AN ANALYSIS OF THE SITUATION OF CHILDREN IN AN GIANG PROVINCE

An Giang Province

UNICEF Viet Nam

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The research was completed by a research team consisting of Edwin Shanks, Nguyen Tam Giang and Duong Quoc Hung.

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Preface

This Analysis is part of a series of provincial situation analyses that UNICEF Viet Nam has initiated to support provinces under the Provincial Child Friendly Programme. The initiative aims to inform the provinces' planning and budgeting, including the Socio-Economic Development Plans (SEDPs) and sectoral plans, in order to make them more child-sensitive and evidence-based.

The Analysis of the Situation of Children provides the first holistic picture of the situation of girls and boys in An Giang province, including an in-depth analysis of remaining challenges that children face. It also examines the possible causes of the situation of children in the province, and analyses them in the context of the Mekong Delta region and Viet Nam as a whole. The report aims to contribute towards establishing a stronger knowledge base on children by compiling and analysing information and data on children's issues that exist but have not yet been consolidated or comprehensively analysed.

The Analysis' findings confirm the province's remarkable progress across a broad spectrum of children's issues, in line with its socio-economic development achievements in recent years. However, there are areas where disparities still exist and progress is needed. This is particularly the case for disadvantaged groups such as children in the poorest communities, Khmer ethnic minority children living with HIV/AIDS, or those left behind by migrating parents, but also in areas such as secondary education, child malnutrition, water and sanitation, social protection and child protection.

It is our intention that this Situation Analysis will be a frequent reference document for An Giang Province during the process of planning and implementing the province's SEDPs and sectoral plans, for development partners working in the province and for the general public.

Lotta Sylwander

Representative

UNICEF Viet Nam

Ho Viet Hiep

Vice Chairman

An Giang Provincial People's Committee

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
CLTS	Community Led Total Sanitation
CRC	Convention on the Rights of the Child
CPFC	Committee for Population, Family and Children
CWD	Children with Disabilities
DOET	Department of Education and Training
DOF	Department of Finance
DOH	Department of Health
DOLISA	Department of Labour, Invalids and Social Affairs
DPC	District People's Committee
DPI	Department of Planning and Investment
GSO	General Statistics Office
HIV	Human Immunodeficiency Virus
HCM City	Ho Chi Minh City
IBCC	Integrated Behaviour Change Communication
IDU	Intravenous Drug Users
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IT	Information Technology
MCNV	Medical Committee of the Netherlands
MMR	Maternal Mortality Rate
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
NCERWASS	National Centre for Rural Water Supply and Sanitation
NTP	National Target Programme
ODA	Official Development Assistance

PCERWASS	Provincial Centre for Rural Water Supply and Sanitation
PCFP	Provincial Child Friendly Programme
PMTCT	Prevention of Mother to Child Transmission
PPC	Province People's Committee
PSO	Province Statistics Office
RWSS	Rural Water Supply and Sanitation
SEDP	Socio-Economic Development Plan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VHLSS	Viet Nam Households and Living Standards Survey
VND	Viet Nam Dong

Exchange rate: **1 USD = VND 20,800**

EXECUTIVE SUMMARY AND MAIN RECOMMENDATIONS

1. This report provides an analysis of the situation of children in An Giang Province, in the Mekong Delta region of Viet Nam. The overall objective of the study is to provide the Government of Vietnam, the development community and the public at large with up-to-date information on children's issues and priorities in the province. The specific objectives are: (i) to consolidate statistical data and analyse the situation of children in the context of the province's socio-economic development; (ii) to identify relevant issues affecting knowledge on child rights and the advancement of these rights; and (iii) to provide recommendations to improve children's situation by making the provincial Socio-Economic Development Plans (SEDPs) and sector plans more responsive to children's issues.

2. The analytical approach adopted by the study has three main elements. Firstly, children's issues are analysed according to clusters of child rights that relate to different areas of sector activity, including the rights to health and survival, development and education, child protection and children's participation. This conforms to the definition of child rights given in the Convention on the Rights of the Child and in Viet Nam's Law on Child Protection, Care and Education. Secondly, a structured analysis is made of programming and budgeting for child-related concerns in the provincial SEDP and sector plans and programmes in the period from 2006 to 2010. The aim is to identify those aspects that are comparatively well covered, and those that are under-resourced and not adequately addressed in existing plans, programmes and services. Thirdly, the study makes an institutional capacity assessment and capacity gap assessment with respect to the institutional responsibilities and arrangements for child care and protection.

3. The report is divided into six main chapters. Following the Introduction, **Chapter 2** sets the scene by describing salient aspects of the geographical setting, demographic characteristics, poverty context and provincial economy in An Giang. Attention is given to patterns of migration and household mobility, and to climate change and environmental vulnerability, both of which are development issues which will have increasing importance in the Mekong Delta Region in the coming years. Patterns of intra-provincial disparities and household vulnerability that affect the situation of children are also identified. **Chapter 3** makes an analysis of social sector programming and budgeting for children. This includes budget trends in the overall provincial budget and the development investment budget included in the annual SEDP, funding for the National Target Programmes and institutional arrangements and funding for social protection policies and programmes. The following chapters provide a detailed analysis of each sector and clusters of child rights: child health and survival **(Chapter 4)**, child development and education **(Chapter 5),** child protection **(Chapter 6)** and children's participation **(Chapter 7)**. Reference is made throughout to statistical data tables that have been compiled in Annex 1.

4. This Executive Summary has two main parts. The first part summarises the distinguishing characteristics of socio-economic development in An Giang and major trends and issues in relation to each sector and cluster of child rights. The second part provides a tabular summary of the institutional capacity gap assessment and main recommendations for enhancing the integration of children's issues and concerns in the provincial SEDP and sector planning for the period 2011 to 2015. Reference is made in square brackets to chapters and sections of the main report where a full presentation and analysis of each issue can be found.

Comparative nationwide, regional and provincial indicators

Indicator	An Giang	Nationwide	Mekong Delta Region	Source
Average annual population growth rate (%)	0.5	1.2	0.6	a) 2009
Population under 15 years of age (%)	24.8	25	24.4	a) 2009
Sex ratio at birth (male births per 100 female births)	113.7	110.5	109.9	a) 2009
Infant Mortality Rate (‰)	17	16	13.3	a) 2009
Poverty rate 2006 (%)	9.7	15.5	13	b) 2006
Poverty rate 2008 (%)	8.5	13.4	11.4	b) 2008
Average per capita monthly income (VND '000)	1,064	995	940	b) 2008
Fully immunised children under one year of age (%) [1]	91	94	94.5	c) 2008
Underweight children under five years of age (%)	17.5	18.9	18.7	d) 2009
Stunted children under five years of age (%)	29.6	31.9	29.1	d) 2009
Communes/wards clinics with doctor (%)	73	66	80	c) 2008
Communes/wards with midwife (%)	100	93	95.5	c) 2008
Cumulative HIV infections per 100,000 people	321	204.5	168.7	c) 2008
Households with safe water supply (%)	62.9	86.7	77.9	a) 2009
Households with sanitary latrines (%)	55.3	54	42.4	a) 2009
Households with permanent housing (%)	10.9	46.3	8.3	a) 2009
Net primary school enrolment rate (%)	92.3	95.5	94.3	a) 2009
Net lower secondary school enrolment rate (%)	64.4	82.6	71.5	a) 2009
Net upper secondary school enrolment rate (%)	33	56.7	40.4	a) 2009

Sources: (i) General Statistics Office (2010) The 2009 Viet Nam Population and Housing Census. (ii) General Statistics Office (2010) Statistical Yearbook of Viet Nam 2009. (iii) Ministry of Health (2009) Health Statistics Yearbook 2008. (iv) National Institute of Nutrition Nutrition Surveillance System.

Major findings of the study

5. The situation of children in An Giang is inter-linked with the unique development context and development trends in the Mekong Delta Region. These include: (i) rapid economic growth over recent years, which is associated with changes in the structure of the local economy and processes of 'rural-urbanisation'; (ii) high rates of out-migration to other regions, especially from rural areas of the province; (iii) a large 'mobile population' due to labour-migration and substantial numbers of households involved in river trade and transport; (iv) increased economic mobility that is resulting in various dimensions of behaviour change amongst some population groups; (v) increasing pressure on natural resources due to high population density; and (vi) environmental vulnerability due to flooding and emerging impacts of climate change.

6. **Rapid economic growth** [Chapter 2.4]. An Giang has achieved remarkable economic growth in recent years. According to provincial SEDP reports, growth in GDP reached 14.2 per cent in 2008, but declined to 8.7 per cent in 2009 and 10 per cent in 2010 with the downturn in the global economy. An Giang has many advantages with respect to agricultural production and is a major producer and exporter of rice and aquaculture products. The recent growth in GDP has

1 Full immunization includes three vaccines against Hepatitis B, Polio, Diphtheria, Pertussis and Tetanus, and one against Tuberculosis and Measles.

been fuelled by rapid development of aquaculture-based industries in particular; aquaculture outputs at constant prices increased by 224 per cent from VND 772 billion in 2000 to VND 2,500 billion in 2009, with current production being about 300,000 tonnes per annum. Cross-border trade is another important component of the provincial economy. In the period from 2006 to 2010, imports and exports across the border with Cambodia amounted to USD 3.9 billion. At the same time, this border zone has become a corridor for smuggling consumer goods, as well as being a route for trafficking in women and children and a hotspot for communicable diseases such as HIV/AIDS. Cross-border coordination and collaboration has therefore become essential to combat these negative influences and impacts of increasing regional integration and economic growth.

7. **Migration, household mobility and vulnerability** [Chapter 2.5]. As with other provinces in the Mekong Delta Region, An Giang has a high rate of out-migration. According to the 2009 Population and Housing Census, the out-migration rate was 55 per 1,000 inhabitants with a net migration rate of -46 per 1,000 inhabitants. Census data on migration only include permanent/semi-permanent relocation of persons over five years old; as such, these figures do not present the full picture of population mobility or the situation of young children in migrant families. The patterns of migration and household mobility in An Giang are complex and location-specific. Nonetheless, several major patterns of intra-provincial and inter-regional migration and household mobility can be identified. Each may have particular implications for children:

    - *Short-term movement of rural families to obtain seasonal agricultural work.* In this situation, the whole family will often move, which may result in temporary withdrawal of children from school. However, the availability of this type of seasonal agricultural work has been falling, due to mechanisation of rice harvesting that is replacing manual labour.

    - *Long-term migration of rural families to obtain work in neighbouring regions.* In this situation, both parents will often migrate; the first child may go with them to obtain work, while younger children may be left in the home community with relatives. This may have consequences for older children who are permanently withdrawn from school, and may adversely affect the care and nutrition of younger children left behind with relatives.

