# 1 DISABILITY IN VIET NAM

## 1.1 Introduction

Viet Nam has a large disabled population due to war and the disease, poverty, and low quality and use of formal health care resulting from its low income country status. Poverty has decreased dramatically since the Đổi Mới policies of the late 1980's, but income inequality has risen. Consequently, the Vietnamese government has introduced social protection programs for selected target groups including PWDs. Programs include monthly cash transfers and free health insurance or medical fee exemption. Beginning with a country overview, this chapter reviews the available information on disability prevalence, poverty, and social protection in Viet Nam.

## 1.2 Country overview

### *1.2.1 Geography and population*

Viet Nam is located in South East Asia, bordered by China in the north, Laos and Cambodia in the west, and the Pacific Ocean in the east. The country is in the shape of an "S" with a distance of 1,650 kilometres from north to south and is about 50 kilometres wide at the narrowest point (total land area = 330,000 square kilometres). The topography consists of hills and densely forested mountains, which occupy 80% of Viet Nam's total land area. Two delta regions, the Red River Delta in the north and Mekong Delta in the south, are the primary food source of the country.

Viet Nam has a tropical climate with high humidity throughout the year. Because of differences in latitude and topography, the climate varies between regions. In the north, there are four distinct seasons whereas the south has two seasons, a rainy and dry season. Temperatures are generally higher in the south than the north; 21 - 28 C over the course of a year in the south compared with 5 C in December and January to 37 C in July and August in the north. The central region is characterised by 'hot winds' blowing from the Truong Son mountain range during the dry season.

The country is divided into 64 provinces and cities, sub-divided into districts and communes. The two major cities are the capital, Hanoi, in the north and Ho Chi Minh City (formerly Saigon) in the south. Da Nang city is the largest city in central Viet Nam and is growing rapidly, with the highest rate of urbanisation in the country.

The current population of Viet Nam is 85.6 million people (22.6 million households) (Socialist Republic of Viet Nam, 2010).[1] This makes Viet Nam the third most populous country in Southeast Asia (after Indonesia and the Philippines) and the thirteenth most populous country in the world. The majority (70%) of the population live in rural areas. Males and females are evenly divided among the population (49.5% versus 50.5%). The population of Viet Nam is disproportionately young; over two-thirds of the population is below the age of forty. Life expectancy at birth is 73 years, 70 years for males and 76 years for females. Viet Nam is an ethnically diverse country with 54 ethnic groups. The "Kinh" or "Viet" ethnic group are 86% of the population.

[1] Where otherwise specified, below figures derive from the 2009 Viet Nam Population and Housing Census.


Figure 1. Map of Viet Nam

### *1.2.2 Political and economic history*

Viet Nam has a tumultuous political and economic history. Viet Nam was a feudal society for centuries until the French Empire colonised the country in the second half of the 19th Century. From 1945 to 1954, the Vietnamese launched a successful war of resistance against the French, gaining victory and independence in the north of the country. Stipulated in the Geneva Accords 1954, the country was partitioned at the 17th parallel with the communist nationalist government established in the north and the government of former French supporters in the south.

In the late 1950's, the northern government supported a guerrilla campaign to overthrow the south. In support of South Viet Nam's struggle against the northern insurgency, the United States and allied forces officially entered the war in the early 1960's. The war continued until April 1975 when the northern army claimed victory with the fall of Saigon. During the decade 1965 to 1975, it is estimated that one million Vietnamese lives and 56,000 American lives were lost not to mention other allied forces including Australia (500 dead) (Hirshman et al., 1995). On 2 July 1976, the north and south were united to form the Socialist Republic of Viet Nam.

