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Mapping the reform process in the public delivery of Social protection services in Viet Nam

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1. Introduction[2]

Impressive strides in poverty reduction notwithstanding,[3] significant pockets of poverty and vulnerability remain in Viet Nam. Over the past decade, policy momentum around social protection has grown, motivated by a concern to reduce this residual poverty and vulnerability, as emphasised in the country's first and second Socio-Economic Development Plans (2001-2005 and 2006-2010). Viet Nam now has an array of social protection programmes in place (Table 1), including social assistance, social insurance and a range of social services and social equity measures.

However, as the country moves towards achieving middle-income status, there is an urgent need to overhaul the country's targeted approach to social protection and develop a more comprehensive social welfare state approach. Existing programmes tend to be poorly coordinated across sectors and levels of government, face a number of targeting errors and are generally poorly equipped to deal with both longstanding and more recent inequities (Joint Donor Group, 2007). Moreover, the recent global food price, fuel and financial crisis underscored the inadequacy of Viet Nam's existing social protection infrastructure to effectively cushion the poor and vulnerable from the economic and social fallout of significant macro-level shocks (CAF and VERN, 2009; Nguyen et al., 2009).[4]

This chapter maps the social protection policy reform process over time in Viet Nam and assesses the extent to which equity considerations are effectively being addressed. The National Social Protection Strategy is already under development, but it is hoped that the review in this chapter will contribute to ongoing policy dialogues.

Section 2 presents a conceptual framework that marries the 2010 Human Development Report's emphasis on institutional reforms that promote human-centred development with theoretical insights into the way that economic and social vulnerabilities and risks from macro through meso and micro levels can undermine the realisation of different social groups' full human capabilities. Section 3 provides a brief overview of the patterning of key vulnerabilities in the country, before Section 4 discusses the contours of Viet Nam's social protection framework and the objectives of some flagship social protection initiatives. Section 5 analyses existing evidence on the impacts of these programmes on key inequities, and Section 6 concludes with a reflection on possible policy implications.

Table 1: Selected social protection instruments in Viet Nam

Type of social protection instrument	Programme examples
Social assistance programmes[5] • Regular, predictable transfers (cash or in kind, including fee waivers) from governments and non-governmental entities to individuals or households to reduce poverty and vulnerability, increase access to basic services and promote asset accumulation	• National Targeted Program for Poverty Reduction: access to credit, agricultural extension services, fee exemptions for education and health services and vocational training, legal aid services • Program 135: infrastructure in impoverished ethnic minority communities • Pensions for the elderly
Social insurance schemes • Schemes to protect people against the risks and consequences of livelihood, health and other shocks, supporting access to services in times of need and typically taking the form of subsidised risk-pooling mechanisms, with potential exemptions for the poor	• Social health insurance for formal and informal sector employees • Voluntary health insurance for the poor: all children under six as well as all households below the poverty line • Various commercial and non-profit micro-insurance schemes

Type of social protection instrument	Programme examples
Social welfare services • Services for members of marginalised groups who need special care or who would otherwise be denied access based on particular social (rather than economic) characteristics, normally targeted at those who have experienced illness, death of a family breadwinner/ caregiver, an accident, natural disaster; or who suffer from a disability, familial or extra-familial violence, family breakdown; or who are war veterans or refugees	• Recovery centres for children and women victims of trafficking, domestic violence and abuse • Inclusive education for children with disabilities • Family Health International's Family-Centred Care for Orphans and Vulnerable Children and HIV-Positive children
Social equity measures • Protecting people against social risks such as discrimination or abuse, through anti-discrimination legislation (in access to property, credit, assets, services) and affirmative action measures to redress past patterns of discrimination. The dimension of voice and agency may be critical in informing the design of social protection instruments and evaluating their operationalisation	• 2004 Law on Child Protection, Care and Education • 2006 Law on Prevention and Control of HIV/AIDS • 2007 Gender Equality Law • 2007 Law on Domestic Violence • 2009 National Urban Upgrading Strategy • 2009 Ho Chi Minh City Blue Book granting long-term temporary residence to migrants • 2010 National Disability Law

2. Conceptual framework

The 2010 Human Development Report is informed by the insights of Amartya Sen (1999) on the importance of investing in human capabilities to promote broader national development, and Joseph Schumpeter's ideas on the vital role that institutions play in shaping the enabling environment for the realisation of such capabilities (see Hosper, 2005). Within this framework, our starting premise is that it is important to consider the extent to which social protection policies and programmes effectively support individuals, households and communities to tackle the diverse set of risks and vulnerabilities that threaten the realisation of their human capabilities, irrespective of geographical location, gender, ethnicity, class, age and (dis)ability.

Although this chapter focuses on formal state-led forms of social protection, we recognise that many people rely on a range of informal and private forms of social support, from social networks to religious organisations to programmes supported by civil society organisations.[6] However, as Viet Nam becomes increasingly urbanised and industrialised, more traditional forms of social support may be eroding (Hugman et al., 2007). Benefits also may be disparate (Fritzen, nd)[7] and, most recently, the impacts of the global recession may have undermined the ability of some social groups and communities to provide such assistance (CAF and VERN, 2009). It is therefore important to consider how formal interventions can best complement and not undermine existing forms of support.

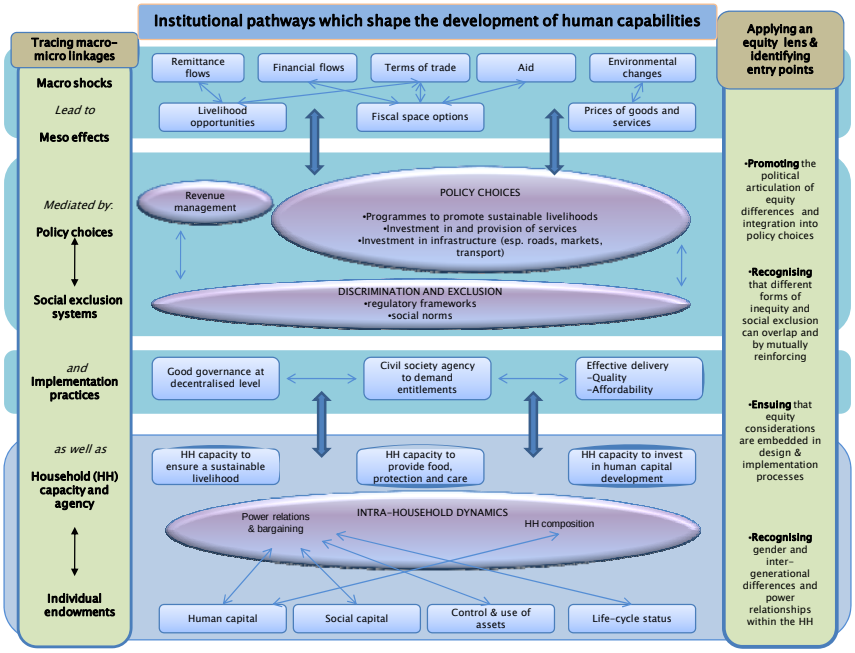
We also pay particular attention to the role of social risks and vulnerability in perpetuating poverty and marginalisation. To date, social protection debates have focused largely on economic shocks and stresses (declining incomes, loss of employment, harvest failures, the costs of chronic ill-health). Yet social risks and vulnerabilities (gender inequality, social discrimination and stigma, unequal distributions of resources and power at the intra-household level, limited citizenship) are often just as important, if not more important, in pushing households into poverty and keeping them there (Holmes and Jones, 2009). Indeed, of the five poverty traps identified by the 2008-2009 Chronic Poverty Report, four were non-income measures: insecurity (ranging from insecure environments to conflict and violence), limited citizenship (lack of a meaningful political voice), spatial disadvantage (exclusion from politics, markets, resources, etc, as a consequence of geographical remoteness) and social discrimination (which traps people in exploitative relationships of power and patronage) (CPRC, 2008).

In addition, vulnerabilities to economic and social risks are frequently intertwined. Understanding this is critical to programme design as well as to the types of questions addressed in monitoring and evaluation (M&E) processes. For instance, rising unemployment and low incomes may undermine culturally sanctioned male breadwinner roles and result in negative coping strategies, such as sexually aggressive behaviour and gender-based violence, in a bid to reassert traditional masculine identities (Silberschmidt, 2001). Similarly, social discrimination based on ethnicity may act as a barrier to employment commensurate with one's level of education (Bennett, 2005), while women's time poverty may hinder their involvement in productive training opportunities and community decision-making processes (Antonopoulos and Memis, 2010).