    - *Migration of young adult semi-skilled workers to urban and industrial zones.* The high rate of out-migration in recent years has been primarily due to this type of migration. Previously, this was mainly amongst the unmarried Kinh ethnic group to obtain manual or semi-skilled work for a period of years on construction sites, in garment factories, housekeeping and others. Recently, the number of young Khmer people undertaking this type of migration has also increased. While this type of migration enables many young adults to obtain an income, there are many reported difficulties they encounter in social living conditions, as well as in establishing a stable base for starting a family and long-term employment prospects.

    - *Return migration to home areas*. Return migration, which is associated with the above categories of out-migration, is often overlooked. The reasons for return migration are diverse, and can have both positive and negative impacts on the migrant workers and their families. Several studies have indicated that the greatest concern amongst returning migrants is the lack of regular employment in the countryside and the decrease in income sources.

- *Migration and displacement caused by flooding.* Some temporary or permanent relocation is made in response to flooding, especially in peak flood years. Children and poorer households may seek refuge from flooding in urban centres. Seasonal movement to urban centres is important for some people seeking alternative livelihoods. Some households migrate permanently if successive flooding causes the destruction of agricultural livelihoods.

- *Urbanisation processes.* Over the last decade, the An Giang population has become increasingly urbanised with a 5.6 per centage point shift in the rural-to-urban population, with the rural share declining from 77.2 per cent to 71.6 per cent. This is not primarily due to rural-to-urban migration within the province. Rather, it is associated with the reassignment of some rural districts and communes to urban status, which reflects the wider process of 'rural urbanisation' taking place in the densely populated Mekong Delta Region. This presents particular challenges and vulnerabilities for peri-urban households and labourers as they need to shift away from agriculture-based livelihoods to new forms of employment and income generation.

- *Mobile households involved in river trade and transport.* While not technically referred to as a form of migration, a sizeable proportion of the An Giang population is involved in various forms of river trade and transport. No precise figures are available on the numbers of households involved. However, this 'floating community' represents a distinct population group with special characteristics and needs. The provision of social services to this population group presents special challenges. Due to their semi-mobile lifestyle, many families find it difficult to ensure full-time school attendance for their children, and school drop-out rates are reported to be higher amongst this population group than others.

8. **Population monitoring amongst mobile population groups** [Chapter 2.5, 3.6 and 6.2]. For all the above population groups, the local authorities have encountered some difficulties in basic population monitoring and understanding the situation of children. Regular administrative data collection may not adequately cover these groups because households are not present during the data collection periods. Furthermore, sampling in specialised surveys is rarely adequate to capture a full understanding of the particular circumstances of these groups. This results in gaps in the availability of basic data on many childcare and protection indicators amongst the general population in An Giang. Filling these gaps in baseline population monitoring should be a priority for the 2011-2015 SEDP.

9. **Increased economic mobility and behaviour change** [Chapter 4.1 and 4.3]. One salient feature of the current socio-economic context in An Giang is the increased economic mobility of many households. This is associated with increased wealth and with the various forms of labour migration. Furthermore, evidence suggests that this is linked to changes in various dimensions of social behaviour, particularly with respect to healthcare, which may have positive or negative consequences. There are many positive examples of behaviour change especially in healthcare for children. For example, ensuring safe birth delivery at specialised hospital units and ensuring children are fully vaccinated love now become regular practice for a majority of families in An Giang. This represents a significant and positive shift in social behaviour. On the other hand, negative consequences are seen in the increasing sex ratio at birth (SRB). According to the 2009 Census, the SRB in An Giang was 113.7 male births per 100 female births, which is higher than the national SRB of 110.5.

These figures reflect nationwide concern with the changing SRB in Viet Nam over the last decade, which can be linked to behaviour change associated with increased access to sex selection technology and private health facilities.

10. **Labour age population and employment** [Chapter 2.2 and 5.6]. The labour force in An Giang has substantially increased in recent years and will continue to do so over the next decade. Providing adequate training and generating productive employment for the increasing number of school-leavers and young labourers, particularly those from rural areas, is therefore a major priority. In order to create a competitive labour force, the provincial authorities give high priority to improving the provision and quality of vocational training for labourers and employment support for school-leavers. However, various sources suggest that the quality of available vocational training programmes is limited. There is a need to strengthen incentives for private sector enterprises to directly provide vocational training, to more closely link vocational training to job-creation schemes, and to improve the quality of vocational training in terms of its periodicity, curricula and methods.

11. **Factors influencing child poverty** [Chapter 2.3]. According to the Viet Nam Household and Living Standards Survey (VHLSS 2008), 52.8 per cent of children in the Mekong Delta Region suffer from multidimensional child poverty, whereas only 15.5 per cent of children are poor according to the monetary poverty rate. This is the second-highest rate of multidimensional child poverty in the country after the North West Region, and is considerably higher than the nationwide rate of 28.9 per cent. The VHLSS indicates that child poverty in the Mekong Delta Region is particularly associated with the lack of safe water and sanitation. Compared with other regions, the child poverty rate in the region in the domains of social protection, safe water and sanitation, shelter, and education are also relatively high. In contrast, the child health poverty rate in this region is lower than in other regions.

12. **Environmental vulnerability and adaptation to climate change** [Chapter 2.6]. The agricultural economy of An Giang is dominated by the annual flood cycle of the Mekong River. Although flooding is integral to the agricultural productivity of the region, each year it brings hardship for households exposed to the floods. Since the mid-1990s, the Government has promoted the strategy of 'living with floods' which has focused on strengthening the system of dykes and transport infrastructure, together with the development of residential clusters aimed at creating stable living for those communities most affected by flooding. This strategy was intensified after the historically severe floods in 2000 and investment in residential clusters was one of the main objectives of socio-economic development in the Mekong Delta Region in the period 2001-2005. An Giang has made considerable investments in flood control and disaster mitigation over the last decade, as well as taking successful actions to safeguard children in times of flooding. The limited human impact of the severe 2011 floods demonstrate the results of the province's strategy and preparedness measures. Yet, the cost in terms of human lives, including 43 children, remains considerable and indicates further efforts are necessary.

13. The Mekong Delta Region is recognised as particularly susceptible to the impacts of climate change, including sea level rise and saline intrusion, variable rainfall patterns and river flow dynamics amongst other factors. It is likely that there will be significant secondary impacts on the agricultural economy. Although these impacts will vary from location to location within the delta region, it is possible that one of the major consequences and adaptations amongst the human population will be increased levels of displacement and migration. Children of migrant households generally, and

in households affected by flooding in particular, are especially vulnerable in terms of child health and survival and loss of schooling opportunities.

14. Adaptation to climate change will need to become an increasingly important and integral part of social and economic development planning in An Giang in the coming years. In this respect, as recommended in a recent report from the Mekong Delta Climate Change Forum, the government strategy of 'living with floods' needs to be more fully elaborated in practice. An integrated approach will be required that combines engineering responses to climate change, with economic and spatial planning, social protection policies, and strengthening natural resource management systems and rehabilitation.

15. **Patterns of intra-provincial disparities affecting the situation of children** [Chapter 2.7]. In some other rural provinces of Viet Nam, intra-provincial disparities in poverty status and the situation of children are clearly linked to factors of 'location' and 'ethnicity'. While this is true to a certain extent in An Giang, in general it can be said that the major patterns of intra-provincial disparities here are less clearly determined by either location or ethnicity than in other provinces. The poverty rate amongst the Khmer ethnic minority population is higher, and per capita incomes are lower, than amongst other ethnic groups. The Khmer still face some disadvantages in access to social services, higher education, and employment opportunities due to social barriers and difficulties in language. For other key social trends and indicators, however, there are less noticeable disparities according to ethnicity. For instance, changes and improvements in reproductive healthcare behaviour and primary education amongst the Khmer population have broadly followed province-wide trends amongst all population groups.

16. The major patterns of intra-provincial disparities that affect the situation of children in An Giang are primarily related to the circumstances of particularly vulnerable population groups and households. Spatial patterns of disparities are less to do with broad differences between geographical or administrative areas, and more with 'micro-level' spatial differences between households and residential locations and communities. This is an exceedingly complex socio-economic context, which relates to the high-population density and highly competitive local economy of the region. Factors of household location, living conditions and productive assets, combine with factors of the labour capacity and social position of the household, to create patterns of comparative advantage and disadvantage. In an aggregate sense, therefore, it can be said that the 'physical space' and 'socio-economic space' occupied by the household is the major determinant on the well-being and future prospects of children.

17. **Province revenue and social sector expenditures** [Chapter 3.1 to 3.3]. An Giang has the advantage of having a large and diverse local revenue base. In 2008, for instance, local revenue constituted 49.8 per cent of the total province income (VND 2,916 billion) while transfers from the central State Budget comprised 37.2 per cent (VND 2,181 billion). Overall province expenditures increased by 82.5 per cent from VND 3,092 billion in 2005 to VND 5,643 billion in 2008. In this period, social and cultural sector expenditures rose by 60.2 per cent from VND 854 billion in 2005 to a preliminary figure of VND 1,989 billion in 2008 (within which education expenditures increased by 73 per cent and health and social relief each by 40 per cent). In proportional terms, this represents a decrease in social sector expenditures from 27.6 per cent of total expenditures in 2005 to 24.25 per cent in 2008.

18. The substantial local revenue base has enabled the provincial authorities in An Giang to devote province resources to augment the implementation of policies and programmes in ways that have had a beneficial impact on some social indicators. In particular, recurrent budgets for service provision (von su nghiep) heve been supplemented. For instance, in 2008 almost 7 per cent of local revenue or VND 402 billion came from the lottery. This is incorporated into the provincial budget and provincial officials indicate that about 70 per cent of this lottery revenue is allocated to health and education concerns. The province has also been able to allocate resources from the provincial budget, as well as mobilising substantial resources from non-public sources, to support implementation of the National Target Programmes (NTPs).

19. **National Target Programmes** [Chapter 3.3]. The NTPs are one of the primary means through which government policies and budgetary resources can achieve social development objectives and strengthen social service provision. According to figures provided by the Department of Finance, total expenditure on the NTPs in An Giang in the period from 2006 to 2010 was in the order of VND 2,289 billion. Around 65 per cent of this was mobilised from 'other sources', while funding from the central state budget and the provincial budget made up 23.5 per cent and 11.5 per cent respectively. This represents a substantial contribution to NTP funding from non-public sources and socialisation policies. In particular, these contributions have been for the NTP on Poverty Reduction, the NTP on Social Diseases, Epidemics and HIV/AIDS (with non-public resources mobilised primarily for HIV/AIDS), and the NTP on Rural Clean Water Supply and Environmental Sanitation (including private sector water supply ventures).

20. **Access to quality healthcare for children** [Chapter 4.1]. There have been positive developments in healthcare provision for women and children in An Giang over the last decade. In particular, there has been significant behaviour change around the combined issues of birth registration, health insurance and child vaccination. Ensuring full vaccination for children[2] has become a routine for most parents, with positive impacts on the incidence of infectious diseases amongst children. There is some evidence to suggest, however, that the actual rates of full vaccination may be lower than reported figures. One recent survey conducted by the Department of Health, based on a sample of 1,100 households in four districts, found that the rate of full vaccination of children by 24 months of age was only 57.2 per cent, which is considerably lower then officially reported figures. Together with near-full coverage of birth registration, health insurance has been successfully extended to a majority of children under six years of age. Another improvement has been in the provision of regular health check-ups for school children; in 2009, for instance, it is reported that 74 per cent of pupils at 93 per cent of province schools received annual health check-ups. Dental checks and advice on oral hygiene are provided to 100 per cent of primary school pupils.