Wars during the period 1945 to 1975 devastated the Vietnamese economy. Much of the country's industry, bridges and transport systems were destroyed. After unification, the centrally planned economy of the north was extended to the south (Dollar et al., 1998, Glewwe et al., 2004, Thorborn, 2009). The model relied predominantly on agriculture led by state-controlled farm co-operatives. Small and medium enterprises were nationalised to form a large sector of state-owned enterprises. Efforts to rebuild the economy based upon collectivised agriculture and subsidised state enterprises failed. By the 1980's, hunger was widespread and the country was

experiencing hyperinflation and economic stagnation. Viet Nam was one of the poorest countries in the world. Poor economic performance, and the economic decline of its major trading partner, the Soviet Union, led to a series of structural reforms in the late 1980's known as the Đổi Mới (renovation) reforms that aimed at transforming the centrally planned economy into a market economy.

Under the reforms, agricultural co-operatives were dismantled and almost all agricultural land was distributed to rural households belonging to the former co-operatives (Dollar et al., 1998, Glewwe et al., 2004, Thorborn, 2009). Price controls and restrictions on private sector activities in commerce and industry were lifted. Unprofitable state owned enterprises were sold or closed down and the workforce at remaining enterprises was reduced. Wider macroeconomic reforms included the relaxation of administrative controls on exports and imports, liberalisation of the official exchange rate, loosening of regulations on joint ventures and allowing 100 percent foreign owned enterprises to operate in the country.

The transition to a market economy was accompanied with high economic growth, averaging 7 per cent from 1988 to 2000 (Glewwe et al., 2004). From a rice importer in the 1980's, by the early 1990's Viet Nam had become the world's third largest exporter of rice and by the end of the decade was the world's second largest exporter of coffee. Perhaps the most acclaimed achievement, however, was the sharp decline in poverty. From a level of about 75 percent in 1984, the rate fell to 37 percent in 1998 and 13 percent in 2008. The Vietnamese people often refer to the pre-Đổi Mới period as "when they didn't have [enough money to buy] a mosquito net" (từ lúc không có màn ngủ).

The downside to achievements in economic growth and poverty reduction has been a rise in inequality. During the five year period 1993 to 1998, when poverty fell 21 percent, income equality, as measured by the Theil index, increased by 17 percent (Glewwe et al., 2004). From 1999 to 2008, the gap in average monthly income per capita between the richest and poorest household quintiles rose by a similar fraction (from 7.6 to 8.9) (GSO, 2008, GSO, undated). Other signs of inequality have emerged in access to health care and education (Glewwe et al., 2004). In 1998, the contact rate at public hospitals was three to four times higher for the better-off than the poor. Despite improvement in primary school enrolment rates among the poor, large socioeconomic differences remain in secondary and post-secondary school enrolments. Ethnic minority persons, in particular, fared relatively poorly across a range of welfare indicators such as income and education (van-de-Walle, 2001, Glewwe et al., 2004).

## 1.3 Disability

### *1.3.1 State definition of disability*

The Ordinance on Disabled Persons (1998), Socialist Republic of Viet Nam, defines a PWD as follows:

> Irrespective of the cause of disability, as a persons who is defective in one or many parts of body or functions which are shown in different forms of disability, and which reduce the capability of activity and causes many difficulties in work, life and studies.

The definition is broadly consistent with an ICF classification of disability in that impairment, activity limitation and participation restriction spheres are represented. However, like the definition contained in the Convention on the Rights of People with Disabilities, the origin of disability is restricted to medical impairment. In this connection, the Vietnamese government adopts the World Health Organisation (1997) seven impairment domain classifications (Le et al., 2008):

i) Physical/moving/motor disabilities (such as amputees; paralyzed persons; persons suffering from polio, cerebral palsy, clubfoot and other birth defects).
ii) Hearing/speech (communication) disabilities
iii) Visual/seeing disabilities
iv) Learning (cognitive or intellectual) disabilities
v) Strange behaviour (resulting from psychotic/mental illness, e.g., schizophrenia and depression)
vi) Fits/epilepsy
vii) Other disabilities, e.g. leprosy