Vulnerability to risk, and its opposite, resilience, are both strongly linked to the capacity to prevent, mitigate or cope with risks at a range of levels, from the macro through to the meso and micro. These risks are refracted through a number of institutional layers, both formal and informal, including government policy, norms and practices of social discrimination and exclusion, labour markets, civil society programme interventions and socio-culturally specific household and family dynamics (Figure 1). Socially constructed inequities, from gender and age power relations to spatial poverty and discrimination against people with living with (dis)abilities and HIV/AIDS, are often

embedded in each of these layers in a variety of ways. As a result, the same economic shock or stress (e.g. a global financial crisis) may have differential impacts on different social groups. As such, unless social protection frameworks are informed by an understanding of the intersection between economic and social risks and vulnerabilities, and the ways these are mediated through economic, social and political institutions, they are unlikely to effectively support the realisation of human capabilities for all.

Figure 1: Institutional pathways which shape human capability development



Source: Adapted from Holmes and Jones (2009).

3. Overview of key vulnerabilities facing excluded groups

We now discuss the patterning of the key vulnerabilities facing a number of excluded groups, including those facing women, children, ethnic minority communities, urban migrants (Box 1) and people living with HIV/AIDS and disabilities.

Box 1: Vulnerabilities created by internal migration processes

The economic expansion unleashed by Viet Nam's *Doi Moi* reforms has been driven in part by internal migration, as rural residents leave their home communities and move to urban areas in search of employment. This migration has not only provided a labour pool for the recent, rapid industrialisation, but also has fuelled income growth for migrants, their families and, through remittances, their home communities.

However, high rates of migration have also led to new vulnerabilities. Urban poverty and overcrowding are growing issues. Provision of urban infrastructure has lagged, particularly in the poor, industrial areas where migrants tend to live. Schools and health clinics, as well as roads, water and sewers, are lacking in many areas (ibid). Un- and underemployment are problematic. Migrants often face discrimination in hiring, leaving them vulnerable to exploitation or forcing them into the informal labour market. Migration is also impacting family structure, leaving children more vulnerable to neglect and abuse. Furthermore, there is concern about migrants' involvement in crime.

Urban planning is clearly key to addressing the infrastructure concerns that plague migrant communities. Reform of the household registration system has also been targeted as a way to improve access to key services.

Source: Arkadie et al. (2010); UNFPA (2007).

3.1 Gendered risks and vulnerabilities

In Viet Nam, there has been considerable progress in recent years in terms of tackling gendered risks and enhancing gender equality. The country is on track to meet the gender-related Millennium Development Goals (MDGs) and their targets, and has sought over the past five years in particular to strengthen legislative frameworks on gender equality, including the passage of the 2006 Gender Equality Law and the 2007 Law on Domestic Violence. Women are more economically active than elsewhere in the region (with over 80% in paid work) and the gender pay gap is comparatively low (women's earnings are approximately 71% of men's, compared with 44% in Japan and 36% in Malaysia). Furthermore, boys' and girls' school enrolment rates, as well as adult literacy rates, are comparable, and maternal mortality rates are gradually falling (from 85 per 100,000 live births in 2002 to 80 in 2005) (Joint Donor Group, 2007).

Nevertheless, women and girls, especially among ethnic minority groups, are considerably disadvantaged in terms of the nature and quality of opportunities and resources available to them. Although Viet Nam's progress towards educational equity has been laudable, ethnic minority girls remain significantly disadvantaged compared with their brothers. They lag 10 percentage points behind their Kinh (majority ethnic group) and Chinese counterparts in secondary school enrolment (for boys there is no variation by ethnicity), and up to one-fifth of ethnic minority young women have never attended school (World Bank et al., 2006).

Women are overrepresented in economic sectors that are particularly vulnerable in times of economic downturn, including the informal sector. They still lack equal access to land tenure (women hold just 19% of Land Tenure Certificates) and to agricultural credit and technologies,

meaning that they bear the brunt of the negative impacts of trade liberalisation and have seen few of the benefits. Intra-household access to resources, decision-making power and time use also remain inequitable. For example, women still spend a disproportionate amount of time on household work compared with their male counterparts (an average 7.5 hours vs. 30 minutes in rural areas, and six hours vs. 90 minutes in urban areas (Le, 2006)), and some 21% of couples experience domestic violence (Gender Brief 2010). Growing migration is often accompanied by increased exposure of women to risks such as trafficking, HIV/AIDS and exploitative labour practices (ibid).

Implementation of existing gender equality policies and legislation is weak. For example, three years after its passage, the Gender Equality Law still has no M&E framework in place to track progress across the country, and capacities to mainstream gender within the government at national and sub-national levels remain limited (Jones and Tran, 2010). This is arguably reinforced by the low level of representation of women within political leadership positions: only 8% of Central Party Committee members are women, and 12.5% of ministers and 9% of vice ministers; at the local level, only one in five members of commune People's Councils is a woman (Gender Brief 2010).

3.2 Child-specific risks and vulnerabilities

Viet Nam has either met or is on target to meet all of its child-related MDG targets. Furthermore, the country is a regional leader in terms of legislation, policies and programmes that protect not only children's rights but also their well-being. The government recently recognised the complexity of child poverty and developed its own multidimensional approach, based on indicators ranging from health and sanitation to social inclusion and time for recreation.

However, significant challenges remain. More than one-quarter of the population is under the age of 16; such a large group of young people stresses available resources. One-quarter of Vietnamese children are monetarily poor, and nearly 30% are impoverished according to the new multidimensional approach (UNICEF and SRVN, 2010). Interestingly, despite significant overlap between the two groups of 'poor,' the two approaches largely capture unique subsets of poor and marginalised children (ibid).

Viet Nam still has a very high rate of child stunting, at nearly one in three (UNICEF and SRVN, 2010). Like the elevated prevalence of diarrhoeal illness, this is attributable largely to sanitation issues, which lead to the spread of disease and parasites. Furthermore, only one in six infants is exclusively breastfed for six months (ibid), with impacts not only on short-term illness susceptibility but also on long-term nutrition and health. Iron deficiency also remains a problem: in 2008, more than one in three under fives and pregnant women were anaemic (ibid). One in six children under the age of 14 is engaged in work, a figure which matches the percentage of sex workers under the age of 18 (ibid).

Although recent economic expansion has driven many of the gains enjoyed by Viet Nam's children, attendant migration and urbanisation trends have begun to erode traditional family life. Potential impacts for children include a greater susceptibility to abuse and neglect (Van Arkadie et al., 2010). Multigenerational households are becoming less common, and it is no longer certain that older relatives will be available to provide care for young children. Accidents are now the leading cause of child mortality in Viet Nam, with traffic accidents the most common. Chronic un- and underemployment of urban parents also have wide-ranging implications for children's well-being.

Ethnic minority children perform worse on every indicator of child poverty. Minority children are less likely to have access to adequate food, education, water, sanitation and health care (Van Arkadie et

al., 2010; UNICEF and SRVN, 2010). For example, the under-five underweight malnutrition rate is 30%, compared with 18% for the Kinh (UNICEF and SRVN, 2010).

Meanwhile, girls face unique vulnerabilities. An increasing sex ratio at birth indicates a trend towards sex-selective abortion over the past 10 years, and girls are also less likely to be admitted to hospital than boys (Van Arkadie et al., 2010). In situations where resources are limited, girls bear the brunt of rationing. Finally, although gender parity in education has been achieved for ethnic majority girls, minority girls are still less likely than their brothers to be in school, further intensifying the experience of disadvantage (Van Arkadie et al., 2010; UNICEF and SRVN, 2010).

3.3 Ethnic minority communities

Almost exclusively rural, and typically located in remote, mountainous areas, ethnic minority communities are among the most isolated in the country.[8] Most families in the 53 ethnic minority groups in Viet Nam are less educated, poorer and larger than those of the Kinh majority (World Bank, 2009). The 2008 Vietnam Household Living Standards Survey (VHLSS) found that 49.8% of ethnic minorities were poor, compared with just 8.5% Kinh. Furthermore, the poverty rate was found to be dropping faster for Kinh families (UNICEF and SRVN, 2010). A result of this is that ethnic minority children make up more than 60% of poor children in Viet Nam. Accordingly, there is increasing emphasis on the need for an immediate strategy to disrupt this intergenerational transmission of poverty (Van Arkadie et al., 2010).

