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Children and Women A Situation Analysis 1994

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Situation Analysis of Women and Children in Viet Nam

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The designations employed in this publication and the presentation of the material do not imply on the part of the United Nations Children's Fund the expression of any opinion whatsoever concerning the legal status of any country or territory of its authorities, or the delimitation of its frontiers.

ERRATA

1. Table of Contents, Chapter VIII, The problems of early child care. Replace 95 with 94.
2. Table of Contents, Chapter XI Communications. Replace 125 with 123.
3. Page 118. "In Figure 49" should read "in Figure 47"
4. Page 121. Delete "(Figure 49)"

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ACRONYMS

ABE	alternative basic education
AIDAB	Australia International Development Agency Bureau
AIDS	acquired immune deficiency syndrome
ARI	acute respiratory infections
AP(s)	assistant doctor(s)
BCG	vaccine against the bacillus of calme
BFHI	Baby-Friendly Hospital Initiative
BI	Bamako Initiative
BIMU	Bamako Initiative Management Unit
BP	British Petroleum
CBN	commune-based nutrition
CBR	crude birth rate
CDD	control of diarrhoeal diseases
CEDC	children in especially difficult circumstances
CEMMA	Committee for Ethnic Minorities and Mountainous Areas
CHW(s)	commune health worker(s)
CIDA	Canadian International Development Agency
CIDSE	Cooperation Internationale de la Solidarite et Economie
CMEA	Council for Mutual Economic Relations with Foreign Countries
CPCC	Committee for Protection and Care for Children
CPMP	Country Programme Management Plan
CP	country programme
CRC	Convention on the Rights of the Child
CMR	children mortality rate
CHE	Centre for Hygiene and Epidemiology
CHC(s)	commune health centres
CVI	Children Vaccines Institute
DCC(s)	day care centre(s)
DDT	dichloro-diphenyl-trichloroethane
DH(s)	district hospital(s)
DTU	Diarrhoea Training Unit
DPT	diphtheria/pertussis/tetanus
DHS	Demographic and Health Survey
DV	double vault
DPHC	Director of Provincial Health Service
DHO	District Health Office

EAPRO	East Asia Pacific Regional Office
ECD	early childhood development
ECE	early childhood education
EFA	Education for All
ENT	ear, nose and throat
EPI	expanded programme on immunization
FAO	Food and Agricultural Organization
FFL	Facts for Life
FINNIDA	Finland International Development Agency
FNSS	food and nutrition surveillance system
FP	family planning
GDP	Gross Domestic Product
GFS	gravity flow system
GM	growth monitoring
GNP	Gross National Product
GSO	General Statistics Office
HEC	health education and communication
HFS	household food security
HIV	Human Immune Deficiency
HCMC	Ho Chi Minh City
HQ	Headquarters Office
ICD	integrated child development
ICP	inter-communal polyclinic
IDD	iodine deficiency disorders
IDDC	iodine deficiency disease control
IEC	information, education and communication
IMR	infant mortality rate
IPMN	Institute of Protection of Mothers and Newborns
IMF	International Monetary Fund
IUD	inter-uterine device
IQ	intelligence quotient
KAP	knowledge, attitude and practice
KG	kindergarten
MCH	maternal and child health
MOET	Ministry of Education and Training
MMR	maternal mortality rate
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
NATCOM	National Committee for UNICEF
NGO	non-governmental organization
NIN	National Institute of Nutrition

NID(s)	national immunization day(s)
NIHE	National Institute of Hygiene and Epidemiology
NCHS	National Centre of Health Statistics
NERP(s)	Nutrition Education Rehabilitation Programme
NIES	National Institute of Educational Sciences
NPA	National Programme of Action for Children
NNT	neonatal tetanus
ORS	oral rehydration solution
OPV	oral polio vaccine
PEM	protein-energy malnutrition
PHS	Provincial Health Service
PHC	primary health care
PVC	polyvinyl chloride
PPA	Provincial Programme of Action for Children
PVO	pre-vocational orientation
RWS	rural water supply
SCF	Save the Children Fund
SD	standard deviation
SIDA	Swedish International Development Agency
SMS	Secondary Medical School
SOWCR	State of the World's Children Report
SPC	State Planning Committee
STD	sexually transmitted diseases
TFR	total fertility rate
TB	tuberculosis
TT	tetanus toxoid
UCI	universal child immunization
UNDP	United Nations Development Programme
U5MR	under-five mortality rate
UNFPA	United Nations Fund for Population Activities
UNESCO	United Nations Educational Scientific Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UPE	universal primary education
USSR	Union of Soviet Socialist Republics
VAC	gardening, fish pond and animal husbandry (in English)

VAD	vitamin A deficiency
VACVINA	Vietnam Association of Gardeners (in English)
VWU	Vietnam Women's Union
VOV	Voice of Vietnam
WATSAN	water and sanitation programme
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WID	women in development
WSG	World Summit goals
WU	Women's Union

FOREWORD

The value of this situation analysis should not be measured in monetary terms. If it were it would be very costly as it has taken a considerable effort of research and time to produce! Rather its value should be measured in terms of the contribution it makes to the ongoing process of reassessing national policies affecting children and women. We hope that the analysis will also lead to the development of a cost-effective Country Programme of Cooperation, 1996-2000, between UNICEF and Government. We also hope that it will be a valuable guide for other development organizations in the formulation of their own programmes of assistance for Viet Nam. Furthermore, we sincerely hope that it will stimulate increased international cooperation and assistance for Viet Nam, particularly for children and women, from the global donor community.

The preparation of the analysis began in March, 1993, with the collection of key statistical data and other information from many Government and other sources. In September, 1993, a first draft of the document was produced and distributed for comment to more than 50 organizations including Government, NGOs, Vietnamese mass organizations, donor institutions and selected specialists. The comments were incorporated into a second draft which was reviewed at a UNICEF workshop with the participation of 13 Government and Vietnamese mass organizations. Further consultations were then held with selected provincial Government authorities and international NGOs. As result of this extensive consultative and participatory process there is now a broad consensus that this document represents a realistic description of the major conditions affecting the survival, development and protection of children and women in Viet Nam.

We hope that the analysis will ultimately benefit all children and women in Vietnam and it is to them that it is dedicated!

Stephen J. Woodhouse
UNICEF Representative to
the Socialist Republic of Viet Nam
Women's Day, 8 March 1994

Chapter I INTRODUCTION

The ongoing success of Viet Nam's policy of *Doi Moi* ("renovation") is in major part due to past investments in child survival, protection and development. Between 1945 and the present day the leadership of the Socialist Republic of Viet Nam stressed human development in general and health and education of children in particular. As a result the Vietnamese people are highly literate (88%); enjoy high life expectancy and low infant and young child mortality and have a high level of female participation in the economy and society. These achievements are particularly impressive considering the low level of GNP per capita. As can be seen from Figure 1, Viet Nam compares very favourably with other countries.

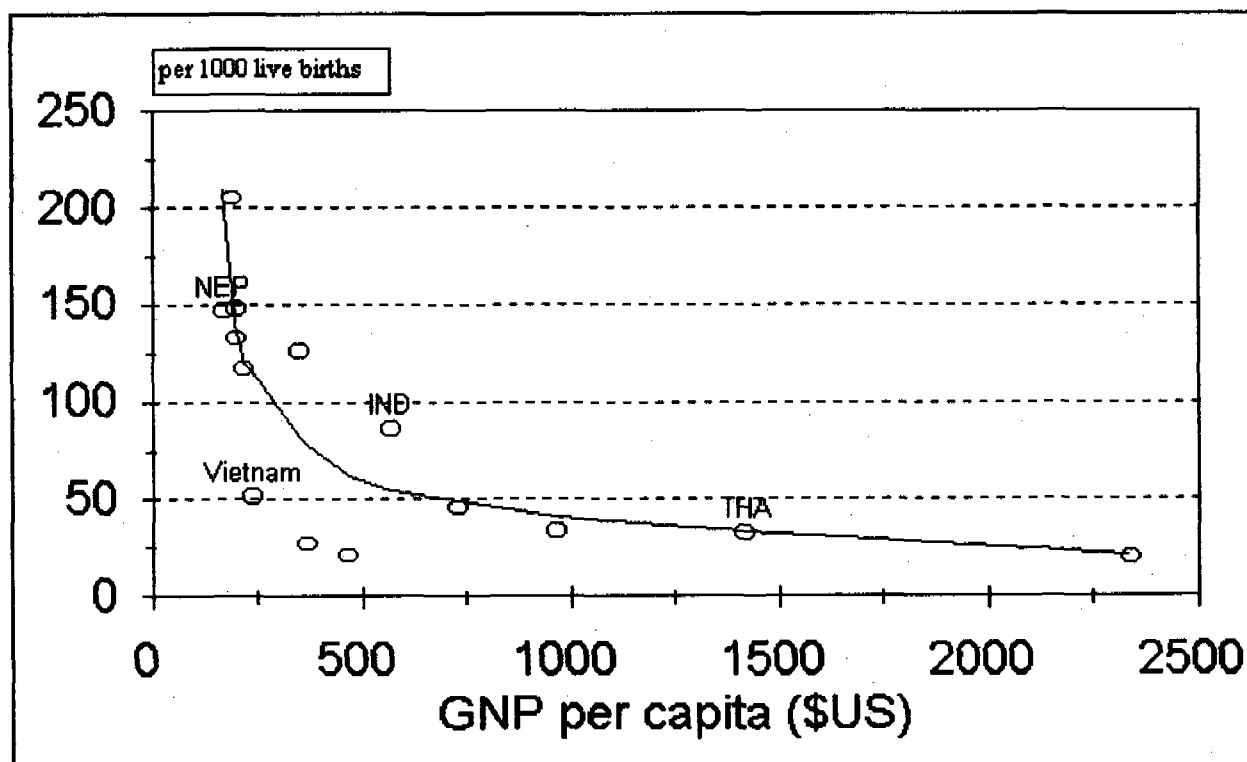


Figure 1: USMR vs GNP in 14 Asian countries (Bhutan, Lao, Nepal, Pakistan, Bangladesh, India, Myanmar, Indonesia, Viet Nam, Philippines, Dem. Peo. Rep. Korea, Thailand, Sri Lanka, Malaysia)
(Source: *The State of the World's Children Report, 1993*).

These social gains of the past have been of great benefit to the realisation of the Government's policy of "Doi Moi" and transition to a market economy. A high literacy rate has enabled the people to adapt quickly and flexibly to new technologies and know-how, and literacy has facilitated mass mobilization around economic objectives, with characteristic discipline and punctuality.

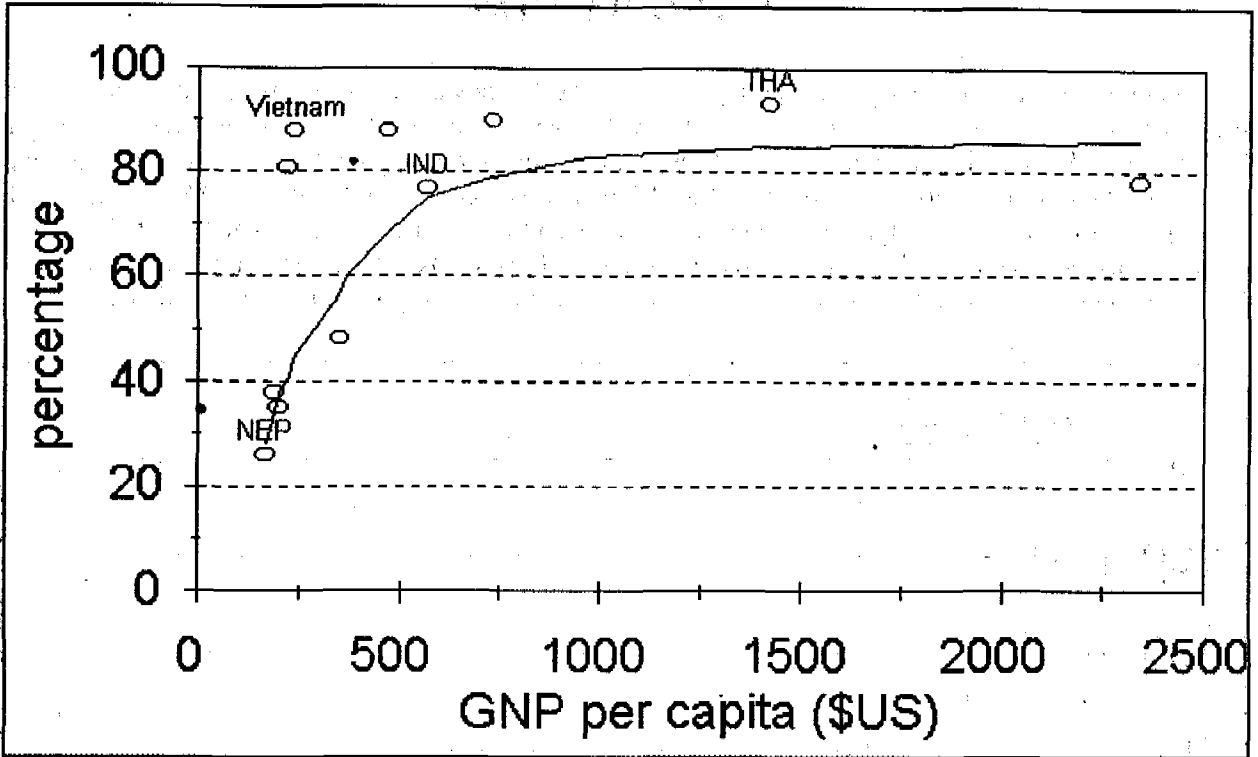


Figure 2: Literacy rate (above 15 year old children) in 14 Asian countries (Bhutan, Lao, Nepal, Pakistan, Bangladesh, India, Myanmar, Indonesia, Viet Nam, Philippines, Dem. Peo. Rep. Korea, Thailand, Sri Lanka, Malaysia)

(Source: *The State of the World's Children Report, 1993*)

Good health has enabled sustained hard work and physical productivity, and the high status of women has vastly contributed to national economic output.

The fact that social gains have been more or less evenly spread throughout the entire population has honed national morale to a high degree and promoted great social cohesion and stability.

There is a great need to protect and further advance these social gains of the past, during and after the present transition to a market economy. This ongoing and rapid transition brings many opportunities to make further progress in child survival and development; but it is also bringing many threats.

Doi Moi has placed greater responsibility for individual and national development on the family -an extremely important unit in Vietnamese society and culture. Most families in Viet Nam have become richer over the past two to three years. Great opportunities now exist to encourage families to invest their increasing disposable income in cost-effective ways to promote the survival, protection and development of their children. Opportunities for family-level income generation activities linked to children's development are also increasing.

Rapidly growing government tax and other revenues similarly present opportunities for promoting cost-effective state expenditure on services for children. Low inflation, a stable exchange rate and a trade surplus present a solid underpinning to Government's ability to generate domestic and international resources.

The development of a more pluralistic service delivery system, especially in the health sector, also presents opportunities for increasing the quality of care through competition.

Even what is in many ways the greatest threat to past social gains presents some opportunities -the sharply increasing disparities in income that are taking place within single communities and over geographical zones. It is increasingly possible to ask social service user fees from those able to pay, and use the proceeds to subsidise services for those who cannot afford them.

The threats arising from income disparities are serious. A growing number of children are at risk of sexual abuse and other forms of mistreatment, particularly in urban centres. Child labour is increasing and school enrolment and retention decreasing. Utilisation of government social services is decreasing, due largely to the imposition of user fees, which are not well-targeted to those who can pay them. Governmental corruption is a continuing threat that is linked to the market economy. Some dynamic social service providers including teachers and health workers are increasingly demotivated by low pay, and they are turning to more lucrative private practice, to the detriment of the poor. The enduring poverty of mountainous regions and some delta areas is a serious threat to the children who live there - a high proportion of them from ethnic minorities. And the position of women in society is eroding due to the resurgence of some negative traditional beliefs and attitudes.

The increasing availability of poor quality private care including useless or adulterated drugs and breastmilk substitutes is also cause for concern.

All of these threats, however, have solutions; and there are many encouraging signs that they will be overcome. Viet Nam was the first country in Asia and second in the world to ratify the Convention on the Rights of the Child (CRC). The Government submitted its report on the first two years of implementation to the International Child Rights Committee in January 1993. The report was very well appreciated. Some CRC committee members have made subsequent visits and communicated their earnest belief that Viet Nam is strongly promoting further implementation of the Convention - a view shared by UNICEF.

A full Cabinet Minister responsible for child care and protection was appointed in late 1992 and has subsequently been very active in completing Viet Nam's National Programme of Action for Children (NPA). The NPA has been usefully expanded to incorporate detailed Provincial Programmes of Action for children.

Government policy continues to be strongly in favour of "investment in people", with particular stress given to education and health.

At a more detailed policy and programme level, various initiatives have already been introduced to further advance child survival, protection and development within the context of "Doi Moi". In addition to the NPA, which is explicitly and articulately linked to the CRC in Viet Nam, detailed policies and plans have been formulated for such areas as child nutrition; primary education, etc. At the programme level the Bamako Initiative and income-generating programmes for women and other schemes have been put into practice to capitalise on the opportunities presented by the market economy.

Chapter II

THE NATIONAL CONTEXT

Viet Nam is a poor country that has made exceptionally remarkable progress in the social development of the population, in particular in the areas of child survival, maternal health and education. Years of *international isolation* have limited the access to funds available for development from abroad. However, a comprehensive structure of government and commitment to social equality and social development have ensured that addressing poverty has been and continues to be a matter of national importance. The situation of women and children is giving rise to concern, particularly as the pace of economic change grows apace. This chapter provides both a glimpse of the country and an outline of life in Viet Nam, as it affects women and children. A description of the geographical and climatic features of the country as well as its population structure provide a basis for an understanding of the specific situation of women and children. The economy and the impact of economic reforms are described and the role of women in the economy is analysed. A poverty analysis outlines the key problems for development over the next few years. The political framework, the legal position of women and efforts to observe women's and children's rights are outlined. Finally the role of mass organizations for development are examined.

1. Geography and Climate

Viet Nam is located in one of the fastest growing economic regions of the world. The land area covers 329,841 square kilometres and stretches 3,260 kilometres in an elongated letter "S" along the eastern coast of the Indochinese Peninsula, bordered on the west by Laos and Cambodia, and China to the north. Hills and mountains cover up to three-fourths of Viet Nam's land area (Figure 3). Only 22% of the land is arable but this varies widely on a regional basis. In 1987 one-fifth of the total land area was cultivated; another 30% was under forests, 45% was unusable and 5% built-up.

Some 24,000 square kilometres of land along the **coast**, particularly in the **central region**, is low-lying and mainly saline. This area is frequently affected by tidal floods and typhoons. As the soil is generally unsuited to agriculture, fishing and salt production are the chief occupations of the local inhabitants. Agricultural production, where developed, is severely affected by typhoons and floods, breaching dykes and levees.

The **delta** regions are the key agricultural regions, with over half of the country's agriculturally productive lands, despite occupying only 17% of the total land area. The deltas cover a total of 47,500 square kilometres of land at the mouth of the Red River in the north and the Mekong River in the south. Except for the areas closest to the sea, the land is fertile and suited for a wide variety of agricultural crops, particularly the country's staple, rice. The Red River delta is smaller but more intensely developed and densely populated than the Mekong River delta. Population pressure in these regions is limiting the availability of land and causing increasingly significant problems for Viet Nam.

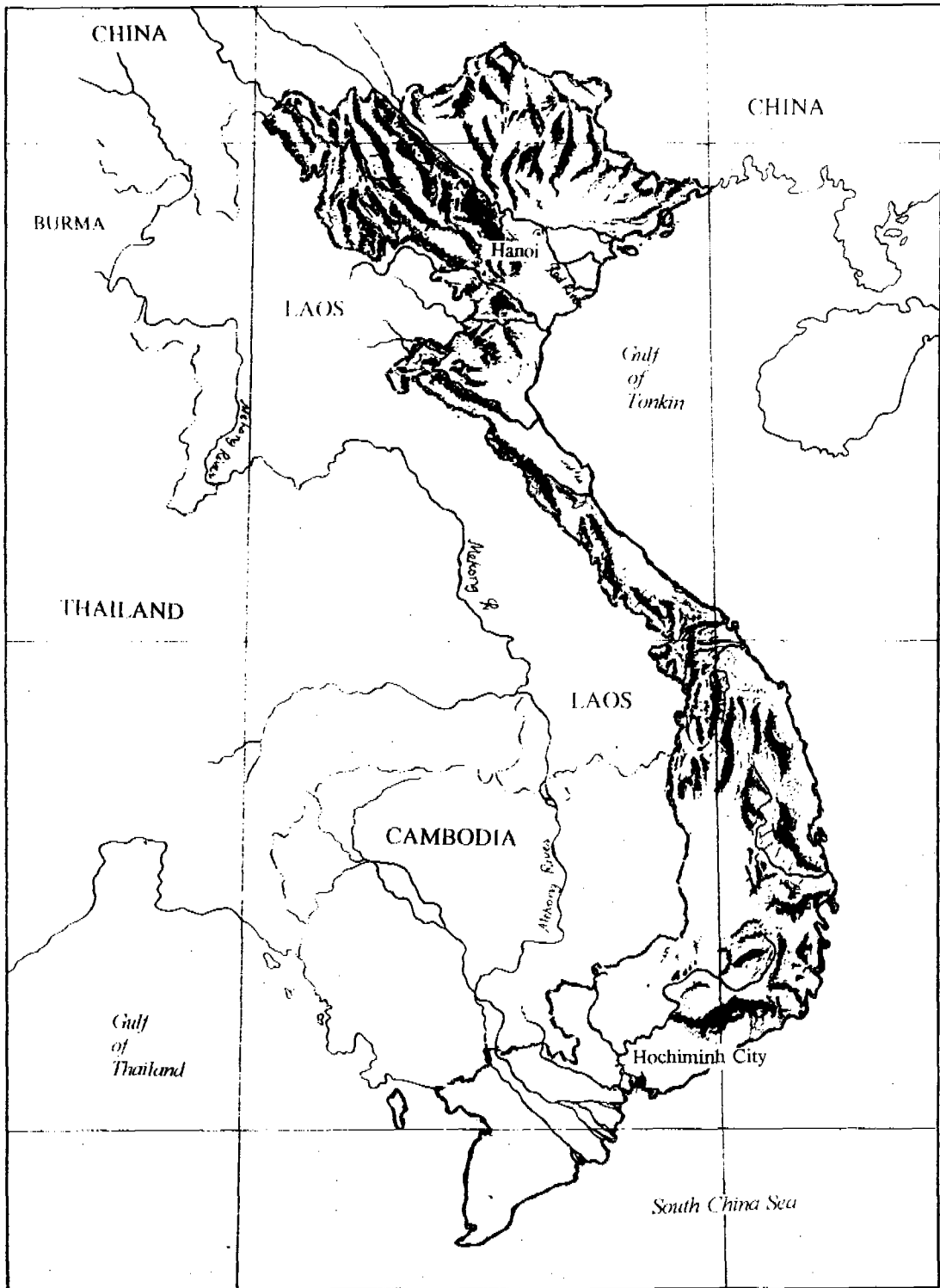


Figure 3: Viet Nam

The **high plateaux and mountainous region** covers much of the country. A large part of this area has been degraded through warfare or logging, and deforestation and soil erosion are causing concern. These areas are often extremely isolated and are mainly inhabited by ethnic minorities who live in scattered communities, some engaged in shifting cultivation - slash and burn agriculture. As far as climate is concerned, rainfall has the greatest influence on human activity. Viet Nam is located in the tropical monsoon area of Southeast Asia. Rainfall is abundant with average annual rainfall of 1,800 to 2,500 millimetres. Viet Nam lies in one of the five biggest typhoon centres of the world. Due to the coincidence of typhoon and the rainy seasons, the complicated topography, and serious deforestation, floods have been a constant threat to life and productivity, particularly in the Red River Delta and in the central provinces.

The 53 different ethnic minority groups can be divided into three language groups of which the Austro-Asiatic group is the largest. These are the Tay, Thai, Muong, Nung, Khmer, H'mong, and Dzao. The Austronesian group is located almost exclusively in the Southern Highlands and includes the Giarai, Ede and Cham and the large Sino-Tibetan language group Hoa. There are a number of smaller groups living along the Chinese border. In general the Austro-Asiatic group which include the majority of the ethnic people practice swidden agriculture and live in the northern highlands and northern midlands with scattered groups in the south and Southern Highlands and Trung Ho. An important point regarding the demographic distribution is the fact that these ethnic groups transgress national borders into Laos, China, Thailand, Myanmar and Cambodia.

Often the floods are followed by periods of drought which have an equally devastating impact on food security for families. Access to villages in remote areas, which is very difficult in normal times, becomes worse during the rainy season.

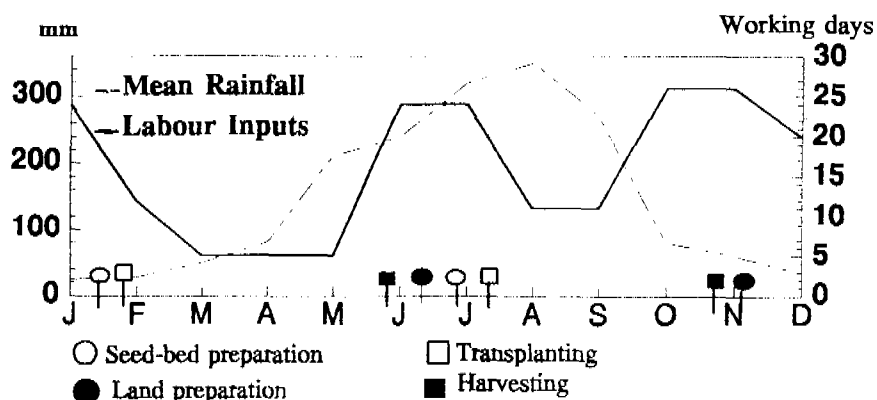
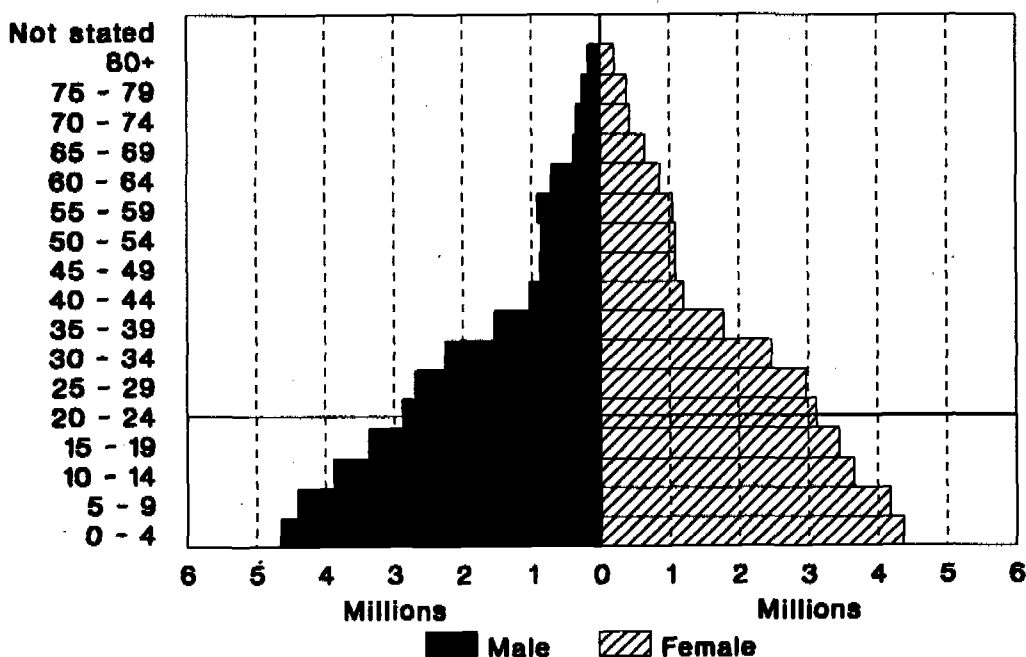


Figure 4: Influence of rainfall on days of agriculture labour (North Vietnam)

Figure 4 illustrates the variation in rainfall during a calendar year and the influence it exerts on the number of days of agricultural labour in northern Viet Nam. The pattern is different in southern Viet Nam where the rainfall peaks in October. From a programmatic point of view household surveys and outreach campaigns should be held during the lean periods when labour activity is low. Nutritional and diarrhoeal problems tend to peak during the pre-harvest periods when the stock of rice at household level is low, market price is high and labour activity is low.

2. Demographic Characteristics

Viet Nam is the second most populous country in Southeast Asia, with a population of more than 70 million. The Viet or Kinh majority account for 87% of the population. The balance of 13% (or about 8.5 million) is made up of 53 distinct minority groups.



Source: Census 1989.

Figure 5: Population distribution by age, 1989

Comprehensive family planning programmes have reduced the average national population growth rate between 1979 and 1989 to 2.1% per annum. There is considerable variation across regions. The central highland region had a growth rate of 5.8%, whilst the Mekong River Delta region grew at 1.9% per annum.

The age pyramid in Viet Nam is typical of that observed in most less-developed countries, with a very wide base and a narrow top. In Viet Nam, the top, especially from age group 35 years, is particularly narrow, reflecting the influence of wars in the years 1940-1975. As a result, the proportion of children below 14 years of age is extremely high (44%). The age structure also depicts the large numbers of people entering the labour force (currently estimated at one million annually) over the next twenty years. The combination of this age structure together with rapidly declining mortality implies that despite a falling fertility rate, the growth rate of the population will remain high for some time. The Census Bureau estimates that the population will reach 80 million by the year 2000 and 100 million by 2015. The addition of 30 million people over the next 25 years will have serious consequences for the economy, the environment, the labour market and social services.

Women comprise 53.2% of the population. The small proportion of males between 45 and 65 years is a result of the wars during the 35 years between 1945 and 1979. The extraordinarily low sex ratio (94.7 males per 100 females in 1989) is unique compared with other developing countries. The sex ratio is higher in urban areas than in rural areas due to migration of single males to urban areas in search of employment, although the urban-rural disparity had declined between 1979 and 1989.

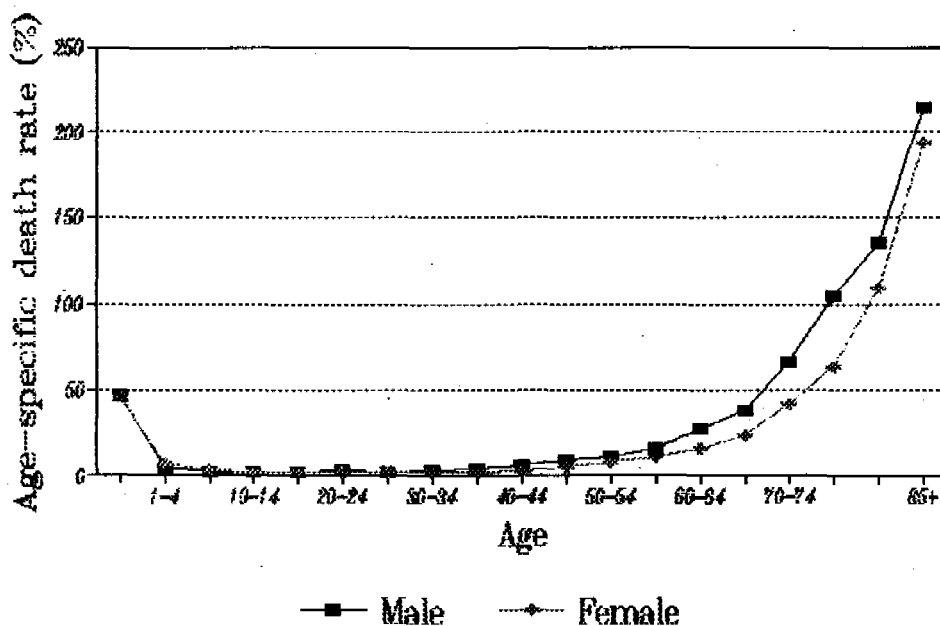


Figure 6: Age-specific death rates, 1988-1989

Birth rates in recent decades may have fallen due to the unusually low sex ratio, separation of husbands from their wives for long periods of time, and high (10%) widowhood. A high sex ratio among the younger age groups will result in an increase in the overall sex ratio in the future. The recent decline in birth rates may begin to slow down unless the family planning efforts by the Government are maintained and strengthened. According to the 1989 Census, Viet Nam has a Total Fertility Rate (TFR) of 3.8

PROVINCE

- 01. Lai Chau
- 02. Lao Cai
- 03. Yen Bai
- 04. Ha Giang
- 05. Tuyen Quang
- 06. Cao Bang
- 07. Lang Son
- 08. Son La
- 09. Vinh Phu
- 10. Bac Thai
- 11. Ha Bac
- 12. Quang Ninh
- 13. Ha Noi
- 14. Hoa Binh
- 15. Ha Tay
- 16. Hai Hung
- 17. Hai Phong
- 18. Thai Binh
- 19. Nam Ha
- 20. Ninh Binh
- 21. Thanh Hoa
- 22. Nghe An
- 23. Ha Tinh
- 24. Quang Binh
- 25. Quang Tri
- 26. Thua Thien Hue
- 27. Quang Nam Da Nang
- 28. Kon Tum
- 29. Gia Lai
- 30. Quang Ngai
- 31. Binh Dinh
- 32. Phu Yen
- 33. Khanh Hoa
- 34. Dac Lac
- 35. Lam Dong
- 36. Ninh Thuan
- 37. Binh Thuan
- 38. Song Be
- 39. Tay Ninh
- 40. Dong Nai
- 41. Ba Ria Vung Tau
- 42. Ho Chi Minh City
- 43. Long An
- 44. Dong Thap
- 45. Tien Giang
- 46. Ben Tre
- 47. An Giang
- 48. Vinh Long
- 49. Tra Vinh
- 50. Can Tho
- 51. Soc Trang
- 52. Kien Giang
- 53. Minh Hai

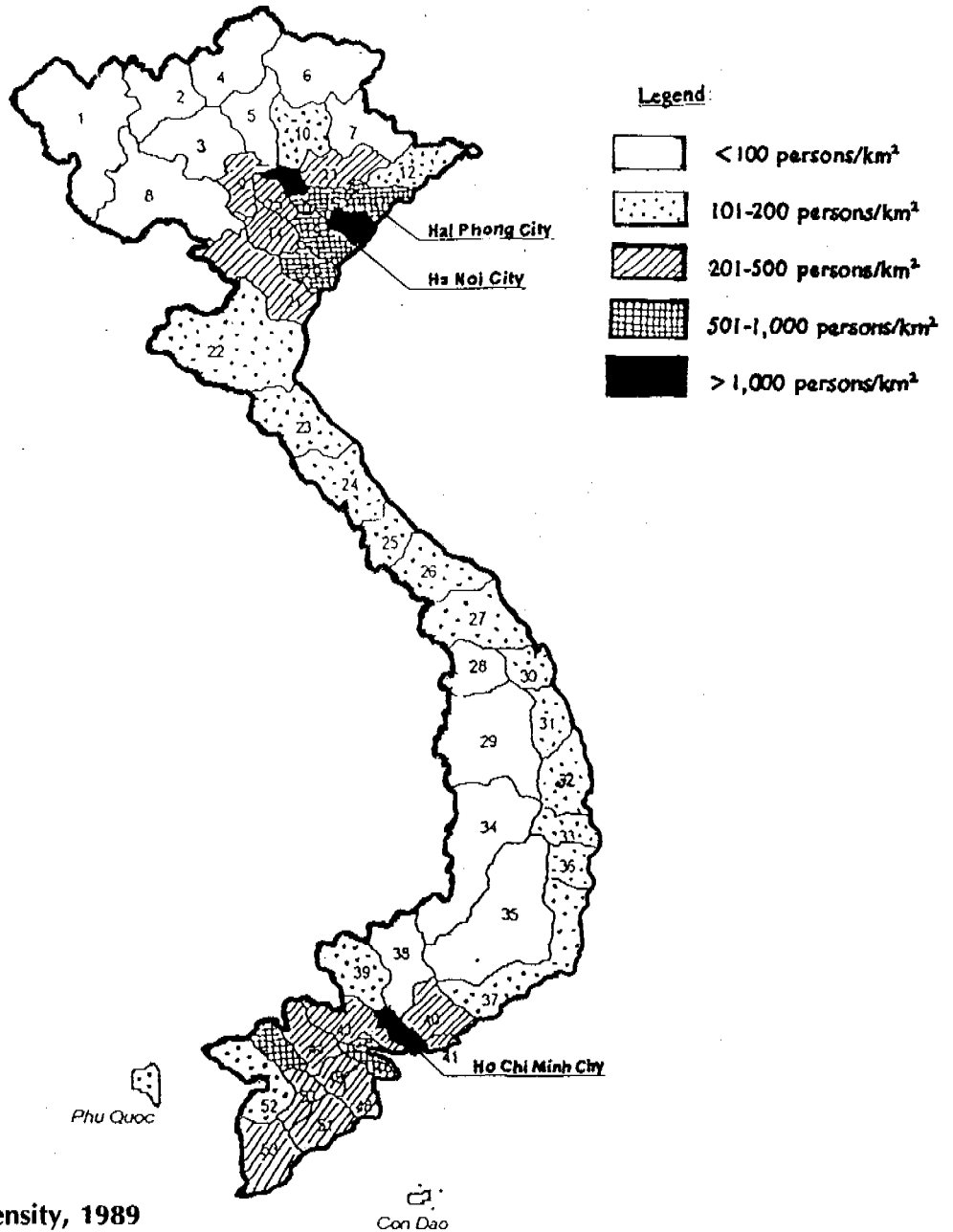


Figure 7: Population density, 1989
 Source: Population Census, 1989

children per women, representing a substantial reduction from the estimate of 5.1 for 1979. Although low for a country of Viet Nam's level of per capita income, this level of fertility is actually high in relation to the infant mortality rate. The 1989 estimates of the infant and under five mortality rates approach 45 and 70 per thousand respectively. There is, however, wide variation in infant and young child mortality within the country. Infant mortality rates range from less than 30 per thousand in the Red River Delta to over 60 per thousand in the northern mountainous and central highlands areas. The slightly lower risk of mortality among females during the first year of life is reversed until about 14 years of age, suggesting differential treatment between boys and girls at a young age. The life expectancy at birth was a relatively high 63 years for boys and 67.5 years for girls in 1989.

2.1 Rural-urban distribution and migration

With a population density of 195 persons per square kilometre in 1989, Viet Nam ranks third behind Singapore and the Philippines in South East Asia. The distribution within the country is uneven. Forty-four per cent of the population live in the two deltas, which comprise only 17% of the total land area, while only 20% of the population live in the northern uplands and central highlands, which comprise 47% of the land area. The thinly populated areas are mainly the hilly and mountainous areas.

One of the key Government policies introduced in 1964 was the redistribution of the population from the more densely to the less densely populated areas. This has involved the resettlement of some of the majority Kinh population, from low-land provinces to road-side communes and villages in the hilly/mountainous areas where ethnic minorities traditionally live. Some of these so-called "New Economic Zones" did not succeed and people drifted back home. There were also settlers who moved on their own in search of a better life in these areas. Different ministries often handled the resettlement and it was not uncommon to find that groups of people being resettled by different ministries were allocated the same land. Provincial authorities have addressed this issue but the pressure on the more fragile mountainous areas will continue.

The country remains overwhelmingly rural: 81% of the population live in rural areas. The urban population between 1979 and 1989 grew at a faster rate (3.4%) than the rural population (2.3%) during the same period due to rural-urban migration rather than a higher urban birthrate. The growth rate of urbanization (proportion of urban population to the total population) however is very small, an increase from 18% in 1979 to 19% in 1989. This is attributed to the past policy of limiting migration to urban areas to those with skills. There are now few controls and the urban drift has begun.