### *1.3.2 National prevalence*

Compared with other countries with similar or even higher income, Viet Nam has a large collection of disability data. The focus of the surveys has been to estimate prevalence and rehabilitation needs for the disabled population. In 1999, Thomas Kane conducted a meta-analysis of existing disability data in the country (Kane, 1999). He concluded that there existed two national surveys by the Ministry of Labour, Invalids and Social Affairs (MOLISA) and

community-based rehabilitation (CBR) data from the Ministry of Health (MOH) which was also representative at the national level. In addition, there existed a number of smaller scale disability surveys conducted by non-governmental organisations and government run rehabilitation centres. Estimates of disability prevalence were broad, ranging from 2-10 percent with the author concluding that the likely prevalence range was 5–7 percent. It was also noted that many provinces and districts were not adequately covered in national surveys and CBR data.

For the ensuing decade, three key disability data sources can be found with high variation in the prevalence of disability reported (3-15 percent) (Table 1). Until recently, the most commonly quoted disability prevalence for Viet Nam was 6.6 percent, an estimate provided by the MOLISA in the national plan to support PWDs 2006-2010 (MOLISA, 2006). The estimate is in keeping with Kane's predicted range. Methods of data collection, particularly relating to selection and measurement biases, were not adequately documented. The estimate probably came from People's Commune Committees data. The data is nationally representative but is likely to be subject to significant measurement error across communes because it is unlikely that standardised procedures or survey tools were used by commune officials to identify PWDs.

In response to the growing international interest in the measurement of disability, an inaugural disability module was included in the fifth Viet Nam Household Living Standards Survey 2006, conducted by the General Statistics Office (GSO). The module included the (United Nations) Washington Group General Disability Measure, an internationally tested and broad measure of disability. As outlined in Chapter 2, the measure included six questions relating to functions of hearing; walking or climbing steps; remembering or concentrating; washing all-over or dressing;

and communicating. Disability was defined as any difficulty in any of these six functions. From a nationally representative sample of close to 46,000 households across 64 provinces, the measure yielded a disability prevalence of 15.3%.

A lesser known estimate of disability prevalence derives from the Viet Nam National Health Survey, 2001-02, conducted by the Ministry of Health. The survey was the first national health survey of the population, collecting extensive health related information. Disability was measured according to an impairment screen: *Does anyone in the household have any of disabilities?* Six impairment domains were included: mobility, hearing, speaking, vision, mental illness (strange behaviour), and learning difficulty. From a nationally representative sample of 36,000 households across 61 provinces, the measure yielded a disability prevalence of 3.2%. The rate may be interpreted as a measure of severe disability.

Table 1. Estimates of disability prevalence from various sources, 2001-2006

| | **2001-02** | **2005** | **2006** |
|---|---|---|---|
| Disability prevalence (%) | 3.2 | 6.6 | 15.3 |
| Source | MOH | MOLISA | GSO |
| Representation | National | NA | National |
| Sample size (households) | 36,000 | NA | 45,945 |
| Disability screen measure | Impairment | NA | Functioning |

### *1.3.3 Types of disability*

Mobility disability is common across the three surveys, ranging between 20-29 percent of all disabilities. Kane (1999) reports a similar finding with mobility disabilities making up more than one-third of all disabilities recorded in national survey estimates and CBR data. Mental

disabilities comprise 15 – 27 percent of all disability, with learning or intellectual disabilities recorded in higher frequency than psychiatric (or mental) illness. In the 2006 survey mental disabilities were under-reported due to a narrow case definition (Mont, 2007). Visual disabilities were also common but more variable across surveys (range 14-38 percent). Hearing and speaking disabilities were consistently less prevalent with hearing disabilities (range 11-14 percent) more prevalent than speaking disabilities (range 9-11 percent) across each of the surveys.