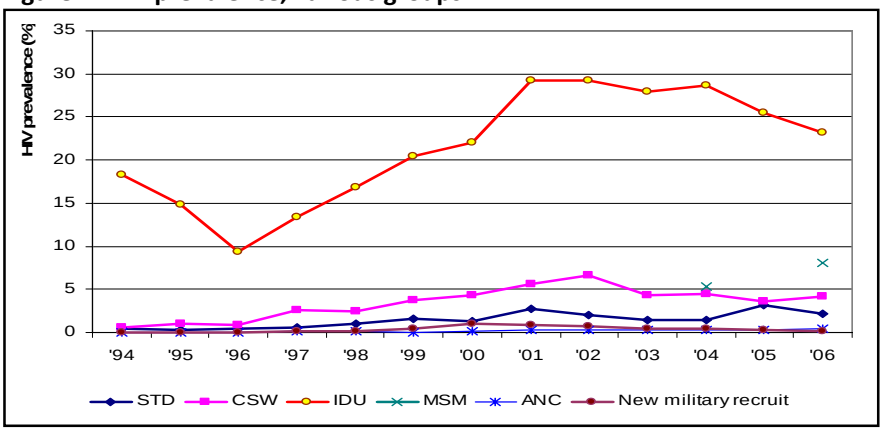
Education is at the core of this. Only four in five primary-aged minority children are enrolled in school; two in three eventually complete primary school and less than half complete secondary school (UNICEF and SRVN, 2010). Girls are particularly disadvantaged, as parents need their labour around the home and see little value in educating them (Van Arkadie et al., 2010; World Bank, 2009). Distance is a key factor: schools, particularly secondary schools, often require long travel times or boarding, rendering education either practically or financially difficult or impossible. Furthermore, the instructional language is Vietnamese, which many ethnic minority children do not speak as a native language (Van Arkadie et al., 2010; UNICEF and SRVN, 2010; World Bank, 2009).

Geographically isolated minority communities face other difficulties. Their land is often less productive, they have less access to financial services and markets and they face stereotyping and other cultural barriers (World Bank, 2009). Epprecht et al. (2009) found that, although remoteness accounts for a great deal of minority vulnerability, ethnicity accounts for even more. Language barriers are certainly key to this, but factors such as age of household head (five years lower for ethnic minority families) and a greater dependency burden (owing to larger family size) are also important (Imai and Gaiha, 2007). Ethnic minority children suffer from malnutrition and death rates twice as high as those of their Kinh age-mates, and maternal mortality rates are up to 10 times higher in ethnic minority communities than they are in the urban areas around Ho Chi Minh City (IRIN, 2009; UNICEF and SRVN, 2010).

3.4 People living with HIV/AIDS

HIV/AIDS has been considered an epidemic in Viet Nam since the first reported case of infection in 1990. The estimated number of people living with HIV increased from 160,000 in 2001 to 293,000 in 2007, and the number of HIV-positive women grew by more than 100%, from 37,000 to 76,000 (MoH, 2007). Viet Nam's HIV epidemic is still in a concentrated phase, with prevalence in the general population estimated at 0.53% and the highest prevalence among higher risk subpopulations, such as injecting drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSM) (Figure 2).

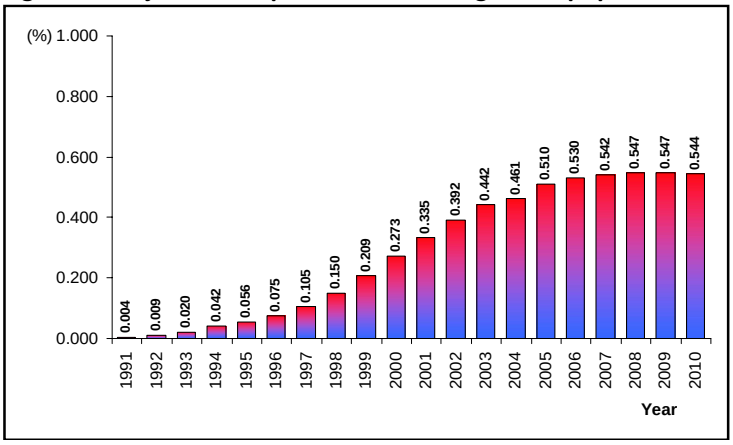
Figure 2: HIV prevalence, various groups



Source: MoH (2007).

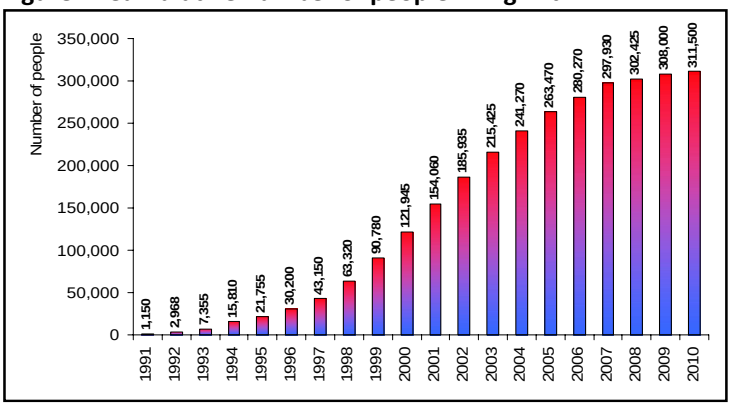
The rate of prevalence has levelled off during the past few years and is expected to stay at the same rate into the next decade (Figure 3), but the absolute number of people living with HIV is increasing, with a higher risk of the disease crossing over into the general population. As such, it is critical in the next few years for Viet Nam to keep the prevalence rate low.

Figure 3: Projected HIV prevalence in the general population, 15-49



Source: MoH et al. (2005a).

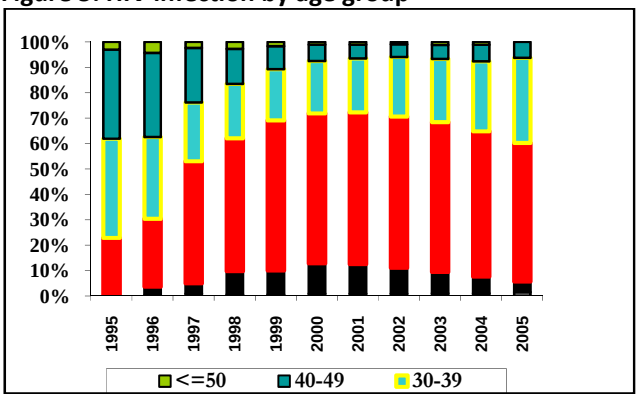
Figure 4: Cumulative number of people living with HIV



Source: MoH et al. (2005a).

Of particular concern is the fact that most of those living with HIV are in the 20-39 age group – the most productive working age.

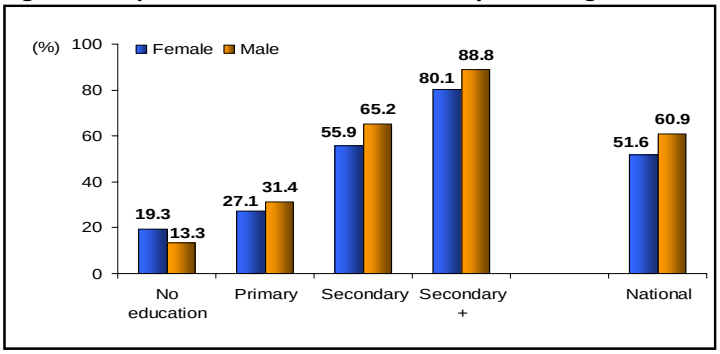
Figure 5: HIV infection by age group



Source: MoH et al. (2005a).

Stigma and discrimination are a pressing problem, in particular because of propaganda associating HIV with the 'social evils' of sex work and drug use. Figure 6 shows that people hesitate to deal with people living with HIV, with acceptance decreasing dramatically with lower levels of education.

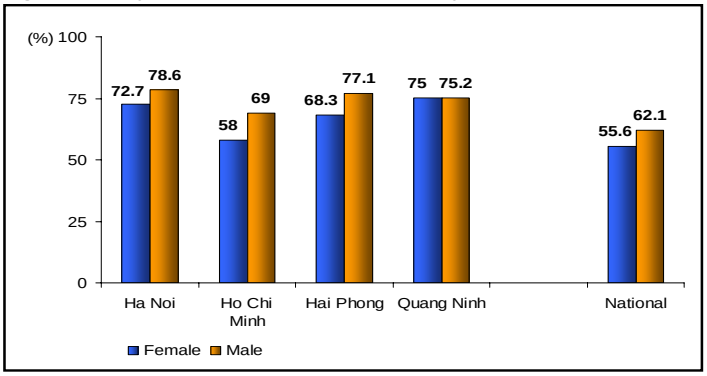
Figure 6: Population 15-49 who would buy fresh vegetables from a person with HIV



Source: GSO and NIHE (2005).