3. The Economy

With per capita income of less than US\$200, according to World Bank figures for 1993, Viet Nam is one of the poorest countries in the world. Agriculture is the main occupation and source of income. It accounts for two thirds to three-quarters of employment, nearly 40% of GDP and over half the export earnings in 1992. Industry provided one-fifth of the national income and accounted for only 10% of

employment. Difficulties are posed for data analysis due to the inadequate collection of data and the recent growth of a large informal economy. No estimation is available for the size of the latter.

Kinh migration to Ben Tre, traditionally a mainly Thai area

This is a village of 24 households of 109 people who came from the delta 50km from Hanoi in 1963. They all came from the same commune and when they arrived the government provided them with a house, food for six months and transported them free to exploit this "New Economic Zone". Many, perhaps 50%, went back soon after they arrived. The village allocated its paddy land in 1990. Each adult was given 3 shares and 1 was given to a child. The farmers see themselves as good at managing lowland farming but they think the upland is not cost effective to farm. They prefer to use their time trading - mostly selling the Thai farmers' produce for them and supplying them with their household needs (mainly tobacco, alcohol, salt, clothes).

Binh came to the district in 1963 when he was 17. He is the son of a poor family and has never been able to go back on a visit. He trained as a paramedic but cannot support his wife and four children on the pay. He does not sell his skills as a paramedic neither does he farm. He says the village has improved since 1990 but his situation has deteriorated. His health is poor and he has no capital or assets. His third child, a daughter (10) is unschooled. He says he will get poorer, and he has little hope for his fourth child, a boy, aged 18 months.

3.1 Impact of economic reforms

The fundamental reforms introduced in 1986 aimed at moving from a centrally planned to a market based economy have had a striking positive impact on agriculture and industry. The control of inflation has been achieved through a number of successful monetary and fiscal policies. There have been correspondingly negative impacts on family spending as social services have continued to decline.

The recent reforms removed many subsidies without adequate opportunities for increasing household incomes to cope with and compensate for these losses. The richer provinces, districts and communes have absorbed some of these costs. It is too early to measure the impact. The existing disparities (IMR, U5MR, school enrolment, etc) between provinces can be expected to increase. Furthermore the process of privatisation and introduction of user fees without adequate controls on the behaviour and quality of the providers and their services have had varying degrees of positive and negative impact on different problems. Again, there is inadequate empirical evidence to describe with any certainty the impact of these reforms. At least in the case of health care the privatisation process may be better described as commercialisation. The separation between public and private practice is losing its clarity. The more recent reforms have resulted in the decentralization of decision-making even further: from commune level to the family or household level.

The resettlement policy

In ethnic minority areas the Government's prime objective has been to resettle the semi-nomadic population in the highland provinces. The Ministry of Forestry through the Settlement Committee has successfully resettled various groups of semi-nomadic ethnic minorities. The Government provides each family who agrees to resettlement with one to three hectares of farmland and three to five hectares of other land. The land is leased to the family for 20 years, which can be extended for another 30 years. Nevertheless, large communities of semi-nomadic ethnic minorities still exist in highland areas.

In order to boost the resettlement policy and to accelerate infrastructure development in the highlands, the Government recently created a National Council and a National Committee for Ethnic Minorities and Mountainous Areas. The Council and Committee develop policy and implement various social and infrastructure development projects. (The former Settlement Committee has been absorbed into the National Committee).

The Government recently allocated VND50 billion for the introduction of substitute crops for opium. The National Committee is also encouraging communities to raise cattle rather than grow opium, which is used as a cash crop in many mountainous areas. The Committee is providing loans of VND1 million per family for this intervention.

The Research Center for Ethnic Minorities Education has also planned various experimental education programmes to increase primary school coverage. Similarly, area-based projects are being considered for overall development of these areas. All these interventions will have a direct substantial impact on the living standards of children.

3.2 Impact of economic reforms on agricultural production

In 1988, the Government established the household unit as the basic unit of agricultural production and recognised the right of the family to use land and sell agricultural surplus on the market. The household thus replaced the agricultural cooperative, increasing agricultural output as anticipated. Agriculture production reached a record 21.1 million tonnes in 1992. About 2 million tonnes were exported placing Viet Nam as the third largest rice exporter in the world.

Despite these gains, poor systems of procurement, appropriate storage and agricultural production in addition to lack of transportation have resulted in chronic shortages in some regions causing undernutrition and surpluses in other regions. According to some analysts, while the yields can be further improved, there is little scope to enlarge the land area under cultivation. The potential for further employment in this sector may also be limited.

Figure 8: Paddy production and rice exports

Rice Production				
	Av. Output 1976-80	Av. Output 1981-88	Av. Output 1989-92	
Total grain output in paddy equivalent (million tonnes)	13.3	17.6	22.2	
Average paddy yield per crop (hundred tonnes/ha)	20.2	25.6	32.2	
Rice Exports (million tons)				
	1989	1990	1991	1992
- Entire world	15.1	12.1	12.7	14.5
- Thailand	6.0	3.9	4.0	4.6
- United States	3.0	2.4	2.2	2.2
- Viet Nam	1.4	1.5	1.0	2.0

From the table above it can be seen that over the past 12 years, average paddy yield has increased by more than 60%. However, because of the increase in population and the doubling of rice exports from one to two million tonnes in just two years, there has not been a corresponding increase in per capita rice consumption in Viet Nam. There are still millions of people who are short of food for some months each year.

3.3 Impact of economic reforms on industry

A majority of industries are state owned. Following the decision to encourage a market economy, price reforms and liberalisation have been introduced. Unproductive units have been closed down, and privatisation and removal of subsidies have been implemented. Industrial development is concentrated in Ho Chi Minh City in the south, and to a significantly lesser degree in Hanoi and Hai Phong in the north. Annual per capita average income in Ho Chi Minh City is US\$480, more than twice the national average of US\$200. This suggests that large numbers of people have an income substantially below this.

3.4 Budget deficit

The reforms have resulted in an increased budget deficit which has grown from 2.5% in 1991 to 3.8% in 1992 to an expected 6.0% in 1993. The increases have been mainly due to the critical need to finance severance pay, retrain those laid-off public sector employees, and to build up the infrastructure in both the social and economic sectors. Government revenue collection is quite low in Viet Nam. Revenue as a share of GDP has varied between 11% and 13%. Before 1988, 75% of total revenue was transferred from State enterprises. This declined to 47% by 1992. The largest recent increases have been from crude oil exports, rice exports and from private sector activities in industry and services. The general trend has been a decline in tax revenue from State enterprises and an increase from external trade taxes. However,

the former has declined more rapidly than the latter has grown. The fortuitous growth in oil revenue has prevented a sharp decline.

3.5 Taxation

According to various sources, smuggling, corruption and complicated tax structures are also to blame for the weak tax revenues from external trade and from the private sector. Tax collection is decentralised. A majority of taxes are collected at the provincial level. The centre approves the revenue and expenditure plan for each province. As can be expected the scope for negotiation is greater for those provinces with larger revenues. The three industrial cities of Ho Chi Minh City, Ha Noi and Hai Phong alone accounted for three-quarters of the revenue transferred to the centre.

3.6 Foreign debt

The total foreign debt in 1992 was US\$4 billion in convertible currency payments and 10 billion rubles to former CMEA countries. The recent (July 1993) withdrawal of US opposition to Viet Nam settling its debt to the IMF of US\$140 million has enabled the country to pay off arrears totalling US\$300 million in 1992. The debt situation is undoubtedly a development constraint and needs to be judiciously controlled. Rescheduling and writing off some of the convertible debt would greatly facilitate meeting the urgent need to rehabilitate and build up both social and economic infrastructures.

3.7 Foreign investment

Foreign investment has been encouraged by a series of laws facilitating the entry and activity of foreign capital. The steady but low level of investment (11 to 13% of GDP) needs to be doubled if not tripled to catch up with other Asian economies. This is constrained by the equally low level of domestic savings, though informal and unrecorded savings may be more important than seems.

3.8 Employment

About one half of the 66 million people in 1990 were in the eligible age groups for work (16-55 for women and 16-60 for men). One million (net) persons enter the employment market each year. A total of 40 million jobs will be required by year 2000. An estimated three quarters of the current work force (or 25 million) is employed in agriculture. Perhaps by increasing investment in more agro-industries and services in rural areas employment needs may be reduced. The challenge in fact will be to curtail an inevitable flow out of agriculture into the urban areas in search of jobs. Viet Nam has only 0.1 hectare of arable land per capita. According to Peter Timmer, Viet Nam, aside from tree crops has no extensive agricultural growth path open to it. This will result in an increase in the number of women-headed households in the rural areas. A further 3.1 million are employed in the public sector in state enterprises and the civil service. The Government estimates that 25% of those working in state enterprises and 20% of the civil service are redundant. Actions to reduce this work force have already commenced. There are no official figures of persons employed in the military and police, an estimate of 1 million has been used recently by the World Bank. Two to three million people remain unemployed or between 6 to 9% of the total work force.

Wages in the public sector vary between US\$6 and \$15 per month. In the growing private sector wages vary between US\$15 and US\$25 per month. Low wages and lack of other incentives is a critical problem affecting the delivery of health care and primary education particularly at the village level. Maintaining worker interest in the remote areas is particularly difficult.

Employment opportunities are expected to grow mainly in the private sector and in self employment. Large infrastructure development schemes are also expected to generate work opportunities. Improving infrastructure in remote and depressed areas will not only help those population groups access the market place but will also help create jobs.

The labour force participation of women is very high, with over 70% of women of working age in the workforce. Women comprise 65% of the agricultural labour force. Women are employed across all occupations, but few are employed in technical and managerial capacity in the agricultural sector, where the vast majority of women work. The extent of the role of child labour in agriculture is unknown.

3.9 Unemployment and underemployment

While unemployment is estimated at a modest 6%, gross underemployment is significantly higher. Some estimates suggest that as many as 4 to 6 million persons may be grossly underemployed. If this is accurate then nearly one quarter of the labour force is severely affected.

Total public sector employment has been reduced from 4.1 million in 1988 to 3.5 million in 1990. 500,000 military and state employed personnel have been demobilized or retrenched. These massive reductions in public employment, and demobilization including the estimated 200,000 workers returning home due to the collapse of the Eastern European economies, has contributed significantly to unemployment. Given the limited scope in the agriculture sector, and the need for massive infusion of funds for industrial growth and infrastructure, self employment and small scale rural industries appear to offer a solution in the short term. This would mean there is a need for substantial investments in vocational and management training and increased access to credit.

3.10 Women at work

Women make up the greater part of the redundant workforce through the reform and privatisation of state owned enterprises, according to some studies. For rural women in agriculture, the labour market problems are limited opportunities and choices in employment and advancement, rather than a lack of work. This is further exacerbated by problems of inadequate skills and remuneration. Most household activities in income and non-income generation work has fallen on women. As social services, such as community-provided child care, are replaced by user-paid services, woman's labour force participation will be intensified because they will be expected to mind children whilst undertaking paid work. This may negatively affect women's health.

Day labour: the rich and the poor - Doan Ket village

Mai is a poor divorcee, she has five children and tries to get by as a day labourer. There is a market for women labourers, weeding and watering in coffee groves and vegetable gardens at 5,000 dong or 2 kgs of rice a day. She welcomes this as "it creates work". The rich in the village are the households with vegetable gardens, and they are just setting up new coffee groves, vegetable gardens and orchards of apricots and longan. Mai says, "The rich are getting richer and the poor are getting poorer, because they are entirely dependent on the rich."

3. 11 Poverty analysis

The recent economic reforms have had a significant impact on the majority of the people. Whilst producing favourable outcomes in terms of productivity and economic growth, there have been some negative social consequences. As has been witnessed elsewhere, economic growth alone will not solve the problems of poverty. Increasing socio-economic stratification and land reconcentration has already been observed in some areas. This may lead to decapitalisation and political marginalisation of the poor. Dismantling of social services provided by the state in education, health and other areas of social development means that these activities are more likely to be carried out by women at home.

Poverty can be analysed on a regional, ethnic, geographic and gender basis. The incidence of poverty tends to be high in the mountainous and isolated areas, often where ethnic minorities live. It is also high in the central areas frequently hit by natural disasters such as typhoons and floods. The position of women has been highlighted as particularly critical, as the economic reforms have directly increased workloads in the home and in the fields.

Of the 14.5 million households in the economy, approximately 45% are poor. Cooperative production and farming has given way to family or household production whilst subsidies for education, child care (creches) and health care have been renovated. These changes have intensified the work undertaken by women. While urbanisation until 1989 was slow, there is every indication to suggest a rapid increase in urbanisation, caused mainly by male migration from rural areas. The females left behind would have to work even harder and for longer hours.

Figure 9: An approximated categorisation of the population into socio-economic groups

5 to 15%
50 to 60%
35 to 45%

Rich; mainly living in cities; higher percentage in Ho Chi Minh City, Ha Noi and Hai Phong

Middle income; mainly in provincial and district towns and near the main roads with good agricultural land plus some savings

Poor; mainly rural; away from main roads; own little good agricultural land; no savings; majority of ethnic minorities

The World Bank Report (September 1993), in its overview of the causes of poverty and vulnerability, indicates that from the preliminary and limited Living Standards Measurement Survey (LSMS), 90% of the poorest 20% of the population is found in rural areas. "Nearly two-thirds of the wealthiest 20% of the population is found in urban areas. On average, urban households have per capita expenditure levels 60% higher than rural households." The World Bank team report that the wealthiest area was Ho Chi Minh City and surrounding provinces. The Mekong Delta and the area surrounding Hanoi were also relatively well off as has been stated already. There were three distinct regions that were very poor: central highlands, north central coast, and the northern mountains. The team also indicates that preliminary results from the LSMS confirm that the average per capita consumption in the Mekong Delta is 55% higher than that found in the Red River Delta.

Single women-headed households account for 20% of all households (40% in some areas). These households are particularly vulnerable to losing their land allocation, as land allocation is in part governed by the availability of labour in the household. Those households with adequate productive inputs, in the form of land, labour and capital, have been able to optimise their return under the reforms. Households without these necessary inputs have either not maximised their output, or have lost land through indebtedness. Evidence has emerged of a landless agricultural labour force. The lower income or poor population have had to bear the brunt of the cutbacks in social services, particularly the removal of the safety net of central subsidies for health care, early childhood care, education, and subsidies for fertiliser.

Government departments measure poverty by identifying the number of food-deficit months per year. A survey undertaken by the National Institute of Nutrition of 1,251 households showed that 9% were experiencing starvation (below 1,500 calories per person per day), 15% suffered from food shortages (1,500-1,800 calories per person per day), 23% were in a more or less satisfactory situation (1,800-2,100 kcal), and 54% had over 2,100 kcal/day, considered satisfactory. This varies widely from one region to another. The central region experiences serious food shortages with 34% of the households in the northern central provinces and 20% in the south central provinces consuming less than 1,800 calories per person per day.

There are also seasonal variations in food consumption. Just before the rice harvest, calorie intake decreases by up to 15%. Given the very low normal intakes, even a slight decrease can lead to starvation, as happened during the bad harvest year of 1987. It is not surprising therefore to see a similar seasonal pattern in incidence of diseases such as diarrhoea and ARI which are usually associated with malnutrition.

Decreasing enrolment and increasing drop-out rates are also a signal for increasing poverty. This occurs largely as children are spending less time in school in order to contribute to family income generation.

Increasing regional disparities are expected. Previously, richer provinces subsidised poorer provinces through redistribution of funds through the central government. Part of the reforms involve reduction of central subsidies to the provincial level. Those provinces with higher revenues have found ways to replace some of the central subsidies. The majority have introduced user fees, charging more from those who can afford. Also, in a majority of the cases, 10% of the agriculture tax is returned to villages to meet the cost of social services for the poor.

Nevertheless, the funds available do not match the local needs. A very rough estimate has identified a shortfall of US\$150 to \$200 million annually to meet the National Plan of Action (NPA) goals alone. Unless affirmative and planned action are not taken soon growth in disparity between regions and between people belonging to the three different wealth categories may well increase.

4. The Political Framework

The Socialist Republic of Viet Nam is ruled by the Communist Party, implementing policy decisions through the Politburo. The Communist Party controls the electoral process and the executive. The National Assembly is the highest representative body elected by the people and the highest organ of State power. It has both constitutional and legislative powers. It exercises supreme control over all activities of the State. In the 1992 National Assembly elections, non-Party members were elected due to the extension of choice in the balloting process.

The fact that Viet Nam has achieved much in human survival (life expectancy) and human development is a reflection of the priority given to these areas in the past, particularly through social mobilization made possible by the **high degree of decentralization**. The priority afforded to human development was reflected in the very high allocation of about 40% of total public resources to these sectors.

The country is divided into provinces and cities. The provinces are further divided into districts and communes, provincial cities and towns. The economic reforms have involved an amelioration of central rule and increased power and responsibility to the provinces for both policy implementation, development and revenue raising.

4.1 The rule of law

The Government of Viet Nam has explicitly stated that Viet Nam will be governed by a Rule of Law. This is an important development. It is in response to Viet Nam's increasing participation in the international community. This is evident in the enthusiasm for signing the various conventions and agreements promulgated by the United Nations and other international bodies. A comprehensive code of laws is being evolved in response to the needs of a civil society and the needs of the state within the macro-economic sphere. This development is necessary and timely. The level of investment may increasingly depend on, or be determined by, a reliable and effective legal system. This will provide the appropriate protection and security deemed necessary for investment.

Capacity building at central, provincial, district and commune levels for planning, budgetary control and service delivery is necessary and urgent. It must be complemented, even more so than in the past, with empowerment at household level. This can be done so that choices being made by the family are optimal and maximise benefit.

4.2 The legal rights of women

Achieving equality between men and women has long been an issue in Viet Nam. The Indochinese Communist Party in the 1930s through the Declaration of Freedom sought to "achieve equality between

the sexes...". In 1930, the Vietnamese Women's Union was established as a mass organization to unite women across society. A women's branch of the party was also formed, over ten years before the formation of an independent nation-state and constitution. The constitution, from its beginning in 1946 instilled clear principles on women's status, claiming, "women are equal to men in all respects".

In the 1959 constitution this principle was expanded to: "Women enjoy equality with men in all spheres of activities: political, cultural, at home and in society... there should be equal pay for equal work... The state guarantees women employees full paid maternity leave both before and after birth".

Marriage and Family Law was promulgated in 1959 and set out the principles of free choice in marriage partner, monogamy, and equality between husbands and wives in the protection of women's and children's interests. In this Law equality between daughters and sons is outlined, as is the equality of ownership of property including equal division of property following divorce, and free choice of occupation. In 1986 the New Law on Marriage and Family prohibited early marriage (under 18 for women and under 20 for men) and marriage without consent. Property provision was further refined: after divorce, women retained all property brought into the marriage. Both men and women were charged with the responsibility for family planning.

Again in 1988 the legal status of women received two significant improvements. The first was the Council of Ministers' decision Number 163 which gave the Women's Union the right to be consulted, informed and involved in any discussion, plan or policy relating to women and children at all levels of government. The second was the Population and Family Planning Policy which states the number of children permitted per couple, age at which women should bear children, and guidance on family planning.

Most recently, in July 1993, the Communist Party Political Bureau adopted "The Decision on the Mobilization of Women", which noted the role of Vietnamese women in the economic renovation process of the country. The Decision articulates the goals for women's emancipation as "improvement of the material and spiritual life of women, increase of their social status, and equality." It stipulates that women's emancipation is the responsibility of the Government, organizations, and every family.

The National Committee for the Advancement of Women consisting of high ranking officers from Government, concerned ministries, the Viet Nam Women's Union and mass organizations, coordinates all activities regarding the implementation of the International Convention on the Elimination of All Discrimination Against Women and the Nairobi Forward-Looking Strategies for the Advancement of Women to achieve Equality, Development and Peace.

4.3 The rights of the child

The Implementation of the Convention on the Rights of the Child in Viet Nam

Viet Nam ratified the Convention on the Rights of the Child in 1990. As Viet Nam was the second country in the world to become a State Party to the Convention, the process of implementation of its provisions is underway. The situation of women and children has to be considered in the context of Viet Nam's commitment to the Convention on the Rights of the Child, and the implementation process has

initiated a series of actions which will have important implications on efforts to improve the situation of children in Viet Nam.

The Convention on the Rights of the Child receives strong support in Viet Nam, and child rights issues have become part of the political agenda. A number of awareness programmes have been initiated and the ratification of the Convention has contributed to an increasing openness to discuss children's issues and problems related to children in especially difficult circumstances.

Subsequent to the ratification of the Convention, and in accordance with the obligations, Viet Nam prepared its initial two-year report in 1992. UNICEF, in cooperation with Radda Bärnen (Swedish Save the Children), provided guidance and advice as the report was prepared in accordance with guidelines set out by the Committee on the Rights of the Child. The final report should be seen as a milestone in the implementation of the Convention in Viet Nam. The frankness of the report is unprecedented and several issues, such as child labour, prostitution and juvenile delinquency, previously not discussed in public, are fully covered.

The Viet Nam Report was considered by the Committee on the Rights of the Child in Geneva in January 1993 at a hearing with Vietnamese Government representatives. At the hearing, a constructive and frank dialogue was initiated with the Committee.

Positive aspects

The adoption by the National Assembly of the Law on the Protection, Care and Education of Children and of the Law on the Universalisation of Primary Education and the stipulations on the rights of the child in the new Constitution are seen as important steps towards the implementation of the Convention. The Committee on the Rights of the Child noted with satisfaction the approval of a National Programme of Action for Children 1991-2000. In addition, the establishment of the Committee for the Protection and Care of Children at the national levels, as well as the establishment of such committees at provincial, district and commune levels, further enhance monitoring of the implementation of the Convention.

The CPCC organization is staffed at all levels by representatives of a variety of ministries and mass or social organizations. The role of the CPCC is, in brief, to:

1. Assist the Government in identifying suitable approaches, activities, projects and policies to promote the protection, care and education of children
2. Ensure that Government agencies and local Government entities coordinate their activities with those of social and mass organizations in the implementation both of the Law on the Protection, Care and Education of Children and of commitments to international bodies in connection with the rights of children.
3. In the name of the Council of Ministers, contact international and foreign organizations and receive from them donations and other assistance for child-related development programmes.

Obstacles to the implementation of the Convention

In its discussion with the Committee, the Government stressed that Viet Nam's transition to a market oriented economy produces new, or aggravates old, social problems which have a negative impact on the situation of children. Traditional values also create some difficulties in applying certain provisions of the Convention. However, during the hearing in Geneva, it was noted that the Government is well aware of existing difficulties and undertakes to address the obstacles with frankness and openness.

In its concluding observations, the Committee expresses its concern about the negative effects of the on-going economic reforms on the situation of children in Viet Nam. The situation of ethnic minority children in remote areas was highlighted, as well as children in conflict with the law with long periods of imprisonment a concern. The lack of adequate training of law enforcement officials as far as the Convention is concerned was noted. The situation of children in rural and mountainous areas is a general concern, especially regarding their health and education.

The growing number of children in especially difficult circumstances was noted, especially children living and/or working on the street, and sexually exploited children.

Recommendations put forward by the Committee on the Rights of the Child

The Committee has stressed the importance for the Government of Viet Nam to take all necessary steps, including international assistance and cooperation, to minimize the negative effects of the economic reforms. In particular, attention should be paid to children in especially difficult circumstances such as children of ethnic minorities, children living in rural areas and children living and/or working on the street. Furthermore, the Committee called for amendments of the Penal Code of Viet Nam to reflect the provisions in articles 37, 39 and 40 of the Convention related to juvenile justice and children in conflict with the law.

Following the Geneva hearing, the dialogue between the Vietnamese Government and the Committee has continued. The Committee, on a recent visit to Viet Nam, praised efforts underway and called for strengthened international cooperation with Viet Nam to further improve the situation of children.

5. Mass Organizations

The main social service organizations for children, women and family welfare are the Women's Union, the Youth Union and the Peasants Union. These organizations in theory reach all communes and therefore tend to have more direct access to families than line ministries for health and other social welfare authorities.

In practice, like every other sector of Vietnamese society, mass organizations are experiencing the strains of marketplace reforms. For these organizations, salary and operational subsidies from central government have been considerably reduced and they must now generate an increasing proportion of their own funding.

Legal framework

Until 1990 the State Council of Nationalities and the Council of Ministers has been the highest level of representation that deals with the formulation of policy and minority affairs. After 1990, a committee for ethnic minorities and mountainous areas led by a Minister with adequate functions and responsibilities has been established. This office operates parallel to the Office of the Council of Ministers but deals exclusively with ethnic minority affairs. It reports directly to the Chairman of the Council of Ministers who is the Prime Minister. Government policy as it relates to the minorities is implemented by the Ministries of Forestry, Agriculture and Food and others which all have special departments for highland development.

In addition, Government expectations about the social welfare services offered by these organizations have changed. These organizations are expected to deliver new kinds of social services. For example, the national Women's Union has undertaken to help boost the family economy through a variety of rural credit and small business training programmes. The Women's Union is also establishing programmes with UNICEF and other bilateral agency funding to support improved child-rearing and child and family nutrition, and combat the growing phenomenon of school drop-outs.

A further example is the Peasants Union, which has established programmes in cooperation with UNFPA to support stronger male participation in family planning. Also, the Youth Union is carrying out activities to prevent HIV/AIDS amongst at-risk youth in major urban centres. Other joint activities include programmes to assist street children and others in extremely difficult circumstances.

Whilst these organizations and activities hold great promise there are some major drawbacks at this time. These organizations are predominantly skilled in political mobilization but lack the strong technical skills and experience to effectively carry out new social service work. Nevertheless, technical training to help organizations make effective use of their extensive membership networks is an important and recognised need by both the organizations themselves and donor agencies.

A major drawback is the sheer size and complexity of many of the social welfare needs. A further drawback is the difficulty involved in successfully joining two different styles of operations when mass organizations must work with technical ministries and other government service agencies. Another significant problem is the creeping decline in membership and operations as a result of the reduction in Government subsidies and a more liberal economic environment. Many grassroots branches have become defunct largely because local officials cannot afford salaries and other costs on their own.

Undoubtedly many of these drawbacks can be overcome by conscious effort. It is important for development agencies to help support these organizations during difficult transitions because they represent an extensive and generally viable community-based self-help system.

One expected trend is for existing mass organizations to continue to downsize and function more on free-market principles. Operations styles are likely to reflect styles common to "western" NGOs. Under the market system, some organizations may cease to operate. However, as traditional mass organizations down-size or become defunct, other "independent" community organizations are likely to be created. There are already proto-groups operating outside the Government system but with Government approval.

The Women's Union in the countryside - a case report from Son La

The secretary of the commune provided this view of the role of the Women's Union. He felt that their main role was to promote harmony between families, give advice on primary health care, child care and family planning, and to encourage others to give assistance when someone falls ill, especially during cropping etc. All women aged 18-45 attend the monthly meetings. Each member pays an annual fee of 2,600 dong (1,000 to commune WU, 1,000 to central WU and 600 for a village fund). Members are fined 500 dong if they miss a meeting.

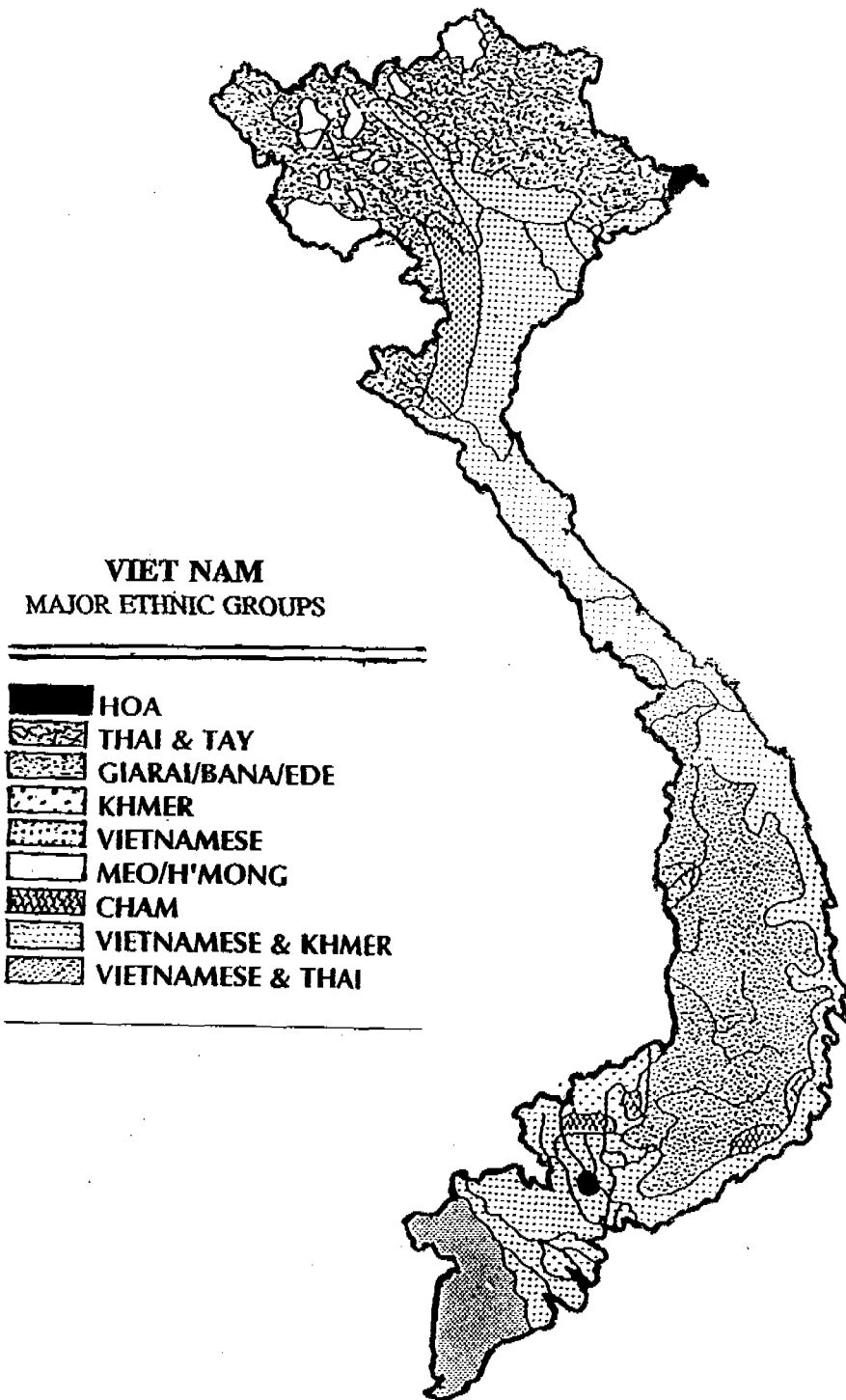


Figure 10: Viet Nam major ethnic groups

Chapter III

THE SITUATION OF WOMEN

The status of women in Viet Nam has benefitted significantly from the vision of legal equality developed early in the country's modern history. Although women's lives have indeed improved since 1945, and women have been provided with significant legislation to protect their interests, their status must be understood within the culture and traditions of Vietnamese society.

This section provides a brief outline of the situation of women in Viet Nam. The recent and on-going period of 'Doi Moi' has resulted in rapid changes in family life. The development of a market economy and the withdrawal of some state subsidies, especially in health and education, are slowing the pace of progress for women and increasing gender disparities are becoming more serious. They are evident in many important socio-economic indicators.

1. The Status of Women

The influence of Confucianism on the lives of women has been a key factor by which to measure women's status. Traditional society was patriarchal and patrilineal. Men had absolute power over women as fathers and husbands. The continuation of the male lineage of the family was paramount and when women married, they moved to the husband's family home. In traditional Confucian society, according to Professor Tran Dinh Huou of the National Centre for Social Sciences, Hanoi (1991), sons might attend schools, daughters only learned from their mothers. The content of that education could be summed up in four words; appearance, work, speech and morals. The important qualities for girls and women were gentleness and delicacy. The need for male children meant that it was not uncommon for men to take a second-rank wife to secure male progeny. These children would be brought up as part of the family. Polygamy was commonly practiced. It was revealed in the study of two rural communes in the north and south, that almost 80% of the women questioned agreed with the saying " a sonless woman is childless and unhappy in life". This was as true for people questioned in urban districts.

During the long period of war, women's role and responsibilities were transformed, with women playing a prominent role in both society and the economy. Women assumed positions of power both in the military and in civil Government and were responsible for maintaining production whilst much of the male population was in combat. Whilst women have been rewarded by the progress made in establishing legal equality and mass representation, the status of women in society continues to be lower than that of men, with many traditional values being reasserted which threatens progress made by women to date.

1.1 The status of women in the family

Women continue to hold lower status than men in the family. Legal pronouncements on the status of women and the equality of husband and wife are distant from the realities of most women's lives. Women are subordinate in the homes despite having responsibility for the care and income of the family. The Confucian tradition of a hierarchy of respect places authority with the husband. Men most often take the

important decisions regarding large items of household expenditure and familial questions such as the marriage and occupation of the children (Figure 11).

This is despite women's shouldering the bulk of the responsibility for income generating and non-income generating household activities. Women have responsibility for day-to-day expenditure at the household level, but the final decision belongs to the males. Direct decision-making by women is restricted to household chores, child rearing, and expenses for daily meals. The overall household income is often controlled by men, who also control large expenditures. The following figure was produced from a household study at three communes.

Figure 11: Decision-making in the family (in three rural communes)

Decision		Tam Son Commune	Dinh Bang Commune	Hai Van Commune
Children's Marriage	Wife	5.6	0.0	2.9
	Husband	25.2	33.8	15.1
	Both	21.0	26.5	45.2
Children's Occupation	Wife	9.3	0.0	3.8
	Husband	35.5	42.6	26.8
	Both	22.8	26.5	40.7
Household Expend.	Wife	20.0	17.6	5.5
	Husband	27.6	30.0	11.6
	Both	33.1	36.7	56.8

Note: Figures are percentages of respondents, the remainder named other persons as the main decision-maker (e.g. grandparents, children.)

It has been noted that cultural attitudes still see husbands and wives as only links in a chain of generations. For the Kinh majority in Viet Nam believe that if a man should die without a son, his whole lineage is believed to die with him, including his ancestors and unborn descendants. These beliefs are different amongst some ethnic minorities which, for example, practice matrilinear rights and the 'law of replacement' in which a dead husband is replaced by his brother or another male relative.

Sons have traditionally been given more importance than daughters. This is primarily because only the son is able to carry out the extremely important task of ancestor worship and continuation of the family lineage. In addition a girl leaves the family home with marriage and becomes responsible for and to her parents-in law. The investment in a girl is perceived to be "lost" at marriage. For the girl child, legal equality has had limited impact. Though provided with equal rights to inheritance, it is common practice in many rural areas for this to be denied to girl children.

¹Source: Tuong Lai 1991, *Sociological Review* N4/Suki Allen, Tran Thi Que, Hanoi 1992.

Preference for sons remains strong, especially in the context of today's smaller family size. However, there are significant differences between ethnic groups within Viet Nam. For example, amongst the hill tribe of Hmong, daughters are considered valuable assets in terms of their labour power and are "allowed to leave only reluctantly". Parents of bridegrooms pay relatively enormous amounts of money and goods for a suitable bride. Nonetheless, most Vietnamese women begin married life with significant disadvantages.

Gender and Confucian Belief

A popular Confucian saying states:

"If you have a son, you can say you have a descendant. But you cannot say so if you have even ten daughters". (Tran Dinh, 1991)

1.2 Political representation

Women hold less than a quarter of the decision-making positions in Viet Nam's National Assembly. Although the State has encouraged women to play an active role in politics, it remains primarily the domain of men. During recent years women's representation at the National Assembly level has declined, only rising slightly in 1992 (Figure 12).

Figure 12: Percentage of female representatives in National Assembly

Year	Total	% Female	% Male
1975	420	32.3	67.7
1976	495	26.7	73.3
1981	496	21.8	78.2
1987	496	17.7	83.3
1992	395	18.5	81.5

Women represent 25% of the Presidents of all the National Assembly Commissions. At present there is one out of six Vice-Presidents, 4 female Ministers or equivalent (9.52%), 11 Vice-Ministers and equivalent (7.05%).

Women's representation in 1992 was highest at the national level (18.5%). They are less well represented at provincial, district and commune levels where they hold less than 3% of Party Secretary positions. In 1992, women represented 16.42% of the total members of the Communist Party of Viet Nam, but only 8.21% of the Party Central Committee.

Women's representation varies within the Province and District People's Committees, but where women are in positions, they are most likely to be vice-chairs.

2. The Reproductive Role of Women

2.1 Family and marriage

The traditional Vietnamese model of an extended family with three or four generations living together has been changing in both urban and rural areas. Households are splitting off from the extended family in a nuclearisation process. However, the recognition of the household as an autonomous production unit appears to have maintained and strengthened the relationships within the family.

The minimum age for marriage was set by the Law on Marriage and Family at 18 for women and 20 for men. Marriage Law stipulates monogamy. Polygamy still exists but at an insignificant level. Women now often get married by choice rather than by their parents' arrangement. The age of first marriage among women and men has increased, although women in urban areas tend to get married later than women in rural areas (Figure 13). According to the 1989 census, the mean age at first marriage was 24.7 years for urban women and 22.7 years for rural women. Only 60% of all women above 18 were currently married.

Figure 13: Mean age at marriage, 1989

	Male	Female
Urban	26.5 yrs.	24.7 yrs.
Rural	23.4 yrs.	22.7 yrs.
Total	24.5 yrs	23.2 yrs.

In the past, remarriage after divorce or widowhood was extremely unlikely. Recently, there has been a significant change in peoples' attitudes towards divorce with cases of divorce on the increase. When marriages dissolve however, women are less likely to remarry than men. Divorced or widowed women face difficulties in finding adequate livelihood, retaining assets, and maintaining their social status. In 1989, there were 2,425,000 widows.

In rural areas, the husband in many families may often be away working or in the army. Although the internal migration of men is officially estimated to be only 3.5 percent, this does not reflect the large number of temporary migrants seeking work in urbanised areas and tribal men who migrate for extended periods. Single-women headed households account for 20% of all households. Up to half the homes in some remote rural areas are estimated to have women as de-facto heads of households.

Male sexual attitudes and practices have been identified as a major problem for women's health. The sex industry has grown considerably in the last few years and it appears that a large number of men have multiple sexual partners. This coupled by male unwillingness to take responsibility for contraception, poses a potential problem for HIV/AIDS transmission throughout the population.

2.2 Fertility patterns

The Family Planning Law of 1988 has reinforced the Government's commitment to population control. Two children is the family limit, except for ethnic minorities in the northern highlands, central highlands

and northwest who are allowed to have 3 children. Ethnic minorities are allowed more children in recognition of the need for additional labour to maintain adequate family food supplies. The penalty for breaking this law tends to vary according to location, unfortunately, most penalties take the form of higher payment for public services and/or access to capital. The law also stipulates that children should be born from three to five years apart unless the mother is over 30 years old.

Due to the increase in the age at marriage and greater contraception use, the average number of children per family has steadily declined from 7-8 before 1945 to 5.5 in 1975, and further to an average of 3.8 children in 1989 according to the latest census. The Government's Family Planning target for the year 1995 is for a family size of one to two children. A 1988 Demographic and Health Survey (DHS) indicated that most parents desired a family with 2.6 children. Approximately 40% of mothers with 2 children desired another child, whereas less than 24% of women with 3 children wanted more.

Urban families in Viet Nam tend to have fewer children than rural families where children, as sources of labour, play a more significant economic role. Fertility is lower in urban than in rural areas, a result of a higher age at marriage and more widespread contraceptive use.

2.3 Knowledge and use of contraceptives

The Law on Family and Marriage stipulates that both women and men are responsible for family planning. Nonetheless, almost all family planning messages are directed to women and women take almost all responsibility for family planning.

Although the Family Planning Programme launched in 1960 was extended to the whole country during the 1980s, knowledge and availability of contraceptive methods remain limited. Only the IUD has been widely and consistently available; condoms have been provided irregularly and the pill is frequently difficult or impossible to find at commune clinics. However it must be added that the pill is readily available on the open market and can be bought. This limited choice of effective contraceptive methods and, combined with the pressure to limited family size, leaves women with few options.