Table 2. Distribution (%) of disability type from various sources, 2001-2006

| | **2001-02** | **2005** | **2006** |
|---|---|---|---|
| Mobility | 23.3 | 29.4 | 19.8 |
| Mental | 27.3 | 23.3 | 15.4 |
| Learning/intellectual | (16.8) | (16.8) | |
| Strange behaviour | (10.5) | (6.5) | |
| Visual | 24.5 | 13.8 | 37.6 |
| Hearing | 14 | 9.3 | 11.1 |
| Speaking | 10.9 | 7.1 | 9.1 |
| Other | | 17.0 | 7.0 |

*Sources:* (MOH, 2004, MOLISA, 2006, GSO, 2008)

### *1.3.4 Causes of disability*

Disease and congenital abnormalities accounted for the majority (greater than 60 percent) of disabilities recorded in the 2001-02 and 2005 surveys. This finding is consistent with Kane's summary of data existing in 1999 (Kane, 1999). Large difference exists between the 2001-02 and 2005 surveys in the share of disabilities incurred during war (11 versus 26 percent). In a 1994-95 national survey conducted by MOLISA, war accounted for one-fifth of disabilities (Kane, 1999).

One decade later the proportion quoted by MOLISA was one-quarter. One would expect the proportion of disabilities attributable to war to be declining over time. In both surveys, accidents attributable to work and traffic accounted for a small proportion of disabilities (5-8 percent) with work accidents the mainstay. The share of traffic accident related disabilities was surprisingly low (1-2 percent). The 2001-02 survey included an additional category, old age, which accounted for approximately 13 percent of all disabilities.

Table 3. Distribution (%) of disability causes from various sources, 2001-2005

| | **2001-02** | **2005** |
|---|---|---|
| Congenital | 27.5 | 35.8 |
| Disease | 34.4 | 32.3 |
| War | 10.5 | 25.6 |
| Old age | 12.5 | |
| Accident | 12.3 | 4.7 |
| Work | (5.9) | (3.5) |
| Traffic | (1.7) | (1.2) |
| Other | (4.7) | |
| Other | 4.7 | 1.6 |

*Sources:* (MOH, 2004, MOLISA, 2006)

## 1.4 Disability and poverty

Little attention has been given to the relationship between disability and poverty in Viet Nam. According a government survey in 2005, around 40 percent of PWDs were illiterate and 25-35 percent were working to support themselves with the remainder dependent upon their family and social protection (MOLISA, 2006). The majority of employed PWDs were working in agriculture which is associated with low income earnings. One-third of households with PWDs were poor compared with 22 percent for the general population. Households with multiple

disabled members experienced a higher rate of poverty: 63 percent for households with 3 disabled members compared with 31 percent for households with one disabled member.

A study by the Institute for Social Development Studies in 2006 examined the social and economic situation of PWDs in four Vietnamese provinces (Thai Binh, Quang Nam, Da Nang and Dong Nai) (Le et al., 2008). The sample included 8,068 households divided into those with disabled members (4,826) and those without (3,242). The study presented poverty correlates among households with and without disabilities, and among PWDs ($n$ = 5,497) in the households interviewed (Table 4 & 5). Relative to other households, households with at least one disabled member earned 19 percent less income per capita, spent 17 percent less on consumption items per capita, had fewer durable assets (television, refrigerator, telephone, motorbike), were 16 percent less likely to use gas/electricity for cooking and were 11 percent more likely to have no or a basic latrine (Table 4). A significant proportion of PWDs had below primary (40 percent) or primary (30 percent) education, had never been employed (40 percent) and among those employed (30 percent) worked predominantly as farmers (50 percent) or unskilled labourers (26 percent) (Table 5). Individual results are similar to those reported by MOLISA (2006).

Table 4. Distribution of poverty correlates among households with versus without PWDs in four Vietnamese provinces, 2006

| | Households | | Difference |
|---|---|---|---|
| | PWD | no PWD | (%) |
| Annual income per capita ('000 dong) | 4827.6 | 5949.2 | 18.9 |
| Annual expenditure per capita ('000 dong) | 4130.4 | 4995.4 | 17.3 |
| Own television (%) | 80.8 | 91.4 | 10.6 |
| Own refrigerator (%) | 13.5 | 25.0 | 11.6 |
| Own telephone (%) | 24.9 | 40.9 | 16.0 |
| Own motorbike (%) | 48.4 | 71.2 | 22.8 |
| Use gas/electricity for cooking (%) | 23.9 | 39.7 | 15.8 |
| Basic or no latrine (%) | 36.7 | 25.9 | 10.8 |