21. **Reproductive healthcare** [Chapter 4.3]. It is notable that about 69 per cent of funding for the NTP on Population and Family Planning in An Giang has come from the provincial budget. Similarly, 94 per cent of funding for the Project on Reproductive Healthcare under the NTP on Social Diseases, Epidemics and HIV/AIDS has come from the provincial budget. This reflects the high priority that the provincial authorities place on family planning and improving reproductive healthcare services. This has resulted in province-wide progress and achievements

2 Full immunization includes three vaccines against Hepatitis B, Polio, Diphtheria, Pertussis and Tetanus, and one against Tuberculosis and Measles.

in reproductive healthcare indicators. The research team suggests that this is a clear example of where provincial budget resources have been allocated to augment national programmes with beneficial outcomes for both women and children. Several indicators substantiate these positive developments:

- According to official figures, the proportion of pregnant women receiving three or more antenatal check-ups has increased from between 60-70 per cent in 2006 to over 95 per cent in 2009 and 2010. Since 2006, over 95 per cent of pregnant women have received tetanus vaccinations and the proportion of pregnant women undertaking voluntary testing for HIV has also increased.

- All communes and wards have midwives and/or junior delivery doctors and this staffing contingent is quite stable; since 2006, the rate of women delivering at health facilities has been over 99 per cent; the rate of deliveries at commune/ward clinics has been steadily decreasing from 23.3 per cent in 2006 to 14.6 per cent in 2009 because a majority now take place at provincial or district hospitals to take advantage of better care and facilities.

- The above improvements are reflected in the maternal mortality rate, which has decreased substantially from 60 per 100,000 live births in 2000, to 28 in 2006 and 20 in 2009. Moreover, these changes are evident amongst all population groups including ethnic minorities. This suggests that Information, Education and Communication (IEC) activities in reproductive healthcare have been effectively strengthened and expanded.

22. Despite these improvements in the coverage and utilisation of services, there are still concerns about the quality of services. A recent survey conducted by the Department of Health in four districts found that only 63.1 per cent of pregnant women received at least three pregnancy check-ups, ranging from 54.8 per cent in Tinh Bien District to 72.8 per cent in Phu Tan district. These are considerably lower than the officially reported figures by the District Health Section. Moreover, only 19.7 per cent of women received full quality pregnancy check-ups according to MOH regulations. These survey results indicate that continuing efforts are needed to improve the quality of reproductive healthcare services.

23. There are two main population groups for which reproductive healthcare provision needs to be strengthened. Young migrant women and those from mobile households are the fist priority group. According to provincial and district officials, there are still difficulties in ensuring regular antenatal check-ups and reproductive healthcare advice for women from these groups. The second priority group where reproductive healthcare advice and awareness need to be strengthened is amongst teenagers and young adults, both generally and in conjunction with secondary schooling.

24. **HIV/AIDS** [Chapter 4.4]. HIV/AIDS emerged at an early stage in An Giang in comparison to other rural provinces in Viet Nam. During the early part of the last decade, the province experienced high rates of new HIV infections, such that An Giang still has a comparatively high number of people living with HIV/AIDS. Whereas children under 16 years of age accounted for 3.8 per cent of the cumulative number of HIV infections in 2006, this has risen to 4.8 per cent in 2009. The province has made considerable efforts to improve HIV/AIDS awareness, prevention and treatment. There has been a 50 per cent reduction in the number of new HIV infections from 766 in 2006 to 388 in 2009, and a reduction in the infection rate from 34.6 per 100,000 inhabitants in 2006 to 18.1 in 2009. At this point in time, the rate of infections amongst the female population of reproductive age and the prevention of

mother-to-child transmission is a major concern for the province. The province has successfully encouraged pregnant women to receive HIV/AIDS voluntary counselling and testing, and there has been focused monitoring and targeting of this population group and female sex workers. These efforts need to be maintained by expanding Prevention of Mother to Child Transmission (PMTCT) activities to all establishments in the health network. This should be combined with increasing the involvement of men in PMTCT activities in both prenatal and antenatal healthcare.

25. **Maternal and child malnutrition** [Chapter 4.5]. According to the Nutrition Surveillance System, over the last decade in An Giang there has been a steady reduction in malnutrition for children under five years of age as measured by weight, from 32 per cent in 2000 to 24.9 per cent in 2006 and 17 per cent in 2010, thereby exceeding the provincial target of 19 per cent for 2010. In common with other provinces, however, stunting rates have remained persistently high, showing only a marginal decline from 30 per cent in 2005 to 28.7 per cent in 2010. This reflects nationwide concern with the health and socio-economic impacts of maternal and infant undernutrition. Generally higher rates of child malnutrition persist in the remote rural districts, amongst the Khmer population, and amongst mobile population groups. All districts report differences in the malnutrition rate according to age group, with lower rates amongst infants under two years of age than amongst children from three to five years of age. One of the major problems relates to the nutrition of young children of preschool age.

26. Child stunting results from chronic nutrient deficiencies of mothers during pregnancy and of young children due to poor feeding practices, including poor breastfeeding during the first 24 month of life. Other known contributing factors include poor hygienic living conditions, water sanitation and infectious diseases. Stunting is therefore an important indicator of the quality of maternal and child healthcare services and living conditions. The recent survey of 1,100 households in An Giang found that less than 10 per cent of mothers practiced exclusive breastfeeding during the first six months and only 56.7 per cent of breastfeeding mothers took Vitamin A supplements. Another survey in three districts found moderate levels of prolonged undernutrition amongst women of reproductive age (19.2 per cent) but high rates amongst young women aged 15 to 19 (33.3 per cent). This survey also found high rates of anaemia amongst pregnant women (46.6 per cent), especially in the last three months of pregnancy (50.6 per cent). It also found severe rates of anaemia amongst children under five years of age (65.7 per cent), especially in Tinh Bien District (84.4 per cent). The same survey found that only 58 per cent of the households in An Giang use iodised salt in their daily meal, and as a result, women and young children in this province are exposed to severe iodine deficiency.

27. It is notable that, in comparison to some other rural provinces in Viet Nam, maternal and child undernutrition in An Giang is not primarily associated with a general lack of availability of either staple or nutritious foods for children. Provincial and district officials frequently comment that while the province is a major producer of rice, fish, fruit and vegetables, undernutrition continues to be a problem. This suggests that the root cause of this problem lies in quality of health and nutrition care for women before and during pregnancy, and in behavioural patterns of feeding practices for pregnant women and young children. This issue is not confined to poor households, as children from all income groups, and from families of labourers as well as administrative workers, may suffer from a lack of regular meals and adequate nutrition. Time availability due to work pressures on parents is often cited as a contributory factor, together with limited full-day kindergarten school attendance.

Circumstantial evidence also suggests that children from rural migrant families may be most vulnerable to a lack of adequate nutrition, especially young children who are left behind with relatives when their parents are away on migrant work.

28. The child malnutrition rate in An Giang, especially child stunting, may only reduce slowly in the coming years. The challenge now lies primarily in improving health and nutrition care for women before and during pregnancy, and improving care for children in the first two years of life; for instance, by preventing undernutrition and micronutrient deficiencies for pregnant women and by improving breastfeeding and complementary feeding practices. These are social and parental behaviour patterns that are slow to change. The health sector will need to broaden the scope and content of its child nutrition and malnutrition prevention programmes to address the changing socio-economic context. According to the Department of Health, the number of overweight children is increasing among some population groups: this issue has yet to be addressed, but should be incorporated into a broader approach to nutrition programmes. The health sector cannot deal with this broad public health concern alone, so it will need to work with other relevant sectors, mass organisations and the mass media.

29. **Water supply** [Chapter 4.6]. According to the 2009 Census, 62.9 per cent of all rural and urban households in An Giang have access to safe water; lower than the regional average for the Mekong Delta (77.9 per cent) and the national average (86.7 per cent). Provincial figures indicate that, as of 2009, 61.64 per cent of rural people have access to appropriate clean water supply, while only 44.34 per cent use safe water according to quality standards of the Ministry of Health. The highest rates of rural people using safe water are in Tinh Bien (58 per cent), Tan Chau (67.1 per cent) and Chau Doc (81.1 per cent). The lowest rates are found in Chau Thanh (27.5 per cent), Cho Moi (29.3 per cent) and Thoai Son (30.2 per cent). Water quality is a major problem in the latter districts – in 72 per cent of rural communes in these three districts less than 25 per cent of people use water of adequate quality.

30. **Environmental sanitation** [Chapter 4.6]. According to the 2009 Census, 55.3 per cent of all urban and rural households in An Giang have hygienic latrines, above the average for the Mekong Delta Region (42.4 per cent) and slightly higher than the national average (54 per cent). Provincial figures indicate that, as of 2009, 46.08 per cent of households have appropriate hygienic latrines, ranging from 34.5 per cent in An Phu to 56.8 per cent in Thoai Son, while 82.46 per cent of households have some form of latrine. Improvements in household sanitation have been made through well coordinated support from the Preventive Health Centre, the Women's Union and PCERWASS, amongst other agencies, to raise sanitation awareness and promote improved latrine usage through appropriate technology development and credit schemes. Various latrine designs have been adapted to the particular housing conditions found in the region, including raised latrines appropriate for flooded areas and stilt-houses along canals. Considerable improvements have also been made in providing water supply and sanitation facilities in schools. As of 2009, 86.71 per cent of all public schools have improved facilities, yet low capacity for operations and maintenance remains a key challenge.

31. According to the 2009 Census, 37.1 per cent of children under fire years old in An Giang still do not have access to improved water (placing An Giang in 14th position amongst 63 provinces and cities). At the same time, 44.7 per cent of children do not have access to improved sanitation (placing An Giang in 45th position amongst 63 provinces and cities). Around 17.5 per cent of the rural population (76,000 people)

still do not have latrines, hence they have to defecate openly in rivers, canals and fields. This results in contamination of water sources and the environment, affecting people's health. Hence, sanitation promotion efforts and innovations should be targeted on this group.

32. **Child injury prevention** [Chapter 4.7]. The major cause of injuries to children in An Giang is road and traffic accidents (about 37 per cent), followed by falls (27.5 per cent) and labour-related injuries (6 per cent). The extensive network of waterways and frequent floods in An Giang create many dangers for children. Following the severe floods of 2000 and 2001, the province introduced a number of measures to safeguard children from these dangers, including a concerted programme of swimming lessons for primary school children and shelter points where children can gather during floods. Although drowning is a common cause of child fatalities in the Mekong Delta, it does not emerge as an outstanding issue in An Giang thanks to these effective preventative measures. These measures need to be continuously maintained, however, to ensure that each generation of children has the necessary life skills and shelter to cope with flooding. Road and traffic safety for children, on the other hand, is a major concern in An Giang. The number of traffic accidents and fatalities has not reduced substantially in recent years, despite awareness raising and law enforcement efforts. Stronger efforts are required to combat this critical public health issue by promoting behaviour change amongst parents and the general public, combined with stronger observance and enforcement of traffic regulations. Coordinated action is needed at all levels to address this issue.