According to the 1988 DHS, 38% of the population accept and use modern contraceptive methods. Figure 14 shows the distribution of modern contraceptives, according to a more recent source (Prof. Hieu, Director, MCH and FP Dept MOH). There is substantial use of less effective methods with high failure rates. Amongst those who practice contraception, the most commonly used method is the IUD which was used by 47%. The next most popular methods are the condom (32%), and the pill (16%).

Figure 14: Distribution of contraceptives: percentage of users

	IUD	The Pill	Condom	Sterilisation
1992	53.59%	26.95%	17.61%	1.8%
1993 (first 6 months)	47.5%	16.43%	31.71%	4.3%

Source: MCH and FP Director's speech, Workshop on Orientation of Family Planning Strategy in Viet Nam, August 1993.

Abortion is widespread in Viet Nam: there are approximately 1-1.2 million cases of abortion/menstrual regulation every year. At least one in three pregnancies ends in abortion and the rate is thought to have increased considerably in the past two years. In the first six months of 1993 there were approximately 550,000 abortions.

Family planning in Viet Nam provides women with few options at present; the majority of modern methods available are invasive methods which can be detrimental to women's health, especially in the setting of the reportedly high rate of anaemia and gynecological infections amongst women and the generally low level of skill and hygiene in most health facilities.

Efforts are being made to increase the practice of contraceptive methods, including alternatives to the IUD method. The condom, oral pill, and sterilisation are being promoted. Provision of better training for health workers at the grassroots level, promotion of family planning knowledge, and the distribution of family planning devices are crucial to the success of the family planning programme.

3. The Productive Role of Women

3.1 Employment and wages

Women constitute 52% of the labour force. The labour force participation of women is a very high (70% of women of working age are within the workforce). This has been made possible by the comprehensive provision of child care by the state, and by policies promoting equality. The majority of the population works in agriculture, while other sectors such as manufacturing, state industries and administration, cooperatives and the private sector each employ less than 15% of workers.

Over 70% of women live in the rural areas, and are engaged in agriculture, forestry and aquaculture. In rice production, women undertake most of the work, having responsibility for planting, transplanting, field maintenance and weed control and harvesting. Women work in all of the different branches of the national economy but are concentrated in agriculture, education, light industry, health, commerce and finance, credit, insurance. Women are under-represented in transport, communications and heavy industry.

Unemployment and underemployment, long a problem in Viet Nam, has sharply increased in recent years. Though data varies, unemployment is estimated to be 20% in urban areas alone. While the rapid evolution from a centrally-planned and subsidised system to an open market economy has permitted women to participate in private income-generating activities, it has also resulted in a dramatic number of lay-offs from the state economic sector. Women constitute a significant portion of the newly unemployed. In 1990 and 1991, it is estimated that the State laid off approximately 553,000 women. According to a Viet Nam Women's Union report, in 1992 women accounted for 71.6% of staff who were laid off in the cultural sector; 78.4% in the health sector, and 82.1% in the commercial sector.

For skilled women employment opportunities have expanded significantly over the past thirty years, following the rise in female educational attainment. Women are, however, concentrated in lower status positions than men in almost every sector of the economy. Whilst female literacy is very high for a developing country, fewer women are literate than men in every age group. Declining patterns of school attendance and earlier school-leaving ages for girls may present a problem in the medium term for women entering and moving across the labour market.

In the private sector, wages and salaries are generally higher than in the state sector, sometimes much higher. However, it is difficult to generalise completely; like in most other developing countries, Viet Nam has a rapidly growing urban informal sector which is heterogeneous.

3.2 Women at work

Women's total contribution to production is greater than that reflected in the above statistics. The statistics reflect women's main occupation, but in Viet Nam today the majority of women have secondary means of income, in addition to their domestic responsibilities in child care and care for the elderly.

After years of communal and cooperative production, the household has returned to its historical position as the main unit of production. This provides new opportunities for income generation and many are seizing the opportunity. Some studies indicate that women feel they have greater autonomy under this system, however, women in both rural and urban areas are working longer hours, often 16-18 hours per day (12-14 hours per day for men).

Child labour is often used to overcome time constraints. It is very common in rural areas for children, particularly girls, to take part in non-agricultural income-generating work. This is particularly the case since cash cropping and animal husbandry are on the increase. Men often do not participate in this work, but still make important decisions in the use of income.

For **rural women**, the dissolution of communal agriculture has brought both opportunities and difficulties. Previously agricultural production was organized cooperatively. Now each household is responsible for its own production. For poor and female-headed households this is especially difficult. All stages of production are done by hand with primitive tools. In addition they are left with the heavy task of ploughing. Images of times past are in some cases returning; for poor families with limited land and assets (e.g. buffalo) it is no longer uncommon to see women harnessed to the plough or cart. Women's health is expected to suffer from a combination of increased work load and the increased costs of health care.

Recent studies have highlighted that households specialising only in rice growing have lower incomes than those growing rice and subsidiary cash crops. Households involved only in crop cultivation are poorer than those doing both crop cultivation and animal husbandry or handicrafts. Trading households are the richest. The poorest households, often single-women headed, are not in a position to increase their income as they generally lack all or one of the key inputs of land, labour and capital. This will lead to further impoverishment as households lose their land entitlement, or become entrenched in a cycle of indebtedness.

Rural women lack current technical knowledge and skills in agricultural production. A high drop-out rate from education for girls in rural areas indicates that their labour is required at home. Increasing costs of education may also make girls' education seem an unnecessary expense, and contributes to lower skills and lower agricultural productivity in the long term. The lack of mechanisation in agricultural production is also an obstacle for family planning as more labour is required by the household.

Kaufman and Sen (1991) have pointed out that the strengthening of family-based agricultural production may well lead to a reduction in women's economic autonomy and a reinforcement of son preference and related beliefs and practices, with negative consequences for the health of girls and women.

Land tenure and land rights

Security of land tenure is as important to ethnic minorities as to the rest of the rural population in Viet Nam. This is especially so for those people engaged in swidden agriculture. Land belongs to the people of Viet Nam and is managed and allocated by the State. The problems arise in the case of those ethnic minorities who do not recognize individual land ownership, only a communal ownership. These groups are likely to become landless as encroachment of the land grows, since they regard the land as being owned by the community. Provisions in the law will also have to be considered for the migratory swiddeners who abandon their land for periods of time. Land taxes, as they are to be implemented, are likely to cause problems as well.

In **urban areas** women work in most sectors. Their situation has, however, also changed dramatically since the late 1980s. Most who have salaries with the state sector have second incomes from the informal sector, which frequently involves market trading. This recent increase in market trade within Viet Nam is largely in the hands of women. Those working in light industry have witnessed the change from centrally planned production to independent enterprises. Their working conditions are often cramped and primitive. Mechanisms for enforcing labour legislation in the interest of workers are very weak.

Discrimination against women workers may occur under a market economy as employers seek to avoid the cost of conditions such as maternity leave and child care. Alternatively, these industrial conditions may be ignored. There is no data available on current conditions for women workers in any sector of industry and no estimation of the use of maternity leave can be made. Anecdotal evidence indicates that in some factories operated by foreign capital workers' rights and conditions are being ignored, for example, with workers expected to work long hours with no overtime payment.

Economic reality for poor women is pushing many into prostitution. There are no quantitative studies indicating the numbers employed within the sex industry, but it appears that numbers are growing rapidly, particularly in the two major cities of Hanoi and Ho Chi Minh City. This involves significant social health problems for women employed, not least of which is the threat of sexually transmitted diseases including HIV/AIDS.

In 1992 there were significant reductions in state-run services and user fees were introduced for education, health and child care. This may directly affect women, as their unpaid family labour often replaces labour which was provided publicly under the communal system. Studies of commune creches show that wages for child care workers have been reduced, whilst fees for child care have increased. In some cases, families have to pay half the cost of child care which previously was provided free of charge by the commune. As the availability of child care is a key factor for the maintenance of women's labour force participation, the effect of increased costs on the utilisation of child care facilities needs to be monitored.

3.3 Resources for women's productive activities

At present, approximately 50 to 60% of rural households lack access to affordable credit. Insufficient resources are then available for them to invest in production for their family's needs. When this occurs, in the short term family members' health status and educational attainment of children may decline. In the medium term, increased income disparity between households may occur. Those with limited land, few or no livestock, and primitive tools for production, for example, may be forced to sell their labour in an effort to meet their family's needs.

3.4 Access to credit

Access to credit for poor women, both urban and rural, is particularly limited. The formal banking structure does not reach most remote areas in which they live, and in those areas where access is feasible collateral requirements, high transaction costs and cumbersome financial procedures result in banks not yet being accessible to reaching the poorest. Poor women borrow money from private money lenders with high interest rates (7-20% per month). It is estimated that 40-70% of farm households borrow from this informal capital market. Other methods of borrowing include loans from relatives and through traditional systems of credit association. Many aid organizations have targeted poor households and are seeking to provide credit as a means to income generation, poverty alleviation and community development.

Hien – the trap of endless debt – a story from the countryside

"I worry night and day about my new bank loan of 1 million dong. It's at 2.15% a month, which is very cheap. But will I be able to repay? You see, I had to use 800,000 of it to repay the private lenders. As I always say the rich are killing the poor through debt. I spent the remaining 200,000 on two piglets and my whole future rests on their doing well. I've had to borrow another 400,000 from the private lenders to get through the hungry season – I'm a divorcee with four children you see. These private loans are not only expensive at 10% a month (compounded quarterly) but getting harder and harder to come by. I got mine because I have always paid on time before. But many families will not get any more loans. The lenders come and look at your fields or at your pigs before they'll give you anything. I reckon I need two years of good harvests to stand a chance of pulling out of this".

The rapid and on-going changes in Viet Nam are having a significant impact on women. Gender disparities are on the increase. Girl children and their mothers are working longer hours on an increasing number of tasks; their representation in the National Assembly is decreasing; and they are a decreasing percentage of those enrolled in higher education.

Although the law stipulates equality between the sexes, the law itself traditionally rests on the notion of duty rather than individual rights. Laws have had a limited impact on the daily lives of most poor women in Viet Nam. Traditional values continue to influence their preference for sons. Frequently the past in Viet Nam is described with emphasis on culture, while the present is approached from an economic perspective. This, however, often leads to misconceptions. A cultural approach to gender studies is vital in this context.



Chapter IV THE HEALTH CARE SYSTEM

Health services in Viet Nam are formally modelled on a five-tier system; at the top is the Ministry of Health (MOH). The Ministry of Health directly manages the Institute of Hygiene and Epidemiology, faculty schools, national production units of drugs and other medical equipment, and all centrally-based hospitals.

The next level is the provincial service which is responsible for the centre for preventive medicine stations, lower-level medical training schools, the local production of medical supplies, and provincial hospitals.

The district level is in charge of all medical facilities that are intermediaries between the provincial and central levels on the one hand, and the commune level on the other.

Commune health centers, with their affiliated brigades, make up the basis of the massive PHC efforts deployed by the Government. Figure 15 shows the facilities and structures available to each tier. In addition to this hierarchical structure, maternity units in charge of maternity care and reproductive health are integrated at all levels.

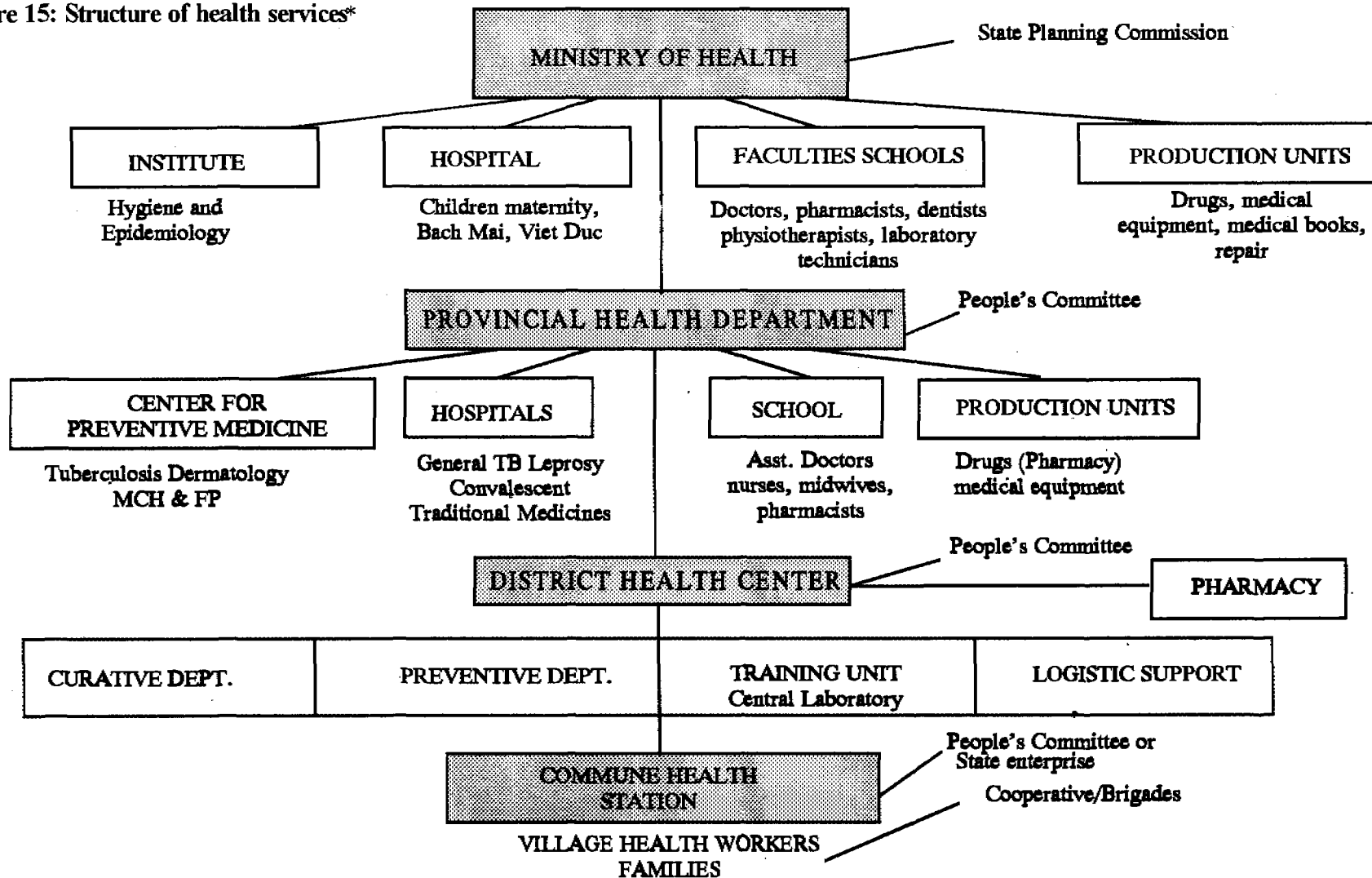
1. Health Infrastructure

Little documentation exists on the evolution of primary health care (PHC) in Viet Nam. What is known now indicates that following the revolution in the northern part of Viet Nam in the early 1950s, a programme to build a network of health centres was vigorously initiated. This network was to be in the frontline in the fight against diseases, providing basic maternal care, emergency services and a whole range of preventive and curative care.

While the stated goal is to achieve health for all through primary health care, the focus of attention has been at the province and district levels, perhaps a reflection of a fiscal policy which allocates resources on the basis of hospital beds.

Figure 16 provides a summary of the facilities and health manpower by level of assignment. While the stated goal is to achieve health for all through primary health care, the focus of attention has been at the province and district levels, perhaps a reflection of a fiscal policy which allocates resources on the basis of hospital beds.

Figure 15: Structure of health services*



(* This structure is under review and expected to change)

Figure 16: Health and medical facilities and personnel by level of assignment

Level	No. of health/medical facilities	No. of health/medical workers	No. of beds
Central	1,206 health and medical facilities (10%)	12,180 health/medical staff (7%)	34,935 (19%)
Provincial	249 general/ specialised hospitals (2%)	60,886 health/medical staff (35%)	55,841 (30%)
District	930 intercommunal polyclinics 550 district hospitals 60 maternities (13%)	62,730 health/medical staff (36%)	43,833 (23%)
Commune	9,243 commune health centres (75%)	39,668 health/medical staff (22%)	52,862 (28%)
Total	12,203 health/medical facilities	175,514 health/medical staff	187,471 beds

1.1 Central level

The health care structure follows the general Government structural arrangements. At the apex of the health care delivery system is the Central Government, with its Ministry of Health as the leader. Although the Ministry itself does not provide services, it gives policy and technical direction. In addition, it has specialised Institutes which provide services of a tertiary nature and referral services in various specialities. The Institutes include the National Institute of Hygiene and Epidemiology, the TB and ARI Hospital, the Institute for Protection of Mothers and Newborns, the Institute for Protection of Child Health and the Pasteur Institute.

Part of the MOH's job is training, carried out through its eight medical and pharmaceutical schools. The Ministry itself is organized into 13 functional departments. There are a number of other Ministries which provide parallel health services, like the Ministry of Defense, even Family Planning, for example, is dealt with by an independent ministry. Altogether there are 33 service-providing institutions at the central level run by the Ministry of Health. There is broad base recognition of the need to streamline the overall management of health services.

The limited evidence available also indicates that, like other centrally planned economies, Viet Nam has developed over the years a number of self-contained vertical health programmes, including malaria, TB and ARI control, and CDD, with structures running from the central to the district level. These structures that were very useful in a socialist state still survive, but are now proving inefficient in resource allocation and use in a market economy where coordination and integration would permit much better cost-efficiency.

1.2 Provincial health services

The Provincial Health Services (PHS) consist of a Health Service Bureau which is administrative in nature. The Director of Provincial Health Services (DPHS) is located in this bureau with the Vice Director for Planning both overseeing health activities in the Provinces. At the provincial level, there are Centres of Preventive Medicines which manage the cold chain for vaccine storage, provide support to Districts to enable them to perform the preventive services listed for the District Preventive Medicines Brigade and maintain a range of laboratory facilities for diagnosis and isolation of specimens coming from the districts.

Provinces also run provincial hospitals and in some cases specialised hospitals. The general hospitals have facilities for care in the specialities such as surgery, obstetrics/gynaecology, paediatrics, internal medicine, haematology, etc. Altogether, there are 249 provincial general and specialist hospitals, including leprosariums and sanatoriums. Manpower at the provincial level totals 35% of the nation's total. This number represents an average of 1,737 staff for each provincial health service.

What these figures demonstrate is that like in other parts of the world, most skilled labour would rather stay in big provincial cities than be deployed in rural districts or communes. It also shows a heavy bias of curative over preventive activities.

The available evidence suggests that most provincial hospitals, with a range in number of beds from 300 to 800, have good occupancy rates. However, it is also known that most outpatients and admission cases are those from the immediate townships in which they are situated, and that rather than serve as referral centres they serve basic curative needs which could be effectively attended to at lower levels of the health care delivery system.

The last important component of provincial health services are the secondary medical schools. These schools train middle level health workers for their provinces, for example; assistant physicians, nurses, midwives, and secondary pharmacists.

1.3 District health services

Further down the hierarchy of PHC services are district health services (DHS), which have three components. First is the Preventive Medicines Brigade, providing preventive services including EPI, CDD, malaria control, vitamin A deficiency control, and iodine deficiency control. The Brigade provides support to CHCs to deliver these services. The station is staffed by technicians, including physicians, assistant physicians, and laboratory technicians, and is headed by a vice director of DHS. The second component of DHS is the district health office (DHO) which has surveillance and programme management responsibilities. The last component is the district hospital (DH), staffed by general practitioners, obstetricians/gynaecologists, paediatricians, ophthalmologists, dentists, and in some cases by ear, nose and throat (ENT) specialists. In most places, the distinction between the DHO and DH is extremely difficult to make as they often share the same premises.

There are a total of 550 district hospitals, one in each district of the country. In most places, district hospitals have more beds than are either needed or than can be properly managed and discussions are being held to reduce the number of beds in most DHs. In the past, DHs were motivated to have many

beds because financial allocations were based mainly on the number of beds they had. This situation led to a scramble for expansion of physical facilities in order to accommodate more beds even at the expense of other important supplies and equipment. Recent field observations show some DHs with between 200 and 300 beds, with an average of 83, and bed occupancy rate averaging only 50% in most places. An optimum number might average 50 beds per DH.

Staff in DHS range from 30 to 300 depending on the population and financial ability of the district. There is an average of 134 health workers to each DHS, as compared with 4.3 CHW to one Commune. This lopsided deployment does not favour PHC in Viet Nam.

The support that DHs provide to lower level health services, which are the ICPs and the CHCs, vary a lot in quantity and quality. In most instances the DHs are simply inaccessible (because of distance and transportation difficulties) to most of the people in the district they serve. It is important to note that most district health resources (manpower, finances, drugs, equipment, etc.) are concentrated in the DHs. In addition, DHS staff receive their pay from the central Government through the district branch of the Ministry of Finance and allocations from the Provincial Health Bureau. This puts them at a special advantage over their CHC counterparts, resulting in discrimination against PHC services, especially preventive care.

1.4 Inter-communal poly-clinics

At a broader level than CHCs in the health facility infrastructure are Inter-Communal Poly-Clinics (ICPs), which were planned to provide basic services at a higher level of sophistication, take referrals from CHCs, and give supervision and other technical services, including training, to CHCs. Each ICP was planned to provide these back-up services to between three and six CHCs, and to be staffed by general medical practitioners, specialists in obstetrics/gynaecology, dentistry and, in a few places, ophthalmologists, in addition to assistant physicians, nurses, midwives and pharmacists.

By-and-large, the ICPs have not fulfilled these roles earmarked for them as they seem to be overwhelmed by the problems of their immediate neighbouring communities. In 1992, there were 930 ICPs, or one ICP to about 10 CHCs, far beyond the intended capacity. Recently, discussions have been initiated on the role of ICPs, either to downgrade them to CHCs or upgrade them to District Hospital status.

In 1992, all ICPs combined had a bed capacity of 9,750, or about 5% of the total 187,471 available in the public sector that year. This total bed number as well as the percentage share may be satisfactory considering the number of ICPs. The manpower situation for ICPs does not lend itself to disaggregation and analysis because the staff at this level are lumped with those of district health services.

1.5 Commune health centres

Viet Nam has made considerable investments in the development of a wide network of health centres designed around the commune cooperative system. Of the 9,929 communes in the country, 9,243 (93.1%) have a commune health centre (CHC), 600 (6.1%) have no CHC but have resident commune health workers (CHWs) and only a very small fraction (78) have no commune based health services. On average, each CHC is staffed by 3-5 CHWs comprising at least one assistant doctor trained for three years and a nurse midwife trained for two years in the team.

At the second most peripheral level of PHC facilities are the commune health centres (CHC); each commune, according to plan, is supposed to have one. These commune health centres are meant to be run by assistant physicians, assisted by nurses and midwives, primarily pharmacists and technicians. The services at this level are to be supported by the cooperatives. With the re-unification of the country in 1975 the southern part of the country also began to construct CHCs and train CHC workers intending to catch up with the north.

At the base of the commune health centre network prior to 1986 were brigade nurses who are trained for between three and nine months and lived in the villages where they provided health care for the people. These brigade nurses were in turn supported by their production brigades. With the dismantling of production brigades the brigade nursing system also collapsed and most of its members returned to agriculture.

This, combined with the cessation of aid from Western donors, put a severe strain on the health budget. Again, since the introduction of the market economy in 1986, the cooperative system has collapsed, but unlike brigade stations, the CHCs endured, as there were physical structures to run and maintain. Although part of the formal health services, the ownership of CHCs has been thrust upon the commune people's committees. This is, in part, a welcome development, because it promotes the possibility that decisions affecting the CHCs will be made at the local level and therefore be more relevant and timely. However, both financially and managerially, the commune people's committees are ill-equipped to run the CHCs.

As of 1992, there were 9,243 CHCs, with about 686 communes yet to have their own CHCs. Further stratification, though not available officially, shows that an overwhelming number of the 445 communes without CHCs are in the northern mountainous region, while of the 1,926 communes in the Red River Delta, only 11 are without CHCs.

Field observations in the northern mountain region and indeed in some other regions, for example in Tay Nguyen, indicate that much work needs to be done even on the quality of available CHC infrastructure. Some of them merely have four walls that cannot stand for much longer; the floors are unplastered; they are lacking even in the most basic equipment. Unless some of these facilities undergo major renovations they cannot even store the equipment that is vital to their existence and proper functioning. Yet in other places, what pass for CHCs are rooms donated within the offices of the people's committees, offices that are not especially compatible for health care delivery.

Altogether the CHCs were estimated to have shown a decline in the number of beds since 1986. This decline can be attributed to a corresponding decline in utilisation of health facilities. The number of CHC beds represents 26.79% of total available in-country that year. However, the percentage of bed availability at the CHC level is very likely to be misleading as CHCs are not meant to admit and care for serious cases. Rather, they are to be used by new mothers for a few days after delivery and to give basic curative care which does not need long-term admissions. Those needing such long-term admissions are to be referred to ICPs, district or provincial hospitals depending on the nature and gravity of cases.

1.6 Maternity units

Maternity units are situated in cities and towns. In rural areas they are an integral part of the CHCs. The maternity units' optimal bed capacity would depend on the population they serve. In a theoretical situation where a maternity unit serves 50,000 people with a CBR of 29.9/1000, this translates to 1,495 babies in that community every year. If we further assume that there is no seasonality of birth during the year, births should average 4 per day. Data available indicates that about 90% of these deliveries will be normal and could be discharged within 48 hours. The maximum number of beds such a maternity unit (serving 50,000 population) should have is 15.

1.7 Traditional medicine

Having looked at the state structure as it has been developed at the central, provincial, district and commune levels, it is important to look at the parallel structures that exist. In the case of traditional medicine this is part of the Government system and accepted as an alternative means of treatment. The second is the development of the private provision of health care.

One of the nine main strategies of Viet Nam's health system is the association of Eastern with Western medicine. Official statistics put the number of traditional medical practitioners at 967, the mass of whom work at commune level, but this figure is likely to be underestimated as many practitioners are actually not registered.

Western health care practitioners in Viet Nam have some training in traditional medicine, and most health institutions have beds reserved for traditional medicine patients. The effectiveness of this traditional practice, however, is not documented. A survey on health-seeking behaviour done in Hanoi at the Bach Mai hospital revealed that next to self-medication with Western drugs, people sought traditional help even before seeking assistance from a health worker. This can be interpreted to mean that there are more traditional health workers than recognized and that people generally believe in their efficacy or trust them more than Western medicine.

The training of traditional medical practitioners is conducted in two national schools for that purpose. One reported concern is the use of Western medication without adequate training by these traditionalists.

1.8 Emergence of private health care

The introduction of the market economy relaxed controls on private medical practice in 1988. The private sector is more visible in the number of pharmaceutical stores than that of clinics. The number of registered pharmaceutical stores has grown from an estimated 2000 in 1990 to 6000 by the end of 1992. Not only do retired health workers take to private practice, even those currently employed in the public sector practice privately, reportedly during off-hours.

The major issue facing private practice is regulation, to ensure that standards of practice are set and enforced. Currently, private practice is a suppliers' market, making it still more difficult to control.

It has also become imperative to make regulations for workers in the public sector so as to distinguish between official and private practice. As things stand, no-one knows for sure how many private

practitioners there are - this is made more difficult by the obliteration of the line between public and private practice. Health workers employed by the state may have private consultations after hours.

One positive factor in private practice is the productive engagement of retired health workers. In the past six years, an estimated 30% of the workforce in the health sector have been forced to retire because of economic difficulties. Some of these are demilitarised personnel from the armed forces. Most of these retirees return to their villages and constitute a huge reservoir of potential for the health sector, especially in rural areas.

In order to harness this potential, it will be necessary to establish a role and specific responsibilities for them in their communities, for which they may be rewarded in-kind by their villages or communes.

1.9 Coordination and supervision

Coordination is one of the major weaknesses of the primary health system in Viet Nam. Programmes which have overlapping interests rarely work together in the same area or at the same time. Information is rarely shared, and it is not unusual that two or more departments/institutes are doing the same thing at the same time.

This is partly the result of categorical programmes that have been in existence for a long time. But in addition, in the present structure of the Ministry of Health, there is no position for a Coordinating Director or Director General who has authority and can therefore foster coordination. As things stand now, coordination depends mostly on the goodwill of concerned directors. The results are duplication of efforts and waste.

Supervision is supposed to take place from the central level to the provincial, from the provincial to the district, etc. However, there are two major constraints to supervision. One is the lack of resources - transportation, overnight allowances and sufficient staff, etc. The other is the lack of know-how. Most supervision takes the form of social visits; care, facilities, records, and drugs are not critically examined, nor are health workers supervised, commended or reprimanded as appropriate. One solution might be the development of checklists for supervision at all levels, so both supervisors and supervisees have same objectives and expectations of supervision.

2. Human Resources Constraints on the Health System

The situation relating to human resources needs at all levels of the health service, and the appropriate training and deployment of personnel is critical if the PHC system is to serve the real needs and provide the basis for the implementation of the NPA goals.

The health workforce in Viet Nam comprise about 175,500 people, including physicians, assistant doctors and medical technicians, nurses, midwives, pharmacy personnel and traditional medical practitioners. Figure 17 presents the distribution of medical personnel by level of attribution. It indicates that approximately half of all health workers are deployed at the central and provincial levels while the other half is employed at the district and commune levels. A closer examination shows that there is a concentration of the most qualified health workers towards the top of the service structure. While 15% of all physicians are employed at the central level and less than 4% of them work in CHCs, only 5% of

assistant doctors, nurses, and midwives are found at the highest level and about 30% at the lowest. To a certain extent this deployment is in line with the principles of primary health care where tasks are delegated to the lowest levels where they can be best performed efficiently and effectively. Most of the tasks at the CHC level do not need highly skilled staff. In this case, assistant physicians as well as nurses and midwives are adequately trained to perform CHC tasks.

Figure 17: Availability of health workers in the public sector by their level of assignment (in absolute numbers and percentages)

Category of Personnel	Central	Provincial	District	Commune	Total
Physicians	4,719 15.0%	14,558 46.4%	10,920 34.8%	1,192 3.8%	31,389 100.0%
Assistant doctors and medical assistants	2,091 4.1%	10,970 21.3%	21,125 41.0%	17,338 33.7%	51,524 100.0%
Nurses	3,218 6.2%	19,041 36.9%	15,988 31.0%	13,307 25.8%	51,554 100.0%
Midwives	546 3.9%	3,239 23.3%	4,615 33.2%	5,493 39.5%	13,893 100.0%
Pharmacy personnel	1,581 6.5%	11,951 49.4%	8,894 36.8%	1,761 7.3%	24,187 100.0%
Traditional medical practitioners	25 0.8%	1,127 38.0%	1,238 41.7%	577 19.4%	2,967 100.0%
Total	12,180 6.9%	60,886 34.7%	62,780 35.8%	39,668 22.6%	175,514 100.0%

Commune health workers (CHWs) numbered 39,668 in 1992, or 22.6% of the 175,514 total health workers available in the public sector that year. This CHC percentage share is less than optimal because an overwhelming majority of health problems in Viet Nam are still infectious and parasitic diseases which could be tackled at the CHC level. There are more CHCs than any other type of health facility and because of their wider availability and better distribution more people are likely to consult CHWs than any other level of care. The 39,668 CHWs translates to an average of 4.2 per CHC.

2.1 Maternal care

Generally speaking, assistant doctors (APs), and not physicians, are in charge of maternity units all over the country. The quality of maternal and child health care suffers from this as there is limit to what the lesser-trained cadres that staff CHC can do, for example, they are ill-prepared to handle complications that may arise during delivery. Their elementary training is best suited for routine tasks like growth monitoring, immunization, identification and referral of women at risk during pregnancies, and

administration of treatments; but not for tasks that demand even a medium level of clinical skills like diagnosis, aside from symptomatic diagnosis.

Another problem arises from the fact that most APs are male. Data on the current situation reveals that 40% of the communes lack trained midwives. Women are more likely to seek help from female health workers, particularly in cases of ante-natal examination and delivery. The option of using APs for maternal care cannot be regarded as optimum, unless an overwhelming majority of these APs are females and their training curriculum is structured heavily in favour of maternal care. It is clear, however, that the other option of using doctors is not cost-effective as doctors cost a lot more to train and to pay. An alternative would be to improve the level of qualifications of midwives. Of the total number of 175,514 workers in the health sector, only 7,308, or 4% are secondary midwives who possess the appropriate skills to care for maternal health problems, and are relatively more disposed to rural postings than their obstetrics/gynecologist counterparts. Another 6,585, or 3% are elementary mid-wives who should be working on maternal care problems under supervision. These numbers are totally inadequate for the estimated 17.5 million Vietnamese women of child-bearing age.

2.2 Human resources training

Training for PHC is currently carried out in eight medical and pharmaceutical schools, plus 25 secondary medical schools. The eight medical/pharmaceutical faculties turn out about 2,000 graduates each year. From the curricula available, PHC training in medical schools still leaves much to be desired. Most medical schools want to train the "best" in the academic field, and therefore design their curricula along the Western model with little focus on their own local health problems. In this pursuit they spend a lot more time as well as other resources to the detriment of PHC. For example, in the Vietnamese medical schools, community diagnosis, management of health services including planning, monitoring and evaluation do not receive attention. Even the concept of essential drugs is not emphasised.

As for secondary medical schools, both facilities and curriculum need a lot of improvement, as does the structure of training, which is mainly didactic. In health care work, hands-on experience would be more useful to students than lectures, especially if this experience is linked to problems they will have to deal with in the field when they graduate. Right now, most of the posting of SMS students are at the provincial hospitals, where the cases and conditions are substantially different from those of CHCs in which they will actually work upon graduation.

3. Drug Supply Constraints

The concept of essential drugs has not yet taken root in Viet Nam. In October 1992, a joint UNICEF/WHO Drug Action Programme mission visited Viet Nam and found that the Essential Drugs Programme has to start from scratch.

The major constraint on this programme is staff time at the local level. The Department of Pharmacy in the Ministry of Health needs to be strengthened on the local level with more staff and training. It is well-known that Viet Nam has laid the foundation for its pharmaceutical sector by having pharmaceutical factories in almost every province. With raw materials from abroad, these factories can manufacture a whole range of medications. What remains to be done is to channel this reservoir of potential into the

essential drugs programme and to better deploy qualified pharmacists more effectively at all levels of the health structure. For the moment, only 7.3% of all pharmacists are located at the commune level while more than 40% of them work at the central and provincial levels.

In Viet Nam, the drug situation is dynamic. From official external aid sources, drug importation value increased from VND1.2 billion in 1986 to VND11.1 billion by the end of 1990. The value of drugs produced locally increased from VND1.9 billion in 1986 to VND5.5 billion in 1990. The overwhelming majority of drugs consumed in Viet Nam, however, do not come from these two sources. They come from unofficial sources, mainly through traders and overseas Vietnamese who send them in lieu of cash to their relations. From these three sources combined per capita drug consumption rose from VND32 in 1986 to VND4,451 in 1990.

However, there are serious concerns about the quality and the variety of drugs available on the uncontrolled free drug market in Viet Nam. Although it has a National Essential Drugs Programme, Viet Nam is only now gearing up to develop an Action Programme on Essential Drugs. The potential for rapid development of such a programme, including the development of in-country drug quality control, is very good. In the meantime, there is a lack of a centralized and/or controlled procurement system to assure that drugs destined for public health facilities conform to quality standards, and to the essential drugs code. This is needed to assure the quality of drugs purchased locally. It is necessary to introduce some standardized and controlled procurement system for public drug supply.

4. Financial Constraints

Central Government support to (PHC) programme activities is, for the most part, channelled through the Ministry of Finance to the Ministry of Health. Officially, the Ministry of Finance provides funds directly to the MOH for its own activities and those of its agencies and institutes. Concurrently, it also provides funds to Provinces and Districts. These are disbursed in lump sums to the respective people's committees by the local branches of the Ministry of Finance, without tying specific amounts to specific projects or sectors. From this pool of money, it is up to the people's committee to allocate to the various sectors and activities.

While it is difficult to come by the figures spent by all the provinces, districts and communes on health, the central level figures are available, and have increased from VND3.99 billion in 1986 to VND367.72 billion in 1990 (Figure 18). Looking at the table which records this massive increase in the National Budget expenditure from 1986 to 1990, the reason why the problems have become so critical is not easily perceived. The MOH budget as a percentage of total central Government's budget ranged from 3.11% to 4% during this period. These figures exclude expenditures on health by other central Government Ministries and agencies.

Figure 18: Comparison of MOH with overall central Government budget, 1986-1990

	1986	1987	1988	1989	1990
National Budget (billion dong)	120.79	154.93	2839.19	6671.17	9186.37
Health Budget (billion dong)	3.99	16.02	110.11	260	367.72
National Budget spent on health	3.31%	3.11%	3.88%	3.9%	4%

Assuming that the provinces, districts, and communes would spend a higher proportion of their respective budgets on health since they are not encumbered with as many responsibilities as the central Government (e.g. military, communication, foreign service, etc.), the total public sector allocation to health as a percentage of total public sector budget can be assumed to be between 5% and 10%. This can be considered as a demonstration of the will of the Government at all levels to ensure adequate health care delivery.

4.1 Provincial and district level financing

Central contributions to Provincial Social Welfare Funds for sectoral development activities include a PHC support component. However, as the proportional allocation of these funds and their intended use is not defined, the portion allocated to PHC and the activities it is used for vary greatly from province to province.

In either case, central Government contributions are principally earmarked for activities at the provincial and district level. Support to commune level through subject specific and vertically managed Ministry of Health National Programmes (on ARI, CDD, EPI, malaria, vitamin A, anaemia control, maternal health and family planning, etc.) is limited.

4.2 Commune health centre financing

Direct support to CHCs by allocation from the MOH is mostly in the form of one-time contributions for re-training of CHWs in programme-specific topics, and in-kind donation of training and health education materials and for specific programme-recommended drugs which are to be provided either free or heavily subsidised regardless of local policies on cost recovery schemes. This is a policy that, in the context of limited and variable financing, has repeatedly proved itself to be not sustainable.

Until very recently, commune health workers (CHWs) were employees of their communes, who paid their salaries. In many instances, salaries were irregularly paid, thereby complicating the extremely low wages. In addition, many CHWs have been stuck in the same positions for 15-25 years with no refresher training and no significant pay increase. These problems had a negative effect on the motivation of CHWs and consequently on quality of care.

Although the CHC network was part of the formal public health sector until recently, CHCs depended financially on the Commune Cooperative System. Cooperatives obtained funds from the collection of in-kind contributions from each family and from the partial retention of commune profits and taxes. Part of these funds were allocated to CHCs and their utilisation authorized by the Commune People's Committees for CHW salaries, outreach services through brigade nurses based at village level, CHC overheads and for the replenishment of CHC funds procurement of drugs.

Socio-economic reforms introduced in 1987 and widely implemented by 1990 have led to the disbandment of the commune cooperative system. The lack of parallel reforms in the health sector financing and management system has left the CHC financing system to cope with a vacuum which neither the Ministry of Health nor provincial and district financial capacities have been able to cope with. This has led to the rapid deterioration of CHC capacities to provide adequate basic health care on a continuous basis and is eroding the reductions in morbidity and mortality Viet Nam achieved in the past.

4.3 Introduction of user fees

In a bid to solve the immediate financial constraints of CHCs, district and commune people's committees have authorized the introduction of user fees and cost recovery on drugs. This has been done without parallel improvement of the quality of care, convenience of service delivery or assurance of the quality of drugs being purchased for CHCs. More importantly, however, the policy is being implemented without defining mechanisms to assure that those without financial access to the burgeoning private sector are not further marginalised by the new user fees system.