*Source:* Institute for Social Development Studies (Le et al., 2008)

Table 5. Socioeconomic profile of PWDs in four Vietnamese provinces, 2006

| | (%) |
|---|---|
| Sex | |
| Male | 60.0 |
| Female | 40.4 |
| Age | |
| 1-19 | 23.3 |
| 20-29 | 14.3 |
| 30-39 | 14.6 |
| 40-49 | 16.5 |
| 50-59 | 17.1 |
| 60+ | 14.4 |
| Marital status | |
| Married | 43.2 |
| Unmarried | 48.2 |
| Divorced/separated | 3.3 |
| Widow | 5.4 |
| Education level completed | |
| Below primary | 40.7 |
| Primary | 29.5 |
| Lower secondary | 17.5 |
| Upper secondary | 7.8 |
| Above high school | 4.4 |
| Employment status | |
| Employed | 29.7 |
| Used to be employed | 30.1 |
| Never employed | 40.2 |
| Occupation | |
| Farmer | 50.2 |
| Labourer | 26.0 |
| Petty trade/service | 14.6 |
| Workers/professional | 9.2 |

*Source:* Institute for Social Development Studies (Le et al., 2008)

The authors reported widespread discrimination against PWDs which they identified as the primary cause for the social and economic exclusion of PWDs (Le et al., 2008). The perception of PWDs in the community is that they are to be pitied, are reliant upon others for support, and cannot support themselves and live a "normal life". Many respondents expressed the view that PWDs would be better placed in institutions than in the community. There was a general lack of knowledge on the rights of PWDs. Superstition was also common with over half of respondents believing that disability was a matter of fate that could not be avoided. Some believed that it was the price for wrong doings of their family members in their previous life.

## 1.5 Social protection for people with disabilities

Article 1 of the Ordinance on Disabled Persons (1998) states that the responsibility to protect, assist and create conditions for the social integration of PWDs is shared between the family, the State and the society. Seriously disabled persons without any source of income and whose family is poor are entitled to public income support and free medical examination/treatment and selected assist devices (orthopaedic aids and wheel chairs). Seriously disabled persons without family are to be cared for in state institutions. Students with disabilities are eligible for reduction of or exemption from school fees. Another class of disabled persons exists in "war invalids and soldiers disabled by disease" who receive preferential benefits irrespective of disability severity.[2]

[2] Refer the Ordinance on Preferential Treatment of Revolutionary Activists, Fallen Heroes and Families of Fallen Heroes, War Invalids, Diseased Soldiers, Activists in the Wars of Resistance and Persons with Meritorious Activities in Assisting the Revolution.

Note this class includes only persons that fought for the northern regime, not the southern regime.

According to a government report, in 2005 around 10,000 PWDs were housed in state "social protection centers" with the vast majority of PWDs residing with their families. Fifty-three percent of eligible PWDs were receiving public monthly income support and a similar proportion (50 percent) had benefited from policies of medical support. Among PWDs receiving medical support, 38 percent were exempted treatment fees and 45 percent received a health insurance card with a small proportion (5 percent) benefiting from rehabilitation services. In response to the acknowledged shortage of formal rehabilitation services, a community based rehabilitation network has been developed in the majority of provinces.

The study in four Vietnamese provinces described above finds that the most common support was from the family with the vast majority (86 percent) of PWDs receiving family support (Le et al., 2008). The proportion of PWDs receiving formal supports in cash transfers or health insurance (48 percent), and free medical treatment (41 percent) were commensurate with national government estimates. The proportion of PWDs that received rehabilitation services was higher than the national average (12 versus 5 percent). The study also reported the proportion of PWDs that received a wheelchair (13 percent), reduction on tuition fees (22 percent) and vocational training (7 percent).