A large proportion of the population thinks that people with HIV should not be allowed to work (Figure 7).

Figure 7: Population 15-49 who think a person with HIV should continue working



Source: GSO and NIHE (2005).

3.5 People living with disabilities

From the 1992 Constitution to the 2010 Disability Law, Viet Nam has implemented a series of increasingly specific and powerful policy and legal tools that not only protect the disabled from discrimination but also guarantee such diverse rights as rehabilitation, work and transportation. By 2015, the government aims to have provided inclusive education to all children with disabilities (Van Arkadie et al., 2010; UNICEF and SRVN, 2010). Civil society plays a large role in promoting the interests of disabled people in the country.

Recent statistics found 15.3% of the population to be disabled, rather than the 6.4% commonly reported, with the number of disabled children in Viet Nam at around 1.2 million (ILO, 2009; Susa, 2010). Mobility impairment and birth defects are the most common cause of disability, with many disabled children suffering the effects of Agent Orange (Susa, 2010).

Disabled persons in Viet Nam face a range of vulnerabilities, which begin in childhood. They are far less likely to attend school, are consequently more likely to be illiterate, are therefore less likely to be employed and are ultimately more likely to be impoverished (Van Arkadie et al., 2010; ILO, 2009; UNICEF and SRVN, 2010). Only half of disabled children attend school, less than 15% finish primary school and less than 5% of adults with disabilities are employed in the formal sector (DED, 2004; Susa, 2008; UNICEF and SRVN, 2010). Nearly 90% of the country's 5.3 million disabled persons live in rural areas (UNICEF and SRVN, 2010). Furthermore, despite a system of community-based rehabilitation centres, nearly half of the disabled have difficulties obtaining health care (Le et al., 2008). In fact, only one-third of families of disabled children have ever sought treatment for their child's disability, and less than 20% of disabled children use any type of rehabilitative aid or device (Susa 2010; UNICEF and SRVN, 2010). Early intervention services are particularly underdeveloped. Services for children are typically sought late and are curative rather than preventative (UNICEF and SRVN, 2010).

4. Existing social protection system and policy framework

Increasingly, international best practice is recognising that, to ensure maximum efficiency and efficacy of social protection interventions, a national policy framework is critical to ensure a strategic approach to tackling multidimensional poverty and vulnerability. This requires a well-resourced implementation plan based on an understanding of context-specific fiscal, political and institutional opportunities and challenges, in order to promote a broad political consensus on what needs to be done and the resource implications (Holmes and Braunholtz-Speight, 2009).

Although the *Doi Moi* ('Renovation') reforms generated growth rates that have consistently placed Viet Nam among the most rapidly growing economies in the world since the 1990s, their impact on the social sectors has been much more contested (Fritzen, nd). On the one hand, social service coverage levels have expanded and social indicators have improved. On the other hand, *Doi Moi* introduced a broader set of institutional reforms that disrupted service delivery, resulting in 'an unfinished agenda of institutional and policy reform to cope with both old and new challenges' (ibid), including growing regional and socioeconomic inequalities, low service use by the poor and service quality deficits and variability (Joint Donor Group, 2007). Here, we discuss what progress has been made in addressing this 'unfinished agenda' and what remains to be done.

4.1 System features

Major social protection reform started after the Seventh National Congress of the Government of Viet Nam in 1991 and has accelerated over the past decade, including during the global crisis.[9] Bender and Rompel (2010) argue that today the country's social protection system comprises three main pillars: i) mandatory social insurance for the public and private sectors; ii) voluntary social insurance for the self-employed, farmers, the wage employed without labour contracts and students; and iii) complementary means-tested social assistance for vulnerable groups.[10] We add a fourth: iv) social welfare services for population groups who require special care and support.

However, there is no overarching national social protection strategy, although the need has been recognised and development of a 10-year strategy (for 2011-2020) is underway, building on Resolution 30 of December 2008. Policies have tended to be quite fragmented, as reflected in the multiple government agencies involved in policy formulation and implementation.[11] However, progress on streamlining was made through the introduction of the 2006 Law on Social Insurance, the 2009 Law on Health Insurance and 2007's Decree 67 on Social Assistance Regimes and Decree 68 on the Establishment of Social Service Centres.[12] The extent to which these policy frameworks are effectively linked with those aimed at promoting equity for the socially excluded (e.g. legislation on gender equality, child protection, disability inclusion) remains very weak, however (see Section 5).

Social insurance

A range of shocks and stresses can have devastating effects on livelihoods and well-being. These include natural disasters, crop failure, serious ill-health, death of a breadwinner and sudden loss of employment. In response, social and market-based insurance schemes have burgeoned in recent years in Viet Nam (Joint Donor Group, 2007). We focus here on state-led mandatory and voluntary social insurance.

Mandatory social insurance for public and private sector employees covers illness, maternity, old age, disability, survivors and work accidents and industrial diseases.[13] Schemes are financed by employers' and employees' income-related contributions, with the exception of old-age insurance, which is organised on a pay-as-you-go basis (Bender and Rompel, 2010). By 2008, coverage had reached 8.5 million people, up from 4.8 million in 2001.

For individuals outside the formal sector, voluntary social insurance provides an important option, targeting the self-employed, farmers, the wage employed with short-term or no labour contracts and students. Provision for voluntary health insurance was introduced in 2005 (see Section 5), and in 2008 a second pillar covering old age, death and disability came into effect. Voluntary insurance is financed by flat rate contributions but coverage remains very low, at approximately 500,000.

Social assistance

Social assistance in Viet Nam entails transfers in cash and in kind (free access to health care, education tuition waivers, vocational training, legal aid, microcredit) to specific vulnerable groups (war veterans, people living with disabilities, orphans) and in-kind – but not cash – transfers to the poor under a framework of temporary programmes, including the government's flagship National Targeted Program for Poverty Reduction (NTPPR) (see Section 5). Regular social assistance is financed by local budgets with support from provincial transfers.

Total coverage expanded from 416,000 beneficiaries in 2005 to more than 1 million in 2008, or 1.2% of the total population (Bender and Rompel, 2010).[14] Beneficiaries of temporary anti-poverty programme in-kind benefits are much higher, with 7.8 million pupils receiving fee exemptions, 4.2 million households receiving preferential loans and 2.1 million people receiving business development and technical training (ibid).

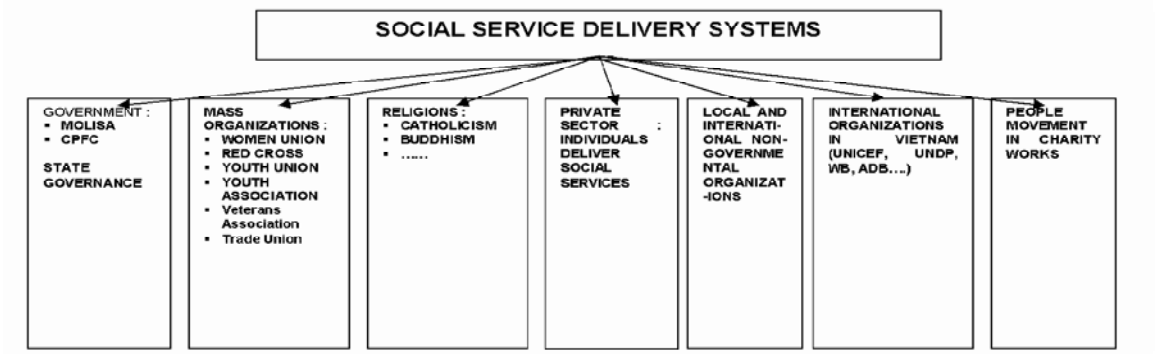
However, total spending remains low, even by developing country standards. Total spending in Viet Nam in 2007 reached approximately D910 billion ($51 million), increasing in 2008 to D1,700 billion ($95 million), equal to just 0.2% of gross domestic product (GDP) (see Pal et al., 2005). This is reflected in very low baseline levels for calculating benefits, equivalent to 18.6% of the minimum wage or 32.5% of the poverty line. Moreover, in-kind benefits provided under poverty programmes are often low as well (for example D5 million or about $280 to build a new house).

Social welfare services

Until the early 2000s, social welfare services were highly fragmented (Figure 8) and of generally low quality, at least in part because of the absence of a professional social work cadre in the country. Hugman et al. (2007) argue that:

> Traditions of support and care have created difficulties in understanding social work, both in the wider society and among policy makers and government officials. The Vietnamese term for social work, *cong tac xa hoi*, also refers to charitable and voluntary effort. At the present time social work is seen by many as a type of movement that can be fulfilled by any person or organization if they have the interests, time and money. As a consequence the necessity for social workers to be professionally trained is not grasped by many people, including some who are in key public decision making roles.