Negotiations are currently taking place to have the MOH take up the payment of three health workers per commune. In addition, the central Government has set up different mechanisms for assisting poor communes. One of these is the granting of VND2,000 per capita per year towards the purchase of drugs. Another involves the transfer of funds from relatively well-off areas to less endowed ones. How all these work in practice is, however, unclear.

4.4 External aid

For many of its health activities, Viet Nam still depends to a large extent on external aid. Aid in the health sector is provided largely by UNICEF, SIDA, WFP, UNFPA, WHO and various NGOs. Figure 19 shows the major organizations providing support to the health sector in Viet Nam and how much the commitments amount to each year from 1990 to 1992. Data on utilisation of these commitments were not available for this analysis. The Government receives between one quarter and one third of its health budget from external aid.

Figure 19: Aid from major international donors in health, 1990-1992

Organisation	1990	1991	1992
	Amount (US\$, million)	Amount (US\$, million)	Amount (US\$)
WHO	2.4	2.5	1.2
UNICEF	4.8	3.9	6.9
UNFPA	3.9	2.3	3.2
SIDA	7.1	6.9	7.8
UNDP	0.4	0.3	0.4
IPPF	0.2	0.3	0.3
WFP	0.3	5.0	7.0
NGO	7.7	8.1	5.8
TOTAL	26.8	29.3	32.6

From the above, the major problems that remain for the health system are:

- The provision of policy directives on financing and facility management;
- Adequate provision of drugs and equipment;
- Appropriate training and continuing education for health workers;
- Improved wages and remuneration for health workers;
- Coordination of services.

Visiting a District Clinic at Ban Cup, Son La Province

This is the main health centre for the district; it serves nine communes both Thai and Kinh. Some patients have to travel up to two days to visit the clinic. There are six beds and a very basic delivery room.

The centre has a staff of one doctor, six assistant doctors and three nurses (all Thai). The doctor has five years' medical training and the assistants have attended technical college after class 10; nurses attend a training course for 1 year to 18 months; all are women and all are Thai.

The centre is open for seven hours a day and a doctor/assistant is available at all times. Patients pay for medicine (e.g. approx. 30,000 dong for a full course of malaria treatment) but not consultation. The centre treats less serious diseases (up to 10 days), maternity, family planning and some abortions.

Malaria has increased in the past two to three years, with an average of 30 cases a month. The number increases dramatically in the rainy season; there were two fatalities in 1992. The next major illness is diarrhoea, mothers generally have poor understanding of keeping fluid levels up and there is fairly widespread use of leaves/traditional medicine. The other major illness is lung infection, mostly among children, a result of poor care, wet clothes and having to leave children to care for themselves all day.

Maternal mortality is rare (no one could recall any cases). There is usually an older woman in the village who attends births; in addition each commune has trained staff in birth practices. There is no ante or post natal care.

Health education is restricted by lack of funding. The Women's Union has recently made a significant contribution to the Family Planning Campaign, but it has not been used as effectively for primary health care education. Although family planning is contrary to Thai culture, many younger couples are adopting IUD use after four children, though this often depends on the number of male children. There is no concept of spacing. There is also a poor understanding of sanitation and there are few latrines to be seen.

According to reports from the staff, the H'Mong community in the area are only treated within their own community. The women cannot be touched or examined by a male doctor, and there is no family planning. It was generally accepted that the H'mong have a better understanding of natural medicines than the Thai, and it is used more extensively. No one knew of cases where the use of traditional medicine had been detrimental.

Chapter V

THE HEALTH OF WOMEN AND CHILDREN

Since the Proclamation of Independence on September 1945, Viet Nam has consistently pursued a policy of protection of and care for children and their mothers. From this time up to the present, a number of laws, decrees and directives have been promulgated in pursuit of these objectives. In spite of the substantial progress already achieved, the Government is determined to improve the health status of women and children. A current assessment of the main problems faced by women and their children in Viet Nam has been set out along with an analysis of the needs yet to be addressed. The main health strategies being developed by the Government are presented in this context.

Goal: To reduce the maternal mortality rate from 110/100,000 live births in 1990 to 70/100,000 live births by the year 2000

1. Women's Health

While an accurate assessment of the health situation of women in Viet Nam should be based on reliable information and statistics, there is as yet no comprehensive database of social indicators as community-based data on maternal health are extremely rare. Most of the data presented should therefore be examined cautiously, focusing on trends and patterns over time rather than on crude data analysis. These trends highlight a number of significant factors which point to priorities for intervention.

1.1 Maternal mortality

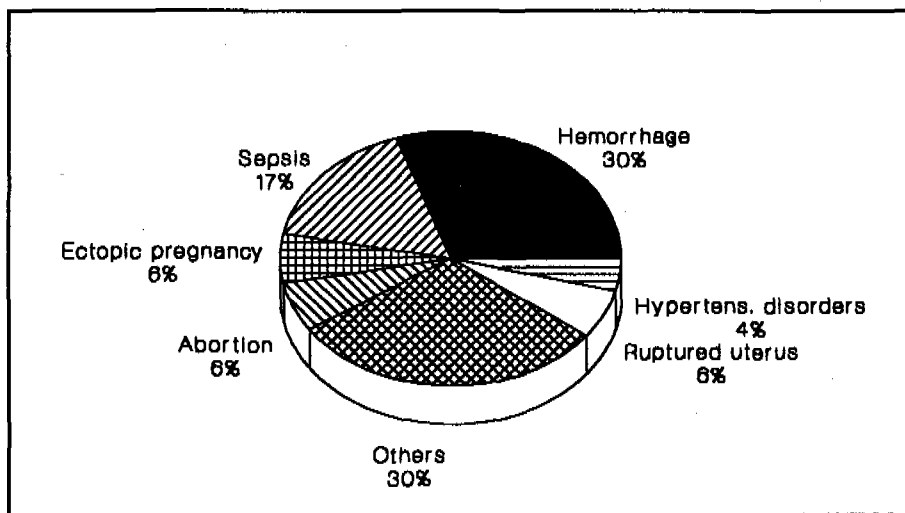
There are varying assessments of the maternal mortality rate. Different sources indicate different rates. For example, routine reporting by the Ministry of Health provided a figure of 110/100,000 live births in 1990, while another MOH survey of MCH main health indicators reported a maternal mortality rate of 220/100,000 live births also in 1990. There is general agreement among various sources, however, that the rate is on the decline, albeit very slowly.

The average rate conceals important differences among the regions of Viet Nam. For example, in 1991 the Red River Province of Hai Phong reported a MMR of 107/100,000 while the central highland province of Gia Lai reported a rate of 418/100,000.

1.2 Causes of death and morbidity

Hospital-based figures show that the major medical causes of maternal morbidity and mortality are haemorrhage, post-partum infection, eclampsia, tetanus, and ruptured uterus. Other causes include gynecological and urinary tract infections, hypertensive disorders, sepsis, anaemia in pregnancy, and

malaria in pregnancy. Figure 20 illustrates the proportional share of each major cause of death. The Ministry of Health considers that 35% of all maternal deaths are definitely preventable and 53% possibly preventable. The avoidable factors identified most often including delay in treatment, delay in referral, delay in diagnosis, incorrect treatment or diagnosis and lack of transport, blood or drugs.



1.3 Personal care

The family is still a very strong unit in Viet Nam. However, family size has decreased significantly to four children, according to the 1989 census, from six children found by the 1979 census. The health and well being of the pregnant woman is, and always has been, of concern to all the family.

Figure 20: Leading causes of maternal mortality, 1984-1985

A number of traditional practices, while intended to be for the good of mothers, actually negatively affects women's health. During pregnancy, women are expected to work hard as it is believed this will make delivery easier. In a recent survey, 25% of the women agreed to that statement and 45% of them declared that they had no rest prior to delivery.

During the first few months after delivery, young mothers, especially those having their first babies, are advised to avoid exposure to the elements. Tradition has it that this will negatively effect the mother's health as she gets older. In addition, new mothers have certain dietary restrictions e.g. to avoid fish as this "may cause diarrhoea for her child".

Malnutrition is an aggravating factor of maternal mortality, especially in the case of haemorrhage. Most pregnant women do not eat sufficiently and are both anaemic and underweight. A recent UNICEF-Government study provides some insight into the kind of advice received and acted upon regarding the eating practices of pregnant women. All the women studied, when becoming pregnant, undertook by themselves to significantly change their diets. This unilateral action suggests a significant commitment to self-care. Women are genuinely concerned to do what is best for their growing baby, a very positive finding. However, nearly every reported modification in eating adopted during pregnancy ran counter to generally recognised professional public health care dietary standards for pregnant women.

In the first place, almost all women reported that they reduced their overall food intake. Secondly, nearly all the women reported that they restricted their protein intake and modified their intake of fruit, vegetables and rice significantly enough to have a potentially deleterious effect on the developing foetus.

All respondents indicated that they modified their behaviour based on tradition and on advice received from their mothers, mother-in-laws and confirmed by other women in their community. According to traditional beliefs, women are not expected to eat much nutritious food during pregnancy so that the foetus will not grow too big, making delivery difficult. The survey found that 39% of mothers believed a difficult delivery occurred because the women concerned had eaten too much during pregnancy. Once the infant is born, only 43% of the women recognised the need for adequate food and rest.

1.4 Reproductive health

The conditions of delivery are a major determinant in the condition of maternal and newborn's health. Reliable data on maternal health services is lacking. The Mothers' Health Survey in Selected Areas conducted by the MOH in three provinces found that 90% of women delivered at a health facility and 9% at home; other surveys, however, have found quite different results. A survey conducted for UNICEF on Health Seeking Behaviours in a rural commune of Thanh Hoa found that 29% of deliveries occurred at home, whereas a survey in Bac Thai Province found that in the past five years 65% of women delivered at home. In one of the surveys, only 57% of the women had had prenatal check-ups.

Routine data available from the Ministry of Health itself indicate a declining trend in the percentage of women delivering at health stations; down from 78.5% in 1990 to 70% in 1992. These data also indicate a declining trend in the average number of ante-natal consultations per woman from 1.2% in 1990 to 0.8 in 1992. Apart from these figures, field observations suggest that in the mountainous regions and in the central highlands (Tay Nguyen) the majority of women have their babies at home. For some women, the health centres are just not accessible. The centres are either too far away, or they do not have the financial means necessary, or some women simply want privacy. Oral evidence even suggests that ethnic minority women often prefer the privacy of delivering alone. These trends suggest that women are not receiving adequate care before the birth, at the time of birth and after the birth of their babies which will begin to impact on maternal mortality rates unless the situation is addressed. Solutions are varied and are dealt with in detail in the chapter which looks at manpower deployment, financial constraints and access to health care – the Health Care System.

Another risk factor to women's health is the use of inappropriate contraceptive methods. Family planning services are widely used in Viet Nam and they continue to make progress overall. IUD usage increased from 925,000 in 1986 to 4.08 million in 1992; pills usage also increased from 101,000 in 1986 to 388,000 in 1992; condom usage suffered a set-back declining from 649,000 in 1991 to 537,000 in 1992; male and female sterilization increased from 26,000 in 1986 to 168,000 in 1992.

In spite of the apparently large choice of modern contraceptive methods available, there has been a noticeable increase in abortions, a major risk factor for women. Figure 21 shows the progressive increase of abortion disaggregated by urban and rural areas. One Vietnamese expert in a survey on the issue found that about 40% of those having abortions would return for another one within 3-6 months.

In the past, family planning commodities came largely from the countries of Eastern Europe. But with most of these countries facing their own economic and political problems, the flow of the commodities has almost halted. The major supplier of contraceptives today is UNFPA through MERUFA based in Ho Chi Minh City. It is important to add here that with the introduction of a market economy, private

pharmacies now offer for sale a range of easily dispensable contraceptives, including condoms and birth control pills.

The characteristics of the contraceptive practices in Viet Nam have important implications for the emerging problem of the AIDS epidemic. Although the disease is a concern for the population as a whole, its recent development and its major routes of transmission are likely to have a disproportionate impact on the health of women.

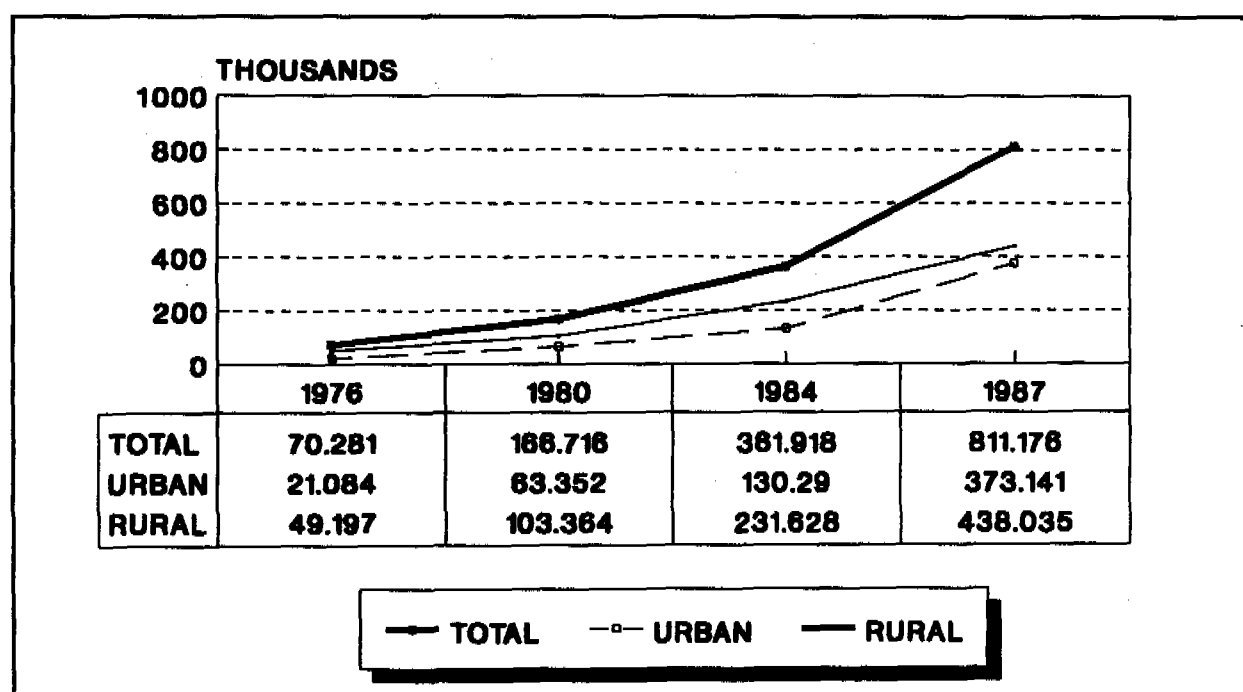


Figure 21: Induced abortions in urban and rural areas, 1976-1987

Source: *Selected indicators on women's status in Viet Nam, 1975-89*; National Centre of Social Sciences; Centre on Women's Studies.

1.5 HIV/AIDS

The HIV/AIDS situation in Viet Nam is becoming more and more serious. The number of HIV infections is rapidly increasing, particularly in the southern provinces where HIV newly-infected people are being found almost weekly. The number of recorded HIV positive cases has increased so that as of April 24, 1993, 304 HIV positive cases were reported. It is clear that more cases are found in HCMC because the city has been better able to diagnose the problem. In many other places, adequate diagnostic facilities simply do not exist. From available statistics 75 of 304 HIV-positive cases are foreigners, mostly Thai fishermen. Though these figures may seem relatively small compared to other countries, it must be added that surveillance is very weak and laboratory capacity at provincial level handicapped by technical skill and equipment.

There are many favourable factors in Viet Nam at the present time for the transmission of HIV to accelerate and a number of these factors put women at particular risk of becoming infected with the virus. The most important of these are the changing patterns of sexual behaviour, the rapid development of commercial sex being only one aspect of it, and women's preferences in terms of family planning methods. Sexual behaviour patterns in urban settings are changing and the rapid increase in risk behaviour and denial of personal vulnerability is common to both urban and rural areas and stem from very poor knowledge of HIV/AIDS, its transmission routes and risk factors. The relatively recent affluence is also reported to have encouraged the practice of extra-marital affairs and multiple partners. While, for a long time, migrations were tightly controlled by the authorities, the new economic policy has induced growing flows of seasonal migrations. Married migrants whose wives have stayed behind tend to engage in unsafe sexual behavior and to carry the infection back to their family. This, in the presence of the reported high incidence of gynecological infections in the general population and the suspected high incidence of sexually transmitted diseases, creates a favourable environment for rapid heterosexual transmission.

Limited access to condoms particularly in the rural areas, and the continued promotion of condoms primarily as a family planning method, deny protection to the young and unmarried but increasingly sexually active population. The fact that over 55% of women using contraceptives are using invasive methods (53.6% IUDs and 1.8% sterilisation) is also of concern. These women and those undergoing abortions and menstrual regulations are unprotected from iatrogenic transmission of HIV/AIDS in the prevailing standards and un-sterile procedures in public health facilities.

The lack of equipment and supplies, together with the poor conditions of hygiene in health services, are also conducive to the disease as reusable equipment (needles, syringes and the like) are not properly sterilised. Given the high frequency of injections used for both preventive and curative treatments, this situation is critical.

Although actual data is hard to find, intravenous drug abuse is said to be on the increase. A new and worrying twist to this re-emerging problem is the intravenous use of opium which has traditionally been a drug to be smoked. However, more distressing are recent reports that health workers in the uncontrolled private health sector, are in some instances assisting drug abusers with "injection services". The same uncontrolled private sector is largely dependent on revenue from the sale of illicit drugs and is increasingly peddling injectable drugs. There is a rampant abuse of injectable antibiotics and vitamins, the most unjustifiable practice being the intravenous injection of vitamin C for beautiful skin. As few private practitioners are able to provide adequately sterilized needles, syringes and invasive medical instruments, there is an obvious need for urgent efforts to educate the general population in self and family protection from HIV/AIDS.

There is also the need to provide targeted education to high risk groups on a wider scale than presently realized. There is a limited number of organizations involved in providing such services and these are recent. Due to the intensive nature of the required face-to-face education, human resources and financial limitations, current efforts are mostly small scale but provide excellent opportunities for intra-country experience sharing methodology and programme development. There are also considerable opportunities for the dissemination of information on HIV/AIDS prevention through the wide network of community organizations like the Women's Union, Youth Union and through popular entertainment media. A number of NGOs, most notably SCF-UK and CARE International, have assisted the Government in setting the direction for combatting the problem. In a survey by CARE International on the risk of AIDS in Viet

Nam, it is apparent that behavioural attitudes and practices need to be addressed through public awareness campaigns. Most Vietnamese in the survey say they are not at risk, because they associate the disease with categories of people they do not belong to: foreigners, rich men, poor men, etc.

1.6 Government strategy

Aware of the situation and genuinely concerned about the health of women, the Government of Viet Nam has set as a priority the reduction of maternal mortality. The most important element of the strategy designed to attain this goal will be an effective family planning programme that dissuades couples from having children if they are either too old or too young, and encourages women to space their pregnancies so that each one is separated from the previous one by a sensibly long interval. This inevitably implies an increase in the number of couples using modern contraceptive methods: it is hoped that the proportion of fertile women using them, at present 40%, will have reached between 65% and 70% by the year 2000. Emphasis will also have to be laid on the provision of guidance and education on health care and nutrition to pregnant women, immunization of all women of reproductive age (and especially of pregnant women) against tetanus, adequate pre- and post-natal care for mothers, and the prevention of malnutrition. The government is determined to promote safe approaches to motherhood through communication and education as an important part of this programme. To combat the spread of HIV, the Government has broadened membership of the National AIDs Committee which is now working with the World Health Organisation to develop a Medium Term Plan of Action. The major strategy of that plan is IEC aimed at behavioural change.

2. Child Health

In order to present a clear picture of their health status, children are categorised here into three age groups; neo-nates, infants, and under-fives.

Goal: To reduce infant mortality rate from 46/1,000 live births in 1990 to 30/1,000 live births in the year 2000 and the under-five mortality rate from 81/1,000 live births to 55/1,000 live births; to continue nationwide implementation of the programme on mother and child health care and protection.

2.1 Neonates

Data regarding the health and survival of neonates has not been given much attention in Viet Nam's public health and demographic circles.

It is universally acknowledged that the first 28 days of a child's life is fraught with many dangers, and that this age group is at most risk from diseases and death. A community-based survey of neonatal deaths in three provinces of Vinh Phu (North), Binh Tri Thien (Centre) and Hau Giang (South) in 1989, with 9,149 surveyed infants, indicates a neonatal death rate of 7.6/1,000 live births. With 1,969,072 estimated annual births, this suggests 14,965 neonatal deaths per year. Of these deaths, 40%, or about 6,000, are due to neonatal tetanus alone.

Figure 23 shows trends in neonatal deaths from 1986-1990 as published by the Ministry of Health. This indicates much higher figures than those found by the survey quoted above.

Based on the MOH figures, the situation would be even more serious, as they equal 43,910 deaths in 1986, 43,319 in 1989 and 50,408 deaths in 1991.

Figure 22: Causes of neonatal deaths

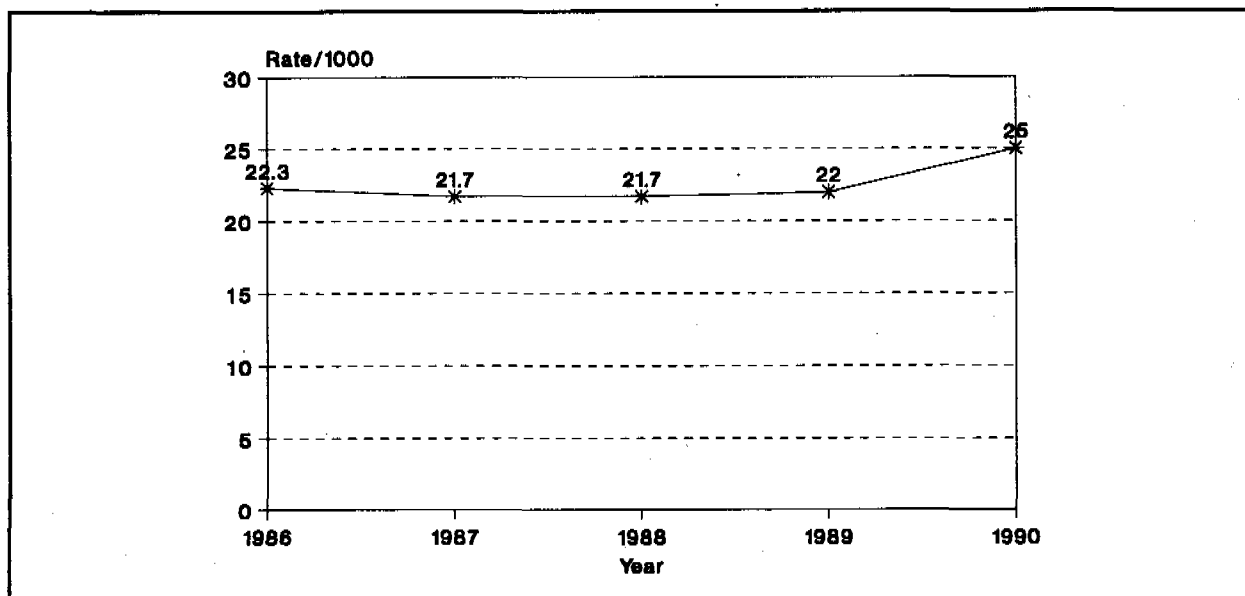
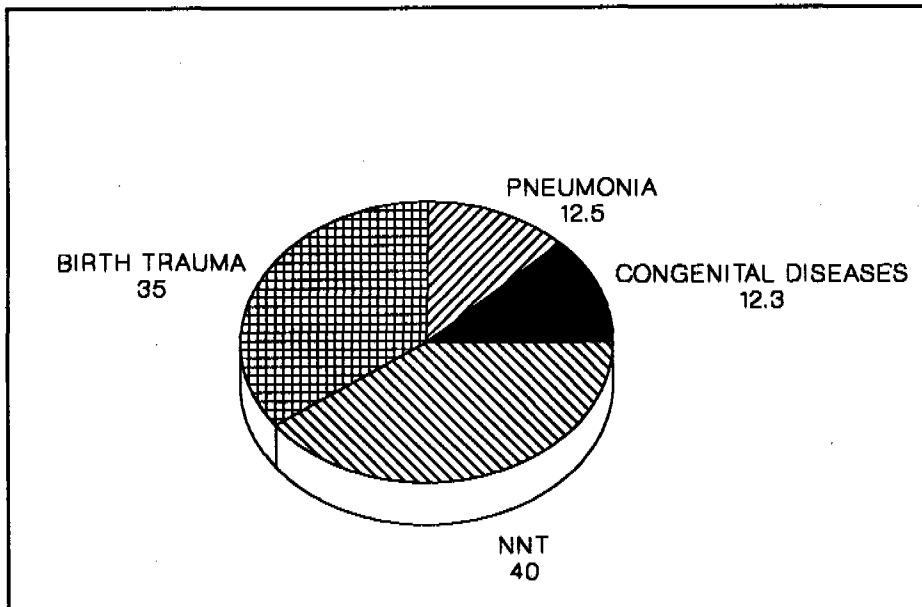


Figure 23: Trend in neonatal mortality, 1986-1990

The difficulty in gathering accurate data is complicated by the practice amongst certain ethnic minority women of delivering at home or alone in the forest for privacy. Infant deaths in these circumstances go unrecorded.

2.2 Infant morbidity and mortality

Information about infants seems to be more readily available than on neonates, although most sources do not agree on the magnitude of health problems and status. Much work remains to be done. Morbidity in infants, as in the general population, is due mainly to malaria, ARI diseases, diarrhoeal diseases, measles, whooping cough, polio, tuberculosis, pertussis, and dengue fever. This list is, however, deductive from the various sources of data that are available. There usually is no disaggregated data to indicate the size of the problem for each disease in infants within the general population statistics.

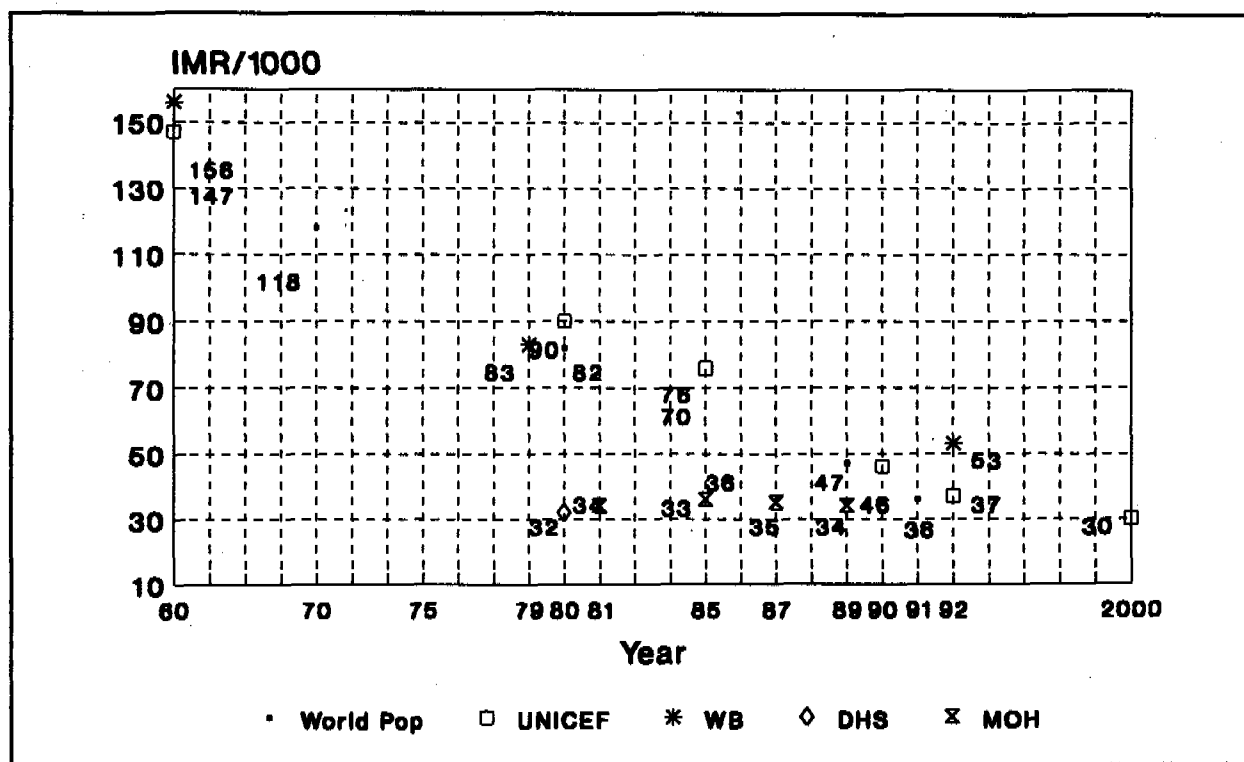


Figure 24: Trend in IMR from different sources, 1960-1992

As for mortality in this age group, considerable gains have been made in the past few years and Viet Nam is now approximating a middle-income country in its infant mortality rate (IMR). Although IMR figures are as varied as their sources, there is general agreement on its decline. The rate probably went from about 100 per 1,000 live births in 1970 to about 50 per 1,000 live births by 1990 (Figure 24). The average quoted rate for IMR is 46/1,000 live births in 1991. As in the case of morbidity, the causes of mortality are deductive and these include malaria, ARI, diarrhoeal diseases, neonatal tetanus, and measles. It is estimated that ARI (33%) and diarrhoea (25%) account for over half of all infant deaths.

2.3 Under-fives

Morbidity in under-fives reflects the same disease conditions listed for infants. These are mainly preventable infectious and parasitic diseases including worm infestations and trachoma. Mortality rate for

this age group has shown a decline similar to that observed in IMR, with an average quoted rate of 81/1,000 live births.

An important consideration in the morbidity and mortality rate for children in Viet Nam is the regional differences. For example, IMR in the Red River Province of Hai Phong (north) was 27/1,000 in 1991 while in the Tay Nguyen province of Gia Lai (central) it was 101/1,000 live births the same year. The national average in 1991 was 46/1,000. Under-five mortality follows this pattern with a figure of 31/1,000 in Hai Phong in 1991 and 148/1,000 in Gia Lai in that same year as compared with a national average of 80/1,000 live births in 1990.

2.4 Underlying causes of mortality and morbidity

Among the underlying causes of morbidity and mortality are:

- Malnutrition (17% low birth weight babies; 42% of under-fives are malnourished; two thirds of pregnant women are anaemic);
- Lack of sanitation (less than 20% of the population has access to sanitary disposal of excreta and less than 30% have access to safe water);
- Lack of basic knowledge and preventive care (TT coverage was only 14% in 1991 and increased to 42% in 1992; little or no antenatal checks; less than 50% communes have trained health workers on proper case management of ARI and CDD; low level of female literacy in areas of high IMR/U5MR; poor personal hygiene; grossly inadequate number of permethrin-coated bed-nets in malaria zones).
- Shortage of essential drugs, medical equipment, incorrect diagnosis, lack of access to health facilities in remote and mountainous area and low wages paid to peripheral health workers.
- Poverty (over one third of households are classified as being below the poverty line).

There are major problems that remain to be solved to reach the NPA targets of reducing IMR and U5MR. These diseases include malaria, which has in recent years made a dramatic resurgence; ARI diseases, especially pneumonia (about 80% in this category), and diarrhoeal diseases.

Malaria has been problematic in Viet Nam for quite a long time. However, with intensification of control activities from the early 1960s to the early 1980s this problem abated. At that time the major intervention for control was DDT spraying. However, when State funding for public health programmes declined along with all State subsidies in the mid-1980s, spraying was stopped. The cessation brought a resurgence of malaria, some strains of which have developed resistance to standard treatments. It should be noted that DDT has been banned in the West as a known carcinogenic substance. Recently, a new drug, artemisinin, has been developed from a shrub that grows in Viet Nam and can be raised industrially. The drug has proved effective especially against the chloroquine-resistant strains, and it is also in use in China.

ARI diseases, especially pneumonia, are the largest killers of children in Viet Nam. Activities to control these diseases started in 1983 with UNICEF support. Although the ARI programme has progressed to all 53 provinces, coverage extends to an estimated 3.7 million under-five children, or 40% of the total. Figure 25 shows the progress of the ARI project from 1986 to 1992.

Figure 25: Progress of the ARI programme expansion

YEAR	No. of provinces	No. of districts	No. of communes	Children under-five (x1,000)
1986	9	11	20	16
1987	13	13	36	26
1988	16	40	165	120
1989	23	80	569	455
1990	37	168	1,800	1,662
1991	40	250	3,395	3,039
1992	53	305 ^{a)}	4,140 ^{a)}	3,700

a) Viet Nam is made up of 550 districts and 10,000 communes in total.

2.5 Child care practices

Child care and nutrition practices have major implications for the health of children. In 1989-91 the Ministry of Education conducted a survey among parents and teachers in eight provinces on beliefs and practices relating to child care. The baby's main care-giver was the mother, (according to 95% of respondents), and the child's main educator was the mother, (85% respondents). Mothers tended to return to work, usually for very long hours when babies reach 3-6 months. In the countryside this is even earlier. Infants are left in the care of grandmothers or older children at this time. Oral evidence suggests that because of the generational gaps, grandmothers may not be the best caretakers of young children, as some of the practices they are familiar with may have become outdated and harmful. As the infants reach the age of 6-9 months, they may be sent to creches, although this practice has declined since the introduction of tuition fees. From there, they move on to kindergarten and eventually at six years of age they move up to primary schools.

Since mothers are the primary providers of child care and education, the education of women is a critical factor in the health status and development of children. This same study found a number of health and child care behavioural practices which have indicated the need for more education in health and child care. In order to achieve the best possible care for women and children, women must have correct and appropriate knowledge, skills and support. Even for those women who are properly educated in health and child care, the great constraint on them is time. Additional work burdens in and out of the home may prevent women from providing proper care. State policy encourages active female participation in the productive sector, and due to poverty many women are involved in the workforce. Women are involved on a number of levels revolving around her primary occupation, household and child care duties and other sideline income-generating activities. A small-scale study on women's time allocation notes that women work up to 17 hours a day, adding to their strain.

2.6 Health care-seeking behaviour

A survey of health-seeking behaviour undertaken by the Hanoi Medical School in Bac Thai province provided valuable information on treatments sought by mothers when their children are sick. The survey indicated, for example, that 47% of mothers fed their children normally during diarrhoea and 47% fed them less. Forty-eight per cent of mothers gave their infants normal quantities of liquid, while about 50% gave more liquid. Only 15% of mothers breastfed less during episodes of diarrhoea. Treatment of diarrhoea with antibiotics was found to be 33% and other anti-diarrhoeal drugs 26%. Only 5% of respondents used ORS or homemade solutions.

Mothers' knowledge and practice related to ARI were studied in a small-scale survey in 1992 by the ARI programme of the Ministry of Health. The results show that: 87% of mothers studied considered pneumonia dangerous, but only 53% knew the signs of the disease; 78% did not know when to bring a child to a health facility - an important cause in the delay of seeking care and a contribution to case fatality of ARI diseases; 53% of children received treatment from mothers and not health personnel; private health care providers were seen more often than public ones when care was sought; antibiotics were the most common means of treatment, but of those cases treated only 22% received the correct antibiotics (18% by health workers and 4% by mothers), and only 26% of these 22% were given correct treatment in dosage and duration. The practices relating to nutrition and breastfeeding are dealt with in the chapter on nutrition. The 1992 Health-Seeking Behaviour survey by the Hanoi School of Medicine in Bac Thai indicates that the first action taken in case of illness is self-medication with Western drugs and the next is traditional medicine. The primary medication purchased by mothers in the study was antibiotics, generally without instruction by trained health workers. These facts reinforce the need for more training for women.

"A very bad state of affairs since ill health visited our family"

Nguyen Van Phuong was at home after a spell away from the village panning for gold. The family is in debt having had to borrow cash over the last two years. The family's present misfortune is a result of ill-health. They have spent 2 million dong over the past two years on medical expenses, for his 6-year-old son (who subsequently died of tapeworm in 1991) and his wife who has suffered from hemophilia for the past three years. They have had to sell their furniture and livestock to cover expenses. The family has experienced a steady decline in their capital. They felt that if they had had some capital they would not have had to sell valuable livestock impoverishing the family further.

3. Government Strategy

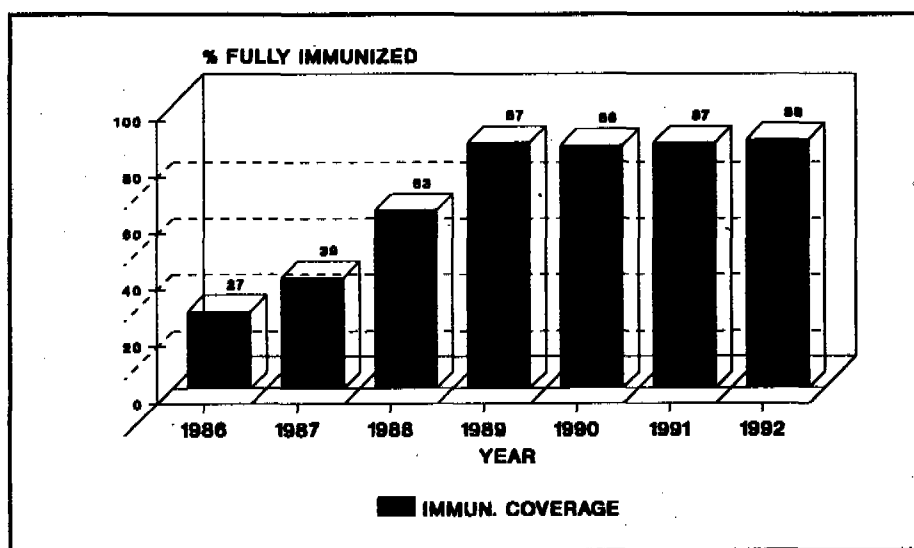
Taking into account the present situation of Vietnamese children, the progress that ongoing programmes on their care and protection have already made, and the fact that the needs of the young generation are likely to change in response to changes in the overall situation in Viet Nam, the Council of Ministers launched the "Programme of Action for the Survival, Protection and Development of Children in Viet

Nam". This plan will cover the period up to the year 2000. The five priority goals in primary health care to be achieved by the end of the century are discussed below.

Goal One: Reaching and maintaining UCI at 85%

From a coverage of about 25% in 1984, Viet Nam first reached UCI in 1989 with a national coverage of 87%. From then, on the EPI programme has ensured that the coverage level has not fallen below the 86% mark for fully immunized children. Figure 26 shows immunization coverage by year. Figure 27 shows EPI coverage by geographical regions of the country. There is every indication that this mark of 85% will be maintained and perhaps even consistently surpassed.

To monitor the maintenance of UCI, the 53 provinces are divided into three categories, A, B, C, with allotted coverage targets to meet. The 19 category-A provinces are judged to have a good network of health infrastructure and personnel, and access is relatively easier in these provinces: category-A provinces have a minimum coverage target by 90%. The 16 category-B provinces are allotted a coverage of 80% fully immunized, because the health network and access are not as extensive as those in category-A. The 18 category-C provinces are those where access are most difficult, and are located mostly in the northern mountain, central highland, and southern delta regions. This last category has to meet a minimum coverage of 70%. In 1993, the emphasis was shifted from provincial to district level monitoring in a bid to further improve coverage by stimulating healthy competition among the 557 districts.



One crucial area to Viet Nam's sustenance of UCI is vaccine self-sufficiency. The position for each antigen is described below.

BCG: At the Dalat/Nha Trang Vaccine Institute and Ho Chi Minh City Pasteur Institute, production for 1993 is projected at five million doses, fully satisfying national requirements.

Figure 26: National immunization coverage, 1986-1992 (% of under-one children fully immunized)
Source: MOH/UCI Programme Secretariat

DPT: DPT production in Dalat/Nha Trang is estimated at 3.0 million doses for 1993, or 25% of requirements. To scale up production, UNICEF has ordered equipment and is also supporting the necessary managerial requirements aiming at self-sufficiency by 1998.