Table 6. Supports received by persons with disabilities in four Vietnamese provinces, 2006

| | (%) |
|---|---|
| Family support | 85.8 |
| Money | 89.4 |
| Food and clothing | 27.9 |
| Moral | 27.0 |
| Cash transfer or health insurance | 47.5 |
| Free medical treatment | 41.2 |
| Rehabilitation | 11.5 |
| Wheelchair | 12.7 |
| Tuition fee reduction | 22.2 |
| Vocational training | 7.2 |

*Source:* Institute for Social Development Studies (Le et al., 2008)

The relatively low level of formal relative to informal income support is explained by welfare dependency concerns and "socialization" – a government term used to describe societal responsibility towards various social issues, including support for the poor and disabled (Le et al., 2008). Citizens were regularly requested by commune authorities to make financial contributions to national and local social protection programs. A statement by a local government official indicates concerns of welfare-induced dependency (p.145):

> People with disabilities should know clearly that they cannot simply ask the government and society to care for them. They must assert themselves first so that they can take advantage of support given to them. Government and societal support should be considered as a catalyst only. They cannot totally depend on the government.

Inadequate state welfare combined with the promotion of "self-help" rather than charity based welfare led to the emergence of disabled peoples organisations (DPOs) in Viet Nam (Vasiljev,

2003). The general aim of the organisations is to foster equal participation of PWDs in society based upon action *by* the disabled rather than *for* the disabled. An umbrella body, the Disability Forum, was established in 2000 to promote cooperation, collaboration and better communication among DPOs and government ministries. The mandate of the Disability Forum includes rehabilitation and health services, employment, inclusive education, awareness of the rights of PWDs and barrier free access to public places. In October 2005, the Forum represented 60 local DPOs and 24 international non-government organisations (Wyndham, 2005). The current number of the organisations in the Forum and the scope of their activities is insufficient to establish a national union with which to serve the needs of all PWDs (Vasiljev, 2003). Furthermore, associations are concentrated in urban areas hence do not service the majority of PWDs that live in rural areas (Vasiljev, 2003).

## 1.6 Conclusion

This chapter provides a background on Viet Nam with respect to disability, poverty and the role for social protection. Viet Nam provides a case study for evaluation of the effectiveness of social protection programs for PWDs in developing countries. The country possesses a large body of disability data for its level of development. Disability prevalence varied widely (3-15 percent) across surveys. Whilst disability prevalence rates varied, surveys consistently showed that mobility and mental disabilities were most common, followed by visual disabilities, and hearing and speaking disabilities to a lesser extent. Disease and congenital abnormalities accounted for the majority of disabilities. War and accidents were also important causes. .

Like many developing countries, little information exists on the relationship between disability and poverty in Viet Nam. Methods of statistical analysis were limited to basic descriptive analysis and results were presented without standard errors or statistical significance. Published national statistics were limited to the disabled population and did not provide comparison with the non-disabled population. An independent study by the Institute of Social Development Studies was limited to four Vietnamese provinces. The study highlighted strong inequalities in poverty correlates between households with and without disabled members. The individual socioeconomic profile of PWDs presented in the study mirrored national statistics. Large numbers of PWDs had little or no education, were unemployed or worked in low paid agricultural or unskilled labour positions. Widespread discrimination against PWDs was identified as a key contributor to the social and economic exclusion of PWDs.

Viet Nam has a relatively sophisticated legal and administrative framework for the social protection of PWDs. Social protection is shared between the family, the state and the community. A small fraction of PWDs, less than one percent of the number quoted by the Vietnamese government, were cared for by the state in institutions. The vast majority of PWDs in Viet Nam resided with their families or alone. Persons with severe disabilities that are poor are entitled to monthly income support and free health insurance or exemption of medical fees. The coverage of programs was not universal. Around half of eligible PWDs benefited from policies of public income and medical support. Family support was the main source of support received by PWDs in four Vietnamese provinces, in particular financial support. One explanation offered for this was that social protection is viewed by government and the community as a form of charity that creates dependency rather than a human right.

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