Figure 8: Social service providers in Viet Nam



Source: Le (nd).

However, professional social work in Viet Nam took a major step forward in 2004, with the approval of a new national curriculum for universities to teach degrees in social work and an expansion of the number of universities offering these (Hugman et al., 2007). Nevertheless, how the social work profession should be organised and how social workers can be employed by government and non-government social welfare agencies remains unclear. Lack of a job code, including a lack of laws and policies to support social work, has been cited as a particular barrier to providing support and guidance for social workers to act, exacerbated by chronic under-resourcing, especially at the commune level (ibid).

Over the past five years, the UN Children's Fund (UNICEF), through close links with the former Committee on the Protection of Families and Children, has played an important role in the development of a comprehensive legal framework on child protection issues,[15] as well as improving the technical capacities of key public institutions involved in the social welfare and justice systems at national and local levels (MOLISA and UNICEF, 2009). This programme of work has sought to establish the new profession of social work and strengthen the capacities of a range of professionals (social welfare officers, police, prosecutors, lawyers, judges, teachers, health workers), para-professionals and community volunteers involved in child protection issues, including family and community-based care options for street children, trafficking and sexual exploitation victims and children living with HIV/AIDS.[16] As important as this work has been, however, comparable high quality technical support has not been provided on other issues, including services for people living with disabilities and undocumented migrants.

4.2 Politico-institutional challenges

The recent rapid change in Viet Nam's social protection infrastructure and related policy frameworks in the absence of an overarching social protection strategy has come at a cost. Coordination between different types of intervention is lacking, exacerbated by the complexity of existing policies, decrees and programmes, which has precluded both implementers and participants from developing a coherent overview of available support (Jones and Tran, 2010). This has made it difficult for champions of the rights of specific vulnerable groups to ensure that an understanding of gender- and equity-sensitive considerations is integrated systematically into social insurance, social assistance and social service policy frameworks and programmes (ibid).

Another challenge relates to Viet Nam's process of political and fiscal decentralisation. In particular, the 2002 Budget Law led to dramatic changes in public expenditure allocations across levels of government: by 2007, 45% of public spending decisions were made at provincial level and below (Joint Donor Group, 2007). This move has been accompanied by an 'equalisation mechanism,' aimed at transferring budgetary resources to the provincial level. Overall, the transfers are substantial, with the poorest Northwest and Central Highlands provinces receiving D25 to D30 billion more per year than rich provinces in the delta regions (ibid). Nevertheless, insufficient budgetary resources continue to plague many communes (an on average 30% to 50% shortfall), and have forced reliance on a range of locally imposed fees and 'voluntary contributions' to raise revenue.[17] Such fees are surprisingly hefty, constituting an estimated 18% of the income of an 'average household' at the commune level (ibid). Moreover, weak local authority capacities combined with social pressures often result in commune-level public expenditure being invested in non-pro-poor infrastructure, for instance communal meeting spaces (Jones and Tran, 2010).

4.3 Fiscal space challenges

Fiscal space is the 'room in a government's budget that allows it to provide resources for a desired purpose without jeopardising the sustainability of its financial position or the stability of the

economy' (Heller, 2005). Such space needs to exist or be created in order for governments to increase spending on national priority areas, including social protection, in a sustainable manner. Handley (2009) also highlights the central role of domestic politics in deciding where public funds are spent, ideally formalised within a policy-based budget process, as 'one of the hallmarks of genuine government "ownership" of public policy.'

In 2008, Viet Nam spent up to 3.7% of its GDP on social protection (Castel, 2010) (also Table 2). In absolute terms, spending on social protection will increase. Relative to GDP, however, the overall size of the social protection sector over the next 10 years is forecast to decline, from 3.5% of GDP in 2010 to 3.0% in 2015 and 2.2% in 2020 (ibid). This expenditure needs to be placed within the context of the country's rising deficit. Figure 9 below illustrates the evolution of the budget deficit of Viet Nam since 2005 and highlights that the government's operating expenditure has been rising more sharply than its tax revenue. Moreover, the stimulus package responding to the recent global crisis meant that the deficit in 2009 was much higher than in previous years. Viet Nam's budget deficit in 2010 is similarly expected to be 6% of GDP and, according to recent reports, could be as high as 6.5% (Ministry of Finance, 2009a).

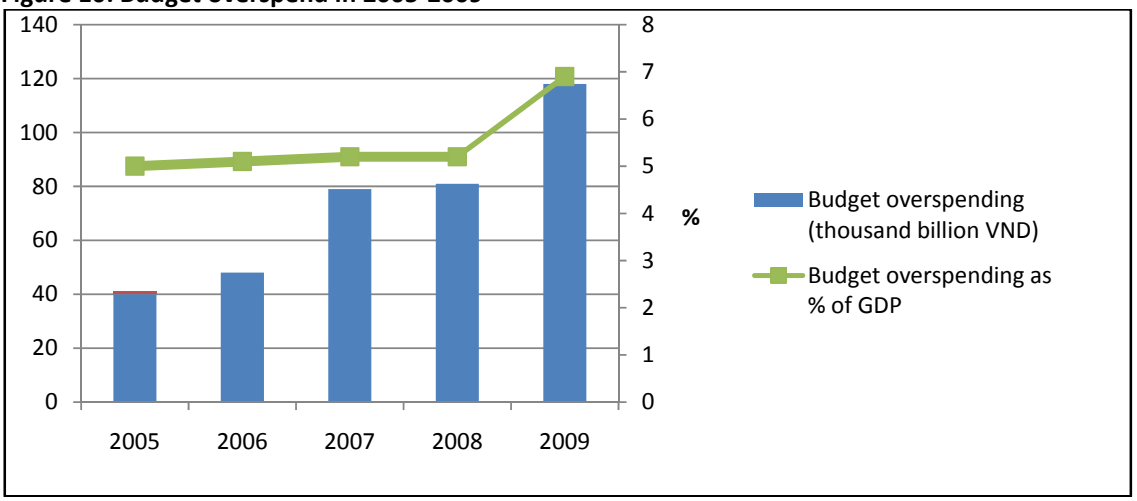
Table 2: Planned social expenditure, FY2009

No.	Name of programme or project	Planned 2009	Investment expenditure	Recurrent expenditure
		Million dong		
	Total	**13,452,456**	**5,043,400**	**8,409,056**
I	**Total national targeted programmes**	**9,168,400**	**2,203,400**	**6,965,000**
1	Poverty reduction	398,400	218,400	180,000
2	Job creation	413,000	380,000	33,000
3	Rural safe water and sanitation	935,000	838,000	97,000
4	Population and family planning	710,000		710,000
5	Prevention of dangerous social diseases, epidemics and HIV/AIDS	1,450,000	230,000	1,220,000
6	Foodstuff sanitation and phyto-sanitation	137,000	7,000	130,000
7	Culture	570,000	360,000	210,000
8	Education and training	4,000,000		4,000,000
9	Crime prevention	170,000	90,000	80,000
10	Drug prevention	345,000	65,000	280,000
11	Efficient and economic energy use	40,000	15,000	25,000
II	**Program 135**	**3,284,056**	**1,840,000**	**1,444,056**
III	**5 million hectare reforestation project**	**1,000,000**	**1,000,000**	

Source: Adapted from Ministry of Finance, 2009b.

Within this fiscal environment, and as in many developing countries, fiscal space is likely to be particularly difficult to create, or preserve (Handley, 2009). At the same time, the need to protect the poorest and most vulnerable from the shocks resulting from the global crisis is critical. Increasing government spending at a time of recession, with revenues contracting (on account of lower economic activities coupled with lower crude oil royalties), poses some complicated questions (Figure 10 below). Moreover, the structure of Viet Nam's government's revenue is characterised by a narrow tax base. Only a small segment of the working population pays income tax, with about 14% of tax revenues derived from oil revenues and another 20% from export and import duties, both of which are difficult to augment in the current economic environment (Table 3). As the remainder of the chapter argues, there are important gaps in social protection programming which urgently need to be tackled, and this will require an innovative approach to all of these fiscal space challenges.

Figure 10: Budget overspend in 2005-2009



Source: Ministry of Finance, 2009b.