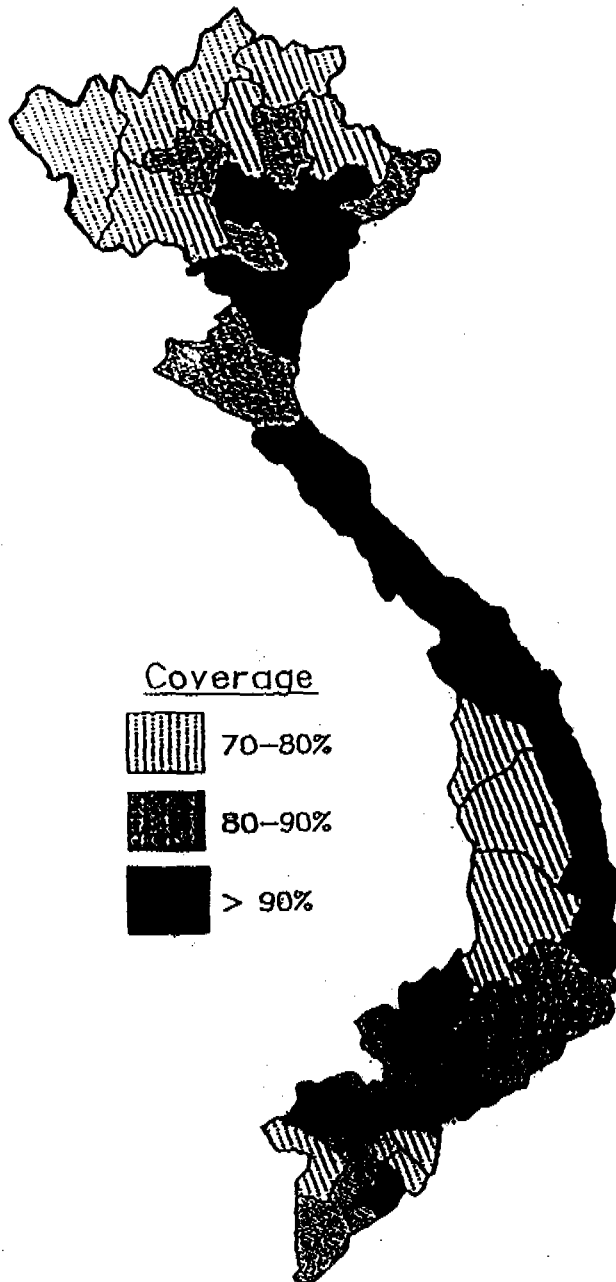


Figure 27: National immunization coverage by geographical regions

OPV: Viet Nam was one of the first few countries to begin the production of oral polio vaccine (OPV) in the early 1960s using seeds obtained from the defunct USSR. The plant in the National Institute of Hygiene and Epidemiology (NIHE) in Hanoi has however not kept up with advances in the field, and due to a decline in quality has been unable to supply OPV to the national programme for two years running. WHO has plans to sponsor a mission to Viet Nam to identify the problem, proffer solutions, and canvass for financial and technical support from donors.

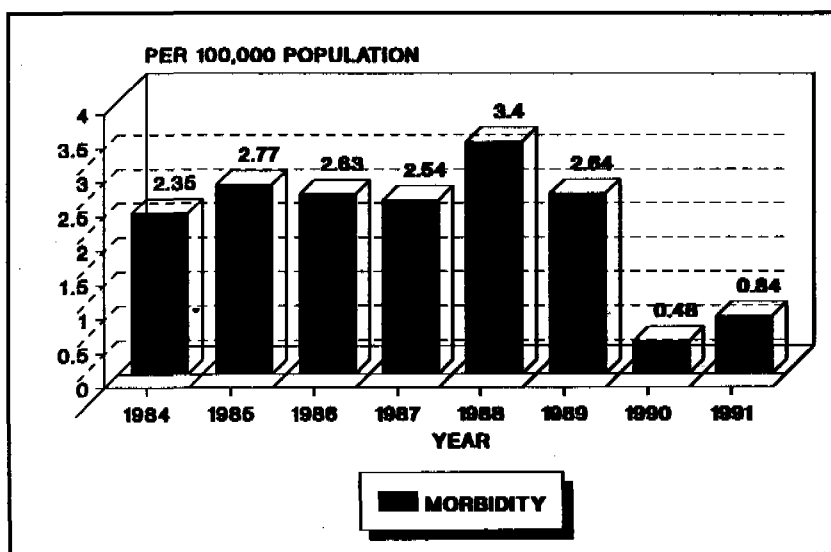
If international assistance is received promptly, NIHE could produce 20.0 million doses, or 55% of national requirements by 1997/98, and could make Viet Nam self sufficient in 3-5 years. The Government itself has considerably increased its financial allocation from VND2 billion to VND8 billion (US\$200,000 to US\$800,000) in 1992 and 1993 respectively.

Measles: Viet Nam has not begun the production of its own measles vaccine. Efforts have been concentrated on bacterial vaccine products and more recently on polio as described above.

TT: The plant in Dalat/Nha Trang is expected to produce 2.0 million doses in 1993, 34% of national requirements for the year. Here again, UNICEF is assisting with material supply and manpower development to increase production. As with DPT, self-sufficiency could be reached by 1998.

Goal Two: Polio eradication

When the EPI acceleration started in Viet Nam in 1984 the incidence of polio was estimated at 1.97/100,000. This rose to 2.68 the following year, probably due to the improved reporting that came with improved awareness. It has gradually declined to 0.86/100,000 in 1991. Although this is still short of the eradication goal, the Government realises the importance of this goal. A lack of vaccines has prevented accelerated immunization.



The major strategy for polio eradication is a series of National Immunization Days (NID) of two rounds spaced one month apart. All children under five years of age, irrespective of their current immunization status will be given two doses of OPV. Also, surveillance activities have been intensified with a strong push for reporting all suspected polio cases.

More recently, additional supplies of polio vaccines have been identified and two rounds of NID have been fixed for the winter of 1993.

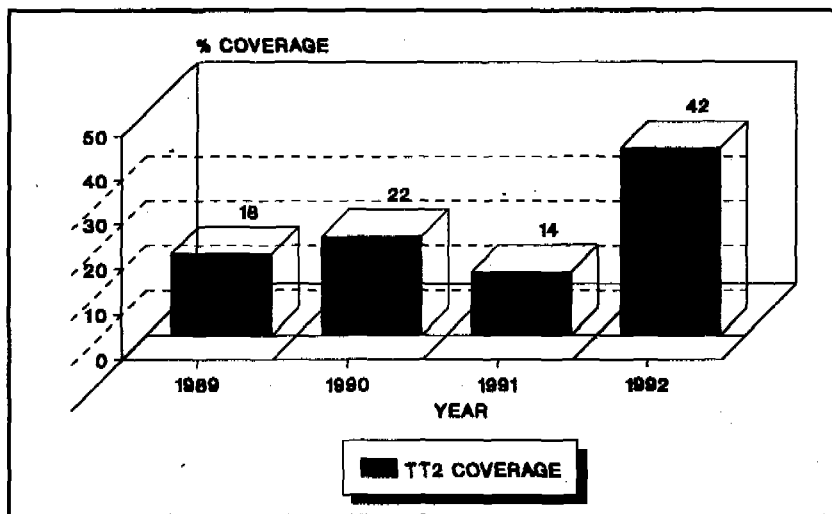
Figure 28: Neonatal tetanus incidence, 1984-1991 (per 100,000 population)

Source: MOH/UCI Programme Secretariat

These NID targets are planned for every year until the 1995-1996 winter when the last rounds are expected to usher in a polio-free Viet Nam. Thereafter, NID will continue for another two to three years on the same scale by which time eradication will have been maintained for about three years.

There are several major constraints for polio eradication. The lack of vaccine assurance for NID in the coming years; the cross-border traffic, especially from Cambodia, where immunization coverage is very low, into Viet Nam's Mekong Delta Provinces and transmissions from Laos into the central provinces.

Goal Three: Neonatal tetanus elimination



On commencement of the EPI acceleration in Viet Nam in 1984, the incidence of NNT was estimated at 2.35/100,000. This rate peaked in 1988 to 3.4, probably due to better reporting and the expansion of the programme. In 1991, NNT incidence was estimated to be down to 0.84/100,000. Figure 28 shows the annual incidence of the disease from 1984 to 1991. Figure 29 shows the annual coverage of TT in pregnant women. Tetanus toxoid was not integrated into EPI until 1992.

Figure 29: Tetanus immunization, 1989-1992 (percentage of pregnant women immunized with TT2)
Source: MOH/UCI Programme Secretariat

The goal of neonatal tetanus elimination was embraced by Viet Nam in the summer of 1992 following negotiations between UNICEF, WHO and the Government. Since that agreement things have moved fairly quickly with the development of a plan of action for NNT elimination. This calls for two interventions: immunisation of all pregnant women throughout the country, and the establishment of clean delivery practices.

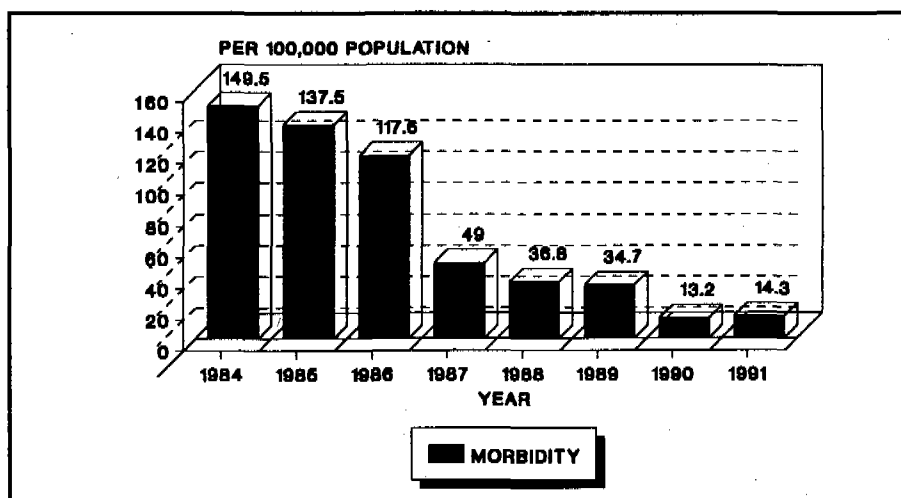
Health and Nutrition

The uplands and highlands have a very poor nutritional status. There are severe food shortages prior to the harvest. Linked to this is the morbidity related to vitamin A deficiency, iron deficiency, anaemia, endemic goitre and malaria. All of these and the very poor access to safe drinking water means that water-borne diseases are a major problem.

In addition, the strategy calls for the immunization of all women of child-bearing age in 142 high-risk districts, beginning with two doses of TT for women in 57 districts during National Immunization Days in 1993, and expanding to other districts for completion by 1995.

The primary difficulties in eliminating NNT are: the lack of access to good maternal health care during pregnancy and delivery in many communes; the difficulty in arousing enthusiastic support among over-extended health workers for a programme that requires a more complicated delivery system; the extra supply and logistics demand of the antigen (syringes, needles, sterilisers, etc), as opposed to the ease of implementing the polio eradication programme.

Goal Four: Reduction of measles morbidity by 90% and mortality by 95%



Upon commencement of EPI acceleration in 1984, measles incidence was estimated at 149.5/100,000. This had gradually declined by 1991 to 14.3, 9.6% of the 1984 rates. While this can be interpreted to mean Viet Nam has reached its mid-decade goal, sporadic outbreaks of measles are still reported in parts of the country. The incidence of measles is shown in Figure 30.

Figure 30: Measles morbidity, 1984-1991 (per 100,000 population)

Source: MOH/UCI Programme Secretariat

Very recently, the National EPI Secretariat has brought this goal to the forefront of its programme again. During NID in 1993, 3,200 communes in especially difficult terrain will benefit from measles immunization in addition to OPV which will be given nationally. In these communes, children 9-23 months will receive measles vaccines.

There are no major obstacles in the way of attaining this goal by 1995, if the current plan continues to be vigorously pursued.

Goal Five: 85% of all diarrhoea episodes to receive oral rehydration therapy plus continued feeding

Viet Nam's CDD programme began in 1983; by the end of 1992 it was reported to cover 80% of all communes, with health workers in 52.1% of all communal health centres trained to manage the programme and advise.

The National CDD programme plans to train staff in all commune health centres in both case management and Inter-Personal Communication (IPC) skills. Currently, all 53 provinces have CDD projects. There are also plans to train private practitioners including physicians and pharmacists. Already, the CDD secretariat is working with educational authorities in selected provinces to introduce CDD skills into the curriculum for the training of primary school trainee teachers. The major obstacle in the achievement of this goal remains the lack of financing.

Chapter VI

NUTRITIONAL STATUS OF MOTHERS AND CHILDREN

Following its commitment to the World Summit for Children, the Government of Viet Nam formulated a National Programme of Action (NPA) which sets nutritional improvement as one of its major goals and provides a framework for achieving these goals. The CPCC has been designated by the Government as the overall body responsible for overseeing the country's programme for child nutrition. At present, there are special committees which have been formed for inter-sectoral planning and management of the control of iodine deficiency disorders (IDD), vitamin A deficiency control, promotion and protection of breastfeeding, and, anaemia control. In addition, there is also an inter-agency committee headed by the State Planning Committee which is responsible for food and nutrition surveillance. As a follow-through of the World Declaration and Plan of Action, the Government with the assistance of FAO and WHO and the cooperation of UNICEF and other UN agencies, is formulating a National Plan of Action for Nutrition which will articulate the specific strategies and projects to achieve the goals set in the NPA.

Goal : To reduce the prevalence of malnutrition among children under five years old from 41.8% in 1990 to 35% in 1995 and to 30% by the year 2000; severe malnutrition to be eradicated by the year 2000.

1. The Nutrition Problem of Women and Children

1.1 Protein-energy malnutrition (PEM)

In spite of the noted successes of the country in significantly improving life expectancy and in decreasing infant and young child mortality, Viet Nam still experiences suffers from high prevalence of protein-energy malnutrition. The most recent available data estimate the prevalence of underweight-for-age children aged under five years at 42%; the underheight-for-age at 49% and the underweight-for-height at 12%. Although data available are not conclusive, there are indications that the situation is not improving based on reports from the food and nutrition surveillance system in the provinces which are more nutritionally at-risk to food shortages due to their susceptibility to natural disasters.

Infants and young children are most severely affected by PEM, because of their relatively high energy requirements and their particular vulnerability to infection. Data from the National Nutrition Survey conducted by the National Institute of Nutrition from 1987 to 1989 suggests that malnutrition in Vietnamese children begins in the first year of life, and increases through the second and third years, with a tendency for boys to be more frequently underweight than girls. The percentage of children of both sexes suffering from malnutrition is nearly twice as high between ages one and three than it is for infants less than one year old. This trend can be observed in both urban and rural areas (Figure 31).

Stunting seen among children over four years old is a result of growth failure when children were two to three years old. Data available indicate that more children suffer from stunting in the rural areas than in the urban areas. This can perhaps be attributed to the combination of low dietary intake, poor child-care practices, limited access to basic health services and poor environmental sanitation conditions.

A strong seasonal pattern exists in malnutrition in the rural areas where a substantial number of children with severe malnutrition are hospitalized in May and in October when the old crop has been consumed, but the new crop not yet harvested. These are the periods when there is insufficient dietary intake and there is a high incidence of infectious diseases, frequently acting together.

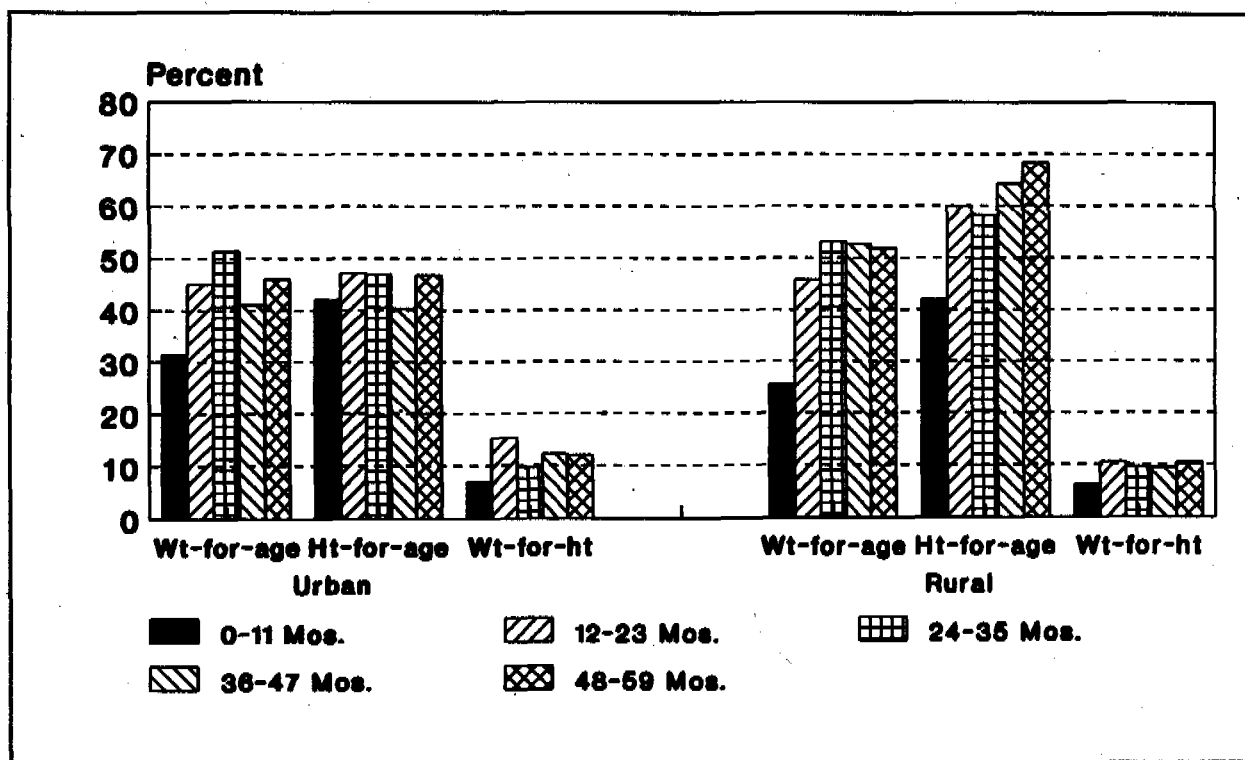


Figure 31: Malnutrition among <5 years by age group, urban and rural (% <2 SD NCHS reference standard). Source: Report on Re-entry and Analysis of General Nutrition Survey, Ministry of Health, 1991.

There are large regional differences in the prevalence malnutrition among children. The Red River delta, the central coast of the north land, the central coast of south land, and the central highlands are most seriously affected. While it was expected that the mountainous areas would have higher percentages of malnourished children, the results of the National Nutrition Survey from 1987 to 1989 found that 44% of urban children, 47% of rural children, and only 37% of children in mountainous regions were severely underweight for age. In addition, 45% of urban children, 59% of rural children, and only 49% of children in mountainous regions were underheight for their age. Recognising that data from the mountainous regions were not representative, a follow-up survey in 5 provinces (Bac Thao, Yen Bai, Tuyen Quang, Son La and Cao Bang) were carried out. In a total of 5,149 under-five children, 54.7% were found to be underweight (less than minus 2SD) for age. These findings have not yet been satisfactorily explained, but may be due to sampling bias. Areas surveyed in mountainous regions were near roads and population centers where there was easy access to food and services.

1.2 Low-birth weight

Low-birth weight (less than 2.5 kg) is an outcome of intrauterine malnutrition. Low-birth weight infants have a higher risk of growth retardation, morbidity and mortality than do other infants. Data available from hospital births estimated the proportion of low-birth weights to be 20% in 1980 and 17% in 1989. Birth reports between 1990 and 1992 showed figures of 12% and 14%, respectively. If the proportion of low-birth weights has indeed increased in the recent years as data available suggest, it indicates a serious decline in the health and nutritional status of women during pregnancy. A report of the MOH showed regional variations in the proportion of low-birth weights with the central coast of north land having an extremely high rate of 23% while the north mountain and midland as well as the central highlands had 12 and 14%, respectively. Other regions reported lower rates.

1.3 Vitamin A deficiency

Vitamin A deficiency can lead to impaired immune function, an increased risk of mortality by 30% and blindness. Approximately 6,000 children aged 6-59 months are at the risk of going blind each year in Viet Nam. A study carried out in 1985-1988 covering 21 provinces and involving 34,214 children showed the prevalence of active corneal lesions attributable to vitamin A deficiency to be 0.07%. Such eye lesions only occur after body stores of vitamin A have been depleted, and high rates of these lesions suggest that a much higher proportion of children are at risk of milder levels of vitamin A deficiency.

The prevalence of more severe ocular lesions such as corneal xerosis and keratomalacia, as well as corneal scars, are higher than the WHO criterion for determining that vitamin A deficiency is a public health problem. The prevalence of corneal scars attributed to vitamin A deficiency is 0.12%, 2.4 times higher than the public health significance level of 0.05%. In addition, reports on the conduct of this survey noted that the prevalence may be underestimated since the survey may not have covered the poorest communes.

1.4 Iodine deficiency disorders (IDD)

Iodine deficiency jeopardizes the physical and mental development as well as the health of children. Severe iodine deficiency may result in foetal death or severe physical and mental growth retardation - a condition known as cretinism. Moderate and mild iodine deficiency result in goitre and impaired brain function with IQ losses of 10 - 20%. Moderate and mild iodine deficiency results in goiter and impaired brain function with IQ losses of 10 - 20%. Grouped together, goitre, cretinism and delayed physical and mental development due to iodine deficiency are known as iodine deficiency disorders (IDD).

In 1993 a nationwide study conducted under the authority of the Ministry of Health on a total of 3,062 children aged 8 to 12 from 30 randomly selected schools in different provinces all over the country showed that 94% of the Vietnamese population suffer from IDD; severe IDD was found in 16% of the sampled clusters, moderate in 45% and mild in 23%. Only 6% of the regions are free from IDD (Figure 32). Iodine intake was found sufficient only in schools at the coastal area and in Hanoi while most areas suffering from severe iodine deficiency are located in the mountainous and midland regions. The iodine excretion did not differ significantly between schools in the highlands and lowlands.

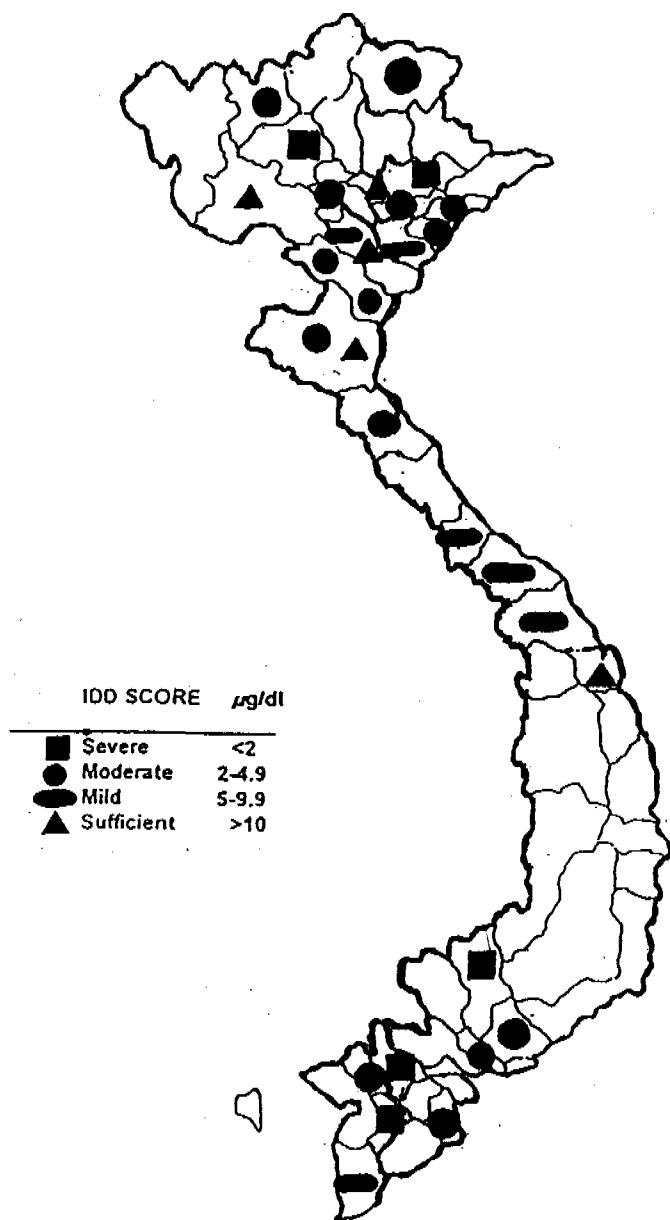


Figure 32: Prevalence of IDD in Viet Nam, 1993 (based on Urinary Iodine Excretion)

1.5 Iron deficiency anemia

Fifty per cent of all iron deficiency anaemia occurs among pregnant women and preschool children. Iron deficiency anaemia reduces work capacity and adversely affects productivity, earnings and the ability to care for home and children. Severe anaemia has been partially associated with 50% - and wholly blamed for up to 20% of all maternal deaths. In addition to serious health implications for the mother, maternal anaemia also retards foetal growth, causes low-birth weight, and increases infant mortality. In infancy and childhood, iron deficiency is known to weaken cognitive abilities severely while impairing the body's ability to combat disease.

Anaemia linked to iron deficiency is a major problem in Viet Nam. It is found to affect about 40-50% of pregnant women in the major cities of Hanoi and Hai Phong and in the provinces of Ha Tay and Nam Ha (Figure 33). Maternal anaemia, especially when due to malaria or iron deficiency, increases the risk of complications of pregnancy and can threaten the life of the mother. Surveys of young children conducted by the NIN and IPMN in the northern parts of the country showed anaemia prevalence of about 35%, when haemoglobin was compared with WHO standards. Both studies showed the mountain areas to be worst-affected.

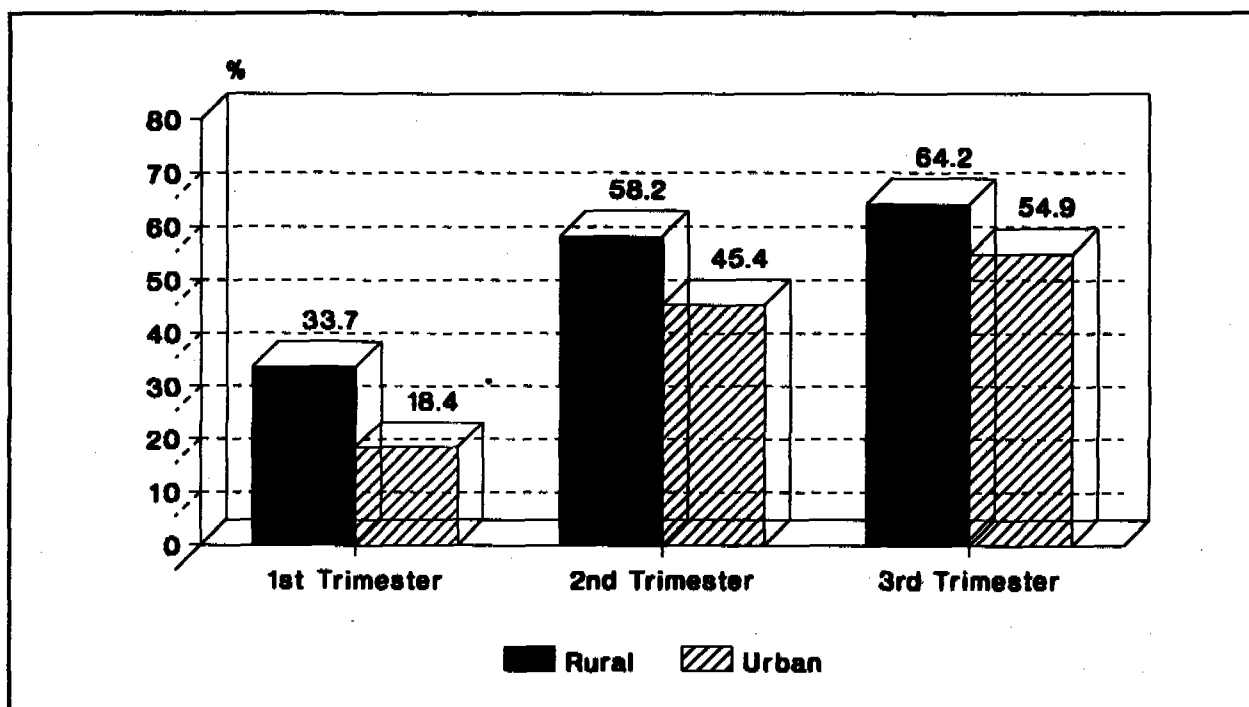


Figure 33: Prevalence of anaemia in pregnant women, Thanh Hoa province, 1991
Source: National Institute of Nutrition

2. Immediate Causes of Malnutrition

2.1 Dietary intake

The Vietnamese diet is principally rice-based and some vegetables added. Foods rich in carbohydrates contribute between 71 and 83% of the total energy intake of adults and between 62 and 83% of energy intake in children under five in different eco-regions. Consumption of milk and milk products is minimal even among young children. Fat consumption is also low, averaging less than half of the 18% of total energy intake recommended. The predominance of rice is of particular concern in the case of young children and pregnant and lactating women, because the caloric density of rice is low, and these individuals may not be able to consume enough energy and other nutrients to meet their special needs.

The combination of low overall calorie intake and little variety in the diet creates a fragile nutritional balance for the most vulnerable groups.

The average dietary intake for children under 5 ranges from 727 to 944 kcal./day and from 1,861 to 2,107 kcal for adults which are short of the recommended allowances by about 40% and 13%, respectively. Protein intake ranges from 50.6g to 60.9g. There are substantial differences between regions but it was only in the mountain and midland areas as well as in the central highland where the average energy intake was found to be more than 2,000 kcal./day. These same regions also showed relatively lower prevalence of malnutrition. The vitamin and iron intakes in all the regions were found to be below the recommended levels.

Figure 34: Mean calorie intake of children and adults, by region

Region	Energy (kcal)		Protein	Vit.A (gm.)	Iron (mg.)	Iron (mg.)
	Children <5 Years	Adults				
North mountain & midland	727	2107		58.1	0.01	10.3
Red river delta	806	1878		50.6	0.01	9.6
Central coast of northern land	792	1880		55.2	0.01	9.8
Central coast of southern land	874	1861		58.4	0.04	8.8
Central highland	--	2059		66.9	0.01	9.0
Northeast of south land	817	1924		63.8	0.03	9.6
Mekong river delta	818	1891		57.3	0.02	8.9
Major cities	944	1886		61.9	0.13	10.1
Total		1928		57.6	0.03	9.5

Source: *Report on Re-entry and Analysis of General Nutrition Survey, 1987-1989, Ministry of Health*

While the mean value for adult intake seems high, there are between 12%-35% of families with adults consuming less than 1,800 kcal/day which is the cut-off point for inadequacy. Those consuming less than 1,500 kcal, the cut-off point for starvation, were found to be 9%.

2.2 Diseases

Diarrhoea, by affecting body losses and the body's ability to retain and absorb nutrients, is a major and persistent cause of malnutrition and childhood deaths. Sick children shun food, while fever and infection consume their meager reserves. As discussed in the previous chapter, malaria, diarrhoea and respiratory infections are the leading causes of morbidity in the country, the last two contributing to the high prevalence of PEM in a synergistic manner. Watery diarrhoea is particularly common. Measles also contributes to PEM.

Intestinal helminthic infections also contribute to PEM in general and anaemia in particular. The high levels of hookworm are of special concern given the prevalence of anaemia. Blood loss due to hookworm is likely to contribute to the high rates of anemia in women and children. In the northern region of Viet Nam, 94% of children examined tested positive for ascaris, 69% for hookworm, and 86% for trichuris. In the central regions, 85% of the children examined had ascaris, 36% had hookworm, and 45% had trichuris. The rates were much lower in the south. Children with these three parasites gain up to 50% more weight than a control group after being treated for the infestation, and also perform better in school thereafter.

3. Underlying Causes of Malnutrition

3.1 Household food insecurity

Household food security is defined as "access to food, adequate in quantity and quality, to fulfill all nutritional requirements for all household members throughout the year".

In Viet Nam, per capita food production has been increasing since the mid-1970s. Rice production in particular has increased, mainly as a result of increased area cultivated. Food balance sheets show an availability of energy of more than 2,250 kcal/capita/day which is higher than the recommended level. This indicates that undernutrition in Viet Nam is not a problem of inadequate food production, but instead of availability, distribution and demand. The poor system of food procurement, transportation, storage and distribution combined with the existence of major agricultural activity differences across regions, has meant that the population in some parts of the country continues to be prone to chronic undernutrition.

Energy availability distribution varies widely from one region to another. According to the World Bank, four regions (Northern mountains and midlands, Central Highlands, North-Central and South-Central Coastal) experienced serious rice deficits from 1988 to 1991. Some of them benefited from transfers of grains from surplus areas, but inefficient distribution in others has resulted in severe food shortages so that 34% of the households in the north central provinces and 20% in the south central provinces are estimated to consume less than 1,800 kcal per person per day. Provinces in the Central region are certainly where the food situation requires urgent intervention.

There are also seasonal variations in food consumption. Just before the rice harvest, calorie intake decreases by up to 15%. Given the very low normal intakes, even a slight decrease can lead to starvation, as happened during the bad harvest year of 1987. An additional factor causing temporary food shortages is the weather: the central provinces, particularly, often suffer from floods and typhoons which destroy harvests and food stores. It is not surprising, therefore, to see a similar seasonal pattern in incidence of diseases such as diarrhoea and ARI which are usually associated with malnutrition.

The VAC ecosystem through which households and communities are encouraged to establish vegetable gardens, aqua culture, and small animal husbandry, is an interesting way to improve household food security. In some communities, it is estimated that as much as one-half to three-quarters of total household income is generated from VAC activities. Use of the VAC system is encouraged by VACVINA, the Viet Nam Horticulturists Association, and has been shown to increase the quality of the diet as well as overall food availability at the household level.

3.2 Health services and environmental sanitation

With the synergistic relationship of malnutrition and disease, particularly infection, access to and adequate delivery of basic health services to children and mothers is necessary for good nutrition. Routine health care such as check-ups and referrals, treatment of diarrhoea, deworming, and immunization of children under 5 and of women of child-bearing age have a definite impact on the nutritional status.

Viet Nam has built up a delivery system that reaches a large portion of the population. The decline in IMR/CMR is most likely a result of this and other factors such as high female literacy, high mean age of marriage, 3 to 5 year spacing of births and pregnancies during the low risk age group. As mentioned in the health chapter, the health system has become too expensive for the central government during the last few years. This has resulted in a lack of essential drugs and equipment, low salaries for health workers, resulting in low morale among the health workers and a decrease in the utilization of health services. Nonetheless, health services still continue to be delivered. Activities undertaken through the health delivery system include growth monitoring, vitamin A deficiency and anaemia control through capsule distribution and nutrition education, iodized oil intervention in severe IDD-endemic areas.

About 28% of all households have access to clean water and only 18% use adequate sanitary facilities. This limited access would explain the high prevalence of diarrhoea affecting the nutritional status of the child.

3.3 Care of women and children

Breastfeeding is common but the child is usually not put to breast until 2-3 days after delivery. Moreover, colostrum, which is rich in immunological components, is often not given. Breastfeeding frequently does not start until the regular milk begins to flow. This is true for both urban and rural areas. Colostrum, which is especially rich in antibodies and other immunological factors, is usually discarded. There is a common misconception that mothers do not have enough milk right after delivery and that colostrum is bad for the newborns.

Another factor of infant malnutrition stems from improper infant feeding. Available data suggests that exclusive breastfeeding is low and declining (Figure 35). Other foods aside from breastmilk are prematurely introduced to infants, even as early as during the first month. This food often consists of

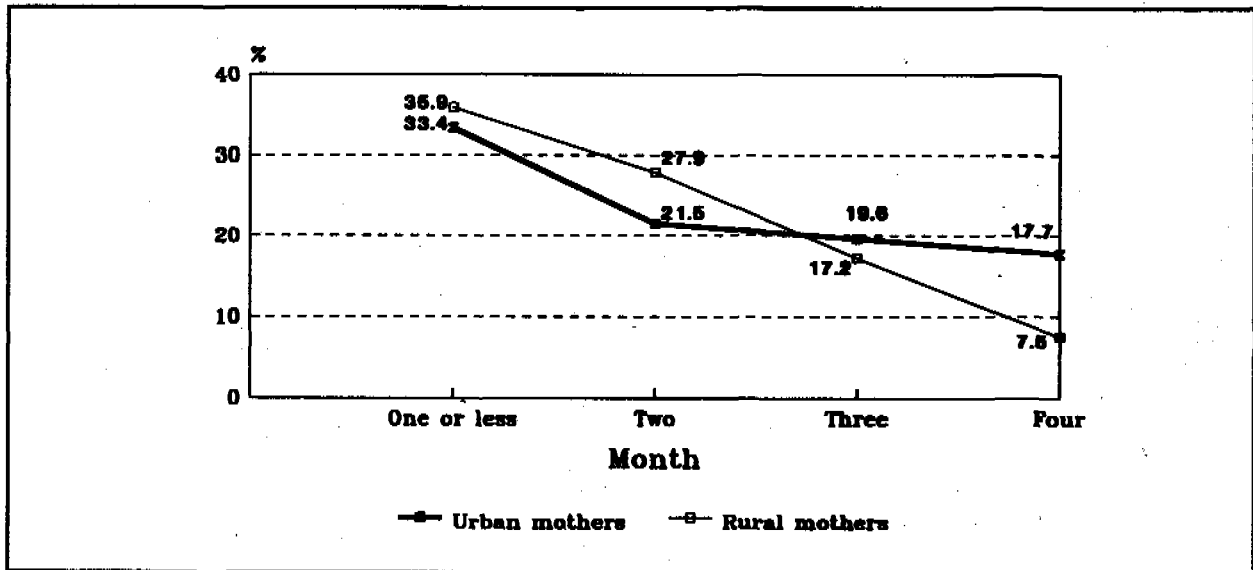


Figure 35: Exclusive breastfeeding (per cent) by months

Source: Current Breastfeeding Situation and Weaning Practices in Some Rural and Urban Areas, *NIN*, 1992.

diluted sugar or rice water or gruel fed during adult meals. The situation is further aggravated by combining breastfeeding with bottlefeeding of diluted condensed milk which is inadequate in nutrients necessary for infant growth. It also introduces sources of infection and decreases opportunity for the infant to stimulate continuous milk production. The prospects for improved breastfeeding practices will be enhanced by the introduction of legislation to restrict the sale of breastmilk substitutes and the educational impact on mothers in provincial and district hospitals being established by the Government as Baby Friendly.

At the household level, intra-family food distribution is a critical factor that often causes malnutrition. Infants and younger children who need to be fed more frequently, since they have smaller stomachs, are only fed as frequently as adults. In poor areas of the country, it is not uncommon that a family will just have two meals in a day. These two meals are insufficient for infants and small children. In addition, since most mothers have to work, child care is frequently passed to older siblings or the elderly, who generally do not take the time to prepare extra meals.

In addition to the inadequate amounts of food, the food given to the infant and growing child is often lacking in a concentrated source of energy. In the lowland areas, the two meals a day may consist of a breakfast of rice noodles and dinner of rice and vegetables. In the mountain areas, the meals may be boiled cassava or sweet potatoes at either time of day especially during the lean rice season. This food pattern is followed by all members of the family regardless of age. These foods do not provide a concentrated enough source of energy for infants and children to consume enough calories and other nutrients.