33. It is notable that 5.2 per cent of child injuries referred to the health service are due to violence and conflict, rising from 3.1 per cent in the 5-14 age group to 9.3 per cent in the 15-19 age group. There is also a high reported incidence of injury due to attempted suicide amongst children and young people of the 15-19 age group at 4.8 per cent, a majority of whom are boys. These figures are cause for concern. During this research, it was not possible to investigate the circumstances behind these statistics. A focused study is needed to determine which children are most vulnerable and to identify the causative factors. In particular, attention should be given to possible links to bullying in schools. As part of the development of the social work system, there is a need to increase the provision of appropriate counselling services for teenagers and young adults.

34. **Preschool education** [Chapter 5.2]. Access to kindergarten classes and the number of children attending kindergarten by age five have increased substantially over the last decade amongst all population groups in An Giang, including ethnic minority children in remote areas. The proportion of children attending kindergarten by age five has increased from 26.8 per cent in 2000, to 67.5 per cent in 2005 and 91.8 per cent in 2010, thereby falling just below the provincial target of 95 per cent for 2010. However, full-day attendance at kindergarten is currently only about 16 per cent, and the proportion of children attending nursery classes was only 5.5 per cent in 2009. Preschool facilities are limited in many communes, with kindergarten classes sharing facilities with primary schools.

35. A main priority for the education sector in the forthcoming SEDP period (2011-2015) is to work towards the universalisation of preschool education in accordance with Decision No.239/2010/QD-TTg, which aims to increase the rate of full-day kindergarten school attendance. Three main issues will need to be addressed to achieve this. Firstly, the preschool network is currently insufficient; investment is needed to substantially increase the number of classrooms and associated facilities.

Secondly, the number of qualified preschool teachers needs to increase. Thirdly, supportive policies are required for investment and staffing, and to encourage the private sector to invest in new preschools particularly at the nursery level.

36. **Primary and secondary education** [Chapters 5.3, 5.4 and 5.5]. Steady improvements have been made in primary and secondary education in recent years, including: (i) investments to consolidate the network of primary and secondary school infrastructure; (ii) enrolment rates have steadily increased at the primary level; (iii) the universalisation of lower secondary education has been achieved and maintained in a majority of locations; (iv) the staffing contingent is generally seen as adequate in terms of numbers of staff and their basic qualifications; (v) there is now better provision of teaching equipment and school facilities; and (vi) parental support has been strengthened, in particular for children in difficult circumstances. The provincial authorities and DOET have stepped up their efforts to enhance the quality and effectiveness of education management and teaching capacities. Even so, the proportion of primary and lower secondary schools in An Giang meeting national standards is below the regional and national averages. Further investment is needed to improve both school infrastructure and facilities and the quality of education.

37. The province has made good progress in reducing the drop-out rate from primary and secondary school in recent years. Even so, this remains a major problem in An Giang, as it is in other provinces in the Mekong Delta Region. Data from the 2009 Census reveal that about one quarter (25.9 per cent) of children between five and 15 years of age in An Giang have dropped out of school. While the primary school drop-out rate is fairly equally spread across urban and rural areas, the lower and upper secondary school drop-out rate is generally higher in rural areas. In all areas, and amongst all ethnic groups, drop-out rates depend greatly upon parental awareness and household economic conditions.

38. The gender balance in school attendance at primary and lower secondary level conforms closely to the sex ratio in the population as a whole. At upper secondary level, the ratio between boys and girls widens (46.4 per cent boys and 53.6 per cent girls). The 2009 Census also confirms a higher upper secondary net enrolment rate for girls (36.3 per cent) as compared to boys (29.9 per cent). This may reflect a higher rate of drop-outs and discontinued schooling amongst teenage boys, which is a cause for some concern. The proportion of ethnic minority pupils declines from primary to secondary school levels; in the three school years from 2007-08 to 2009-10, ethnic minority pupils constituted 5.5 per cent of primary and 4.6 per cent of lower secondary pupils, but only 2.8 per cent of upper secondary pupils. This is indicative of generally lower levels of educational attainment amongst ethnic minorities at secondary level, particularly amongst Khmer teenagers.

39. **Education and training** [Chapter 5.6]. As with other provinces in the Mekong Delta Region, the 2009 Census revealed the tremendous challenges facing education and training in An Giang. Across all indicators of educational attainment of people over 15 years old, An Giang ranks in a low position as compared to other provinces. According to the 2009 Census, nearly 32 per cent of people over 15 years old in An Giang had not completed primary school. This is the highest rate of non-completion in the country, double the nationwide average of 14.5 per cent. Only 14.3 per cent of people over 15 years of age had completed lower secondary school, which is the lowest rate nationwide and half the national average of 28.9 per cent. Similarly, only 5.7 per cent completed upper secondary school, which is again half the national average of 12 per cent. The census also revealed that only 1.8 per cent of the

population over 15 years of age in An Giang had completed vocational training.

40. **Factors influencing educational completion and attainment** [Chapter 5.6]. Across all indicators of the highest level of educational attainment of persons over five years of age, An Giang ranks in a low position in comparison to other provinces in the Mekong Delta Region and nationwide. According to the 2009 Census, 37 per cent of people over five years of age in An Giang had not completed primary school. This is the highest rate of non-completion in the country, and is considerably higher than the nationwide average of 22.7 per cent. Only 11.8 per cent of people over five years of age completed lower secondary school, which is the second-lowest rate nationwide and half the national average of 23.7 per cent. Similarly, only 9.5 per cent have completed upper secondary school, somewhat below the regional average (14.3 per cent) and half the national average of 20.8 per cent.

41. This research identified a wide range of immediate and underlying causes of the comparatively high rates of drop-outs and discontinued schooling in An Giang. These include the demand for children to work, household poverty situations, the lack of children's motivation, weak academic performance, language barriers, a lack of good role models, negative peer pressure and influence, and negative impacts of modern lifestyles. Many of the causes mentioned above are subjective factors that relate to the quality of education and learning. At the same time, there are underlying causative factors that run deeply in the structure of the local economy in the Mekong Delta and in public attitudes towards education and learning. As such, a long-term perspective is required to address these factors. In particular, making concerted efforts to achieve universalisation of preschool education will do much to instil a 'learning ethic' amongst the next generations of school children, and this should receive the very high priority in the forthcoming SEDP period.

42. **Legislative framework and institutional arrangements for child care and protection** [Chapters 3.5 and 6.2]. The provincial authorities have paid much attention to strengthening the legislative framework and institutional arrangements for child care and protection. This includes strengthening the basic provisions for realising child rights, such as improving the system of birth registration. With the cessation of the Committee for Population, Family and Children in 2008, there has been a reassignment in these institutional responsibilities. There appears to be good understanding amongst all provincial and district agencies about the new institutional arrangements and their respective roles and responsibilities. The province has also taken steps to augment human resources to help ensure that child care and protection activities at the commune, ward and township level are maintained. In particular, this is done through maintaining an additional Family and Children's Officer (in 156 communes/wards) with funding from the provincial budget.

43. **Cross-sector coordination for child care** [Chapters 3.5 and 6.2]. Effective cross-sector coordination and collaboration mechanisms have been established around some of the most important child care issues; (i) birth registration; (ii) the prevention of drowning; (iii) trafficking in women and children; (iv) learning encouragement, and (v) environmental and household sanitation. However, it is suggested there is a need to strengthen cross-sector coordination and collaboration around some other aspects, such as: (i) child injury prevention, particularly for road and traffic safety and (ii) introducing a broader approach to child nutrition efforts, including integrating child nutrition objectives in the universalisation of preschool education.

44. **Data coverage and data gaps on child protection indicators** [Chapter 6.2].

Administrative data on child protection services in An Giang are fairly comprehensive (such as data on the number of children who receive financial support under social protection policies and data on birth registrations). On the other hand, there is a lack of data on the broader child protection situation in the general population (such as data on the child labour situation and the overall number of orphans and homeless children in the province). This makes it difficult to determine the proportion of children in need of special protection who actually receive such support. One of the main reasons for this is because An Giang has a large and highly mobile population, which makes regular population monitoring extremely difficult. DOLISA will undertake a baseline survey of children in 2012, and this should make these gaps in basic population monitoring a high priority.

45. **Birth registration** [Chapter 6.2]. Over recent years there have been steady improvements in the system of birth registration. Between 2006 and 2010, a total of 210,000 births were registered, of which 48 per cent were registered on time (within 60 days of birth), as compared to 20 per cent of children registered on time in the preceding five years. Overall, about 95 per cent of children are now registered by five years of age, which meets the provincial target under the Plan of Action for Children. This is a notable achievement. The province has made intensive efforts to tackle the backlog of delayed birth registrations, by organising mobile birth registration teams to work in each locality. While these efforts have been made across the province, there is still some delays in registration in border areas and among the Khmer population. Moreover, these improvements in birth registration have been fundamental to the progress that has been made in the expansion of child health insurance.

46. **Children with disabilities** [Chapter 6.3]. According to figures provided by DOET, there are about 5,000 children with disabilities in An Giang as of 2009-2010, while DOLISA reports a lower figure of 1,900. The difference in these figures is likely due to differences in the definition of disabilities and criteria used by these departments. A recent survey of 10 communes in Phu Tan and An Phu districts, covering more than 6,000 households with 22,000 children under 16 years of age, indicates that almost 2 per cent of the children in this group have disabilities. However, the data are insufficient to understand the situation in the entire province. Following decrees No.67/2007/ND-CP and No.13/2010/ND-CP on policies to support social protection, financial support has been extended to an increased number of families of children with disabilities. However, there are no data available for the total number of children with disabilities who may be eligible for such support. This is a weakness in the targeting criteria in Decree No.13. There needs to be a clarification of the targeting criteria for social assistance for people with disabilities at the national level.

47. At the same time, there is a lack of advisory services for children with disabilities and their carers. The Social Protection Centre in Long Xuyen is currently building new facilities for the institutional care of children with severe disabilities. This needs to be combined with strengthening the capacity for providing a combination of home-based care and institutional support for parents and carers (e.g. through a specialised service unit dealing with functional rehabilitation programmes for children with motor disabilities). There has also been a positive and steady increase in the proportion of children with disabilities attending school, from 41 per cent in 2005 to 61 per cent in 2010. However, the proportion of children with physical disabilities attending school is still low at 42 per cent. All schools still lack appropriate facilities and teaching provision for children with physical disabilities. One priority for the next few years therefore need to be enhancing access to schooling for children with disabilities.