Table 3: Predicted budget balance for 2010

No.	Content	Estimate for 2010	
		(billion dong)	
A	**Total revenue**	**462,500**	
I	State revenue	461,500	**% of total**
1	Domestic revenue	294,700	63.7%
2	Oil and gas	66,300	14.3%
3	Export and import duties	95,500	20.6%
4	Grants	5,000	1.1%
II	Brought forward	1,000	0.2%
B	**Total expenditure**	**582,200**	
1	Investment	125,500	
2	Debt service and grant	70,250	
3	Expenditure on socioeconomic, defence, security and administrative	335,560	
4	Wage reform	35,490	
5	Transfer to financial reserves	100	
6	Reserves	15,300	
7	Transfer source		
C	**Budget deficit/surplus**	**-119,700**	
	% of GDP	*-6.2%*	
D	**Source of balancing**	**119,700**	
1	Domestic borrowing	98,700	
2	External debt	21,000	

Source: Adapted from Ministry of Finance, 2009b.

5. Impacts of selected social protection programmes on inequity

This section reviews the equity impacts of a select number of programmes from each of the three broad types of social protection interventions discussed in Section 4.[18] The NTPPR and Program 135 are discussed as examples of social assistance to tackle income poverty, spatial poverty and broader social exclusion among ethnic minority groups. We also discuss social health insurance, as well as support services for people living with HIV/AIDS as an example of social welfare services.

5.1 National Targeted Program for Poverty Reduction

The NTPPR, along with Program 135 (see below), is the 'cornerstone' of the government poverty reduction approach from 2006-2010 (MOLISA and UNDP, 2009). Established in 2007 as the successor to the 2001-2005 Hunger Eradication and Poverty Reduction Program, it seeks to address a range of deprivations experienced by poor households and communities and to improve their productive capacities. Access to credit, basic services, agricultural extension, landholdings and legal aid are coupled with human capital development, through school fee exemptions, vocational training, loans for tertiary education, investments in health and sanitation and improved community infrastructure.

Although it is difficult to assess this, it seems that targeting leakage (i.e. coverage of the non-poor) has been extremely low by international standards (10%), and beneficiaries' level of satisfaction is 'relatively high,' especially with regard to credit support, health and educational support, housing support and infrastructure development (MOLISA and UNDP, 2009). However, the NTPPR pays very little attention to the gendered nature of poverty and vulnerability (ibid). Apart from targeting female-headed households and a general mention of the need for gender-sensitive programming, it contains no gender-specific targets or measurable outcomes, nor any specific provisions for gender training for implementers to support their ability to respond to gender vulnerabilities. Accordingly, this subsection focuses on a gendered analysis of the programme.

Despite a lack of gendered targets, the NTPPR has been found to be meeting some important practical gender needs (Jones and Tran, 2010). For many participants, the health insurance card enables them to conserve scarce resources and, owing to increased preventative health-seeking behaviour, reduces the amount of time women need to be absent from paid work to tend to ill children. Moreover, it helps women seek advice regarding reproductive health issues. The school fee exemption scheme is similarly important, allowing many children to remain in school for longer, although for the poorest households a number of other barriers to education remain (cost of clothing, transportation, loss of children's labour). These improvements have been backed up by investments in roads and electricity, which have improved community access to health clinics, schools and markets.

Access to credit is another key programme impact, with the Viet Nam Women's Union stepping in as an intermediary for poor women. Positive impacts of credit are seen in terms of not only economic empowerment, but also enhanced women's domestic decision-making power in some cases.

Impacts have been more limited in other areas. The programme has made limited inroads into reducing the pockets of food insecurity and malnutrition found especially in highland communities, in part because it lacks a dedicated nutrition component. Social risks, such as language barriers facing ethnic minority women, for instance in access to market, training and community participation opportunities, have also not been tackled in any systematic manner, and positive spill-over effects on intra-household violence appear to have been minimal.

A number of politico-institutional and socio-cultural challenges have contributed to the mixed implementation record of the NTPPR, including its gender dimensions. The programme's recognition of the multidimensional nature of poverty calls for a level of coordination among line ministries that has yet to be realised, evidenced in considerable fragmentation and overlap. Moreover, despite the recent passage of quite comprehensive gender equality legislation, the relevant department in the Ministry of Labour, Invalid and Social Affairs (MOLISA) both is under-resourced and lacks the institutional positioning to effectively ensure that gender is integrated across sectors, including social protection. A national focus on human capital development and reaching middle-income status means that attention to households and communities still vulnerable to food insecurity and hunger is largely absent, despite important pockets of nutritional deprivation. Furthermore, funding, particularly for M&E, is limited.

These institutional weaknesses are exacerbated in efforts to mainstream gender. They are reflected in a dearth of gender-disaggregated data; a lack of practical training on gender mainstreaming; inadequate or insufficient accountability mechanisms (especially binding executive decrees);[19] and under-recognition by line ministries and senior political leaders of the potential for gender equality to contribute to the realisation of developmental and poverty reduction goals. Language and cultural barriers also prevent women from being adequately served by programme provisions and result in their effective exclusion from community discussions. Finally, although the National Assembly's Social Affairs Committee and donors are increasingly calling for the inclusion of gender considerations in programme development, a relatively weak civil society has rendered civic oversight challenging.

5.2 Program 135

Designed in consultation with local stakeholders, P135 was established in 1998. In 2006, it was expanded to over 1,700 villages and targeted ethnic minorities more explicitly, particularly in border and mountainous regions. The programme aims to narrow the gap between ethnic minority populations and the rest of society by supporting their economic and social development. Communes are identified based on population, remoteness, poverty rate, infrastructure and health and education indicators. Currently, P135-II is providing support in four key areas: i) basic infrastructure; ii) agricultural capacity and market-based agriculture; iii) living standards through services such as schools and clinics; and (iv) capacity development for local officials. P135-II's 2010 targets are to eliminate hunger, reduce the number of poor households to below 30% and ensure that 70% of targeted households have a per capita income over D3.5 million per year.

Despite not being on track to meet targets, P135-II has led to a significant increase in access to infrastructure (Table 4) (MOLISA, 2009). The programme also contributed to a 6% to 8% reduction in poverty from 2006 to 2008, as well as higher levels of participation in capacity building. Uptake of social services has improved considerably in P135-II communes, where services are both free and of high quality (ibid).

Table 4: P135 infrastructure improvements

Type of infrastructure	HHs using completed works
Electricity	70.6%
Transportation	96.7%
Water supply	48.3%
Health stations	86.7%
Markets	76.9%
Communal/commune cultural houses	61.8%

Source: MOLISA, 2009.

Data from the VHLSS 2006 and 2008 corroborate that P135-II has had a beneficial impact on standards of living. Table 5 shows that P135-II communes are more likely to report improvements in living standards owing to changes in agricultural income, infrastructure, education and health services. Table 6 shows infrastructure development across time in P135-II communes. Although gaps remain, it seems that identified communes are gradually catching up with their non-targeted sister villages. Another positive impact, with implications for other programmes in Viet Nam, is the emphasis on gender inequality. Earlier this year, the programme issued a gender mainstreaming manual to address women's differential access to productive assets and resources and their lack of involvement in decision making.

Table 5: Improvements in standards of living

	Agricultural income	Commune infrastructure	Health services	Education
Communes with better living standards in 2008 compared with 2002-2003				
P135 commune	93.4%	70.6%	3.5%	12.4%
Non-P135 commune	85.6%	50.9%	1.2%	3.1%
Communes with better living standards in 2006 compared with 2000-2001				
P135 commune	92.2%	71.6%	6.2%	11.9%
Non-P135 commune	84%	55.7%	0.9%	4.5%

Source: Adapted from GSO (2006; 2008).

Table 6: Commune infrastructure

	Electricity	National electricity grid	Cultural post office	House of culture	Radio relay station
2006					
P135 commune	95%	91.7%	87.8%	27.1%	59.4%
Non-P135 commune	100%	99.1%	86.6%	37.1%	85.8%
2008					
P135 commune	95.3%	93%	92.3%	36.3%	61.5%
Non-P135 commune	99.9%	99%	89%	44%	84.5%

Source: Adapted from GSO (2006; 2008).

Despite progress, P135 is clearly not a panacea. Poverty rates among minority groups were more than five times those of the Kinh in 2008 (49.8% vs. 8.5%) (UNICEF and SRVN, 2010) and, as discussed above, the Kinh poverty rate is dropping faster (ibid). Over the past year, nearly half of P135-II households lacked food, clean water and medication; one-third did not have adequate income to cover school fees. Half of respondents reported general unhappiness with their standard of living. Although three-quarters were engaged in the labour market, most were underemployed.[20] Male/female disparities in access to, control over and use of assets and productive resources, and in decision making, remain significant. Meanwhile, although younger ethnic minority children are increasingly learning Vietnamese in school, adults still primarily speak other languages: it is difficult to encourage village-level participation without language sensitivity. There are also calls for greater transparency in the infrastructure component of the programme.