Two other aspects of child care which are of importance are discussed in the Health chapter. These are: the declining utilization of basic health services and the hygiene of feeding and caring practices for the children.

4. Resources

The fulfillment of the three necessary conditions to improved nutrition - appropriate food, access to basic health services and a healthy environment together with consistent care at home - require human, economic and organizational resources. The way resources controlled by the households are being used depends a lot on the educational level of the parents. Primary education is widespread and literacy rates are high in Viet Nam. Literacy however does not necessarily mean that people would have acquired the necessary skills to control resources at household level. This depends both on the content of education, the style of teaching used, and a supportive environment at the family level.

As indicated earlier, Viet Nam has basically a strong human resources base. Communities are well organized and this provides an important resource for development efforts including nutrition interventions. The existing PHC delivery system and the primary school system provide other organizational opportunities for programme implementation. Economic resources, however, are poor. A very large proportion of households live in poverty and the income of many has been declining. Obviously, the many years of war have influenced the overall resource base. However, an important resource consideration in the country is the position of women in communities.

Truong Van Chien, Van Puon, Chieng Mai District — Finding enough to eat.

Chien is a 27-year-old mother of five. Her home had bamboo floors and walls and was in a poor state. The children were dirty and one appeared to be malnourished. Her eldest is a boy of 9 and was very small, (stunted) looking more like a 4-year-old.

The family farms 700 sq.m. of allocated paddy; this provides enough food for about 3-4 months. They also have 2 hectares of upland, on which they grow upland rice, cassava and maize which gives them enough for 4-5 months. They grow a little cotton in order to make mattresses for the home. She also has 3 chickens and a small fishpond, which help supplement their diet. The family's only income is from the sale of excess cassava and maize. This brings in about 500,000 dong/pa. They also make small sums from the sale of firewood.

There is a food deficit for 2 months each year. She borrows 200 kg paddy rice at 50% interest for the season, but with a total rice yield of only 500/600 kgs, the family is left with only 200/300 kgs after harvest. No interest is charged on small rice loans from relatives in the village.

Chien borrows cash, from outside the village, at 15% interest per month to buy the paddy rice which she owes, but it is becoming increasingly difficult to borrow as she has no collateral. These cash loans which she takes in small amounts are then paid back out of the cassava and maize sales. There is nothing left to spend on medicine, clothes and provisions. Neither her own parents or her parents in law are in any position to help them out, other than as an extra pair of hands at harvest time. She felt that pig raising may help her situation since the sale of the pig would add to the family income. At the moment none of the children go to school but she hopes that as they grow up the family will gradually get out of debt.

5. Basic Causes

The material/technical and social conditions of production, together with political and cultural factors, determine the level of resources and the way these resources are controlled.

Food availability in areas suffering from seasonal food shortages is partially influenced by the government policy on food export particularly of the staple food, rice. Since 1992, consideration has been given by the Government to meet the domestic needs by setting the volume of rice for exports. However, there is still need for public policy interventions to achieve major improvements in food procurement, storage, transportation and distribution systems so that food can move from surplus to deficit areas efficiently and quickly.

The food deficit regions need sustainable means of improving their food security to meet the needs of their population by allowing them to exploit their comparative advantage in crops other than rice, providing support for agricultural inputs such as fertilizer and improved technology, among others.

The abolition of food subsidies in 1989 and the agricultural taxation system may have had an impact on the purchasing power of households and consequently on the food consumed. Evidence in this regard is not available.

**An experience – Save the Children – US
Sustainable Nutrition Education and Rehabilitation**

Save the Children US, sponsored by BP, started its Nutrition Education/Rehabilitation programme by targeting all children identified as second and third degree malnourished in the four poorest communes in Thanh Hoa Province. Prior to the start of the project 36% of all children under the age of 3 suffered from second and third degree malnutrition. At the end of the Programme these figures showed a 90% reduction from 36 to 2%. This has also been entirely sustainable as families have been able to maintain the improved nutritional status over a period of more than 2 years. How was this achieved? In studies done in advance of the project beginning, it was revealed that the "deviant behaviour" in poor households of feeding greens and tiny shrimps and crabs from the rice paddies to the children was in fact a very "positive behaviour." These children were receiving adequate nutrition. It was clear then that the poorest people could, within the context of their poverty, markedly improve their children's nutritional status.

At the outset NERP invited the mothers to bring the children to local rehabilitation/training centres. Here, trained health volunteers were able to give basic nutrition messages which stressed the importance of frequency of feeding and the inclusion of greens, shrimps and crabs in the family diet. The children were fed a calorie - rich meal as well. Mothers had to supply handfuls of greens, shrimps and crabs as a "price of admission" to each session. Over a period of 25 monthly sessions the transformation took place. Families have been able to maintain this satisfactory nutritional status with no further outside assistance.

A complementary component of the programme is the Revolving Loan Fund for families of malnourished families who have participated in at least two NERPs. The objective of the programme is to provide the malnourished children with immediate access to supplementary food. Loans are provided for either poultry raising or mat making. The produce (or income) from the projects enables families to improve their nutritional status and the loans, (provided in kind) are repaid to the fund and is made available to other families of malnourished children. As of April 1993, 91 % of all children whose parents received loans had been rehabilitated, and remained so 15 months after getting the loan.

Chapter VII

ACCESS TO SAFE WATER AND ENVIRONMENTAL SANITATION

Trends, Coverage and Status on Achieving NPA goals

1. Access to Safe Water

NPA Goals: To increase the proportion of the overall population with access to safe drinking water from the current 29.7% to 82%, and, in rural areas, from 20.9% to 80%; one public source of safe water to be provided for every 300 people by 1995 and for every 120 people by the year 2000; by 1995, 5,000 primary schools to be provided with safe drinking water and 13,000 schools to be covered by 2000; maintenance network to be set up to ensure that handpumps remain in operation consistently; the proportion of the overall population with access to adequate sanitation facilities to rise from 23.6% to 65% for the country and, in rural areas, from 13.2% to 60% by the year 2000.

1.1 National policy, priorities and goals

Improved access to safe water is one of the greatest perceived needs of the people of Viet Nam. Water-borne and water-related diseases are among the most important factors in child morbidity and mortality. Furthermore, the collection of water significantly increases the workloads of rural women and children when water sources are far from their homes.

Problems related to the lack of safe water and adequate environmental sanitation have a severe impact on the health of the population, particularly women and children. Because poor health has a negative economic impact, improving access to safe water and sanitation can have far-reaching consequences.

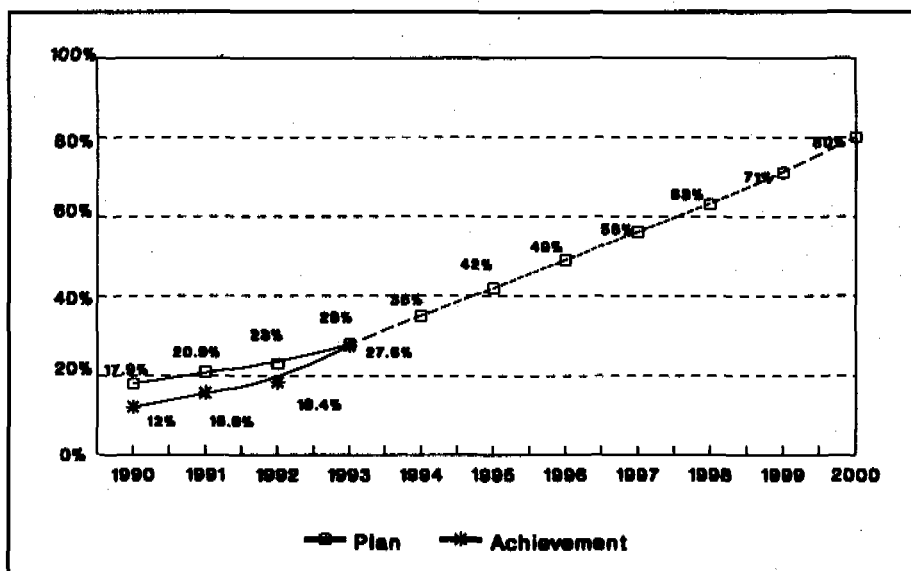


Figure 36: Percentage rural population with access to safe water

Source: MOLISA, (Project of achievement based on availability of US\$4.5 million in 1994 and \$5.5 million in 1995; resource requirements for 1996-2000 are about US\$8-9 million per year).

Only 45 to 50% of the urban population has access to piped water supply, and many of these systems are in poor condition. According to the NPA, only 21% of the rural population has access to a safe and adequate water supply; other estimates are much lower. Problems associated with a lack of access to a potable water supply are particularly acute in remote coastal and mountainous areas.

The NPA goal for the year 2000 is to provide 80% of the rural population with access to safe water. To provide access at an average ratio of 120 people per public water source, will require the construction of about 244,850 new water sources. About 54% of the rural population currently has a basic level of service: 300-400 people per public water source providing a minimum of 20 litres/capita/day within a maximum distance of 500 meters. A total of 100,000 water sources are needed to achieve the NPA goal for 1995 of 100% coverage at this basic level.

Theoretically, this goal could be achieved. In practice, however, only 120 to 250 people are actually using each existing handpump/water source, making actual coverage much less than expected. An explanation for the lower usage rates is that provincial Rural Water Supply (RWS) projects depend on the financial and/or manual participation of the recipient communities for construction and maintenance of new water sources. Willingness to participate is usually related to the level of service offered. While households near the water point are willing to contribute and make use of the facility, those living at a greater distance (350-500 metres) are unlikely to assist in construction. Instead, they continue to rely on other available, but usually polluted, water sources. This problem must be addressed if NPA goals are to be met.

Achievement of the NPA goal also faces technical constraints due to the variety of hydrogeological conditions found in Viet Nam. Provision of basic coverage in mountainous regions is impeded by the lack of technology to exploit aquifers covered by consolidated rock. Similarly, the technologies commonly used are not always adequate to reach deep freshwater aquifers in the alluvial plain of the Mekong Delta. Available hydrogeological information is often inadequate, particularly in the mountainous areas and the Mekong Delta. Therefore, further studies are needed to facilitate decisions concerning the appropriate technologies for these areas. Geophysical studies and aerial photography surveys will assist in proper site selection. Drilling equipment currently in use by the Government, made in the former USSR, is more suitable for the exploitation of mineral resources than for groundwater, and it will be necessary to introduce more cost-effective drilling technologies.

Finally, several institutional factors have hindered efforts to expand access to safe and adequate water supplies. In particular, insufficient communication between the various concerned ministries and a lack of reliable and relevant data have made it more difficult to reach people in need and offer appropriate service to solve real problems. The UNICEF-supported project continues to be the only substantial RWS project implemented in Viet Nam with international assistance; the intervention of other international organizations will be necessary to allow Viet Nam to reach its NPA water supply targets.

1.2 Urban areas

According to government statistics and other available data, approximately seven million urban dwellers, or 45 to 50% of the urban population, have access to piped water supplies. Eighty per cent of the urban population is concentrated in cities with a population of more than 15,000 inhabitants. While most of these larger cities have piped water supplies, the systems are in generally poor condition, and coverage is incomplete. Very few of the smaller towns (5,000-15,000 inhabitants) have piped water systems. Some

of these urban systems have no treatment facilities at all, and contaminated water is distributed directly to consumers. This is a critical problem in the ancient capital of Hue, which suffers from periodic outbreaks of cholera.

The Government is aware of the needs. With support from FINNIDA the rehabilitation of the Hanoi water supply system started about six years ago. The Hai Phong, Ho Chi Minh City and Hue water supply systems are also being improved. Nevertheless, a major effort from Government and provincial authorities combined with increased foreign investment, assistance and expertise will be required to overcome the present serious water situation in Viet Nam's cities.

1.3 Rural areas

With the exception of the central highlands, which do not experience a distinct dry season, Viet Nam has a typical bi-seasonal tropical monsoon climate. Throughout most of the country, annual rainfall averages 1,500-2,000 mm, but almost 80% of it falls during the summer wet season. This seasonal variation can cause acute shortages of fresh water in many rural areas. Other major problems include saltwater intrusion in coastal areas and flash floods due to extensive deforestation in upland areas. In addition, many surface water sources are becoming increasingly polluted through the intensive use of pesticides and fertilizers, along with the development of industries which discharge untreated waste water into rivers.

Figure 37: Water supply facilities implemented from 1982 to June 1993 (UNICEF supported RWS only) (Cumulative)

	1982-90	1991	1992	1993	Total
Installed Handpumps	33,916	16,557	13,264	8,971	72,709
New dug wells	0	0	1,076	133	1,209
Rehabilitation of existing old dug well	1,211	483	1,624	644	3,962
Rainwater catchment (4 sq.m)	0	0	2,420	149	2,569
Rainwater jars (250 lit.)	0	261	518	1,198	1,977
Slow sand filters	0	127	155	12	294
Pipe/gravity flow system	9	9	33	1	52

The RWS project began in 1982 as part of the International Drinking Water and Sanitation Decade. Project activities were initiated in three southern provinces and extended to three northern provinces the following year. As of 1993, the project has expanded to all 53 provinces. While the project has not yet reached all 550 districts, it represents an important step toward attaining national coverage by the year 2000. During 1993, nearly 25,000 additional water sources will be constructed using low cost technologies that are culturally acceptable, easily maintained by the users, and appropriate for the local hydrogeological conditions. These new facilities consist mainly of rainwater harvesting tanks, slow sand filtration systems, gravity flow systems, shallow dug wells, and manually drilled wells. Figure 37 provides information on the achievements of the RWS project since 1982, showing the number of each type of system implemented during the past decade. Figure 38 provides some information on average per capita costs for each type of system.

Figure 38: Current average per capita cost for different water supply systems

Water Source	Total cost per capita	Contribution (US\$)		No. of beneficiaries per scheme
		Beneficiaries	UNICEF	
Borehole with HP	1.51	0.62	0.89	150
Protected dug well	1.19	0.49	0.70	150
Gravity/pipe system	5.20	2.14	3.06	3000
Rainwater catchment	6.60	2.72	3.89	6
Slow sand filters	1.12	0.46	0.66	120

1.3.1 Rainwater Harvesting

The rainfall in Viet Nam is rather high, varying from 1,600 mm to 3,200 mm per year, which makes it the greatest water supply potential and the most appropriate source for direct use (harvesting) as a community-based intervention.

Rainwater harvesting is a traditional technology used to reduce water shortages during dry seasons, and in some areas the rural population depend heavily on rainwater for all domestic uses. However, rainwater is not consistently available, and stored supplies are not always clean. Surveys have shown that only 60 per cent of collected rainwater meets the standards for safe drinking water due to pollution during harvesting and storage. In some cases, improper storage of rainwater was reported to have increased the prevalence of mosquito-borne diseases such as dengue fever and malaria. Few activities have been directed towards the development of improved rainwater harvesting systems, but UNICEF has assisted in the construction of simple roof catchment systems since 1991. However, promotion of proper water

utilization and storage may reduce the risk of contamination as well as the risk of mosquito-borne diseases.

In the north, the volume of a typical household tank is 1.5-2.0 cubic meters, and the tanks are made of bricks lined with cement. The rural population in the southern provinces generally prefer relatively small rainwater reservoirs (usually earthen jars with a volume of less than 1 cubic meter). The water quality in these systems is fairly good in the rainy season, but the quality declines during the long dry season. During this period, the rainwater supplies are reserved for drinking and cooking, and residents must rely on polluted surface water supplies for other domestic needs.

Larger rainwater catchment systems with a capacity of four cubic meters, primarily for public institutions such as health and child-care centers and schools have been constructed. Since 1991, about 4,500 rainwater harvesting systems have been installed with UNICEF assistance.

As a cost-effective, community-based intervention, construction and utilization of ferrocement tanks and jars with various capacities have been proven successful in many countries, especially Thailand. Viet Nam has the potential to establish a successful rainwater harvesting programme and, therefore, the rain water harvesting techniques should be promoted in a more extensive way.

1.3.2 Surface water supplies

Due to high rainfall, Viet Nam's surface water resources are relatively abundant. During the rainy season, the major river systems -- the Red River and the Thai Binh in the north, the Mekong and the Dong Nai in the south -- provide sufficient water for irrigation, water supply and potential industrial needs in the surrounding areas. However, it must be noted that these rivers are getting more and more polluted. The situation is less favorable in the dry season, particularly in the central part of the country where catchment areas are small.

In certain coastal areas, mainly in the delta regions of the Red River and the Mekong River, the most serious problem is the lack of year-round fresh water sources for domestic and livestock use. During the dry season, the Mekong Delta is subject to intrusion of brackish water from the South China Sea through streams and man-made waterways. During this period, the saline water in rivers, canals and ponds is unsuitable for drinking and sometimes even for irrigation. Even the shallow dug wells may be contaminated. About one quarter of the Red River delta is similarly affected during the dry season.

Slow sand filtration

In communes near less-polluted, perennial surface water supplies, slow sand filtration systems have been introduced. These systems are appropriate in areas without chemical contamination. Since 1991, 300 slow sand filtration systems have been installed.

Gravity flow systems

For communes in mountainous areas with nearby clean water sources, gravity flow systems (GFS) can supply good water directly to households and villages. UNICEF began supporting the construction of these systems in mountainous provinces in 1991. Because GFS are more sophisticated systems than most villagers are accustomed to, better planning and preparation through community participation is necessary

to ensure their acceptance, use and proper maintenance. To work effectively, GFS projects require careful evaluation of the needs of the target groups. The use of gravity flow systems, like slow sand filtration systems, is limited by the number of appropriate sites.

1.3.3 Groundwater sources

In the alluvial plains, where surface water is not always a dependable source of fresh water, groundwater exploitation is the best alternative. The bacteriological quality of the groundwater is generally very good due to the natural protection given by the upper layers. In the Red River Delta, shallow fresh-water aquifers can be tapped using low-cost drilling technologies. The exploitation of the deeper fresh-water aquifers in the Mekong Delta area is much more complex, and more sophisticated equipment will be needed to reach the deep aquifers with acceptable water quality. As mentioned above, the expansion of borehole construction in the mountainous areas is constrained by the lack of appropriate technology.

Shallow dug wells

Shallow dug wells are a form of traditional water supply in Viet Nam. The local population constructed about 3.9 million hand-dug wells throughout the country from 1975 to 1985. Most of these wells provide freshwater for the private use of one or two households. A survey conducted in 1992 found that more than 80% of these wells are bacteriologically contaminated and of sub-standard quality. Despite their poor construction and contamination, these wells continue to be the preferred water source in some areas. Since 1982, 1,200 hand dug wells and the rehabilitation of an additional 4,000 have been completed.

Manually drilled wells

Manual drilling (Jet - and Sludger-boring) is the most appropriate and cost-effective technology for soft-formation areas such as the Mekong and Red River deltas. Drilling teams, consisting of four to six workers directed by a master driller and/or one hydrogeologist, can implement 100 tube wells per year. The depth of the wells varies from 20 meters in the northern and central provinces to 140 meters in southern provinces.

Since 1982, the UNICEF-sponsored RWS project has installed more than 93,000 wells with handpumps. PVC pipe, produced in Ho Chi Minh City and Hai Phong, is used as casing. The locally produced VN6 suction pump is a durable and easily maintained handpump. Maintenance and repair is accomplished by trained caretakers, usually a single member of each user's group. The installed handpumps have proven to be very sustainable. In a survey conducted during 1992 in eight provinces, about 83% of the installed pumps were reported to be in working condition, i.e. in use and in good condition, as much as ten years after installation.

Some problems encountered

It has been noted that many handpumps installed in public places have suffered from frequent breakdowns due to children playing with them. In response to this problem, UNICEF now seeks an agreement with the community to site the handpump in a private yard, with free access to the community. In these cases, the landowner is generally trained as the caretaker.

Groundwater quality is another major problem faced by the RWS project. Many wells yield water that has a relatively high iron and chloride content. These problems affect the water's taste and therefore negatively impact the people's acceptance of a new well. To combat the problem of high iron content (sometimes as high as 20 or 30 mg/l), the project has begun installing low-cost iron removal systems which precipitate essentially all of the iron from the water.

Water sources in Co Sao in Chiang Mai

Children indicated where the villagers bathe (in a stream) and where they get water - a simple spring with a tiny earth embankment and a bamboo pipe: it looked clean. There are ten such sources in the village, four of which are regularly used. Only two run all year. Women collect the water in two buckets on a yoke. They place it on a raised veranda for drinking, washing food and recycling to wash dishes and finally to feed to the pigs. There are also one or two hand dug spring fed wells. There is also a well with warm water but it is said to harbour a devil.

People defecate in the open though some households have fenced off an area. There are no pit latrines and the Government campaigns have been ignored. Only 20% of the village have a modern conception of disease; the other 80% think disease is caused by the devil and people take to prayer to cure illnesses.

1.3.4 Institutional issues: mobilization, participation and financing

To improve the sustainability and positive impact of a new water supply system, the mobilization of local resources and the involvement of the community and of local authorities is essential. Previously, the project has relied entirely upon the provincial People's Committees for social mobilization. Action has been taken more recently to reinforce the provincial authorities activities and to provide guidance in mobilization efforts.

In the past, community involvement has not always been solicited in site selection for new water sources; changing this practice will doubtless'ly improve the sustainability of future projects. In contrast, the participation of recipient communities, either financially or in the form of manual labor, during the construction and maintenance phase, has always been an integral part of the RWS projects. Each family's share is established by the district/commune People's Committee in accordance with the capability of the concerned family. UNICEF has supported the poorest families by covering their share of the local costs while they continue to provide labor.

Contributions by beneficiaries and provincial authorities cover about 40% of the total cost for each water supply system, with the remaining funding coming from UNICEF assistance. Some RWS projects, especially those among ethnic minority groups scattered over a wide area, suffer from limited financial capacity to cover local costs, including transport and the provision of construction materials. The Ministry

of Finance occasionally allocates funding to provide water supplies to the poorest communities, in particular ethnic minorities, but a more permanent source of support is needed.

2. Access to Environmental Sanitation

2.1 National policy, priorities and goals

The MOH has promoted rural sanitation for nearly four decades by providing cement for the construction of latrines. The types of latrines that have been supported by the MOH are the double-vault (DV) composting type, the pit type (for mountainous areas), and more recently pour-flush (water-seal) toilets. Despite these efforts, the NPA estimates that only 13% of the rural population had access to safe sanitation facilities in 1990. Coverage increased to 18% by 1993.

A nationwide study on intestinal parasite infection, conducted in 1989, found infection rates of 95% in the north, where double vault (DV) latrines are widely used, and 40% in the south, where fishpond latrines are most common. This study underscores the need for expanding the knowledge and practice of environmental sanitation.

The sanitation situation in ethnic minority areas of the mountainous provinces in the north and the western parts of the central provinces is particularly critical. Providing the necessary infrastructure and developing management and technical skills in these areas will require increased investment at all levels. The remoteness of many of these areas increases the cost of materials and makes it more difficult to finance, manage and monitor sanitation projects.

Policy makers at the national level are giving more attention to the problem of inadequate sanitation. Community participation, capacity building, and the coordination, control and distribution of materials are all receiving greater emphasis. The MOH is devoting more resources to expanding the environmental sanitation project nationwide, and the Ministry of Education and Training has, for the first time, provided some funding for sanitation facilities to schools participating in the Health Education in Primary Schools (HEPS) project. Unfortunately, the provincial authorities have yet to include financing for the promotion and implementation of the environmental sanitation project in their budgets.

While this additional funding represents an important step forward, it is important to recognize the financial implications of the NPA goals. To achieve the NPA target of 65% household coverage by the year 2000, nearly seven million additional households will have to build latrines. The funding requirement to provide 500,000 households with demonstration latrines will be about US\$10 million. Until the Government can mobilize additional funding sources, the efforts to promote environmental sanitation will continue to be hindered by insufficient financial resources. International and national NGO activities in this field remain negligible and should be expanded.

2.2 Present state of sanitation coverage

During the last few years, efforts to increase the public's awareness of sanitation and hygienic practices have begun to show results. Primary school teachers and mass organizations, particularly the Viet Nam Women's Union, have been very active in this process. The training of commune leaders, health workers, motivators (who advocate and solicit contributions for a community programme) and masons (who can build and train others to build latrines and other facilities) has been the key to the success of these activities. UNICEF has supported these efforts through two complementary programs: the Environmental Sanitation Project and the Health Education in Primary Schools project.

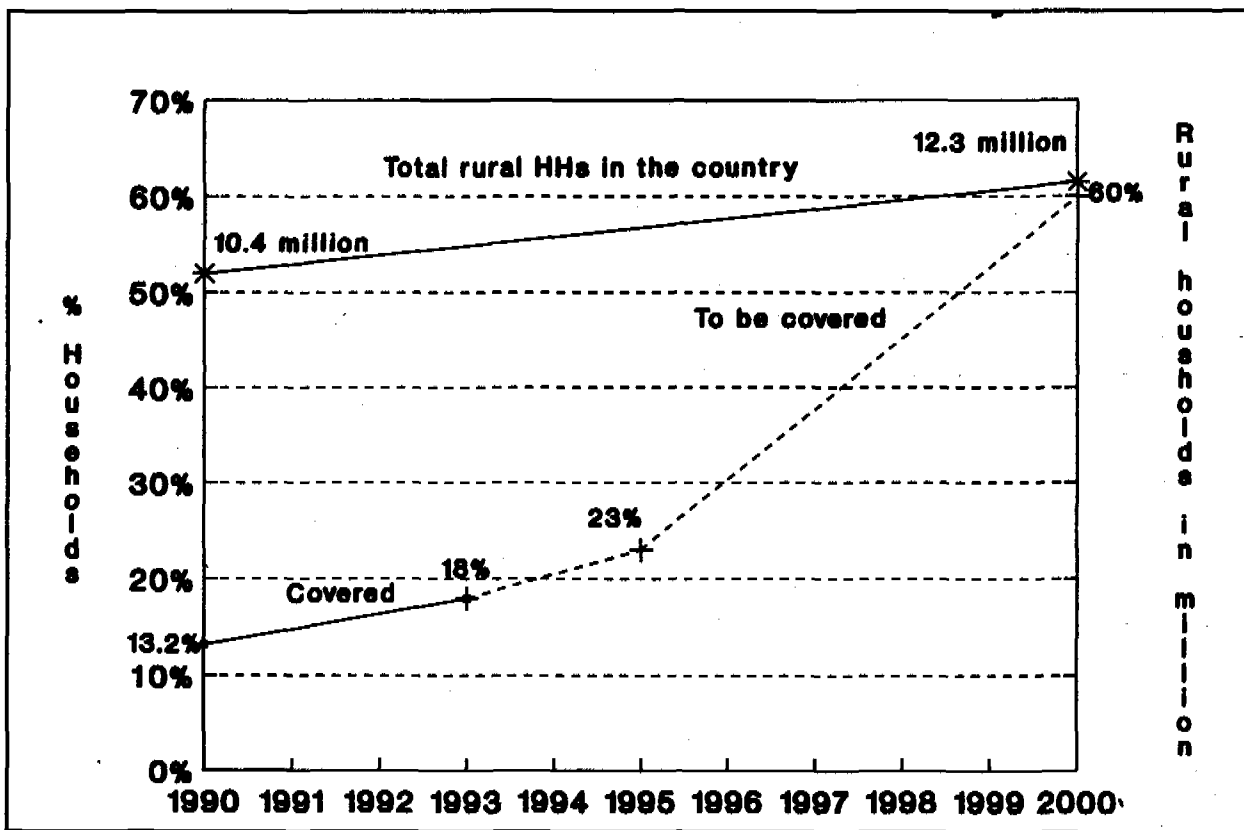


Figure 39: Population with access to sanitary latrines

Source: MOH, Environmental Sanitation Unit - 1993 (Projection based on availability of approximate \$1 million per year in 1994 and 1995 and about \$2 million per year for 1995 to 2000).

2.2.1 The environmental sanitation project

In 1987, following two years of testing and surveying, MOH began introducing low-cost water seal latrines at the household level. By the end of 1990, communes in 13 provinces had been provided with these latrines to assess their appropriateness, feasibility and acceptance in the community. In the same year the Ministry of Health decided to discontinue the promotion of DV latrines and the use of night soil

as fertilizer in the field, a practice which had been supported by the Government since 1954. This decision was a significant step forward in promoting hygienic disposal of human excreta.

Institutional features

The 44 provinces where the project is currently active have established an effective organizational structure at the province, district and commune levels to implement the environmental sanitation project. The vice-chairperson of each provincial People's Committee coordinates WATSAN activities in the province; while the director of the Health Service oversees the environmental sanitation project. Actual implementation activities are under the direction of the Health Service vice-director and/or the Director of the Center for Hygiene and Epidemiology (CHE) of the province with the assistance of a secretary from the CHE. The project has included an extensive training component that has involved personnel down to the commune level, and it is now theoretically possible for most of these provinces to implement more than 3,000 latrines a year. Unfortunately, due to lack of funds, the project is currently unable to support that level of activity.

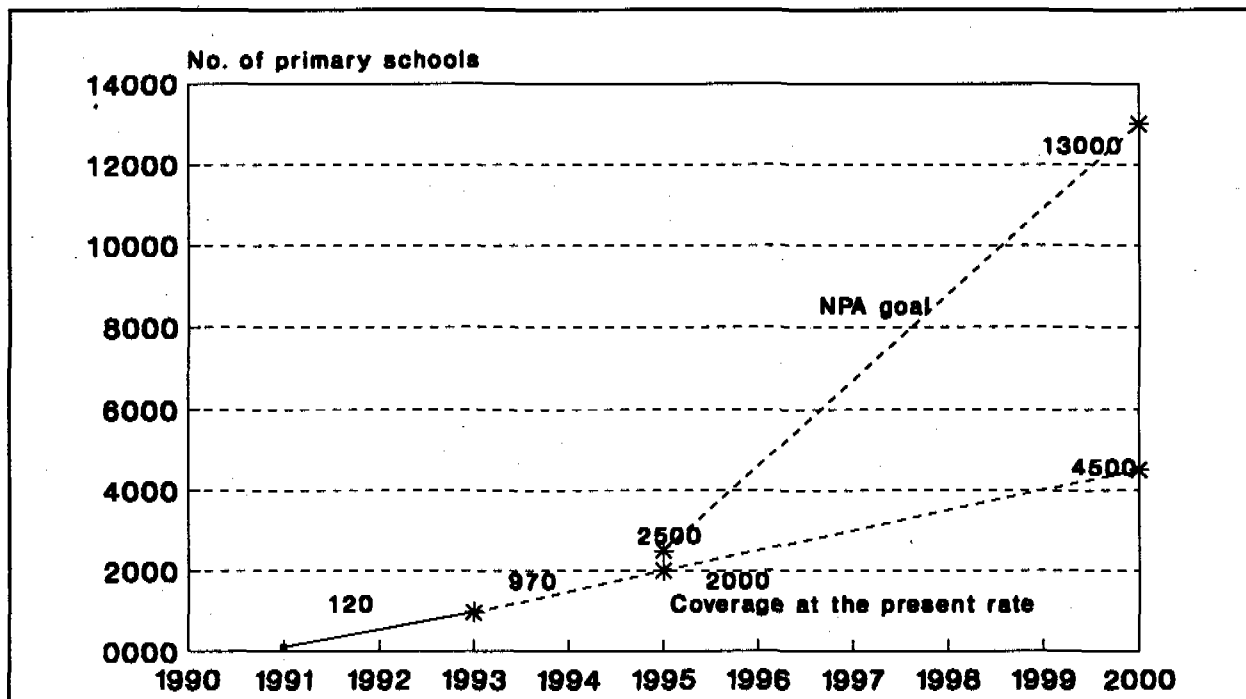


Figure 40: Sanitation in primary schools

The success of the project varies from province to province, and even within provinces. Where the People's Committee Chairmen of the commune, the district and the province have taken an active interest in the project, the number of families motivated to construct latrines on their own after the demonstration has been significantly higher. It is the representatives themselves who can successfully persuade people to accept and construct the sanitation facilities.

Project accomplishments

- Approximately 58,000 households have been covered with low-cost demonstration latrines in about 1,600 communes of 44 provinces, including four mountainous provinces in the north;
- The Viet Nam Women's Union has a project for house-to-house promotion of environmental sanitation and hygiene education in 20 communes of two provinces;
- An intensive sanitation project has started in one district of Thai Binh province, where a package of sanitary facilities has been provided to families at cost, along with hygiene education;
- In addition to latrines, UNICEF has also supported other sanitary facilities including smokeless stoves, bathing/washing platforms, soakage pits, garbage pits, clean animal sheds, and covered water storage tanks.
- A vector control project, in which families are educated on measures to eliminate or reduce the breeding of mosquitoes and other disease-carrying insects, has expanded to five communes in two provinces, with a particular focus on controlling the spread of dengue fever;

2.2.2 Health education in primary schools (HEPS) project

In order to inculcate good sanitary habits and practices as well as knowledge of the danger of unsanitary practices at an early age, the Ministry of Education and Training implements two projects for primary school age group children. One project installs water supply and sanitation facilities in schools and the second introduces the students to health education. This is one of four compulsory subjects at primary level. A curriculum, support text books, teachers guidebooks and workbooks and teacher training curricula have all been established for health education.

Efforts are now underway to establish links between the demonstration household latrine construction and school sanitation projects. In an attempt to enhance impact these two projects will be implemented in the same communes to enable the children to put into practice at home the knowledge and the good sanitary habits learned in school.

A variety of strategies will be explored and developed in order to improve the situation and raise awareness in the communities as a whole. In order to encourage the primary school teachers' active participation it has been proposed that they also receive latrines for their homes.

Through the Ministry of Education and Training (MOET), UNICEF has supported the development of a series of health education materials for use in primary schools. The provincial Director of Education is responsible for administering the HEPS project at the commune level, including the training of commune functionaries and teachers. MOET has recently made a significant contribution of VND2 million to each primary school to supplement UNICEF support for sanitation and hygiene education, and has also persuaded the provinces, districts, and communes to contribute.

More than 500 primary schools in 22 provinces have been provided with water, latrines, urinals, hand washing facilities and hygiene education. In 1993, 450 additional primary schools are being covered in 26 provinces, including four mountainous provinces.

2.3 Priorities for the year 2000

The NPA goals for access to sanitation is 65% of families and 13,000 primary schools by the year 2000. Figures 39 and 40 emphasize the need for greater attention to the provision of environmental sanitation facilities to both households and primary schools if the NPA targets are to be met. The expected coverage by the end of 1993 is 28% of families and 900 primary schools, far short of the pace necessary to achieve the targets.

The NPA goals on sanitation and hygiene education have put a tremendous responsibility on the Government, UNICEF and other donor agencies to mobilize the minimum needed funds by 2000 (US\$15.69 million for environmental sanitation and US\$7.25 million for sanitation in primary schools).

These funds are needed mostly for promotion activities, for a limited number of demonstration latrines, and for about 25% participation in the construction of WATSAN facilities in primary schools (the rest being contributed by the provinces, districts, communes and the beneficiaries themselves).

Based on these assumptions, the national priorities on sanitation and hygiene education up to 2000 are as follows:

- To inspire the provinces, districts and communes to accept environmental sanitation as a national priority;
- To emphasize communication and publicity, using all available channels and media, to promote the acceptance of sanitation as a way of life, for the good of the family and the community;
- To improve coordination with mass organizations and NGOs in educating the public about hygiene and sanitation;
- To give adequate funding and attention to deprived and ethnic minority areas;
- To include the provision of water and sanitation facilities in the budget estimates for the construction and renovation of primary schools, kindergartens, health centers and other community projects.

Chapter VIII

EARLY CHILDHOOD DEVELOPMENT

Background

The high literacy level in Viet Nam estimated at 85%⁽⁵⁾ is supported by a widespread network of day-care centres (DCCs) and kindergartens (KGs) which prepare children for further schooling. The first day-care centre and kindergarten in Viet Nam was established in 1956. The mass provision of such facilities was closely connected to the policy of advancement of women and their participation in the economic development of the country. Over the years, the state-controlled subsidy-based national economy has fostered a nationwide network of day-care centres and kindergartens. During the school year 1986-1987, the number of day-care centres peaked to almost 41,000 with more than one million children (27% of children under three years) and almost 158,000 teachers on the job⁽⁶⁾. At the same time the number of kindergarten classes peaked at 63,761, with 1.85 million children enrolled; among them about 5% were children of ethnic minorities⁽³⁾.

1. National Policy with Respect to Early Child Care

Goal: According to the National Plan of Action for Children the aim of the Government is to have 14% of children under 3 and 40% of children under 5 in day care and 80% of 5-year-olds in kindergartens.

The Government has issued several decrees concerning the laws on preschool education. At the time of its creation in 1945, the responsibility of preschool education was given to the Viet Nam Women's Union. In 1963 the programme was administratively split into two: urban preschools and rural pre-schools. Urban preschools were administered by the Worker's Union and rural preschools were administered by the Agricultural Committee. The aim was to free women's time for the building of national development tasks.

A national policy document⁽¹⁾ in 1979 states "*Care and education given to children from birth to six years of age is of prime importance we should gradually take children of this age range into creches and kindergartens in order to give them an optimal development.*"

In 1987 a Department of Children's Protection and Education was created under the Ministry of Education and Training (MOET) for the management of the pre-school education programme. This new department was able to make a necessary link between various agencies and departments to meet the needs of DCCs and KGs. This administrative shift gave the required technical orientation to the pre-school programme. Recently, the 7th Communist Party Congress Resolution states "pre-school education is a part of the national system of education with an administrative system from central to grassroots levels".

MOET has also developed several criteria for the operation of pre-school education classes in urban areas, including a minimum floor space requirement (at least 40 sq metres) and a minimum pupil-teacher ratio (one teacher for every 10 children). There are no criteria applicable to rural areas.

Equal attention is also given to the many needs of growing children, such as health, nutrition and mental stimulation necessary for later years in primary school.

Over the past few years the Ministry of Education has seen a gradual decline of day-care centres and their enrolment rates. The policy of the Government is to maintain the existing number of day-care centres and increase home-based day-care centres. In areas where there are no KG classes (three to five years old), the Government will encourage local educational services to open KG classes for five-year-old children.

1.2 Organization of early child care education

MOET is responsible for the management of pre-school education. At the central level, the Department of Child Protection and Care is responsible for implementation of all pre-school activities. The activities of this department are complemented by the Institute of Early Childhood Studies, which is responsible for development and production of teaching aids and curriculum.

At the provincial and district levels, the Deputy Director of Educational Services is responsible for all activities relating to pre-school education. There are at the moment 7,872 day care centres and 30,342 day-care groups with 448,692 children and 61,307 female teachers. There are 6,870 kindergarten schools with 59,497 classes and 65,691 female teachers. This group of cadres is supervised by the deputy directors of educational services.

In 1988, the Government introduced the concept of the home-based day-care centre in areas where the enrolment of children in DCCs had decreased. The home-based DCC was also flexible to parents' working hours, which made such centres popular. The number of such centres at the moment stands at 10,774.

The teachers or the "owners" of such centres are trained and supervised by the Department of Child Protection and Care. The Government does not have any financial or operational obligation other than the training and supervision of staff. The fee per child in home-based DCCs is usually more expensive than Government-financed DCCs.

All provinces have one pre-school teacher-training institute. These institutes offer three different courses: nine months, 18 months and three years. These institutions are managed by different managerial levels, some by the Ministry and some by the provinces. In addition there is one institute in Hanoi that offers a five-year course on pre-school education and management.

At the field level the programme is implemented by a steering committee with representation from the MOET, the Viet Nam Women's Union, the Farmer's Union, the Ministry of Health and the chairman of the local People's Committee. These characteristics including the very adaptable budgeting arrangements make the organization and implementation of DCC and KG programmes very participatory, flexible, coordinated and affordable and therefore sustainable. However, the costing of pre-school education in rural and urban areas must be critically analysed to justify future allocations of funds.

2. The Problems of Early Child Care

2.1 Impact of socio-economic reforms

Until recently the early child care programme in Viet Nam had a strong family tradition and robust political support. The organization of formal child care institutes, in addition to providing appropriate mental stimulation to children, promoted economic development of the country because of the nationwide participation of women. This scenario changed as a result of the economic restructuring of the national economy.