48. **Child labour** [Chapter 6.4]. There are a large number of children working in An Giang. However, there is a lack of statistical information on the numbers of children involved or a detailed understanding of the patterns of child labour. Improved data and understanding of the child labour situation are a high prioritied. Particular attention should be given to determining: (a) the numbers and circumstances of children involved in hazardous forms of work (e.g. work in brick kilns or carpentry enterprises); and (b) the number and circumstances of children involved in types of work that leave them vulnerable to exploitation and abuse (e.g. cross-border trading of goods). Data collection and survey work should focus on gaining a better understanding of these most serious forms of child labour, rather than gathering general statistics on the numbers of children engaged in non-paid domestic work for their families. Direct regulatory interventions should be introduced to ameliorate the situation of children involved in hazardous form of work where it exists. Preventative measures should also be made to reduce the flow of children into child labour, including (i) continued improvement of secondary school access; (ii) enhancing remedial measures whereby children temporarily removed from school can catch up and complete schooling; and (iii) continued awareness raising amongst local communities and parents on these issues.

49. **Trafficking of women and children** [Chapter 6.6]. The border areas of An Giang, Dong Thap and neighbouring provinces have been a hotspot for the commercial exploitation and trafficking of women and children. Large numbers of Vietnamese people have migrated to Cambodia in recent decades, whose children remain largely stateless and vulnerable to exploitation. It is difficult to obtain precise figures on trends over time in the number of women and children involved. Through regular cross-border coordination and collaboration, and with support from international organisations and projects, the provincial authorities in An Giang have put in place of measures to comprehensively address this situation. Cross-sector coordination within the province, as well as international cooperation, is reported to be good.

50. **Social protection and counselling for children living with HIV/AIDS** [Chapter 6.7]. Ambitious objectives and targets for strengthening the protection and care of children living with HIV/AIDS are set out under Decision No.84/2009/QD-TTg. During this research, it was not possible to make a comprehensive assessment of the extent to which these objectives and targets have been met in An Giang. However it appears that while good progress has been made in extending medical services and treatment for people living with HIV/AIDS, social protection and counselling services are still lacking. As of 2010, 109 poor children living with HIV/AIDS received social assistance under Decree No.13. However, this represents only about 20 per cent of the total number of children living with HIV/AIDS. The criteria of only targeting ‘poor’ people living with HIV/AIDS under Decree No.13 appears to exclude a sizeable proportion of the affected population. Many provincial and district officials in An Giang said that strengthening the provision of counselling services for families and children living with HIV/AIDS was a high priority.

51. **Development of the social work system** [Chapter 6.10]. Over the next few years, the introduction of the social work system following Decision No.32/2010/QD-TTg will provide an important opportunity to build a more comprehensive system of child protection. Several issues will need to be considered to develop the social work system in the most cost-effective ways. These are: (i) the types of social work service capacities and staff skills that are most needed in each locality; (ii) the integration of roles and responsibilities for those aspects of child care and protection that require a coordinated and multi-sectoral approach at the grassroots level; and (iii) the most

appropriate organisational set-up and mechanisms to fulfil these needs. The social work system will need to adapt to the particular socio-economic circumstances and priority social protection issues in each locality.

52. **Gender and ethnic disparities** [Chapter 7.3]. Only minor gender differences exist in some of the most important indicators of child care and development in An Giang. Girls as well as boys have benefited from the improvements in primary healthcare for children. There is also good gender balance in primary and secondary education. As of 2009-10, while girls constitute 48.5 per cent of primary school pupils, this increases to 49.3 per cent for lower secondary and 53.6 per cent for upper secondary schooling. The overall proportion of ethnic minority pupils declines from primary to secondary school levels; in the three school years from 2007-08 to 2009-10, ethnic minorities constituted 5.5 per cent of primary and 4.6 per cent of lower secondary pupils, but only 2.8 per cent of upper secondary pupils. Ethnic minorities comprise five per cent of the total population and, as such, the above trend illustrates the lower levels of educational attainment amongst ethnic minorities at secondary level. However, the differentials between ethnic minority girls and boys education are not as extreme amongst the Khmer and Cham in An Giang as compared to some other ethnic minority groups in Viet Nam. It is widely acknowledged that Khmer parents have become more aware of the value of education and therefore pay more attention to education for their children regardless of gender.

53. There are several contemporary social development issues in which gender is an important aspect. Firstly, the increasing sex ratio at birth in An Giang is a fundamental concern that has underlying aspects of gender discrimination. Secondly, according to emerging corporate recruitment strategies of export-oriented enterprises in the Southeast Region, there is a trend to attract girls, including under-age girls, from the Khmer community to address labour shortages, especially after the global financial crisis in 2009. Thirdly, some of the concerns over emerging 'moral degradation' amongst children, such as antisocial behaviour and high levels of Internet usage, are more related to boys. Some other problems, such as a lack of appreciation of the value of education, have emerged amongst both boys and girls.

54. **Recreation and out-of-school learning opportunities for children** [Chapter 7.4]. The lack of safe and attractive recreation and out-of-school learning opportunities for children of all age groups emerges as a major issue in An Giang. This was highlighted by provincial and district officials, as well as by community leaders, parents and children themselves:

    - Immediate causes for the lack of recreation facilities include a lack of space; indeed, in the heavily populated environment in the Mekong Delta, there is a severe shortage of physical space in which to construct safe playgrounds and parks for children to gather and play in.

    - Some local officials state that the lack of budget allocations for recreation facilities is another constraint, while others state that the lack of funds is less important than a lack of attention to this need in local planning decisions.

    - The Youth Union and other agencies seek to organisie a wide range of learning promotion activities for disadvantaged children and summer vacation activities, but only a limited number of children can be involved, and their success depends on the capacity and enthusiasm of the local staff who facilitate these types of activity.

- Some parents, teachers and local officials say that the lack of alternative and safe recreation facilities leads some children into patterns of antisocial behaviour, such as high levels of Internet access and usage.
- The strong work ethic amongst the population means that some parents may not have the time or energy to devote their attention to the wider developmental needs of children; some commentators have noted the limited ‘reading culture’ amongst parents and children in Viet Nam, which may also influence these patterns of recreational behaviour amongst children.

Main recommendations for the provincial SEDP and sector plans

1.	CROSS-CUTTING SOCIO-ECONOMIC DEVELOPMENT ISSUES	
	Issues	**Institutional capacity gaps – priorities and recommendations for SEDP and sector plans**
1.1	Mobile and migrant population groups [Chapters 2.5 and 3.5]	❖***Data and research.*** Improve the coverage and quality of data on child care and protection and understanding the situation of children in migrant and mobile households, particularly: (i) rural households engaged in long-term labour migration; and (ii) mobile households involved in river trade and transport. ❖***Policy and regulatory framework.*** Introduce a more comprehensive response to the care and protection of children in migrant and mobile households. ❖***Community organisation and collaborators.*** Strengthen the system of local collaborators amongst these population groups; this may be best achieved by recruiting women from within these communities to be more actively engaged in awareness raising and information dissemination with their peers and other families.
1.2	Addressing the increasing sex ratio at birth (SRB) [Chapters 2.2 and 4.3]	❖***Data and research.*** Conduct a study to better understand the factors lying behind the recent rise in the SRB and changes in sex selection practices amongst different population groups in An Giang. ❖***Human resources and skills.*** Provide training and information for health sector staff at all levels (including private health practitioners) to increase their awareness of the issues surrounding the SRB and how to address this in the community. ❖***Behaviour change communication.*** Strengthen IEC work on the issues surrounding sex selection amongst the general public, as well as amongst government agencies and mass organisations, including underlying rights aspects. ❖***Policy and regulatory framework.*** Ensure that private health units and practitioners are fully aware of and follow correct ethical standards in providing prenatal screening and abortion services.
2.	**CHILD HEALTH AND SURVIVAL**	
	Issues	**Institutional capacity gaps – priorities and recommendations for SEDP and sector plans**
2.1	Shortage of doctors and health collaborators in some districts and communes [Chapter 4.1]	❖***Incentive systems.*** Provide appropriate incentives to ameliorate the shortage of doctors in some districts and communes, which results in a lack of human resources for regular diagnosis and treatment for children in some localities. Ensure sufficient allowances are maintained for local health collaborators, in particular for those working on child nutrition and malnutrition amongst difficult-to-reach population groups.

2.2	Monitoring child health insurance card usage [Chapter 4.2]	❖***Data and research.*** Conduct more detailed monitoring of patterns of child health insurance card usage in order to identify potential gaps in insurance coverage and health service provision for children (especially with respect to the types of treatment not covered by either health insurance or the NTPs such as acute respiratory infections). ❖***Service content and quality.*** Propose policy and service adaptations as required, based on more detailed monitoring.
2.3	Reproductive healthcare facilities and services [Chapter 4.3]	❖***Service content and quality.*** Improve the quality of services to ensure that national health standards are met with respect to the regularity and quality of antenatal and postnatal care for women and infants. Focus improvements in the quality of services for antenatal and postnatal check-ups for women and infants at the inter-commune polyclinic level, to allow easy access for parents, and cost-effective strengthening of facilities. ❖***Human resources and skills.*** Provide training to reorient commune health staff to provide regular reproductive healthcare advice in the community and quality pregnancy check-ups as the rate of deliveries at commune/ward clinics decreases, and the rate of deliveries at hospitals increase.
2.4	Reproductive healthcare advice for teenagers and mobile population groups [Chapter 4.3]	❖***Information, education and communication.*** Strengthen provision of appropriate and sensitive reproductive healthcare advice for teenagers, combined with HIV/AIDS awareness, in conjunction with secondary schools, in both urban and rural areas. ❖***Information, education and communication.*** Strengthen IEC work in reproductive healthcare combined with HIV/AIDS awareness and prevention amongst women and men from migrant and mobile households. ❖***Cross-sector coordination and collaboration.*** Promote collaboration between DOH (Sub-Department for Population and Family Planning), DOET and other agencies to strengthen reproductive healthcare advice for secondary school children. ❖***Community organisation and collaborators.*** Explore the potential for working through a network of ‘peer educators’ to provide trusted and confidential reproductive healthcare advice for teenagers.
2.5	Expanding Prevention of Mother To Child Transmission (PMTCT) activities [Chapter 4.4]	❖***Service content and quality.*** Expand PMTCT activities to all establishments in the health service network. This should be combined with increasing the involvement of men in PMTCT activities in both prenatal and antenatal healthcare.

