not be available;
- (ii) The quality of the information on SP transfers must be good. This is not always the case, particularly with regards to irregular relief for emergencies or special occasions (e.g. Tet) and the imputing of values for benefits received in-kind (e.g. food, clothing, seed). Missing values can also be significant, e.g. where someone states that they have received a particular benefit but there is no entry for the value of the benefit;
- (iii) Imputation is also necessary to estimate the cash value of transfers where no money is received, e.g. exemptions from school and health costs and taxes. These will not always be known to the beneficiary;
- (iv) The time and technical expertise required to manipulate a survey database in this way is substantial and will not be available in many countries; and
- (v) Household survey information is only likely to become available every few years; thus, precluding the more frequent updating of the SPI.

An indicator of the importance of SP transfers to poor beneficiaries can, however, be developed using the same approach as for the poverty-targeting rate by substituting information on program expenditures (from Table 5.2) for the numbers of beneficiaries in Table 5.7 and expanding the table to include all programs listed in Table 5.6. These expenditures are then multiplied by the already derived poverty-targeting rates and summed to give an estimate of the total SP expenditure going to the poor. The procedure is actually simpler as there is no need to consider the overlaps between programs. The results of this exercise are presented in Table 5.8.

Table 5.8 shows that total SP expenditure on the poor in 2002/03 was around D5,500 billion, just under 30% of total SP expenditure. Just over half of this expenditure comes from pension payments and assistance to war heroes and invalids. This indicator is, however, not very useful for international comparisons, as it will clearly vary with the incidence of poverty in each country; although it could be “standardized” by taking it as a ratio of the overall poverty ratio. Overall however, we consider it preferable to derive an indicator where SP expenditure on the poor is expressed as a percentage of household income/expenditure. The derivation of these indicators is shown in Table 5.9.

Table 5.9 contains the summary results and derived indicators, which could be used in the formulation of an SPI. Average SP expenditure on the poor is D223,300 per capita. This can be compared to the current (2002) annual per capita poverty line income, D1.93 million. Based on this, the ratio

Table 5.8. SP Expenditure on the Poor

Category	SP Program	Expenditure (D billion)	Poverty- Targeting (%)	Expenditure on Poor Beneficiaries	
Labor Market programs	ESCs, SOE retrenchment	438	15.0	66	
	NEPF	973	15.0	146	
	Targeted training programs	42	29.0	12	
Social/Health Insurance	VSIF	8,552	18.4	1,574	
	Contributory health insurance (VHI)	1,440	15.5	223	
	Voluntary health insurance (VHI)	116	15.5	18	
	Subsidized treatment costs/ health cards (HEPR)	69	64.4	44	
Social Assistance	War invalids and heroes	3,724	30.0	1,117	
	Regular social assistance (excl. SPCs)	117	48.4	57	
	Residents of SPCs	35	100.0	35	
	Rehabilitation of prostitutes and drug addicts	156	100.0	156	
	Day for the poor	230	100.0	230	
	New Year gifts to the Poor	20	100.0	20	
	Land tax exemptions	191	73.3	140	
	House improvement loans	200	75.7	151	
	Microcredit	VBSP	1,155	68.4	790
		PCFs	40	56.6	22
Loans from other sources		0	0.0	0	
Disability Programs	Agent Orange victims	84	50.0	42	
	Other foreign funded— disability programs	111	50.0	56	
Child Protection	HEPR education component	216	56.0	121	
	Street kids; orphans; disabled children	200	80.0	160	
	All Programs	18,109	28.6	5,180	

NB. Poverty-targeting rates for shaded programs have been obtained from VHLSS02; others have been estimated.

Source: Tables 5.2, 5.6, 5.7 and consultants' estimates.

of the SP expenditure per poor person to the poverty line income per capita is 12.4% increasing to 22.7%, if only poor beneficiaries are considered.

The above indicators have their own advantages and disadvantages and which one should be used in the formulation of the SPI is by no means clear cut. The section Social Protection Index and Multicountry Analysis of this book will discuss this issue in more detail.

Irrespective of differences between the above estimates, it is apparent that the impact of SP transfers on total per capita expenditure can be significant. At the same time, the disparity between the high poverty-targeting

rate (51%) and the much lower impact on incomes underscores the need to include an indicator of this type into the SPI.

It is also noteworthy that the analysis of VLSS98 revealed that transfer payments to poor beneficiaries were equivalent to 11.6% of their income, around half the figure estimated in Table 5.9. Even allowing for the difference in methodologies,⁶² the implication is that SP assistance to the poor has increased in recent years. This conclusion, when set against the higher current poverty-targeting rate is perhaps the first demonstration of how this type of work can produce useful information.

Table 5.9. Impact of SP Expenditure on Incomes of Poor Households

Variable	Value
Total Expenditure on the Poor (D billion)	5,180
Poor Population ('000)	23,200
SP Expenditure/Poor Person (D per poor person)	223,300
Poverty Line Income/Expenditure Per Capita (annual) (D/person)	1,930,000
Per Capita SP Expenditure as a Percentage of Per Capita Poverty Line Income	11.6%
As Above but for Beneficiaries Only	22.7%

Source: Table 5.8 and information in Chapter 2.

⁶² The analysis of 1998 data used observed transfers rather than expenditure estimates of SP programs. This will inevitably lead to lower estimates of the impact on recipients' incomes as it excludes any administration expenses and benefits from health and education programs where benefits do not come in the form of direct transfers.