2.2 Decline in use of day-care services

Economic and agricultural reform, especially the removal of subsidies, have resulted in a dramatic decline in the use of day-care services. As a result the coverage has dropped from 27% in 1986-1987 to 13% in 1991-1992.

Nearly 2.1 million children are born in Viet Nam every year. If the current rate of closure of DCCs continues, the coverage of DCCs will be rendered insignificant very soon. Fortunately the percentage of decline in the number of KG schools, classes and children is less than the decline in DCCs. Another reason for the decline has been the fact that many parents found themselves redundant when communal industries began to adapt to a market economy and child care shifted to the home.

2.1.2 Shift in financial responsibility

These sudden economic changes created a problem in the early childhood care and education programme. While many women continued to work, leaving children at home with relatives and or in functioning pre-schools, parents began to shoulder partial financial responsibility for keeping child care centres running. The contribution from the parents could be in-kind -- such as 10 kg of paddy per child per month -- or in cash, which could range between VND5,000 per child per month in rural areas to over VND150,000 per child per month in some private centres in cities. In some provinces such as Hai Phong, more than 50% of the DCCs and KGs have been turned over to the community.

The shift of the financial burden for the management and operation of DCCs and KGs from state-owned subsidised units to community-based units is perhaps healthy in the long run. But the transition in financial responsibility is coming too rapidly for communities to cope, particularly in rural areas. Ironically, pre-school education programmes in urban areas are still largely funded by the central Government while in rural areas the funding is being shifted more onto the community.

In practical terms, the poor families will not be able to continue sending their children to pre-school education programmes. While many countries are trying to introduce pre-school education programmes to foster mental development of children, in Viet Nam, a system which already exists is deteriorating due to the changing economic and political climate of the country.

UNICEF has consistently supported pre-school education in Viet Nam. The experience of the 1988-1990 programme cycle indicates that of the total establishment cost, the local community bears about 65%, the central Government about 15%, and UNICEF inputs amount to the remaining 20%, mainly in the form of toys and equipment and teacher training in provinces covered by UNICEF projects.

It was noticed that some non-project neighbouring communes replicated these examples entirely out of their own resources. This initiative indicates community acceptability and the potential for effects to multiply.

2.3 Delivery structure in early child care

2.3.1 Uneven budget distribution between urban and rural areas

The Ministry of Education and Training allocates a certain portion of its budget to pre-school programmes, however budget distribution between urban and rural areas is fairly uneven. The pre-school budget for urban areas (53 provincial headquarters, including five cities) is allocated at a rate of US\$13 per child per year in DCCs and US\$7 per child per year for KGs. In rural areas the budget is allocated at a rate of US\$1.5 to \$2 for both DCCs and KGs. The distribution of central Government budget by expenditure is presented in Figure 41; the amount is sufficient for the salaries of headmasters of these schools and the district staff employed by MOET.

This budget is complemented by the provincial, district and commune funds, which are mainly used for salaries of locally employed teachers, maintenance of facilities, and other overhead costs. The amount of local contribution depends upon the resource capacity of the communes and districts. The teachers employed by the MOET in pre-school facilities are paid by funds received under the central budget. Teachers employed locally are paid by local resources, which could be in-kind or in cash. In rural areas the cash remuneration ranges between US\$3 to \$5 per teacher per month, or 30 to 50kg of paddy per teacher per month, or a combination of both. In addition teachers in rural areas also receive about 720 sq.m of land for cultivation.

In urban areas the teacher's monthly salary is as much as US\$10 or more. Urban teachers do not receive land but may receive presents from parents. The service contract for teachers is thus not uniform. The expenditure pattern for districts is also skewed, as can be seen in Figure 41.

Figure 41: Pre-school budget in percent by expenditure heading for three selected districts for 1992

	Rural district	Highland district	Urban district
Staff cost	26	85	34
Maintenance	72	14	35
Toys & equip.	2		21
Administration	2	1	4
Others			6
Cost per child/year (in VND)	96,300	10,150	464,826
All expenditure (million VND)	1,664	241	3,026

The study documented in Figure 41 shows that in mountainous areas a very large portion of the budget was allocated for staff costs, and there was no budget for toys and equipment. Whereas in rural districts large amounts were allocated for maintenance and construction and this budget was from the communities. The pre-school cost per child in rural, highland and urban areas were VND96,238/year, VND10,150/year and VND464,826/year respectively. Similarly the teacher pupil ratio is estimated at 1:16, 1:10 and 1:7 respectively. These averages may not be exact for all other districts but they reveal the discrepancies between rural and urban areas.

2.4 Impact of reduced central subsidies and introduction of user fees

Teacher's salaries and most of the operational costs such as maintenance, toys and equipment, will be paid by the local communities. Poor parents, in particular, are unable to afford these costs.

It is also noted that the situation of DCCs is deteriorating due to lack of funds for replacing old toys, furniture and other expendibles. As a result, stimulation activities are not extensively organized. This is especially true for centres in rural areas.

The decline in kindergarten coverage is not as great. This may be an indication that parents are prepared to pay for pre-school once children attain a certain age.

The current approach is to expand pre-school classes for five-year-olds. The potential benefit of this expansion is that it exposes children to formal school at an early age and provides support for early enrolment into primary school. There may be some positive implications for improving retention and drop-out rates.

2.5 Regional and provincial differences

Many of the curriculum and teaching aids are produced for the majority Kinh population. Many teachers in rural areas are Kinh who do not speak minority languages. These factors are partly responsible for low enrolment in pre-school programmes, and perhaps affect drop-out rates in primary schools. Bilingual language teaching is an attractive possibility. Experience from other countries such as Bolivia⁽⁶⁾ showed that bilingual teaching (mother tongue and the national language) introduced during childhood has a considerable impact in improving examination grades in addition to reducing drop-out and repetition rates.

3. Coverage of Early Child Care

3.1 Linkage with primary school

The present system of pre-school education in Viet Nam creates a natural flow from day-care centres to kindergartens to primary schools. The activities for children in the centres include various play activities designed for motor and cognitive development, facilitating adjustment to the learning environment of primary schools.

3.2 Health and nutrition in pre-schools

The pre-school programme in Viet Nam has three main functions: provision of age-appropriate mental stimulation, health and nutrition services. The central Government provides one complete set of

curriculum, teaching aides, toys, equipment and other supplies to the DCCs and KGs. This is further complemented by the local budget.

Children are grouped into classes according to their age. The teacher pupil ratio is about 1:6 in day-care centres and about 1:20 in KGs. Mental stimulation occurs through various play and educational activities, which are usually done in groups. Most teachers have a background in pre-school education and are capable of implementing a systematic child-care programme, provided other conditions are suitable. The teachers also receive basic training in child health issues in case of illness. In addition, the local health services can be called on whenever necessary for assistance.

The pre-school classes also organize monthly growth-monitoring sessions but this is not always regular for several reasons, such as an untrained teacher or the lack of functioning weighing scales, etc. The results of such weighings are discussed during periodic parent education sessions, organized for when they come to collect their children. This activity also depends upon the time availability of mothers and teachers at the end of the day.

Most day-care centres cook at least one main meal and two snacks a day. In others, parents may send pre-cooked meals. Parental contribution for meals varies widely. In some DCCs parents pay in-kind, often with rice and vegetables, while in others parents pay VND200 to 1,000 per child per day. In private centres in cities the parents' contribution can be much higher. In KGs most children are collected by parents at lunchtime. It is hoped that the recent introduction of VAC will provide additional nutritional inputs in the form of fish, vegetable and fruits for children in DCCs.

A comparative study made in eight districts of the nutritional status of children on admission to the DCC and then three years after being in the DCC, as measured by weight for age, indicated an improvement in the weight/age index in most districts (Figure 42). This does not, however, directly imply benefits of DCC programmes by way of direct health and nutritional interventions. It may be an indication of the positive impact, through a mixture of regular and timely feeding, improved care at home, and parent education.

Figure 42: Trends in weight by age index in selected districts in 1990 and 1992

Districts	Percent of children in various weight for age categories					
	Normal		Mildly malnourished		Severely malnourished	
	1990	1992	1990	1992	1990	1992
Tu Liem	70	63	27	28	3	4
Hoa Lu	59	65	33	33	8	3
Kim Son	63	76	28	22	9	2
Hai Hau	53	75	40	24	7	1
An Hai	57	65	34	31	8	3
Nghi Xuan	59	64	34	30	7	4
Nam Dan	59	55	35	38	6	7
Dong Son	58	63	33	35	9	2

3.3 Parent education inputs

In addition to financial and material contributions from the communes, parents are also directly involved in child-care practices. This happens through parent education programmes at the pre-school. These have been carried out since 1988. At least one teacher in each DCC and KG is trained as a trainer for parent education. Topical issues such as diarrhoea in children, vitamin A deficiency, family planning, nutritional deficiency, mental stimulation, measles, ARI, etc. have been selected for weekly discussion with parents. These sessions are expected to reinforce the health and child-care messages delivered through other field workers and through various mass media. This programme also provides person-to-person (teacher and parent) contact in discussing child health and development issues. However, regularity of such sessions depends upon the time availability of mothers and teachers. The quality and output of such sessions vary greatly in different districts.

3.4 Informal creches/home-based day-care centres

The success of home-based DCCs indicates that parents do feel the need for early child-care programmes. The training of child-care takers in private institutes is done by district and provincial education authorities, while supervision is done by one of the fully-staffed state-owned DCCs. The home-based DCCs have successfully replaced the State-owned DCCs that were forced to close for economic reasons. The cost per child in these centres is fairly high but is still acceptable due to its flexibility and homely environment. So far these arrangements have benefited not only the owner of the home-based day-care centre but also parents and the Government.

Parents needing health care services for their children are sometimes referred to home-based DCCs where the owner is trained by the Department of Children's Protection and Education. While the prevalence of malnutrition is similar in urban and rural areas, the prevalence of diarrhoeal diseases and acute upper and lower respiratory infection is much higher in rural areas, and home-based DCC caretakers may be better equipped to handle these problems.

However, services available in State-owned DCCs and KGs such as regular health check-ups, immunization of children, parent education programmes and other health and nutrition programmes, are not available in the home based centres. The home-based centres now are increasing in Viet Nam both in urban and rural areas, although their coverage is only 1.09% of the total child population at present. Community child care centres continue to play an important role for child care and development. As state-owned day-care centres are replaced by private ones, two questions remain: What will be the role of the early childhood education department of the MOET? Should the Government be spending its budget to train teachers for home-based day-care centres, which are essentially private institutions?

3.5 Future direction

Pre-school teachers are in daily contact with children and the nature of this contact could help most social sector programmes deliver intended services to children. Considering the rapidly changing social, economic and political environment of the country, the MOET will need to operate pre-school education programmes through several models to accommodate flexibility, cost and sustainability. The issues highlighted above, such as cost, accessibility to the poor, rural-urban discrepancies, and the role of Government in home-based DCCs must be a priority when considering future decisions.

Chapter IX

BASIC GENERAL EDUCATION

1. Background

Basic general education or primary education is for children in Grades 1-5, generally aged between 6 and 11. In Viet Nam however, basic general education is for some, not for all. Prior to 1945, formal education was available only to children of a small, mostly urban elite. Formal primary education has developed as a Government priority since President Ho Chi Minh launched a country-wide campaign against illiteracy in 1945. In 1994, 9.4 million children were enrolled in primary schools. However, 1.4 million children drop out of primary school, and a further 1 million children never enrol. Regional disparities are serious. Three regions: the northern mountains, the central plateau, and the Mekong Delta, are far behind in participation rates. Areas where ethnic minorities live suffer severe shortages in facilities, materials and teachers. According to Government statistics, while the 53 ethnic minority groups account for 13.1% of the population, ethnic minority students represent only 4.2% of the general population.

Goal: By the year 2000, 90% of children aged 15 will have completed primary education, the remaining 10% reaching at least third grade. There will be no illiterate children under 15.

Trends in national Government policies and goals

In April, 1991, the National Assembly of the Socialist Republic of Viet Nam passed a law on Universal Primary Education requiring compulsory basic education for primary school-aged children. This is one of four national basic education priorities to the year 2000, adopted from the Education for All guidelines presented at the Jomtien Conference in March 1990, which promote:

- + universalisation of primary education;
- + expansion of literacy courses , especially those designed to meet the needs of minority populations and disadvantaged groups;
- + improving non-formal education and training; and
- + expansion and improvement of pre-primary education.

The education system has gradually become unified since 1975. For example, by the school year, 1992-93, grade 12 began to use the same program and graduate examination paper. Viet Nam has developed from a country where 90% of people were illiterate before 1945, to one where, in the 1992-93 academic year there were approximately 16 million students in the whole country (from early childhood education to the university level.)

From 1986-87 onwards, education reform paralleled general renovation in Viet Nam, with the goal of raising the academic level of the population, and of training people according to the needs of national development. This had led to a diversification in the types of schools that have developed, but it has also

led to growing disparities between urban areas and those areas disadvantaged either geographically or economically.

A Resolution on "Continued Renovation of the Education and Training Cause" was approved at the Plenary Session of the Central Committee of Viet Nam held in January 1993. The 1993 Resolution set out the guiding strategies and measures for attaining the Education for All objectives. It stated that "Education-training is the driving force and basic condition for the realization of socio-economic objectives" and that "Investment in education is considered as one of the principal directions of investment for development". A comprehensive strategy is to be implemented through 12 measures. The following strategies relate to primary education:

- + Improvement of the structure of the national educational system, the certificate and degree grading system. Upgrading the public schools, encouraging the opening of semi-public schools, allowing of the private schools in the pre-primary, vocational and higher education;
- + From now until the year 2000, eradication of illiteracy for those in the age group of 15 and 35, universalisation of primary education for children in the age-group 6 to 14.
- + Redefinition of education and training objectives, redesigning of curricula, improving methods of education and training at every level of education.
- + Promotion of research and application of scientific and technological progress, educational research included.
- + Consolidation and development of education in ethnic minorities and areas with difficulties.
- + Strengthening of the Party and Government leadership with regard to education. Legislation of educational policies and strategies, increasing of the rate of expenditure for education in the Government budget and mobilization of other funding resources for education and training.
- + Consolidation of the teaching staff and educational administrators.
- + Renovation of educational management.

There is no doubt that the Government of Viet Nam values education. What is yet to be decided is how best to make the strategies described above, a reality. Present difficulties include:

- + Budget limitations in relation to development needs in education, especially in mountainous areas inhabited by ethnic minorities, in the Mekong River Delta, and in the central part of Viet Nam, where natural disasters such as typhoons and floods are frequent.

- + Teacher shortages in almost all provinces: as of 1994, 52,766 more teachers are needed throughout the country, approximately 20,000 in ethnic minority areas. (Applying a ratio of 1.15 teachers per classroom).
- + Low teacher salaries: 80% of teachers live on the poverty line.
- + The poor and deteriorating quality of schools, school furniture and equipment, particularly in early childhood and primary education classrooms.
- + The high number of school dropouts
- + The poor quality of instruction
- + The inappropriateness of some curricula to the rapidly changing social situation in Viet Nam
- + The lack of time for the approved curriculum in the light of reduced time allocated for school instruction due to multiple shifts.

1.1 Access to education enrolment

Enrollments in primary education have consistently increased in real numbers over the past 12 years, although in proportion to population, enrolment has decreased. In 1981, 8,092,071 primary students attended school. By 1993-1994, primary student enrollments had risen to 9.725 million. However, the proportion of primary school aged children actually enrolled in primary school has declined by approximately 0.8% per annum in the past few years.

A 1993 statement on education in Viet Nam describes the very low enrolment rates for students in remote mountainous or delta regions: in Ha Giang region there is only 22.1% attendance, in Lao Cai, 23% and in Kon Tum, 25%. Declines are also evident at secondary levels. According to the 1993 publication, Education in Viet Nam, the number of children aged between 6 and 14 who have failed to go to school at all, or left soon after starting grade one is approximately 2.2 million.

Schools in the mountainous regions, inhabited by ethnic minority groups, have the lowest enrolment rates. There are broad differences across the country: average levels of attainment range from 5.9 years in Hanoi to 2.5 years in Lai Chau. The proportion of primary graduates entering lower secondary level was 92% in 1986-1987 and 72% in 1989-1990.

Access to education decreases as students increase in age. The nature of the changing economy in Viet Nam may well mean that large numbers of students quit school to work. While enrolment statistics have become the main signal for the success or failure of education in Viet Nam, little analysis has been made of the causes for fluctuation in enrolment. If students do not go to school, why not? What are the influences outside school which draw children away?

Figure 43: Total number of Students (000's)

<u>Cycle</u>	<u>1988-89</u>	<u>1989-90</u>	<u>1990-91</u>	<u>1991-92</u>	<u>1992-93</u>
Creche	788,454	649,758	526,600	488,900	503,185
KG	1,801,806	1,607,940	1,495,400	1,493,600	1,779,363
Cycle 1	8,634,819	8,853,000	8,858,000	9,105,900	9,476,441
Cycle 2	3,049,934	2,758,871	2,708,000	2,609,000	2,813,992
Cycle 3	841,572	691,279	527,925	522,735	576,732

(Ministry of Education and Training statistics, 1993)

1.2 Rates of completion, continuation and dropout

At the primary level, for every 1000 students entering school, only 448 graduate. It takes an average of 8.1 years for students in primary school to complete the normal five-year programme. Drop out rates and repetition rates have been reduced during the 1992-1993 school year in comparison with previous years, but they are still too high.

Figure 44: Rates of repetition and dropout

<u>School Year</u>	<u>Repeaters</u>		<u>Dropouts</u>	
	<u>1991-1992</u>	<u>1992-1993</u>	<u>1991-1992</u>	<u>1992-1993</u>
Cycle 1	8.16%	7.94%	13.8%	9.24%
Cycle 2	2.7%	2.9%	32%	17.3%
Cycle 3	1.03%	1.0%	14.5%	12.9%

1.3 Regional and provincial variations

Urban areas

The urban population accounts for 20% of the total population. In cities it is possible to run semi-public, community and people (privately-run) founded schools. In urban areas, the number of repeaters and dropouts is low, and the efficiency of primary education training is high, between 70 - 85%. Whereas in the remote and mountainous regions, the training efficiency is low, between 12 - 40%.

Lowland and mountainous Areas

In lowland and mountainous areas, large numbers of students leave school between grade one and grade five. In addition, large numbers of girl students drop out of school. The following table gives some indication of these issues.

Figure 45: Students in grade one and grade five for selected provinces (1992-93)

<u>Province</u>	<u>No of grade 1 students</u>	<u>No of grade 5 students</u>
Ha Giang	19,109	3,485
Tuyen Quang	34,493	10,961
Cao Bang	27,866	6,374
Lang Son	34,682	8,945
Lai Chau	19,401	3,490
Son La	38,377	5,980
Gia Lai	29,985	8,970
Kontum	18,360	2,879
An Giang	80,995	26,652
Tra Vinh	44,768	16,105
Soc trang	51,745	16,498
Kien Giang	63,340	16,788
Minh Hai	88,310	28,792

1.4 Curriculum

Three programmes of primary education have been developed: a 165 week curriculum (five 165 day school years) for the majority of students; a 120 week program for ethnic minority students, and a 100 week program for students in difficult circumstances, and alternative education classes. Alternate Basic Education classes started in 1978, after the war, to cater for 80,000 students who had never been to school. By 1994, the Ministry of Education will support 400,000 students involved in Alternate Basic Education classes.

Primary students should average five hours of schooling per day, but they often get only three or four hours, due to double or even triple shifts. The demands of the approved curriculum exceeds the time available to teachers for lesson preparation, assessment and other school-related activities. In addition, many teachers must pursue further employment to boost meagre incomes.

Because of the overloaded curriculum, there is a discrepancy between espoused and actual curriculum content, and many teachers concentrate on those areas covered by the certifying examination. A narrowing of curricular content is probably an important factor in high dropout rates as students find school tasks relate little to their out of school experiences.

There is great shortage of teachers and fewer teachers are able to teach subjects relevant to a rapidly changing social system. Shortages of equipment and materials for experiments mean that instructional methods tend to emphasize memorisation and rote practice rather than individual problem solving.

The need to make school more relevant to the needs of a rapidly changing society which is gaining wider access to the international community, should be a major concern for educators in the years leading to the year 2000. Increasing personal costs of schooling and higher education and the need to supplement family income by younger family members working may put schooling at a lower priority for some groups.

In response to this situation, the Ministry of Education intends to develop a new primary education curriculum, to be implemented by 1997.

1.5 Teaching and learning materials

There were 796 textbook titles put into circulation for use during the 1992-93 school year, of which 61,514,388 copies were made. In addition to this, teachers' books, homework books, reading books and dual language instructional materials were produced. However many students fail to procure a full set of textbooks.

1.6 Physical conditions

School facilities remain generally poor, particularly at early childhood, primary and lower secondary levels. As many as 5,379 classes operate three sessions a day, mainly in primary education for grades 1 and 2 in the Mekong River Delta and in high mountainous areas. As many as 16,950 classrooms consist of hut structures with thatched roofs. A 1993 Government official estimated that 96,760 classrooms need to be built, to get rid of third shifts, to repair thatched roof classrooms, and to complete coverage in remote areas. Few schools have recreation yards, and hygienic sanitary facilities, although UNICEF has assisted the provision of safe water and hygienic sanitary facilities to 970 schools. Expenditure on educational equipment in the 1992-93 school year amounted to 12,087,000,000 VND; double the amount spent in the previous school year. However, such increases in expenditure do little to meet the equipment needs of schools in Viet Nam. One particular area of need is the area of ethnic minority boarding schools. Thirty six such schools exist at provincial levels, 113 at district levels. These boarding schools provide opportunities for ethnic minority students to continue with education and are the main source of recruitment for ethnic minority teachers. The Ministry of Education estimates that at least 17 new ethnic minority boarding schools should be constructed every year. The development of district Accelerated Teacher Training Centres for training ethnic minority student teachers is one solution to the need for 20,000 teachers in remote and mountainous areas.

1.7 Quality and quantity in education

Teachers

Teaching quality in primary schools varies enormously between regions. Cities can provide primary schools for large numbers of children with concomitant resources and possibilities for teacher in-service development. However in rural areas, and especially in remote and mountainous regions, there is a constant shortage of teachers for primary education. In 1993-94 the Ministry of Education and Training estimated that there was a shortage of 52,766 teachers for the whole country. One mountain province needed nearly 2,000 extra teachers, while another province could only replace those teachers who had resigned or were on leave, without opportunities for expansion.

1.8 Teacher training

Quantity

Teacher training is provided in a two-year program after grades 10 or 12 for primary school teachers. Most teacher training institutions have poor facilities and equipment. Many provincial junior training colleges are situated away from provincial towns, and consist of deteriorating buildings and overcrowded hostels. The loss of occupational prestige through reduction in salaries and poor training facilities probably contributed to the significant under-enrolment in 1990-91. National training colleges operated at only 38.4% capacity, while national junior colleges operated at 61.2% capacity. Only provincial junior colleges operated at full capacity. Staff-student ratios are high, and funding is based partly on enrolments. For this reason, serious financial problems exist in many smaller colleges. There is a need for strengthening teacher training to respond to current and future needs. With 40% of children under the age of five years, the educational needs of Viet Nam including the need for teachers can only increase dramatically. There is a need to consider accelerated models of teacher training with in-service support, especially in those areas where schools and teachers are scarce. Alternative methods of teacher upgrading and initial training need to be considered if the Government is to respond quickly to current and future needs. Often training for teachers is too specialised and not related enough to the practicalities of daily teaching in classrooms. With the surpluses of secondary teachers in some urban areas, and the parallel shortages of primary teachers, secondary teachers are being employed to teach at levels for which they have no experience. In remote and mountainous regions, teachers have responsibilities for teaching in multigrade schools, teaching alternate basic education or charity classes, teaching literacy courses especially for women and girls, providing primary health care and supervising reforestation of remote areas. It is little wonder that teachers run away from their posts or seek alternative and more financially viable jobs.

Quality

The reduction in popularity of choice of teaching as a profession has led to a decrease in the entry admission scores of students. Thus, not only are there less student teachers, but their academic standing is also lower. At most levels of general education, a large number of teachers are underqualified and receive insufficient in-service training. Sixty per cent of primary teachers lack standard formal qualifications. Participation in in-service training has been encouraged by remission of fees and possibilities for accelerated promotion. The most common time for in-service training is during summer vacations, so that training workshops provide opportunities for vacation as well as learning. However, in-service training workshops, although providing opportunities for the sharing of teachers' experiences, depend heavily on lecture modes and do not necessarily respond to teachers' needs. Courses do not include self-instructional materials designed for adult learners.

Salaries

Salaries of teachers and other education staff are low (at an average of 190,000 VND, 1994 figures), and are not keeping pace with increases in the cost of living. In September, 1985, the minimum salary for a teacher was 220 VND, which at that time was equivalent to 45 kg of rice. By October 1991, the average salary of a primary teacher could only buy 23 kg of rice. In comparison with other counterparts in the region, teachers salaries are also low. The Asian average pay for a teacher is 3.8 times per capita GNP (World Bank, 1991). The average pay for a secondary teacher in Viet Nam is 1.2 to 1.7 times GNP

(UNESCO, 1992). A serious consequence of real salary reductions is that many teachers seek work outside their normal jobs. The Sector Analysis Synthesis Report (UNESCO, 1992) cites available 1991 data which indicates that approximately 67% of teachers work overtime, with 50% involved in jobs that do not relate to their profession. Salary increases are generally considered to be based on seniority and not on quality of work practices. Appointment to isolated, disadvantaged and certain rural areas is considered by teachers to adversely effect promotion and prospects for career advancement. Thus, in these areas, there is often a shortage of teachers.

Incomes and incentives for teachers will have to be introduced, especially for those working in rural, remote and mountainous regions, and in specialized fields. Appropriate and on-going training needs to be provided for all teachers. This will involve the redevelopment of pre-service teacher training, along with the upgrading and diversification of teacher in-service development, and the establishment of workable criteria for teacher selection, assessment, promotion and classification.

2. The Financing of Education

If the provision of education and training is to be expanded and improved, additional resources will need to be made available for the financing of education. Viet Nam spends about 2% of GDP on education, compared with an average of 3% of GDP for education in other Asian countries (UNESCO, 1992). Doi Moi reforms and rapid expansion of the service sector have accounted for a relatively high economic growth rate, however state budgetary expenditures do not reflect this rate of growth, primarily due to an inability to raise tax revenue.

In the 1992-93 school year, there was a budget increase of 78%, compared with the previous year. In 1994, the Government input to education will increase by 150%. In real terms, expenditures per capita have diminished due to depreciation of the dong. Salaries and scholarships make up most of the state budget for education, thus reducing available funding for those other activities which support the quality of teaching and learning, such as textbooks, training, reference material, laboratory equipment, and repairs and maintenance. In the 1992-93 school year, the State issued a policy of giving financial support of 20,000 VND per month to teachers working in State-run kindergartens, all primary education teachers, and to teachers working in ethnic minority boarding schools. However most teachers are very poor and such a gesture did little to change the difficult financial situation of most teachers.

Budget allocations are provided both centrally and locally. Nearly all of the budget for higher and vocational education is financed by the central budget, and approximately 80% of the general education budget is paid from local resources (provincial level or below). Approximately 75% of the total state budget for education and training is paid from local sources. Funding for new facilities is very limited. Central budget allocations provide only enough for funding of salaries and scholarships. Therefore provinces, districts, and localities must meet budget requirements for new educational facilities, as well as learning materials, and maintenance of the school facilities. There are differences among provinces with regard to budget capacity and investment strategy; and per capita funding for education differs dramatically from province to province, and from one district to another within a province.

Over time, parents are being asked to pay more for the costs of their children's education. Only primary education to the end of grade five is completely free. The policy guidance on fee structure for lower secondary and upper secondary has a two tier structure, one for urban areas and one for others. The fees

per month increase from 3,000 dong for grade 6 to 9,000 dong for grade 12 in urban areas and is 1,000 dong less per grade for other areas. The fees charged in the rural areas vary. Parents are also required to cover costs of books, clothing and food, along with special contributions being made for school improvement. However, contributions from parents and students are not well proportioned among levels of education, schools and regions. Richer parents in one region may pay proportionately less of their salaries to support their children's education than poor parents in another region.

3. Education Planning and Management

The merger in 1990 of the Ministry of General Education and the Ministry of Higher, Technical and Vocational Education has created a more coherent system for educational planning and management, although some overlap in function and responsibilities still exist. Decision-making within the Ministry of Education and Training is centralised. Training in management and planning has been provided to about 60% of the management and planning staff at the district education offices, but so far it has been minimal. In the past year the Ministry of Education and Training has spent \$US 475,800 on the purchase of micro-computers to improve data collection.

The budget for Education is prepared by the Ministry of Finance: the delegation of the responsibility for management of human and financial resources in education institutions has not been completed. Thus budgeting procedures should be negotiated between the Ministry of Finance and the Ministry of Education and Training, if the latter is going to develop workable and practically integrated planning, programming and budgeting, in order to improve its management.

Monitoring, reporting and evaluation are seen to be mainly as legal or supervisory requirements with little reference to the important role of monitoring in curriculum development, or in meeting EFA goals. The professional inspection of teachers is low in frequency: in 1990, the average number of teachers inspected range from 10 to 70% with a national average of 34%. There are few resources available for travel, and an overemphasis on supervision for control rather than assistance in improving the quality of teaching and learning.

4. Possible Solutions to Education Issues

In order to implement UPE by the year 2000, the Ministry of Education will focus on:

4.1 Formal education

- + Increasing the number of schools and trained teachers
- + Teacher performance through in-service training and better supervision
- + More relevant material to enable children to learn effectively
- + Improvement of school management through the training of school principals
- + Improvement in the effectiveness of resources

- + Strengthening of the effectiveness of teaching/learning quality
- + Mobilization of the support of community participation
- + Education for ethnic minority people in mountainous areas

4.2 Non-formal education

- + Diversification of the models of Alternate Basic Education classes so they are appropriate to each region
- + Simplification of the curriculum to provide basic learning and skills for children

Other assistance will be provided by:

- + Provision of a World Bank Primary Education loan for 78 million, which will do much to support the development of ethnic minority language curriculum materials as well as infrastructure development.
- + Finding appropriate models for teacher training to respond to the growing teacher shortage
- + Devising systematic, simple and effective ways of monitoring education in remote and mountainous areas.
- + Providing incentives to keep teachers in teaching.
- + Providing efficient in-service training for multigrade and alternate basic education teachers

5. The Prospects for Education for Women and Girls

For female children generally, education in Viet Nam holds fewer prospects than for male children. In all education sectors, female enrollments are lower and drop-out and repetition rates are higher. Overall, the quality and coverage of female education is still quite poor, with disparities more evident in rural areas than in urban areas. Female children are required for economic and household tasks which, in turn, help to lessen the value and urgency of primary education. Literacy rates for women in rural areas are nowhere near the 92 % national average. If rapid socio-economic changes are to influence the lives of women and girls in Viet Nam in positive ways, then provision of education for them will need to be upgraded and refocused.

Chapter X

CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES

Background

In recent decades a growing number of children around the world have been unable to count on adequate family protection and care, devoid of love, shelter, nourishment and sometimes even an identity. These vulnerable children have been termed *Children in Especially Difficult Circumstances (CEDC)*. Many of these children end up living in the streets of urban centers. Exact numbers are not known as no full survey has been conducted. It is estimated, however, that there are three million children in Viet Nam in this category.

Some of these children have no families at all; others have been separated from their families; and many belong to families that have been traumatized by man-made or natural disasters. There are children belonging to abusive and neglectful rather than protective families.

Sometimes family incapacity and dire poverty mean that children are separated from their families in search of a livelihood. Frequently children begin work as early as five or six years in order to help provide some supplementary income to their families. Many children are also born with physical and mental deformities that limit their full potential. The current status of CEDC in Viet Nam is presented in Figure 46 below.

In a country with a long history of war, national programmes in Viet Nam have traditionally focused on orphans and children with disabilities. Many of the latter are born to mothers who had been exposed to chemicals used during the war. While the concept of CEDC in a broader perspective is new to Viet Nam, an increasingly large number of children are now being affected by changing conditions that place them in difficult circumstances. Economic restructuring, which has put the financial burden increasingly on the family and in turn on children, has led to the resettlement of groups of the population in new economic zones, contributing to the causes of CEDC. The return of unaccompanied minors among Vietnamese asylum seekers from various places in Southeast Asia has added to the numbers.

The growing numbers of CEDC in Viet Nam can be loosely categorised into five overlapping groups. However, the disadvantaged children referred to are those without access to basic services, and include ethnic minority children.

1. Street Children

Street children are children under the age of 18 generally involved in informal trade. They may or may not have family links, and may or may not actually be living on the streets, but they are becoming increasingly noticeable in the streets of the major cities of Viet Nam.

As yet no systematic assessment of the number and distribution of street children has been made. Government officials believe this problem will continue to grow if causes are not monitored and controlled in time. There are 5,000 street children in Hanoi according to estimates by the Ministry of Labour, though the number varies according to how the population is defined.

Figure 46: A summary of the status of CEDC in Viet Nam

CEDC Category ^(a)	Age range	Estimated number
Street children ^(b)	6 to 17 yrs	22,000
Sexually exploited children	10 to 17 yrs	8,000 to 20,000
Unaccompanied minors Refugee children	under 16 yrs	20,000 overseas camps: 15,000 returnees
Disadvantaged children ^(c)	under 15 yrs	3,300,000
Disabled children ^(d)	under 16 yrs	400,000 to 1,200,000
Children in conflict with law	under 16 yrs	no data available
Working children	under 15 yrs	no data available
Orphaned children ^(e)	N.A.	9,600

- (a) *The categories are not mutually exclusive. The same child can be classified into more than one category.*
- (b) *The estimates are for Hanoi and Ho Chi Minh City only. The number of street children in other urban centers such as Hue, Haiphong, Da Nang, etc. are estimated to be small.*
- (c) *This category includes children of ethnic minorities. Being born to an ethnic minority group in itself is not necessarily a disadvantage, but due to geographical location, access to social services such as education and health care, renders children in these areas very vulnerable.*
- (d) *It is estimated that 6,000 children between 6-59 months go blind annually due to vitamin A deficiency.*
- (e) *Data from 46 provinces in 1993.*

Some street children have had some primary schooling but have dropped out for various reasons. Some can still read and write. There are many more boys than girls on the streets.

1.1 Who are the street children? What do they do? What are their aspirations?

Early in 1993 three Vietnamese sociologists worked for four months with street children in Hanoi in order to understand who they are and where they come from, why they had taken to the streets, how they make

a living, and what their aspirations were. The analysis focused on the most densely populated districts of Hanoi, and information was collected through unstructured interviews and observations while they spent time on the streets with the children.

Results of the study found that many of the children came from very poor families in Hanoi or its neighbouring provinces, mainly Thanh Hoa, Nam Dinh, Thai Binh and Ha Bac. A large number of street children met during this assessment were from Quang Xuong district in Thanh Hoa province. People in this district are mostly fishermen. This area is also prone to annual floods. Many children often return home but this would depend largely on the economic situation there. The number of street children in Hanoi seems to depend on the changes in the economic situation in surrounding provinces.

An important qualitative and quantitative survey conducted by Terre des Hommes in Ho Chi Minh City on street children has been undertaken. It focused on the commercial areas, the railway station and the Western bus station.

The backgrounds of children, their jobs, and the ways they have organized themselves were very similar to the situation in Hanoi. Some of the highlights of the study are presented in Figure 47 below.⁽⁸⁾

Figure 47: Some characteristics of street children in Ho Chi Minh City

<u>Social Characteristics</u>		<u>Education</u>	
Average age	14 yrs	Can read and write	58%
Boys:girls ratio	12:1	Attending classes	3%
Living with natural parents	32%	Dropped out of school	82%
Parents separated/divorced	23%	Never been to school	15%
One or both parents dead	39%		
Parents unknown	6%	<u>Police records</u>	
Have step-parent	36%	Arrested once	36%
		Arrested twice	10%
<u>Reason for being in street</u>		Arrested three or more times	15%
Broken home	55%	Never arrested	39%
(beaten/neglected/dispute/abandoned)			
To earn money	14%	<u>Use of time</u>	
Attracted by others	12%	Roam about	37%
Parents dead	10%	Sleep/rest	26%
Others	9%	Gamble	11%
		Video/cinema/games	32%
<u>Main occupation in Street</u>		Study	5%
Scavenging	33%		
Begging	26%	<u>Daily income</u>	
Street vending	13%	Less than 5,000 VND	28%
Pick-pocketing/theft	9%	5-10,000 VND	51%
		> 10,000 VND	15%
<u>Use of income</u>		Very variable	6%
Spend on self	82%		
Spend and save	10%		
Share with family	8%		

1.2 Preventive and rehabilitative efforts

The Government response to street children varies widely from the development of rehabilitation and education programmes to occasional round-ups. The Ministry of Labour, Invalids and Social Affairs (MOLISA), District and Provincial-level People's Committees, and the CPCC have been cooperating with multilateral and bilateral donors and NGOs to address the problems of CEDC. Programmes that have been implemented include reuniting children with their families, providing shelter, and formal and informal education.

Results of programmes vary. Sometimes children run away again after being reunited with their families; some return to the streets because their families are economically dependent on their street income. Some programmes fail to answer the emotional and social needs which encourage the sort of stimulation necessary for healthy development.

Some of the services that have been established are described below.

1.2.1 Drop-in centres

As a result of the personal initiative of a few committed social workers and NGOs, several drop-in centres have been established by the Committees for the Protection and Care of Children in Hanoi, HCMC and Da Nang for children who want to get off the streets. The main objective of these centres is to provide attractive alternatives to street life. The centres, also known as children's homes, aim to provide shelter, a caring home environment, alternative basic education, vocational training, and recreational activities. They also try to provide the opportunity for children to be reunited with their families, if they have families and if they want to be reunited.

These homes have had varying degrees of success. They are able to help only a fraction of those children who would like such an opportunity.

Children expressed a preference for newspaper, postcard and book vending and shining shoes. However, two drop-in centres in Hanoi with UNICEF assistance have been experimenting with income generation projects: chalk production for primary schools and a poultry farm. In the event of this project succeeding in its objectives of keeping children off the street and providing them with a decent income, similar training programmes for the development of specific skills may be introduced at other drop-in centres. Vocational training in tailoring, carpentry, and motor mechanics for jobs is often inappropriate in cities like Hanoi and HCMC because a competitive market for such skills already exists.

The education component of the drop-in centres has not had much success. Many children, accustomed to an independent street life, find it difficult to adjust to the routines imposed in a structured teaching-learning situation. Some drop-in centres have introduced basic reading, writing and mathematics skills. In general the education component of drop-in centres requires more planning.

The education factor is further complicated by the centres being unable to fulfil the conditions that the various ministries and institutes which have a variety of training require. A large number of scholarships provided by NGOs also remain under-utilised. Many of these centres are assisted by university faculties, international NGOs and donors such as World Vision International, Radda Barnen (Swedish Save the Children), UNICEF, Terre des Hommes, Christina Noble Foundation, and others.

1.2.2 Government institutions for street children

Ethnic Minority Children

Being born to an ethnic minority family is in itself is not a disadvantage. However, many ethnic minority children in Viet Nam face serious problems in receiving educational, health and nutritional services equal to national standards. In general the nutritional status of children in Viet Nam is low, by a variety of indices. There have been no nutritional studies on specific minority groups, but it is presumed that in highland areas, where food shortages and other environmental problems exist, the nutritional status of children is worse than the national average.

The overall fertility rate among minority populations is also high compared to the national average. Among some minority groups about 30% of females are married by the age of 14 years which in itself is a risk. Many children suffer from various preventable illnesses, causing high rates of morbidity and mortality among children. Malaria and deficiency disorders of iodine, iron and vitamin A are disproportionately high among the highland and minority populations. Minority children also have the additional plight of water-borne diseases, as access to safe water and sanitation in these areas is very low compared to areas inhabited mostly by the Kinh, the majority ethnic group.