5.3 Social health insurance

Until the mid-1980s, health care in Viet Nam was fully subsidised and implemented through a centralised system. However, despite extensive coverage, the system suffered from inefficiency and service quality deficits, in part because of very low public financing (Chen et al., 1994). Following *Doi Moi* in 1986 and related cuts in health care allocations, the government legalised private medical practice, privatised pharmaceutical production and sales, imposed user charges in public medical facilities and launched a pilot national health insurance scheme in several provinces (Ensor, 1995). However, with user fees accounting for just over 5% of funding, in 1992 the government recognised

the need to cost share and issued a decree calling for compulsory payroll-based health insurance (Ron et al., 1998), to cover all employees earning a salary from the state or working in state-owned enterprises, and those in private enterprises exceeding 10 workers. The decree also made provision for a system of voluntary insurance to appeal to workers in small businesses and rural agricultural employment (Ensor, 1995), with a number of other groups added in 1998 (MoH and Health Partnership Group, 2008). Initially, both schemes were administered by Vietnam Health Insurance, a separate body accountable to a multi-ministerial steering group. In 2002, Vietnam Social Security took over the management of both social insurance and social health insurance.

The government defines social health insurance as 'a health insurance scheme where the premium is generally calculated in proportion to the income level of workers, while curative care benefits are received based on health care needs, not level of contribution.' (MoH and Health Partnership Group, 2008). The compulsory part of the system consists of three separate programmes: Social Health Insurance (SHI), Health Care Funds for the Poor (HCFPs) and free health care for children under six.

SHI is an employment-based scheme for public and private formal sector workers, with costs shared by employers and employees. Although coverage (11% in 2007) remains at around half of the target, impacts have been positive in terms of promoting service utilisation through affordable health care, reducing household health expenditure by 20% and influencing health care and outcomes as expressed in a reduction in self-medication (Ekman et al., 2008).

HCFPs, introduced in 2003, cover the poor, ethnic minorities in mountainous areas and people in particularly difficult circumstances. They represent a substantial increase in the resources allocated to health care for the socially excluded, with 75% of costs covered by central government funds and the remainder by provinces. HCFPs have increased health care utilisation and reduced household out-of-pocket spending and the risk of catastrophic health spending (Ekman et al., 2008), but it has also been argued that funding per beneficiary is inadequate, with errors in poverty measurement and a mismatch between geographical allocation of resources and local needs (Adams, 2005).

The compulsory programme targeting children under six covers some 11% of the population. Evidence on its impacts is still very limited, although there is concern about potential inequity: the programme appears mainly to benefit wealthier households with better access to facilities, while remaining relatively ineffective for the poor (Ekman et al., 2008).

Voluntary health insurance (VHI) focuses on the dependents of those covered by compulsory health insurance and on farmers, the self-employed and students. The insured are entitled to the same benefits with identical exemptions as those covered by compulsory health insurance. However, coverage remains very low – just 9% to 11% of the population in 2008.[21] The overwhelming majority were students and school children, to whom VHI had been marketed 'with some element of persuasion' (Ekman et al., 2008). An important and disputed feature of VHI was the notion of group membership, according to which '100% of household members, 10% of households in a commune and 10% of students in a school must enrol' in order for an individual to be eligible. The government introduced this measure to avoid the possibility of mainly high-risk individuals joining the programme, but in 2007 the minimum community enrolment threshold was eliminated.

Coverage limitations notwithstanding, VHI has been successful in terms of service utilisation, with a reported 200% reduction in average out-of-pocket spending for outpatient care in sampled regions (Ekman et al., 2008). It has also increased use of outpatient facilities and public providers and decreased self-treatment and utilisation of private providers, with these effects particularly strong at lower income levels. However, VHI appears to have a negative effect on quality of care received,

which tends to be traded off with the financial gains made by providers (Jowett, 2001). Moreover, there are significant concerns that government subsidies will be needed for some years (ibid).

5.4 Social welfare for people living with HIV/AIDS

As in many developing countries, support services for people living with HIV/AIDS have been funded heavily by the international community (including the US Agency for International Development (USAID), the Asian Development Bank (ADB), the Australian Agency for International Development (AusAID), the UK Department for International Development (DFID), the Swedish Agency for International Development Cooperation (Sida) and the World Bank).[22] The largest funding package up to now has been the US President's Emergency Fund for AIDS Relief (PEPFAR), which amounts to almost $90 million a year for prevention, care and treatment initiatives.

Here, we focus on an initiative undertaken by Family Health International (FHI) with USAID-PEPFAR support in partnership with the Ministry of Health (MoH) aimed at providing a family-centred continuum of care that integrates prevention of mother-to-child transmission (PMTCT) into comprehensive adult and paediatric HIV care, treatment and support at 11 district hospital sites. The service includes: counselling and testing; health checkups and CD4 count; treatment and prophylaxis for sexually transmitted infections (STIs); psychosocial support; nutrition support; and infant feeding counselling. Antiretroviral therapy (ART) is prescribed for women who need treatment for their own health, and azidothymidine is started at 28 weeks for pregnant women who are not eligible for ART. HIV-infected pregnant women attend antenatal clinic appointments in the obstetric department on the same day as they receive their HIV checkups, in the same district hospital.

The programme has adopted a three-pronged approach:

1. Strengthening the capacity of the MoH/National AIDS Standing Bureau/AIDS Division, provincial AIDS authorities, local non-governmental organisations (NGOs) and other implementing agencies;
2. Developing and expanding coverage of behaviour change and HIV/AIDS/STI risk reduction interventions, especially among such vulnerable populations as IDUs, FSWs and their sexual partners, MSM and mobile youth;
3. Developing community-based care and support interventions and materials for people living with HIV/AIDS and their families/caregivers and linking them with other appropriate HIV/AIDS/STI prevention and treatment services.

It is difficult to tease out specific effects of the FHI/MoH programme. Given its significant level of funding, however, it is possible to argue that it has contributed to the important increase in people living with HIV/AIDS who are receiving treatment (Table 7). More than 27,000 people living with HIV/AIDS received treatment through one of the 207 district-level clinics put in place in 2008 and approximately 6,000 peer educators and health workers distributed information about the disease to 53.8% of the country's districts (MoH, 2009). The partnership has also provided care to 2,434 orphans and vulnerable children, enrolled 60 HIV-positive children in clinical care and supplied ART to 45 children. This component is currently operating in 16 sites covering seven provinces, and will be rolled out nationally in conjunction with the MoH over the next few years.

Table 7: HIV/AIDS programmes and impacts on adults and children

Expenditure	
National funds from domestic sources	$9.4 million (2007)
National programmes	
Adults with advanced HIV infection receiving ART	30% (2007)
HIV-positive pregnant women receiving ART in PMTCT	13.9% (2007)
Most-at-risk populations reached by prevention programmes	Male IDUs 43.2%, MSM 25.6%, FSW 62.5%
Impact	
Most-at-risk populations who are HIV infected	FSW 4.2%, MSM 9%, male IDUs 23.1%
Adults and children with HIV known to be on treatment 12 months after initiation of ART	Adults 81%, children 93.1%

Source: MoH (2009).

6. Conclusions and policy implications

Multipronged social protection initiatives are increasingly recognised as a critical tool to address a range of economic and social vulnerabilities and risks. Overall, Viet Nam's social protection infrastructure has made a useful contribution towards addressing a range of vulnerabilities, especially the costs associated with accessing basic health and education services, providing microcredit and improving community-level infrastructure. It has also seen rapid progress in scaling up the reach of social welfare services, especially for child protection-related deficits but also for people living with HIV/AIDS and disabilities. A limited contribution to women's economic empowerment has been made, which in some cases has had valuable spill-over effects on intra-household gender power relations. However, overall, a number of social protection policy and programme design features, as well as implementation practices, need to be improved if Viet Nam is to maximise the transformative potential of its existing social protection infrastructure over the next phase of its development.

Policy and programme design: Policies and programmes need to be informed by a clear analysis of economic and social gender vulnerabilities and risks, and the ways these often intersect to perpetuate inequities at intra-household, community and workplace or market levels. The growing body of evidence on the patterning of vulnerabilities in Viet Nam, including gender- and age-specific vulnerabilities, those related to ethnicity and spatial disadvantage and those related to disability and HIV/AIDS status, needs to inform programme design to ensure maximum effectiveness. Addressing inequities should not be seen as a technical task to be completed but rather as integral to social protection outcomes.