2.6	Maternal and child nutrition and undernutrition [Chapter 4.5]	❖***Policy and regulatory framework.*** Child stunting and micronutrient deficiencies, including iodine deficiency, amongst women and children are a major health burden in An Giang and need to be addressed more fully in provincial policies and programmes (see specific recommendations below). The child stunting indicator should be a key health indicator for monitoring the SEDP. Include micronutrient deficiency indicators as key indicators in the health sector plans. ❖***Data and research.*** Track the child stunting rate by strengthening the quality of data collection under the nutrition surveillance system (MOH/National Institute of Nutrition). Conduct more detailed sample surveys of maternal and child nutrition issues amongst vulnerable population groups, which may not be captured by regular nutrition surveillance (migrant households and the 'floating population'). More detailed surveys should also be conducted to track the status of iodine deficiency and anaemia amongst women and children, as well as to determine the prevalence of worm infections in children. ❖***Service content and quality.*** Strengthen the outreach capacity and quality of basic maternal and child nutrition care services to address the high child stunting rate and micronutrient deficiencies amongst women and children. Short-term measures are needed to address micronutrient deficiencies amongst particularly vulnerable groups. There is a need to strengthen knowledge and practice in the preparation of meals for pregnant women and small children, to improve their nutritional quality and to reduce iodine deficiency and nutritional anaemia in children and mothers. This needs to be combined with improving the quality of related healthcare services (prenatal examinations, personal hygiene and deworming). ❖***Behaviour change communication.*** Broaden the scope of IEC work to address underlying behavioural issues (amongst both parents and children) affecting child nutrition and malnutrition. This should also address the emerging issue of dietary causes of overweight children amongst some population groups. ❖***Cross-sector coordination and collaboration.*** Promote collaboration between DOET, DOH (preventative health centre) and other agencies to develop a strategy for integrating nutrition objectives in the implementation of universal preschool education.
2.7	Water, environment and sanitation [Chapter 4.6]	❖***Data and research.*** Conduct further applied research on appropriate systems of clean water supply in: (i) districts where water quality is the major problem (Chau Thanh, Cho Moi and Thoai Son districts); and (ii) districts where sustainable water supply is problematic due to water shortages or a lack of economically viable systems (Tinh Bien and Tri Ton districts). ❖***Service content and quality.*** Introduce improved systems of clean/safe water supply in these locations (one option may be to introduce improved technologies for simple household water treatment, such as the use of biosand filters). ❖***Service content and quality.*** Expand Community Led Total Sanitation (CLTS) approaches to help address the growing problem of indiscriminate waste disposal and environmental pollution, around rural communes and district towns, through measures to change public behaviour and introduce effective waste management systems. ❖***Funding and financing mechanisms.*** Ensure adequate recurrent budgets are allocated for operations and maintenance of school water supply and toilet facilities. In urban areas, schools are able to collect fees to clean, equip and maintain toilet blocks, but this is more difficult in rural areas, as the education sector budget does not provide sufficient funds for Operations and Maintenance.

2.8	Road and traffic safety for children (child injury prevention) [Chapter 4.7]	❖***Policy and regulatory framework.*** Strengthen efforts to promote behaviour change amongst the general public, combined with stronger observance and enforcement of traffic regulations (recent Government legislation has tightened the regulations and penalties relating to child helmet use through Decision No.34/2010/ND-CP). ❖***Behaviour change communication.*** Public education and community mobilisation around all aspects of road and traffic safety is essential to address the high rate of child injuries resulting from traffic/road accidents, and to promote behaviour change amongst parents and the general public. ❖***Cross-sector coordination and collaboration.*** More intensive coordination will be required to tackle road and traffic safety for children, for which a multi-stakeholder approach is essential, involving DOLISA, DOET, the Department of Public Security and the local police, the district authorities, mass organisations, parents associations of schools, and possibly the local private sector. Coordinated action is needed at the commune and ward level, especially in order to increase public awareness and community mobilisation around road and traffic safety.
3.	**CHILD DEVELOPMENT AND EDUCATION**	
	Issues	**Institutional capacity gaps – priorities and recommendations for SEDP and sector plans**
3.1	Universalisation of preschool education [Chapters 5.2, 4.4 and 7.5]	❖***Service content and quality.*** Increasing access to and enhancing the quality of preschool education is one of the highest priorities for the SEDP from 2011 to 2015-20 in An Giang. This will fully engage a larger proportion of preschool age children in the education system, and thereby instil a 'learning culture' in the next generations of children from an early age. ❖***Human resources skills and capacities.*** Increase the contingent of qualified preschool teachers, the current shortage of which is one of the main capacity gaps in the education sector in An Giang. ❖***Funding and financing mechanisms.*** Considerable investment from both public and non-public sources will be required to achieve universalisation of preschooling in An Giang, including substantial expansion in the number of classrooms and associated facilities, and teacher training. The network of preschools is currently insufficient, and will require substantial investment to upgrade infrastructure and increase the number, qualifications and skills of teachers at this level. ❖***Funding and financing mechanisms.*** Ensure sufficient resources are allocated to meet the objectives of Decision No.239/2010/QD-TTg on the universalisation of preschool education, by integrating full-day preschool attendance with the provision of regular and nutritious midday meals to help reduce the malnutrition rate for children under five. ❖***Policy and regulatory framework.*** Supportive policies will be required on investment and staffing, and to strengthen socialisation of preschool education, by providing appropriate incentives to encourage the private sector to invest in establishing new schools.

3.2	Primary and secondary education and factors influencing educational completion and attainment [Chapters 5.3 to 5.6]	❖***Data and research.*** Introduce more detailed monitoring and reporting on school enrolment, drop-out and completion rates – disaggregated by sex, ethnic group and population group (mobile and migrant population groups) to gain a better understanding of patterns of educational completion and non-completion in the province. Conduct more detailed surveys to better understand the reasons for discontinued schooling amongst priority groups (such as teenage boys and children from migrant households). ❖ ***Policy framework and service content and quality.*** Strengthen efforts to achieve and maintain the standards of universalisation of primary and lower secondary education, and focus efforts to improve the transition rate between primary and secondary education. ❖***Service content and quality.*** Strengthen efforts in all primary and secondary schools in the province to introduce the child and adolescent-friendly school approach, through the introduction of learner-centred teaching methods, participation in schools, life skills and extra-curricular activities related to children's needs and interests. ❖***Service content and quality.*** Strengthen the capacity of the education sector to implement inclusive education for children with disabilities.
4.	**CHILD PROTECTION**	
	Issues	**Institutional capacity gaps – priorities and recommendations for SEDP and sector plans**
4.1	Basic population monitoring on social protection and child protection indicators [Chapter 2.5, 3.6 and 6.2]	❖***Data and research.*** Improve the coverage and quality of baseline population monitoring and compilation of statistics on the child protection situation in the general population, including the numbers of children in need of special protection, children with disabilities, and working children. DOLISA plans to undertake a baseline survey of children in 2012 – this should prioritise these gaps in basic population monitoring on the child protection situation.
4.2	Education and services for children with disabilities [Chapters 3.5 and 6.3]	❖***Service content and quality.*** Strengthen capacity for a combination of home-based care and institutional support for children with disabilities and their parents and carers (e.g. through a specialised service unit that is able to support parents with functional rehabilitation programmes for children with physical disabilities). ❖***Service content and quality.*** Strengthen teaching provision and appropriate facilities to enhance access to schooling for children with physical disabilities. ❖***Cross-sector coordination and collaboration.*** Enhance collaboration between the Department of Health, the Department of Education and Training, and the Department of Labour, Invalids and Social Affairs to achieve the above objectives.

4.3	Improved data and understanding of the child labour situation and introducing remedial measures [Chapter 6.4]	❖***Data and research.*** Conduct a survey to address the lack of statistical information and detailed understanding of the patterns of child labour. Particular attention should be given to determining: (i) the numbers and circumstances of children involved in hazardous forms of work; and (ii) the numbers and circumstances of children involved in types of work that leave them vulnerable to exploitation and abuse (e.g. cross-border trading of goods). ❖***Service content and quality.*** Strengthen preventative measures to reduce the flow of children into child labour, including (i) continued improvement of secondary school access; (ii) enhance remedial measures whereby children temporarily removed from school can catch up and complete schooling; and (iii) continued awareness raising amongst local communities and parents.
4.4	Strengthening implementation of the National Plan of Action for children living with HIV/AIDS [Chapter 6.6]	❖***Service content and quality.*** Strengthen the provision of confidential counselling services for women as part of the development of PMTCT activities, as well as for families and children living with HIV/AIDS. ❖***Policy and regulatory framework.*** Provide guidelines for commune/ward officials and grassroots healthcare and social protection workers on confidentiality (who has the right to know the identities of people living with HIV/AIDS and obligations they have to protect their identities). This is in order to complement steps that have been taken to combat discrimination against people living with HIV/AIDS.
4.5	Child abuse and violence at school [Chapter 4.7 and 6.7]	❖***Data and research.*** There is a growing problem of children who suffer from various forms of physical or psychological abuse at home, bullying at school or conflict between children. There is insufficient information, however, to quantify the magnitude of this problem, or to fully understand the circumstances. A useful starting point would be to verify and further analyse the statistics on child injuries caused by violence and self-harm. Based on this, preventative measures may include: ❖***Information, education and communication.*** Increase public awareness around these issues, and strengthen appropriate preventative measures against violence in schools. ❖***Service content and quality.*** Provide more counselling services for children. ❖***Policy and regulatory framework.*** Continue the strict enforcement of judicial sanctions against perpetrators of child abuse.

4.6	Development of the social work system (following Decision No.32/2010) [Chapter 6.8]	❖***Organisational development and staffing.*** Over the next few years, introduction of the social work system according to Decision No.32/2010/QD-TTg will provide an important opportunity to build a more comprehensive system of child care and protection. Based on the analysis made in this report, it is recommended that the social work system for child protection should be developed along three main lines in An Giang, as follows: • ***Specialised service units.*** Not all child care and protection services can or should be provided through the regular contingent of commune staff and local collaborators. There are some aspects requiring specialised capacity that cannot be provided by these local staff, and neither would it be the most cost-effective. Examples of these types of specialised service units include: (i) counselling services for children; (ii) advisory service units for children with disabilities and their parents and/or guardians. • ***Local collaborators and peer educators.*** The network of local collaborators will need to adapt to the particular population characteristics in the province, such as the mobile/migrant population. It is recommended that particular attention should be given to recruiting social work collaborators from within these population groups to work as peer educators (along the same lines as peer educators within the community living with HIV/AIDS). Similarly, social work collaborators amongst the Khmer ethnic minority population should primarily be trusted men and women from within these communities. • ***Commune/ward social work cadres.*** An Giang is in a good position to further develop the capacity of commune/ward social work cadres, by already having in place the Family and Children's Officers (in 156 communes/wards), in addition to the Population Officers. These Family and Children's officers may later become the commune social workers. ❖***Human resource skills and capacities.*** An intensive 'training and coaching programme' is required to equip these commune officers and local collaborators with the necessary knowledge and social work skills, combined with appropriate incentives (including monetary incentives and other types of incentives) to encourage them to become fully engaged with their work.
5.	**CHILDREN'S PARTICIPATION**	
	Issues	**Institutional capacity gaps – priorities and recommendations for SEDP and sector plans**
5.1	Shortage of conducive recreation facilities and out-of-school learning opportunities for young children of preschool and primary age [Chapter 7.4]	❖***Funding and financing mechanisms.*** Expand the provision of safe recreation facilities in kindergarten and primary schools. Physical space is generally more available in school grounds than in other public places in the heavily populated Mekong Delta environment. According to Decision No.239/2010/QD-TTg, there needs to be adequate equipment and toys for the realisation of the new preschool education curricula, and the application of information technology should be stepped up at preschool institutions so that by 2015 at least 30 per cent of preschools have access to information technology. This provides the opportunity to instil favourable learning attitudes amongst children from an early age.