School enrolment is very low for a number of reasons which have been discussed in considerable detail in the chapter on Education. In some areas only about 5% of school-age children are enrolled. Out of this enrolment only a fraction are girls of minority group such as the H'Mong.

The minority children are also disadvantaged by the fact that all formal education is in Vietnamese, a language foreign to them. A high primary school drop-out rate ranging between 50 to 70% and a repetition rate between 30 to 40% are perhaps the results of teaching in a language not known to the children together with a curriculum that may not be relevant for the highland populations

In most ethnic minority areas the population is scattered and there are few schools. Families and children find it more convenient to work at home and in the field rather than attending school. Despite several Government development strategies in the way of satellite and boarding schools, due to the current economic climate and the way of life of the minorities the Government finds it hard to reach this scattered and mobile population with basic services.

City authorities periodically round up children and street families. Between 1981 and 1991 Hanoi police rounded up 24,344 people from the street, of whom more than 6,595 were children under 17 years of age. The children are usually sent to Government institutions. There are 40 such institutions, including five SOS villages managed by MOLISA. Children may be sent home or reunited with the families if they

are claimed by their parents. The families may be sent to the new economic zones. If children are orphans they are sent to SOS villages. The rest are kept in social camps. The procedure, following the round-ups is the same as that for the drop-in centres.

One of the most positive programmes of SOS centres and the social camps is the alternative basic education organised by MOLISA. Known as "affection classes", the 120-week primary school curriculum offers free classes for children in the centres.

This programme is however hampered by lack of funds for trained social workers, developing physical facilities, and providing resources to meet the needs of different groups of children. It is difficult for staff to develop rapport with children essential for developing their confidence.

According to the study conducted in Hanoi, a number of children have run away from social camps, returning to the streets. In the camps children and adults are reportedly not differentiated; drug addicts, prostitutes, and vagrant children are all treated in the same way. Small children are victimized; those picked up for loitering are treated the same as children caught for civil offences. Children running away from formal institutions reported they were treated badly and often physically abused by the staff. The routines, monotony and hard discipline in such centres are counter productive often encouraging violent and anti-social behaviour learnt while in the camps and once back on the streets they run into further conflict with the law.

According to the children interviewed who had managed to leave the social camps, the regular and frequent rounding-up of children, and the sending of them to large closed institutions via a lock-up transit centre, is basically unjust and creates an atmosphere of fear and hostility towards society and the authorities. Few children are helped to lead a normal life. Such measures may be justifiable for frequent offenders. For runaway children and homeless children, more humane and better solutions must be identified. The constraints stemming from a lack of resources to provide children with the social services they need, and a lack of staff trained to rehabilitate rather than simply control children need to be addressed. Programmes must be developed to meet the unique needs of this troubled population.

1.2.3 Private support

In early 1992 a private citizen brought together a number of street children and formed a group called "Away from the Mother" with an aim to provide them with economic and social support. The children were given identity cards and newspapers, postcards and maps to sell in commercial districts of Hanoi. This worked well as children were able to make a decent living. Children are also given basic educational skills and assistance for health needs. In recent months several private groups in Hanoi have begun to use street children as roving newspaper, book, and magazine salesmen. Groups of children are also allowed to sleep in private houses and are given simple meals at a fixed cost. This collaboration appears to be mutually beneficial.

However, the private groups that have appeared recently have been criticised by some social workers for the nature of the employer-employee relationship which is closer to child labour, as opposed to the original social service concept of the "Away from the Mother" group. The commercial groups offer no education or help for the children to become independent.

Responsibility for street children has not been clearly defined yet. Street and working children and the whole issue of disadvantaged children fall into a grey area with several offices and Government departments directly or indirectly involved. These include the Ministry of Labour, the People's

Committee, the Department of Security (Police), the Red Cross, and the Committee for the Protection and Care of Children (CPCC). Coordination between the concerned departments of Government and street-based NGOs is essential if effective support and help is to develop an appropriate social work approach towards street children's programmes.

2. Sexually Exploited Children

Pre-adolescent and adolescent children have become a common target for sexual exploitation in many developing countries. Sexual abuse causes physical, mental and emotional trauma in children, in addition to the risk of sexually transmitted diseases⁽¹⁸⁾ and AIDS. Viet Nam has been experiencing the problems relating to a growing sex industry which is involving growing numbers of young people. The introduction of an open door policy and a market economy has had both positive and negative results in society and the economy. Traditional social values may be deteriorating, as families are faced more and more with material desires which they cannot meet. As a result, child employment and the sale of children for labour (and eventually other forms of exploitation) have been increasingly noticed in Viet Nam.

Broken families and poverty have caused many children to leave their place of origin in search of economic opportunity, whereby they may fall victim to pimps. The number of prostitutes in major Vietnamese cities combined is estimated between 80,000 to 200,000. The National AIDS Committee has reported that approximately 7% of all Vietnamese prostitutes are under 18. In Hanoi and Ho Chi Minh City this figure is 16%, an alarming statistic. Prostitution is openly available under different pretexts, in places such as beer kiosks with girl attendants, karaoke bars, restaurants, recreation centres, railway and bus stations, cafes and hotels.

2.1 Appropriate legal protection

Prostitution in Viet Nam is illegal, but laws against child prostitution have not been enforced rigidly. In the eyes of the law, prostitutes are treated as criminals rather than victims. The organizers of such crimes and the pimps somehow manage to escape the law.

No specific plans have been developed due to the lack of specific data on children involved in prostitution. Prostitutes picked-up from various brothels and streets, including minors, are kept in camps temporarily until they are reunited with their families. Child prostitutes may be sent to social camps where other street children are kept. Under the umbrella of the National Plan of Action for Children, the Government is developing a policy and action plan to rehabilitate all categories of CEDC. Special programmes will be provided along with suitably protective measures to help vulnerable children.

3. Refugee Children

Out of over 80,000 Vietnamese asylum seekers in refugee camps in Southeast Asia, about 20,000 are under 16 years of age. Many of these children were born in the camps. It has also been acknowledged that a number of these children were sent by boat from Viet Nam by parents hoping to join them once they had been officially resettled in a third country. About 3,000 child refugees are assumed to be unaccompanied minors.

Of the more than 43,000 refugees who have returned from Hong Kong and other Southeast Asian countries since 1989, over 15,000 of them were children. They have been reunited with or resettled with their families in 43 provinces. More than 70% of the resettled/reunited children are in/from Dong Nai,

Hai Phong, Kien Giang, Quang Ninh and Hue provinces. Many of the children in camps today will be repatriated to Viet Nam like others before them.

3.1 Repatriation programmes

Many international organizations have worked with Viet Nam to assist repatriated refugees. Among them are the European Community, International Organization of Migration, Nordic Assistance to Repatriated Vietnamese, UNHCR and several other bilateral donors.

The Government has accepted the Orderly Repatriation programme, and with the assistance of UNHCR has taken active participation in resettlement of all returnees, including children. Children who returned without relatives were provided special care by the local authorities in locating parents or relatives.

In order to resettle the returnees and to discourage them from leaving again, UNHCR is providing each returnee with a reintegration allowance of US\$410, and US\$25 pocket money upon arrival in Viet Nam, in addition to funding commune-level micro-projects. The outflow of people from Viet Nam is ending. In 1992 only 55 Vietnamese illegally reached Hong Kong and other destinations, none of them children, compared to 22,422 in 1991.

4. Disabled Children

Estimates on the number of disabled children in Viet Nam vary from about half a million to well over one million depending upon the source of information. MOLISA estimates the total number of disabled children at one million; Hanoi Children's hospital estimates 1.2 million; while the National Institute of Educational Sciences estimates about 400,000. These figures have not been officially published. The two former estimates may include impairments which do not prevent an individual from acquiring education or participating in other activities (eg. the loss of a finger, a mild hearing loss which could be treated, etc.). The 1989 national census estimates the number of disabled people at 2.2 million but only for individuals above 13 years of age. Estimates for children are not available.

In a recent house-to-house survey of 300 communes covering 1.6 million individuals in 10 provinces the Institute for the Protection of Children's Health reported a prevalence of 31.2/1000 cases of disabled people in the general population: 11.7/1000 cases in children under 15 years and 43.8/1000 cases in adult population. About 35% of the total disabled population was reported to require rehabilitation support. The types of disability is presented in Figure 47.

The National Institute of Educational Sciences (NIES), responsible for the development of an education programme for disabled children, conducted a separate house-to-house survey in 187 communes in eight districts, including two mountainous districts, covering 1,454,017 individuals, of whom 512,824 were children under 15 years of age. This survey reported a total of 9,403 children under 15 years with some form of debilitating condition (Figure 48): equivalent to 18/1,000 cases per child population. This rate of disabilities is close to the global prevalence estimated by the WHO.

Figure 48: Percentage of children under 15 years of age with various disabilities in 187 communes

Types of disabilities		(n)
Visual	15.1%	1,429
Severe	11%	
Mild	89%	
Hearing	11.2%	1,056
Severe	30%	
Mild	70%	
Speech	17.0%	1,589
Severe	22%	
Mild	78%	
Movement	19.6%	1,839
Severe	34%	
Mild	66%	
Learning	25.8%	2,423
Severe	30%	
Mild	70%	
Strange Behaviour	1.2%	117
Severe	39%	
Mild	61%	
Multiple conditions	5.5%	518
Severe	65%	
Mild	35%	
Others	4.7%	446
Severs	25%	
Mild	75%	
All conditions	100%	9,403
Severe	29%	
Mild	71%	

Source: National Institute of Educational Sciences Survey conducted between 1991 - 1993.

Learning and movement difficulties appear to be the most common form of disabilities in children, followed by speech and visual impairment. Within each category of disability nearly one-third are reported to be severe, and the remaining are assumed to be mild conditions which can be rehabilitated with minimum resources.

4.1 The rehabilitation programme

Childhood disability has been recognized by the Government as a major problem. There are two schools for the blind and sixteen schools for the deaf providing educational and life skills. In addition there is one school for mentally retarded children and one school for children with speech difficulties.

All provincial hospitals of Viet Nam have a department for rehabilitation of disabled individuals. Recently the Government has made a special effort to implement the community-based rehabilitation programme to assist the large population of disabled individuals living in rural areas. The current Government programme covers a pilot scheme in 300 communes in 10 provinces. The Rehabilitation unit of the Institute of Protection of Children's Health provides the necessary technical support for this programme which includes staff training, production of artificial limbs and body parts, mobile supports such as wheel chairs, etc. This programme is largely funded by Radda Barnen, World Vision International and the Komitee Twee of the Netherlands.

The birth of a disabled child is seen as a curse to the family, a social stigma, and disabled children are usually hidden from the communities. As a result the rehabilitation programme has come across a number of social obstacles. However, many such problems have been successfully overcome with proper information and appropriate services.

Since 1991 the NIES, in line with the Convention on the Rights of the Child and the UPE, has developed a project to integrate mildly disabled children into mainstream primary school education. This was not the case in the past. NIES has trained 4,626 teachers for education of disabled children and have managed to integrate 9,334 mildly disabled children into 4,601 regular primary school classes.

The support provided to children includes special furniture, writing surfaces products, text books and exercise books, and hearing and visual aides.

5. Working Children

Children have always worked, especially in underdeveloped countries, in tending livestock, harvesting crops, weaving, knitting, vending household products, looking after younger siblings, cooking family meals, carrying water and firewood, etc. These categories of children's work can be considered as an integral part of family activities and can be viewed as a way of building self-confidence and self-esteem in preparation for the future.

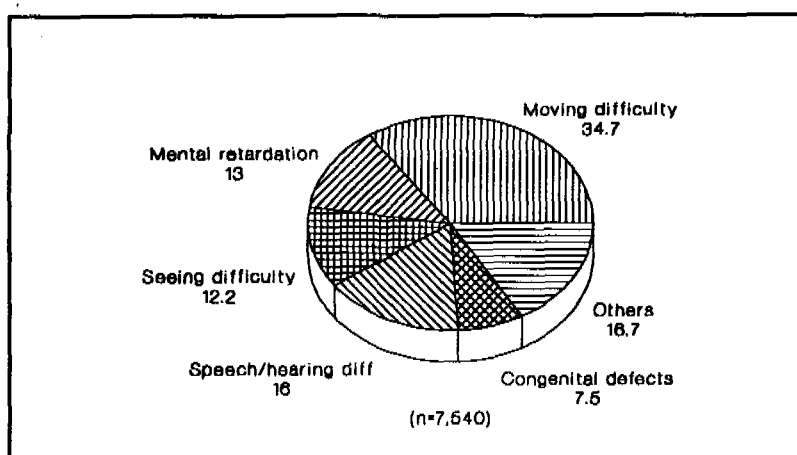
However, in many urban and suburban areas children are actually employed full-time in knitting, weaving, vending, working as house-maids, cleaners in restaurants and garages, etc., to supplement the family income. It is not easy to draw a line between learning and socialization vs. child labour. But when children start work at too young an age and for too many hours, doing heavy physical labour, and when work conflicts with school time and playtime, the situation may be classified as exploitative.

The lawful age for official employment in Viet Nam is 18 years. However, like in many other developing countries children work in the homestead, fields, and in private homes to help parents by sharing their workloads or by directly contributing financially. As assessment of their contribution to the family economy could not be appraised easily. In mountainous areas, where schools are few and difficult to reach, many children help parents in their agricultural work. There are in Viet Nam many large plantations for rubber, tea, sugar, coffee, etc., employing hundreds of thousands of families. In such areas there are few secondary schools. Many children who complete or drop out of primary schools help their parents (and are not directly employed) in collecting rubber-sap, plucking tea leaves, coffee beans, harvesting sugar-cane, etc.

In implementing the Convention on the Rights of the Child, in accordance with the World Summit for Children, Viet Nam is finalizing a National Programme of Action for children which will try to review labour laws and minimum wage laws to address the needs of children.

6. Children in Conflict with the Law

A small number of socially unsettled children -- vagabonds, vagrants, etc. exist in all societies, especially in urban centres. In Viet Nam there is a small number of children in this group living in Hanoi, Ho Chi Minh City and other cities. They often come into conflict with the law as a result of their activities. The city police in Hanoi arrested a total of 24,344 vagabonds between 1981 to 1991, of whom 6,595 (27%) were children. Out of this total, 4,958 children (75%) were arrested between 1989 to 1991,



indicating a growing problem of children in conflict with the law. An analysis of 1,297 cases of juvenile prisoners indicate theft to be the main cause (49%), followed by 17.4% causing physical injuries to others including 25 cases of murder and 30 cases of rape. Others include 13% of extortion, 12% breaking public order including gambling, and 8% other minor offences such as drunkenness, traffic accidents, etc. (Figure 49).

Figure 49: Percentage of disabled children by types of disabilities in 300 communes

Source: Institute for Protection of Children's Health, 1993.

Police interviews with a sample of children in custody concluded that poverty and family instability are the main reasons children commit crimes. The families of these children share one or more of the following characteristics: parents earn their living illegally, are gamblers, use narcotics, are divorced, physically abuse the children, or one or both parents are dead.

About 46% of children in police custody had primary school education, 40% had lower secondary education, 1.5% had secondary education and 12.5% had no education. The Director General of the Police is of the opinion that since many children who have been arrested have had some education, the educational system itself must be failing to keep kids from dropping out of school and getting into trouble.

6.1 Juvenile penal codes

There are several penal codes related to juvenile offenders. One issued by the office of the Prime Minister (decree 217/TTG/NC) states that any individual under 14 years, if caught in the act of violating social norms, can be released with a warning, may be fined (to be paid by parents), or can be sent to industrial agricultural school to complete studies in agriculture. Almost 12,000 juvenile offenders have benefited from this school since 1967. The general public, however, seems unaware of the existence of juvenile penal codes. Many social scientists believe that the Vietnamese juvenile justice system needs to be updated.

6.2 New strategies and approaches

The global concept of CECD is quite new to Viet Nam. In the past the Government paid particular attention to specialized care of disabled people by opening rehabilitation centres, special schools, vocational schools, etc. The National Programme of Action for Children prepared by the CPCC will try to address the problems of CECD in various ways, through providing adequate educational and recreational facilities for children where appropriate. This should help address some of the causes of CECD in Viet Nam.

1. The Government is fully committed to the implementation of various plans to provide necessary services to children according to the guidelines provided under the Convention on the Rights of the Child. The development of provincial programmes of action is also a testimony of this commitment.
2. Different groups of Children in Especially Difficult Circumstances will require different approaches to counter the problem. The largest groups of CECD in Viet Nam appear to be street and working children.
3. The large number of children involved in the domestic/private sector economy is a concern. Careful review and enforcement of labour law and minimum age and wage law may help prevent child labour. Children employed in the private sector must be carefully monitored. Various ways and means should be explored to provide alternative education to this group of children.
4. The problem and situation of street children in Viet Nam in terms of their number, distribution and their involvement in undesirable activities is not yet a cause for alarm. This is probably the first generation of street children. The numbers involved are still manageable and should be given a high priority to contain them. A large number of street children come from families with low household income. It is possible to identify the at-risk communes or at-risk districts. Small-scale projects to improve the economy of poor and disadvantaged families in these communes may put a stop to the influx of children to urban centres.
5. The vocational training of street children appears inappropriate for two main reasons: there are other skilled competitors and most children are still too small for any substantial training. A direct service and income-orientated programme will probably benefit them more than vocational training. For the older children aged 16-18 years, vocational training may be appropriate. A single common solution will not meet the needs of all children, who are in the street for a variety of reasons. Separate economic and social development programmes should be developed to address the emotional, physical and social needs of children.

*Case study: Children in Especially Difficult Circumstances
Nguyen Thi Lan (15-year-old female)*

Nguyen Thi Lan was born in 1977 in Thanh Hoa province. Her father, a 37-year-old farmer, deals in longan trading. Her mother used to work in the field. Lan used to go to a primary school in her native village. Lan was the only child in the family. The family was close-knit and happy, Lan said.

*Case study: Children in Especially Difficult Circumstances
Nguyen Thi Lan (15-year-old female)*

(continued)

When Lan was about six, her father began to have an affair with another woman in the same village, and began to treat her mother and her very cruelly. In 1989, when Lan was 12 years old, her mother fell seriously ill and died. Three months later her father remarried. After the wedding her father sold his property and went to live with his second wife.

Lan could not get used to the step-mother and the new house. She had completed only six years of primary school education. She could not concentrate on her studies. One day she decided to come to Hanoi to find her mother's aunt whom she had not met for several years. She found Hanoi too big a city and was unable to find her aunt. She found a job in a Com Pho shop in Hang Bot street. The owner, Lam, gave Lan food and shelter but no cash payment. She treated her well for a few months.

One day Lam forced her to have sexual intercourse with a customer who came to the shop. At that time Lan was only 12 years old.

After this incident she wanted to leave Hanoi but did not know where to go. She knew of a man from Haiphong who used to visit her family. She decided to go to see him in Haiphong. She went to Haiphong and stayed with Do's family doing household work for nine months. While in Haiphong she also learnt martial arts. She wanted to grow strong and be able to defend herself.

One day she decided to come to Hanoi and look for work. At the Hanoi bus station she met a man named Cuong who promised her a job and a place to stay. With hope for a job and a place to stay she followed him. Lan stayed at his home, doing housework for a few days. One day Cuong forced her to have sexual relations with him, and later that day took her to a couple, Tuan and Ngoc. She was left in their custody. She knew that Cuong was paid for bringing her there; she knew that she had been sold.

Lan worked in the tea shop of Tuan and Ngoc. Within a few days she discovered that the tea shop was a brothel in disguise. She was forced into prostitution by Ngoc almost regularly. Whenever she refused she would be beaten, sometimes severely. Sometimes she is dropped off at the Bong Sen Hotel for meeting customers and Ngoc brings her back regularly to their house/tea-shop/brothel.

In 1991 Lan and Ngoc were arrested by police while at the Bong Sen hotel. Since Lan was under 16 years old she was released after few months. After her release from prison she went back to Bong Sen to meet a girl with whom she had developed friendship. Her friend Tam, a 21-year-old, is also a prostitute. She helped Lan get work selling fruits in Phuc Tan commune near the Red River bridge. During the daytime Lan sells fruit and at night time she still works as a prostitute.

*Case study: Children in Especially Difficult Circumstances
Nguyen Thi Lan (15-year-old female)*

(continued)

Lan now feels that she is used to the life of a prostitute. She has been arrested three more times but detained (in Ba Dinh police station) only for a short time, since she is still under 16 years old. She is helped by a 22-year-old man to find customers. She and Tam have jointly rented a house near the Red River bridge with a monthly rent of VND100,000, where the customers are taken during the night. She makes enough money for living. She does not have to pay for the patrons. Sometimes the middlemen take her to big hotels where she serves Vietnamese as well as other Asian tourists, mostly from Taiwan, Thailand and Hong Kong. When the customers are non-Vietnamese she often makes US\$20 to \$30 daily. For Vietnamese customers the prices ranges between VND50,000 for immediate sex to VND100,000 Dong for overnight stay.

She does not feel like changing her occupation now. She still wants to go back to her father, but she does not know how to confront him. She was told that her father now lives in Saigon. Lan likes reading cheap novels, going to cinemas, visiting pagodas and meeting friends around Ho Tay lake.

6. A carefully review of the positive and negative aspects of the present programme of rounding-up children from the streets needs to be conducted. State-operated institutions for these children and families need more staff with social work training if they are to effectively carry out their responsibilities. Children and families picked up for different reasons must have separate accommodation. The newly-created economic zones seem to be a source of street children; the Government should analyze the reasons why this happens.
7. The Government should continue to encourage and support individuals who are interested in opening children's homes.
8. Much of the out-of-school child population is from ethnic minority regions of Viet Nam. The social development policy of the Government needs to be strengthened to extend education, health and other social services to these areas to provide necessary support to children.
9. The sexual exploitation of children is not very common in Viet Nam but a careful monitoring system must be created to stop this developing.
10. The treatment and rehabilitation of disabled children is making good progress. The education of disabled children to support the national goals of UPE is highly commendable.
11. The return of child refugees from various places of asylum and their reintegration and reunion with families and relatives shows Viet Nam's commitment to solving the problems of boat people.

Chapter XI COMMUNICATIONS

1. Introduction

The economic transformation has had an inevitable impact on family welfare. The most relevant change in empowerment of the family has been the creation of a greater range of family choice for earnings and spending, food production, shelter, social and welfare services and education. With greater choice there is also greater risk. Because people have more options, and must themselves pay for many previously free or subsidized social services, the need for educated decision-making by families has increased significantly. The economic and social transformation has empowered the family by broadening available options but it has also created new pressures on family welfare decision-making.

At this time of rapid social change families need help in accessing new and relevant information and appropriate family welfare skills. In order to take advantage of increased opportunities and spending power, they will need new Government and private sector services to support effective family decision-making and sustain new welfare practices. Viet Nam's extensive mass media system, large existing network of mass organizations and family commitment to self-care need to be exploited in order to protect and improve family welfare in these times of increased choice but greater risk.

2. The Informal Communication Network

How then are family practices influenced by the informal communication networks and the mass media system? Public studies done on decision-making, channels and sources of influence and health-seeking behaviour are discussed in the Health chapters and the chapter on Women. Very few systematic studies are available on actual mass media use by Vietnamese audiences. However, UNICEF and Government have undertaken a number of new studies on these issues in the last two years; these form the basis of this section of the analysis.

Women are the main family welfare providers. They produce most of the food consumed by the family, they manage most animal husbandry, they prepare most of the food, they treat most of the family sickness and are chiefly responsible for managing household finances. Naturally women within the family help each other, there is a natural communication hierarchy based on age and blood-ties. In a recent UNICEF-Government study on sources of influence within the family in a rural delta region and a small delta city the importance of the family network was confirmed. In the study, most women reported that they sought advice from their own mothers first and other family members next. (They also preferred advice from close personal friends before husbands and fathers). In terms of receiving unsolicited advice women reported that they received this more from their own parents, especially mothers, rather than in-laws. In terms of whose advice mothers tended to act upon most, they ranked the following sources - the mass media as most followed, their own mother next, followed by health workers.

The study also provided some insight into the difference between rural and urban influences. One key difference was that amongst urban women, workplace friends were an important source of solicited advice. This small study confirms some other anecdotal evidence about key sources of influence in family welfare decision-making and provides some new information about the high value placed on welfare advice coming through mass media channels and the role of workplace friends in urban situations.

If mothers are influenced by family members, what then is the quality of this health advice and how do they act on this information. Another recent UNICEF-Government study provides some insight into the kind of welfare advice people receive and act on from the informal family network. The implications of this study relating to self-care are described in detail in the chapter on Health.

However in terms of the network of communication these findings are instructive because they illustrate two important features of how, and from whom mothers learn about, and practice, child and self-care. Firstly the informal women's network of family members and respected friends is a key channel in influencing both child and self-care practices. Therefore any positive influence that child and maternal welfare organizations have on these key channels will probably impact positively on family welfare practices. Secondly, a respected, credible and accessible mass media can help mothers accept new welfare information. It has a potential role in helping to change behaviour by shaping the advice available through this highly influential informal women's network. The promising use of the mass media to provide direct skills-based instruction targeted at rural mothers and women requires improved and appropriate media programming which is yet to be developed.

Trends indicate that self-care and the use of private sector (modern and traditional) care-givers will increase. Poor and marginal groups have much less choice and will be forced to fall back more on their own limited resources. Consequently influencing the informal network of poor and marginal groups is a critical and difficult task. "Independent" decision-making is likely to increase in the interim period as the public social service system reforms and stabilises. The need to influence more directly the informal channel will increase as market choices multiply. The critical goal is to promote "educated" decision-making favouring child and women welfare in a dynamic, exciting, but not always reassuring environment.

3. Mass Media

3.1 The challenge

As with the rest of the country, Viet Nam's mass media system is engaged in redefining its role in a rapidly developing market economy system. Government still maintains direct control and this has an advantage in that it can greatly simplify access to the media for social development programming. Government is reorganizing programming and upgrading physical plant for the newspaper press, radio and television. The transition is a challenge. Programming in the past emphasized almost exclusively support for the political development process. Government is now relearning how to use the mass media for social development to improve the capacity of ordinary people to make effective choices in a market economy. In today's Viet Nam, persuasive communication is more effective than didactic communication because the market reforms have placed many public choices outside the direct control of Government. Government can no longer compel people to use Government health facilities or use new Government-encouraged health practices simply because the private sector now offers new and attractive choices and because by and large, people must pay for previously free Government services.

Therefore, Government media has a new role in "persuading" people to recognise the intrinsic value of new health and welfare practices since they are unable to compel their adoption. However, it must be recognized that "persuasion" of non-captive audiences through the mass media is neither inexpensive nor easy.

Viet Nam's media has both pluses and minuses. The country does have an extensive, viable, but nevertheless stressed, mass media system, and this system still commands respect and credibility amongst the mass of the people. The relatively high literacy rate and the existing dominance of the printed media are also pluses. However, on the other side of the equation Viet Nam's mass media system faces serious challenges. It must remain financially solvent in a unforgiving market setting and it must learn new communication and programming techniques to reach an audience which is now subject to many new and non-controlled influences such as the burgeoning video market. It must maintain credibility and respect amongst an increasingly demanding population.

3.2 Media access

Whilst there is an extensive mass media infrastructure media access is problematical. A recent Government press release indicated that 80% of newspaper circulation is urban. TV access is limited by the lack of television sets especially in rural Viet Nam. There has certainly been a rapid increase in the number of TV sets available in urban and to a lesser extent, rural households due to market reforms but coverage is still very limited.

Radio access is also problematical. Whilst there are many more radio sets people struggle to pay for batteries in rural areas. Peak broadcast times are dominated by news programming and women, who are key target audiences for child and family welfare programming do not often have the time to listen to radio because they are too busy with family work. Targeting programmes to secondary child-care providers in the family such as grandmothers, young single women and other female relatives is an important option.

Viet Nam has two immediate options: (i) Strengthen social development programming in all sections of the media; and (ii) Increase staff training in such areas as audience research, programme management, and innovative programme production. UNICEF has initiated a range of assistance activities designed to stimulate circulation of children's newspapers, strengthen radio production capacities through training and increase and improve mass media dissemination of child and women's welfare information through sponsored programming and technical assistance. But there is much more effort required before significant results will be seen. Successful use of the mass media for behavioural change is a cumulative process and Viet Nam is just beginning.

3.3 Print media

There are approximately 300 newspapers and periodical publications nationwide, including six dailies in Vietnamese and one daily in English. The most heavily circulated newspaper is Nhan Dan (The People's daily) which is published simultaneously in Hanoi, Da Nang and Ho Chi Minh City with a circulation of 300,000 copies. The reading of this newspaper is made compulsory in most Government agencies and party organizations at all levels.

Almost all State agencies, mass organisations as well as provincial People's Committees have their own newspapers which beside their professional concerns also feature articles on socio-cultural issues. The following newspapers are most active in promoting children's rights and children and women's welfare concerns:

- Vi Tre tho (For the children); weekly paper of the Committee for Protection and Care of Children, circulation: 50,000;
- Quan doi Nhan dan (People's Army); daily paper of the Ministry of Defense, circulation: 120,000;
- Phu Nu Viet Nam (Vietnamese Women); weekly paper of the Viet Nam Women Union, circulation: 80,000;
- Hanoi moi (The New Hanoi); daily paper of Hanoi Capital, circulation: 50,000;
- Tien Phong (The Vanguard); weekly paper of the Ho Chi Minh Communist Youth Union, circulation: 120,000;
- Nhi Dong (children under nine years of age); weekly magazine, circulation: 230,000;
- Thieu nien Tien phong (The Pioneers); weekly paper of the Central Council of Pioneers, circulation: 100,000;
- Sai Gon Giai phong (The liberated Saigon); daily paper of Ho Chi Minh City People's Committee, circulation: 50,000.

On the average each person reads fewer than six copies of various newspapers per year, according to an unofficial statistic in 1992. This is due partly to the relatively high price of print paper and high distribution costs. In general most newspapers are available only in urban and delta areas while in mountainous remote areas newspapers arrive several days late and sometimes are not available at all.

3.4 Audio media

The national Radio "Voice of Viet Nam" was established in 1945. It can now cover more than 70% of the country. On six air waves (two medium and four short wave) and with a total capacity of 730kw, the VOV broadcasts 68 hours daily including 42 hours of home service and 26 hours of overseas service in 11 languages (Vietnamese, English, French, Russian, Spanish, Indonesian, Thai, Lao, Khmer, Mandarin, Cantonese and H'mong).

The daily broadcast of VOV, beside news and other political economic issues or entertainment, includes three hours of programmes in all on socio-cultural affairs, women and children, population and environment.

The programmes of VOV are received nationwide by a network of 52 provincial radios which relay these programmes while adding local programmes as well.

Technical plans are envisaged to improve the quality of broadcast and to increase the national radio coverage beyond 70%. It is estimated that for a population of more than 70 million there are 7 million radio sets and 800,000 cabled radio sets. On a national average, one radio is owned by every two five-member households and one cabled radio by 14.3 families

Few people in the urban areas listen to the radio, but people in rural and coastal areas often turn to radio as the only reliable source of information and entertainment.

4. The Mass Organizations

The main social service organizations for children and women and family welfare are the Women's Union, the Youth Union, the Peasants Union and VACVINA. These mass organizations are discussed in some detail in the chapter on the National Context. Whilst these organizations and activities hold great promise there are some major drawbacks at this time. These organizations are predominantly skilled in political mobilization and therefore lack the strong technical skills and experience to effectively carry out the new social service work - preventive health, appropriate nutrition, child-raising and education support.

Technical training to help organizations make effective use of these extensive membership networks is an important and recognized need by both the organizations themselves and donor agencies. Another drawback is the sheer size and complexity of many of the social welfare needs - e.g entrenched negative child-rearing practices heavily influenced by poverty; new market opportunities making schooling less attractive. A further drawback is the difficulty involved in successfully joining two different styles of operations when mass organizations must work with technical ministries and other Government service agencies. There is a strong tradition of vertical and competitive operations making coordination and joint action difficult. Another significant drawback is the creeping decline in organizational membership and operations as a result of the reduction in Government subsidies and the greater non-Government opportunities now offered by a more liberal economic environment. People are now much more preoccupied with their own businesses and family priorities. Grassroots branches have become defunct largely because local officials cannot afford salaries and other costs on their own. Undoubtedly many of these drawbacks can be overcome by conscious effort - a long-term capacity-building exercise. But the brutal truth is that many organizations will decline. It is important for development agencies to help support these organizations during the difficult transition because they represent an extensive and generally viable community-based self-help system. Generally, it is easier to maintain systems than it is to create them so there is value in activities which strengthen mass organization networks.

One expected trend is for existing mass organizations to continue to downsize and function more on free-market principles. Operation styles are likely to reflect styles common to "Western" NGOs - dependant on donor funding, needs driven with an increased apolitical approach.

5. Traditional Channels of Communication - Festivities

Traditional festivities and national celebrations provide good communication opportunities because festivals and celebrations are times when people more consciously examine important life issues. Viet Nam's traditional holidays tend to follow the lunar calendar. Aside from the national celebrations, the most famous of which is Tet, there are many local festivities offering homage to local deities or patrons of local temples. In general there are festivals which are national and historically significant (eg. Trung Sisters Day), or national and religious or local, regional and recreational. "Renovation" in Viet Nam has led to a resurgence in the explicit observance of religious, recreational and other traditional festivals. People have more discretionary income to celebrate with and the new life risks associated with the free-wheeling market system make people more inclined to seek spiritual guidance. Celebration of traditional and other cultural festivals therefore figure more prominently in the lives of Vietnamese people and provide opportunities for new communication outreach.

TET - Lunar New Year

Tet, or Tet Nhat, its full name, is the biggest Vietnamese celebration. It is celebrated on the day of the first new moon of the lunar year and falls between January 19 and February 20. It is a time of great merriment, generosity and renewal. Traditional belief has it that the god of the household returns to heaven to report to the Jade Emperor. The household, including household graves, are therefore thoroughly cleaned, in anticipation of an auspicious report. Special decorations and symbolic plants and foods are prepared. Invitations are issued including to ancestors, and much thought is given to preparing for a good future. In Vietnamese chronology, Tet is also everyone's birthday.

Other significant festivities especially relevant to the promotion of family welfare are:

Hoi Lim Festival -- This is an alternating song contest for girls and boys who court each other through song dialogue. The contest follows strict rules about how the songs can be sung with conditions set for how many melodies can be repeated and how many must be extemporaneous. The songs deal with daily life and are practiced and rehearsed throughout the year as young people go about their daily rural work.

Trung Sisters Day -- This festival celebrates the successes of two sisters against the Chinese in AD 40 - this festival celebrates Vietnamese independence and promotes perseverance and courage and asserts the important protective role of women and their equality with men in Vietnamese society. This festival has become the traditional festival venerating the women of Viet Nam.

Perfume Pagoda Pilgrimage-- This series of pagodas receives pilgrimages from throughout the country. People visit the pagodas to request favourable treatment from the gods and the granting of special wishes - good fortune, healthy birth, pregnancy, successful business and other needs.

Phat Dan Day -- This celebrates the birthday of Buddha and is a significant celebration for Vietnamese Buddhists.

Thanh Minh Day -- This day honours the dead. There is a continuous connection between the living and the dead in Viet Nam. The treatment of one's ancestors by the family has an important bearing on the family's good fortune. Burial remains are sometimes exhumed for reburial in more favourable sites.

Vu Lan Day -- Day of the Dead/Wandering Souls day - This day honours the family dead. Offerings are made to the ancestors.

Hung Viewing Kings Day -- This celebrates the founding of Viet Nam by the Hung Viewing Kings. Vinh Phu province celebrates this with special water puppetry and wrestling shows.

King Din Temple Festival -- This festival celebrates the unification of Viet Nam in the 10th Century.

Tet Doan Ngo -- This celebration marks the summer solstice. There are customs designed to protect people from common diseases which occur in this period. This is a time to harmonize the male and female elements of Nature. It is celebrated on the fifth day of the fifth lunar month, usually at the end of May and early June.

Viet Nam has an elaborate network for both formal and informal communications for women and children's welfare improvement. The extensive system of social and political organisation makes communication for mass mobilization a relatively easy and productive option for improved welfare. The extensive mass media system has great potential but must restyle itself to become more "attractive" in the growing inevitable market system "hubbub". Increased growth in civil organizations and increased prominence of family decision-making in choosing services imposes new communication challenges on the social welfare services. The resurgence of spiritual and traditional values and practices also provides both new communication opportunities and challenges. Viet Nam's people will continue to make choices in their best individual and family "perceived" interests, opportunities and challenges remain in using communication to shape those perceptions and influence choices in the best interests of the child, the woman and the family.

Chapter XII EMPOWERMENT

Viet Nam is rapidly becoming a highly pluralistic society. Ten or even five years ago Viet Nam was remarkably homogenous in terms of income and wealth; availability of social service; sources of information and non-formal education. These changes have had major implications for child survival, development and protection.

There is growing income disparity within the country. People living in urban areas and those in rural areas near major roads are getting richer. They are increasingly able to meet the survival, development and protection needs of their children using their own family resources. This course is further encouraged by evolving Government policy to devolve more power to the family unit and introduce systems of user fees. In contrast, people living in remote rural areas, particularly in the mountainous and inaccessible delta areas of Viet Nam are suffering from a stagnant or even declining standard of living. Urban-rural terms of trade have turned significantly against rural people. Single headed households, smaller ethnic minorities, families visited by natural calamities in sickness are particularly badly off.

Along with the growth of income and geographical disparities has come the breakdown of many of the social service support structures that benefitted nearly all Vietnamese. Chronic underfunding of peripheral health services and schools has contributed to reduced morale of staff and quality of service delivery has correspondingly declined. Fees for services have been progressively introduced, making these services less attractive. Simultaneously, there has been an increase in alternative forms of social service facilities particularly in health care. There appears to have been a surge in self treatment and in the number of people bypassing trained medical personnel to go directly for care to pharmacists-employees are turning to full-time or part-time private practice. A large number of demobilized army medics are practicing privately. Many people are placing more faith in superstition or in spiritual healing, etc.

In the field of education, there has also been a rapid growth in private educational facilities, most particularly in urban centres. Some teachers are providing private or additional teaching for families who are prepared to pay for it. In many parts of Viet Nam, teachers and other social service workers are forced to neglect their duties in order to conduct private business to augment extremely low salaries. It is creditable that the moral and motivation and dedication of peripheral workers is as high as it is given their conditions of employment.

It remains true that the great majority of problems facing the survival, development and protection of children are amenable to solution at family level through the combined provision of information/education and the means to increase family income. Diarrhoeal diseases, acute respiratory infection, measles, malaria and other major diseases can be prevented and treated by oral rehydration therapy, provision of impregnated bed nets, early parental diagnosis and treatment. Malnutrition is also amenable to family level solutions by increasing family food production and availability and through improved child feeding practices and better basic health care. Improved household sanitation and hygiene will constitute greatly to reducing rates of malnutrition, child illness and death. Early childhood stimulation and education is entirely dependent on family and particularly parental actions. School absenteeism and decisions to withdraw children from school (drop-out) are taken at family level, as are decisions on non-enrolment.

A major conclusion resulting from the above analysis is that there needs to be a shift away from relying on the supply of high priority, high quality social services to the promotion of demand at family level for them. The promotion of this effective family level demand requires attention to the provision of relevant information and education, along with increasing family level resources for the economically most disadvantaged.

"Empowerment" needs to be based on the following realities:

1. There is much greater access to information through wider international exposure and multiple new mass media.
2. There are many new sources of advice and assistance, some good and some detrimental.
3. Private sector organization and activities will increase in their influence on and outreach to the family.
4. Spiritual and traditional values and activities will grow in importance as influences on every-day living and family decision-making.
5. Families have greater responsibilities for self-care and self development as a result of the market system.

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