Another critical challenge at the design stage involves the development of clear and operational coordination mechanisms that will promote an inter-sectoral approach to tackling multidimensional vulnerabilities, but simultaneously tackle the fragmentation and duplication that plague Viet Nam's current social protection infrastructure. Coordination mechanisms need to be designed with strong leadership to ensure: clarity of focus; synergies between different types of social protection (social assistance, social insurance and social welfare); and more strategic and joined-up planning between different levels of government, especially in the poorest provinces. A single registry system could facilitate such coordination, as introduced in the successful conditional cash transfer models in Latin America, whereby all programmes and services taken up by a household or individual are recorded and monitored through a central database.

Implementation: Translating programme design into grassroots practice is never an easy task. This chapter has highlighted two broad implementation challenges which need to be addressed to capitalise on the transformative potential of social protection in addressing inequity.

First, it is vital to develop tailored and ongoing capacity-building support for programme participants and implementers alike in order to reap the benefits of programme linkages. It is critical to support implementers in understanding the rationale for pro-poor and pro-equity measures embedded in programme design and in developing a coherent knowledge of the range of services and programmes available to poor and socially excluded groups. By the same token, it is essential that participants are aware of programme objectives and of complementary programme linkages, so that they can make informed choices and participate in programme governance in a more meaningful way. In this regard, tackling language barriers facing ethnic minority communities, especially women, is a crucial first step.

Second, sustainable financing mechanisms need to be secured, especially given the need to expand existing social protection coverage so as to better tackle key inequities in the country. In this regard,

collective realisation of the importance of social protection in cushioning not only the chronic poor but also the near poor from livelihoods shocks, as experienced during the global economic crisis, should be harnessed to ensure political buy-in. Moreover, pro-poor and equity-based budget monitoring (e.g. gender- or child-sensitive budget monitoring) tools should also be utilised to track relative investments in attacking the different sources of risk and vulnerability facing different social groups.

M&E and learning: Given scarce resources, there is an urgent need for investment to ensure that equity considerations are integrated into the M&E of social protection programmes, including the collection, analysis and dissemination of gender-, age- and equity-disaggregated indicators that capture progress on both economic and social vulnerabilities. Institutionally, linkages and lesson learning between government- and NGO-implemented programmes should be promoted through frequent knowledge exchange activities among donors and international agencies to identify opportunities to strengthen equity-sensitive social protection programming. Linked to this, mechanisms need to be in place to translate the lessons from training into performance indicators which are monitored, with good performance rewarded.

[1] The authors wish to thank Roo Griffiths for her valuable editorial support.

[2] This chapter draws on, but also goes beyond, research findings from the first stage of a three-year AusAID-funded study by ODI and Viet Nam's Institute of Family and Gender Studies (IFGS), which is exploring the linkages between gender, food security and social protection effectiveness.

[3] Following the introduction of the *Doi Moi* policy reform programme initiated in 1986, Viet Nam recorded a decrease in people living below the national poverty line from 58% in 1993 to 16% in 2006 and 12.1% in 2008. *Doi Moi* promoted a greater reliance on market mechanisms, coupled with participation of the poor in mainstream development programmes (Joint Donor Group, 2007).

[4] Growth rates declined from 8.2% and 8.5% in 2006 and 2007, respectively, to 5.3% in 2009 (Bauer and Thant, 2010).

[5] Note that the recent fiscal stimulus package in response to the global economic crisis contained a number of social assistance measures, including a one-off D200,000 per person transfer on the occasion of the New Year holiday (CAF and VERN, 2009).

[6] It is difficult to estimate the relative proportions of social support provided by formal/state-led sources and informal forms in Viet Nam. Evans and Harkness (2008), drawing on VHLSS data, found that, among the elderly, the less well-off are least likely to be in receipt of state support and depend largely on income from their own labour and from familial transfers. Jones and Tran (2010), drawing on household survey data from Ha Giang and An Giang provinces, found that households rely predominantly on formal/government social protection mechanisms (such as cash or asset transfers – 42%) and individual efforts (undertaking additional paid or unpaid work, organising rotating labour during harvests, fishing and frog catching to supplement food supply, borrowing buffalo for ploughing, reducing quality and quantity of food consumption, making new rice terraces – 38%). Far fewer households resort to adverse coping strategies (including distress sale of assets, increasing indebtedness, mortgaging land to wealthy farmers, relying on family for food and child care, relying more on children's labour inputs and withdrawing children (mainly girls) from school – 5.6%); and social/community-based forms of help (relying on family members, social networks – 7.4%).

[7] Remittances from overseas Vietnamese, estimated at $2 billion dollars per year, are highly unevenly distributed geographically (Fritzen, nd).

[8] The Committee for Ethnic Minority and Mountainous Area Affairs (CEMA) is Viet Nam's ministerial-level body for ethnic affairs.

[9] Bender and Rompel (2010) trace the process of reforms over the crisis period and argue that they were not decelerated, citing the evidence of the adoption of the new Law on Health Insurance in November 2008 and the complementary Decree 62 in August 2009. Indeed, they argue that, at the agenda-setting level, the financial crisis was 'used' by the government to signal its commitment to social protection reform. Only in the case of the implementation of new instruments did the crisis result in a delay in the introduction of unemployment insurance.

[10] This is in keeping with the government definition: 'through the discussion held so far on the topic and the Government's activities in this area, both social protection researchers and practitioners seem tentatively not to object to define social protection as (i) direct assistance to poor and vulnerable household, (ii) social insurance and (iii) other activities aimed at reducing the vulnerability caused by such risks as unemployment, aging and disabilities' (Le et al., 2005, in Joint Donor Group, 2007).

[11] Three ministries, the Prime Minister's Office and one implementing agency are involved. There are two regulatory agencies: MOLISA (especially the Social Insurance Department and the Social Protection Bureau, which is responsible for policies related to social assistance and the implementation of the NTPPR 2006-2010) and the MoH. The implementing agency for social insurance (including health insurance) is VSS, and district-level MOLISA offices (DOLISAs) are responsible for implementing social assistance programmes.

[12] It is important to note that, currently, groups covered by Decree 67 and poverty programmes are not mutually exclusive, which leads to duplication of benefits. Transaction costs are also unnecessarily high, as administrative processes related to Decree 67 and poverty programmes are not combined (Bender and Rompel, 2010).

[13] An unemployment insurance scheme for workers with a labour contract of at least 12 consecutive months was proposed, but this was postponed as a result of the financial crisis. According to the 2006 Social Insurance Law, unemployment benefits will amount to 60% of the average salary.

[14] The elderly (above 85 years old) constitute the largest group (43.1%), followed by persons with disabilities (24.5%) (Bender and Rompel, 2010).

[15] This included the drafting of the Administrative Bill, the Law on Adoption and the Law on Human Trafficking, and the revision of the Penal Code, the Penal Procedure Code, the Ordinance on Prevention of Prostitution and other related laws. UNICEF also provided technical support in implementing the National Plan of Action for Juvenile Justice and guidelines for polices to prevent juveniles from being institutionalised and to improve support services/reintegration. UNICEF helped assess the court system for children in conflict with the law, leading to the creation of a Youth and Family Court.

[16] www.unicef.org/vietnam/protection.html.

[17] One study found that farmers were subject to 28 types of local fees (in Joint Donor Group, 2007).

[18] For an excellent overview of poverty reduction in Viet Nam, see Jones et al. (2009), who highlight 41 projects and policies with either a direct poverty reduction focus or a strong impact. Both financially and in terms of implementation, the most significant are Program 135, NTPPR and the newly approved Resolution 30a on Rapid and Sustainable Poverty Reduction Program for the 62 Poorest Districts. Together, they account for over 40% of all interventions.

[19] Monitoring gender equality in poverty reduction was one of three priority areas of the gender trigger under Poverty Reduction Support Credit Round 9 (2009-2010), but this was not met and needs to be followed up in PRSC 10 (2010-2011).

[20] Agricultural income sources (crops, livestock, forestry, fisheries) accounted for about 60% of total household income, with other non-farm income sources (wages, non-farm enterprises) contributing nearly 30%. Transfers of all types represent around 9% of the total average income.

[21] VHI premiums vary across group and urban/rural residence but are reasonably affordable, ranging from D30,000 to D50,000 for students and from D70,000 to D160,000 for other groups (MoH and Health Partnership Group, 2008).

[22] AusAid and the Dutch government are supporting initiatives aimed at reducing HIV transmission among IDUs in high need provinces in northern Vietnam. The Australian government is also supporting the Clinton Foundation in Vietnam, especially with regard to the care and treatment of children living with HIV/AIDS.

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