5.2	Shortage of conducive recreation facilities and out-of-school learning opportunities for teenagers [Chapter 7.4]	❖***Policy and regulatory framework.*** Develop policies to support the diversification of the options available for local communities and teenagers to become more actively and directly involved in organising and conducting their own recreation activities, including: ❖***Funding and financing mechanisms.*** Increase the resources made available to youth clubs of various kinds to strengthen and diversify their activities, by designing their own entertainment and learning programmes (such as producing their own videos that can be used in peer-education and outreach programmes). ❖***Community based initiatives.*** Support the establishment of 'healthy Internet clubs' in urban areas, where a variety of educationally friendly and Internet-based learning activities are provided for children, as well as ensuring access for poor children. This may be through: (i) small grants to promote collaboration between secondary schools and residential clusters, with possible support and sponsorship from local businesses and enterprises; (ii) development of the commune learning centres. Promote a 'reading culture' by encouraging the setting up of family bookshelves, creating reading habits in families, learning how to conduct readings in schools, and strengthening the facilities and performance of libraries to become a more attractive destination for the general public.

CHAPTER 1: INTRODUCTION

1. Introduction

1.1 Research objectives and questions

Over the last decade, the Government of Viet Nam has embarked on a process of decentralisation and has delegated some planning and budgeting responsibilities to the provincial government authorities. However, the capacity of the provincial government administrative system and sector agencies to manage the socio-economic development planning process in the most effective ways, to allocate resources, and to execute projects and programmes that achieve results for the poorest, marginalised and most vulnerable sections of society is still weak. Although they have greater decision-making and budgetary responsibilities, the local government authorities have not used many opportunities to maximise the available resources to address local concerns. The prioritisation of children's concerns requires evidence-based planning and budgeting for children through the Socio-Economic Development Plan (SEDP) process. Unfortunately, data and information on social issues and on children in particular, although they exist at the provincial level, are not always in a systematic and consolidated form that can be used to analyse the full picture in each locality.

This study provides a Situation Analysis of Children in An Giang Province in the Mekong Delta Region. The overall objective of the study is to provide the Government of Vietnam, the development community and the public at large with up-to-date information about children's issues and priorities in the province. The specific objectives are: (i) to consolidate statistical data and analyse the situation of children in the context of the province's socio-economic development; (ii) to identify relevant issues affecting knowledge of child rights and the advancement of these rights; and (iii) to provide recommendations to improve the situation of children that can be incorporated into the provincial Socio-Economic Development Plan and sector plans.

Research questions

- What are the major nationwide, regional and locally specific socio-economic trends that impact on the quality of life of children in the province, both today and in the future?
- What are the major issues and challenges facing children and families in the province today and what are the causes of these issues and challenges?
- What are the capacity gaps of rights-holders to claim their rights and what are the capacity gaps of duty-bearers to fulfil these claims?
- How have the government and province responded to children's issues, what are the existing policies and programmes supporting children, and how effective have they been?
- Have the government and province given a sufficient proportion of their budget resources and public investments to the realisation of children's rights?
- What are the key issues that policy makers should take into account when planning for the provincial annual and five-year SEDPs?

1.2 Analytical framework and research methodology

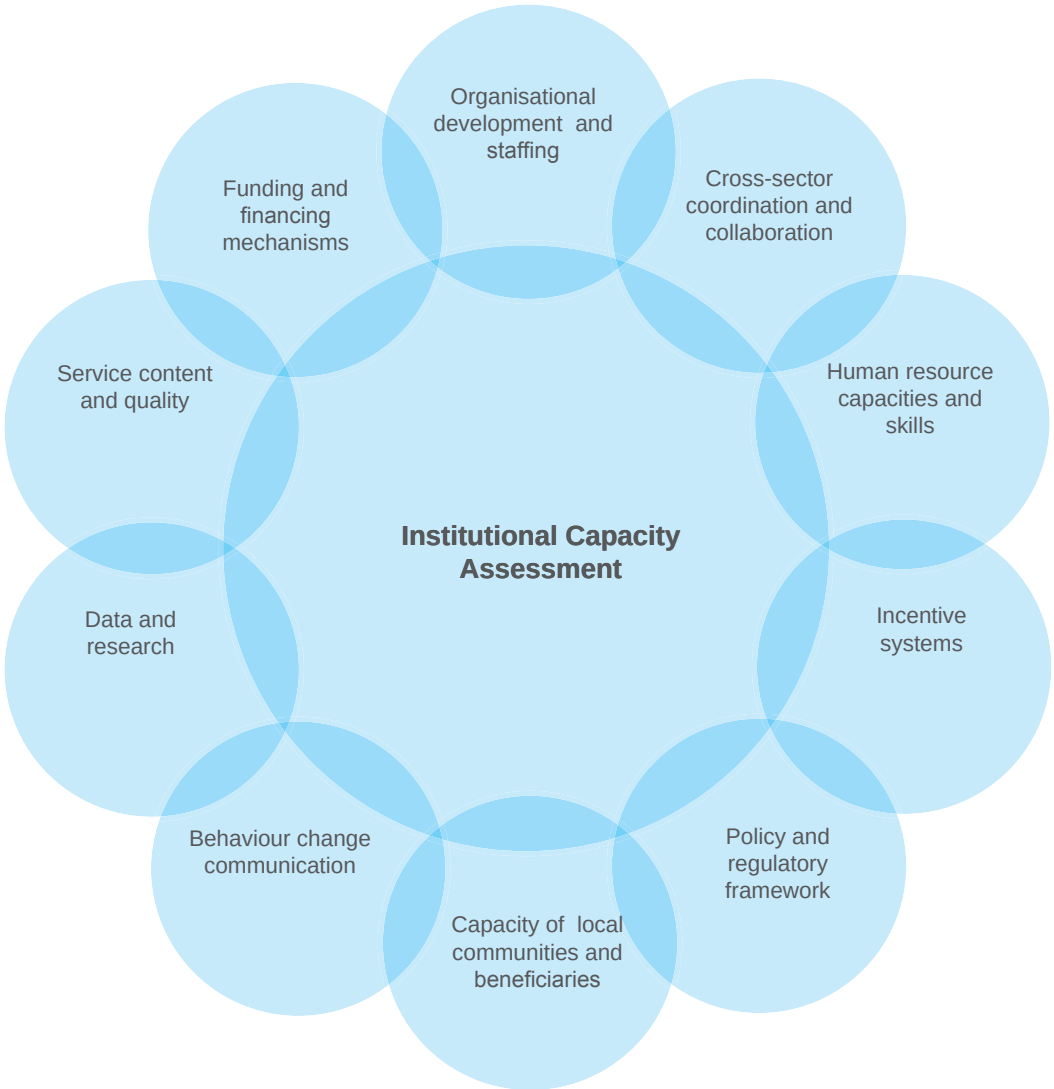
Analysis of child rights according to sectors. The analytical approach adopted by this study has three main elements. Firstly, children's issues are analysed according to clusters of child rights that relate to different areas of sector activity. These include: (i) *the rights to survival* – including healthcare, water supply and sanitation and shelter; (ii) *the rights to development* – including education and learning; (iii) *the rights to protection* –

including care of children in need of special protection, child labour, and legal aspects of child protection; and (iv) *the rights to participation* – including the right to contribute ideas to the family, community and to the process of decision-making on children's issues. This conforms to the definition of child rights in the Convention on the Rights of the Child, the Law on Child Protection, Care and Education, and the National Plan of Action for Children (2001-2010).

Analysis of programming and budgeting for children. Secondly, the study combines this rights-based approach with a structured analysis of programming and budgeting for child-related concerns in the provincial SEDP, sector plans and programmes. This includes a review of progress and achievements over the last SEDP period from 2006 to 2010, in order to identify those aspects that are comparatively well covered, and those that are under-resourced and not adequately addressed in existing programmes and services. Budget information has been compiled from the SEDP, and data provided by the Department of Finance and sector reports.

Institutional capacity assessment. Thirdly, the study makes an institutional capacity assessment – and capacity gap assessment – with respect to the institutional arrangements and responsibilities for child care and protection. In this respect, we adopt a broad definition of 'institutions', as relating to organisational development, the regulatory environment, and human resources development (Figure 1).

Figure 1. Institutional capacity assessment framework



Data and information sources. The study combines quantitative and qualitative information sources (Figure 2). Qualitative information and understanding has been collected from primary sources during fieldwork, as well as from provincial reports and background research studies. Statistical data has been collated from secondary sources, including national, provincial and local sources. Where possible, time-line data have been presented to analyse trends over time. As far as possible, the data have been cross-checked and validated from several sources. Inconsistencies have been identified where they occur, as well as gaps in currently available statistics. Reference is made throughout the report to the statistical data tables presented in Annex 1.

Figure 2. Sources of quantitative and qualitative information

Quantitative information sources	Qualitative information sources
Compilation of statistics from national surveys and databases (e.g. 2009 Population and Housing Census, Nutrition Surveillance System…).	Meetings and interviews with provincial and district authorities, technical departments/sections and mass associations.
Compilation of provincial statistics on children indicators, and compilation of budgetary information from the provincial SEDP.	Focus group discussions with commune/ward authorities, mass associations, teachers and health workers, school children, parents and elders.
Comparison of the province's socio-economic indicators with neighbouring provinces in the region and nationally.	Review of the analysis of 'advantages', 'difficulties' and 'solutions' in provincial and district reports.
Analysis of trends over time and comparison of differentials within the province according to geographical area and social group.	Review of research studies and other secondary information

1.3 Fieldwork locations and research participants

The study covers the entire province in terms of background statistical data collection and overall analysis and discussion of the results. Meetings and focus group discussions were held with a wide range of agencies at the provincial level, as well as in Tan Chau Town, Tinh Bien District and Long Xuyen City (see the list of agencies below). Fieldwork was conducted in two rural communes and one urban ward (Table 1). These locations were selected to be broadly (but not fully) representative of the province's different demographic and socio-economic conditions. Vinh Trung is a rural commune in Tinh Bien, characterised by a comparatively high poverty rate and a majority Khmer ethnic minority population. Tinh Bien is one of the poorest districts in the province, situated in an area of low hilly country on the border with Cambodia. Chau Phong is a more densely populated rural commune in Tan Chau Town, with members of the Cham ethnic minority. My Binh is a densely populated urban ward in Long Xuyen City, with a majority Kinh population.

Research participants. In total, 192 people participated in the research: 91 provincial participants, 35 district and township participants, 61 commune and ward participants, and 25 children (of whom 39 per cent were female). The agencies and participant groups involved in the research are listed below. At the commune/ward level, separate focus group discussions were held with the commune/ward authorities, mass association representatives, health workers and teachers, groups of parents and secondary school children.

Table 1. The research locations

District, town or city	Tinh Bien District	Tan Chau Town	Long Xuyen City
Number of rural communes/wards	3 towns, 11 communes	5 wards, 9 communes	11 wards, 2 communes
Population (2009)	122,000	152,978	279,849
Population density	343 people/km²	897 people/km²	2,424 people/km²
Per centage of ethnic minority people	29.3%	2.2%	1%
Per centage of poor households (2010)	12.1%	2.9%	1.7%
Commune or ward:	Vinh Trung Commune	Chau Phong Commune	My Binh Ward
Area (hectares)	2,485	2,214	161
Population (2010)	10,261	25,100	24,137
Population density	413 people/km²	1,113 people/km²	1,499 people/km²
Number of households	2,442	6,002	4,596
Per centage of poor households	26.0%	4.3%	2.3%
Ethnic groups	Khmer (63%), Kinh (35%)	Kinh (85.5%), Cham (14.5%)	Kinh (99.8%), Hoa (1%)

Sources: (i) Provincial Statistics Office (2010). *Statistical Yearbook 2009; (ii)* fieldwork data collection from commune People's Committees.

The report includes statements made by children at several points. These are not direct quotations, but transcriptions from the focus group discussions. In all cases, children were freely asked if they wished to participate in the group discussions, and they were asked to sign a letter to confirm that their ideas and opinions could be used in the report.

Provincial level

- Provincial People's Council
- Provincial People's Committee
- Party Propaganda and Education Committee
- Department of Planning and Investment
- Department of Finance
- Department of Labour, Invalids and Social Affairs
- Department of Health
- Department of Education and Training
- Centre for Rural Water Supply and Environmental Sanitation
- Provincial Statistics Office
- Provincial Women's Union
- Provincial Youth Union
- Provincial Ethnic Committee
- Department of Justice
- Department of Public Security
- People's Court
- Provincial Social Insurance
- Social Protection Centre

District and commune or ward level

- District People's Committee
- Planning and Finance Section
- Labour, Invalids and Social Affairs Section
- Education and Training Section
- Health Section
- Preventative Health Centre
- District Hospital
- Youth Union
- Women's Union

- Commune or ward People's Committee
- Village leaders
- Commune or ward health centre
- Mass association representatives
- Commune or ward schools
- Local pagodas
- Secondary school children
- Parents' groups and elders in the community

1.4 Research limitations

This study builds up a composite picture and understanding of the situation of children in An Giang Province, based on existing quantitative data and qualitative information. It should be noted that the research has not attempted to gather new primary data. It

is therefore limited by gaps in currently available data and information; such data and information gaps and inconsistencies are identified in the report and recommendations are given for priorities for improved monitoring, further research and analytical work to fill these gaps.

The major limitations encountered during this research are as follows:

- Firstly, there is a lack of sufficiently disaggregated statistical data to develop a full picture and understanding of the patterns of intra-provincial disparities between administrative areas, ethnic groups, and income groups as well as gender-disaggregated data. Of these, the major limitation is the lack of ethnically disaggregated data, particularly in health and education, which would allow a fuller analysis of the key differences in the situation of children between the main ethnic groups in the province. This is a main priority for the future. Provincial and district officials are generally well aware of the major patterns of intra-provincial disparities in their locality, for which circumstantial or qualitative understanding is often available, but there is often a lack of hard data to support the analysis and to confirm trends. During this research, it was not possible to collect and analyse a large amount of data at the commune level, which would have allowed us to at least partly fill this gap in understanding. Moreover, the selection of fieldwork locations was only intended to be broadly representative, rather than covering the full spectrum of conditions in the province.
- Secondly, in monitoring and evaluation reports prepared by different sectors that have been reviewed for this research, there is often a lack of assessment of the effectiveness and impacts of different policies and programmes on the situation of women and children. There are several aspects to this. For example, linkages are not often drawn between resource allocation (to different policies and programmes) and outcomes in terms of changes to indicators of women's and children's well-being. Similarly, the effectiveness of new methods and technical interventions made in different sectors (which may be introduced through donor-supported projects or government programmes) is rarely assessed. During this research, through discussions with local officials, it was possible to explore these outcomes and impacts to a certain extent, but it was not possible to provide a more comprehensive evidence-based analysis because monitoring data are often insufficient.

CHAPTER 2:
DEVELOPMENT CONTEXT

2. Development context

This chapter sets the scene by describing the key aspects of the geographical setting, demographic characteristics, poverty context and economy in An Giang. Attention is given to patterns of migration and household mobility, and to climate change and environmental vulnerability, both of which are development issues that will be increasingly important to An Giang and across the Mekong Delta Region in coming years. In doing so, comparisons are made between the situation in An Giang, neighbouring provinces and other regions of the country. Attention is also given to patterns of intra-provincial disparities and household vulnerability that affect the situation of children.

2.1 Geographical setting

An Giang Province is situated in the upper reaches of the Mekong Delta, where the Hau Giang and Tien Giang branches of the Mekong River form the dominant geographical features of the province. Administratively, the province comprises one city (Long Xuyen), two major towns (Chau Doc and Tan Chau), eight rural districts and 156 local administrative units (16 district towns, 120 rural communes and 20 urban wards). With an average elevation of 2 meters above sea level, a majority of the province consists of flat delta land, crisscrossed by many hundreds of kilometres of canals and small river channels. An area of low hills is found to the west of the province in Tinh Bien and Tri Ton Districts. An Giang Province has many advantages with respect to agricultural production and is a major producer and exporter of rice and aquaculture products. The province has a total land area of 3,537 km^2, of which 80 per cent is used for agricultural production and 74 per cent is under paddy rice cultivation.[3]

Cross-border linkages. An Giang shares a 96 km border with Takeo and Kandal provinces in the Kingdom of Cambodia, with five districts and towns and 18 communes lying along the border. Cross border trade is an important component of the provincial economy. In the period from 2006 to 2010, imports and exports across this border amounted to USD 3.9 billion, 3.6 times the amount between 2001-2005, and exceeded USD 1 billion in 2010.[4] The province has invested heavily in border economic development, including three industrial zones and 26 border markets, and has promoted trade and business relations. There are strong historic connections between the Khmer communities living in An Giang and those in Cambodia and these communities maintain cross border social, cultural and labour relations today. The provincial authorities in An Giang give special attention to cultural development amongst these communities along the border, through the promotion of cultural villages and households, sports and recreation facilities, and by organising cross border events.[5]

At the same time, in recent years this border zone has become a corridor for smuggling in consumer goods; for instance, in 2010 it is estimated that 800 million packets of cigarettes were smuggled through the Cambodian border with An Giang, Dong Thap and Kien Giang, equivalent to 20 per cent of the nation's total cigarette consumption.[6] The border with Cambodia is also a route for trafficking of women and children, as well as being a hotspot for communicable diseases, including HIV/AIDS. Cross border coordination and collaboration have therefore become essential to combat these negative influences and impacts of increasing regional integration.

3 Provincial Statistics Office (2010) *Statistical Yearbook for 2009.*

4 "Border trade volume in An Giang exceeds 1 billion USD." *Investment Review Newspaper. January 10, 2011.*

5 Provincial People's Committee, Plan No.01/2011/KH-UBND (dated 07/01/2011) *Plan for construction and development of "cultural light points" along the border line in the period 2011-2015.*

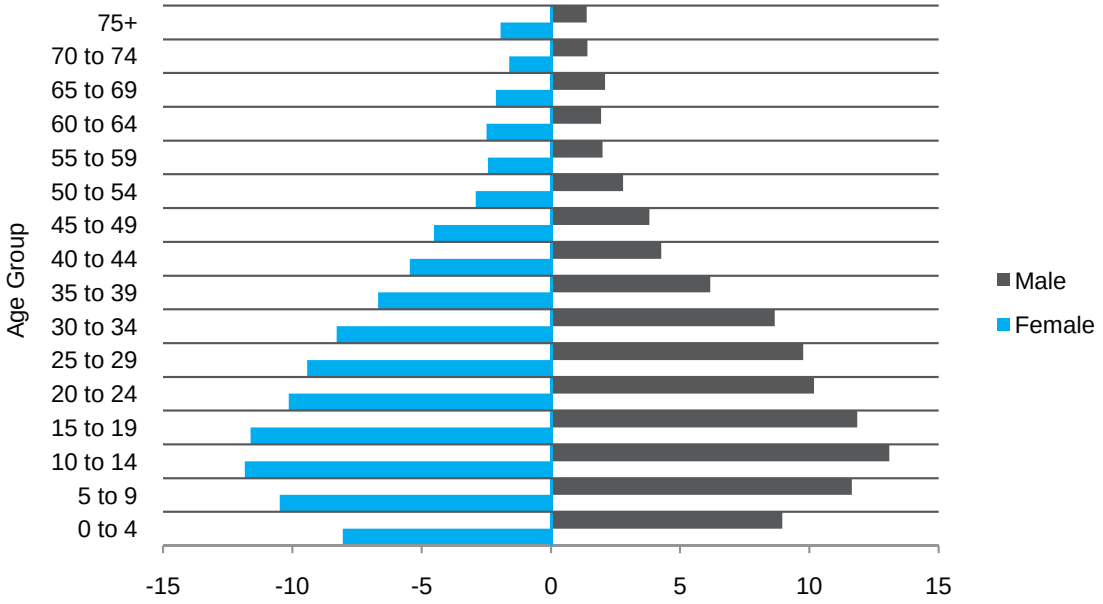
6 "Smoking gun evades Delta officials." *Viet Nam News. January 13, 2011.*

2.2 Demographic characteristics and trends

According to the 2009 Population and Housing Census (2009 Census), the province's population stands at 2.14 million, of which 71.6 per cent is rural and 28.4 per cent is urban (Annexes 1.1 to 1.4).[7] The female population comprises 50.2 per cent and children under 18 years of age comprise 30 per cent of the current population. The average population density is 606 people per km^2, which is above the Mekong Delta Region's average density of 423 per km^2. The average rural population density is 551 persons per km^2, with the lowest in Tinh Bien (343 per km^2) and Tri Ton (221 per km^2).

Ethnic minorities. Ethnic minorities comprise 5.3 per cent of the province population (Annex 1.6). The main ethnic minority groups are the Khmer (4.2 per cent), Cham (0.66 per cent) and Hoa (0.38 per cent). About 50 per cent of the Khmer live in Tri Ton District (where they represent 34 per cent of the district population) and 39 per cent live in Tinh Bien District (29 per cent of the district population), along the Cambodian border. Over 90 per cent of the Cham are located in four districts: Tan Chau, An Phu, Phu Tan and Chau Phu. The Hoa population is concentrated in the urban centres of Chau Doc and Long Xuyen City.

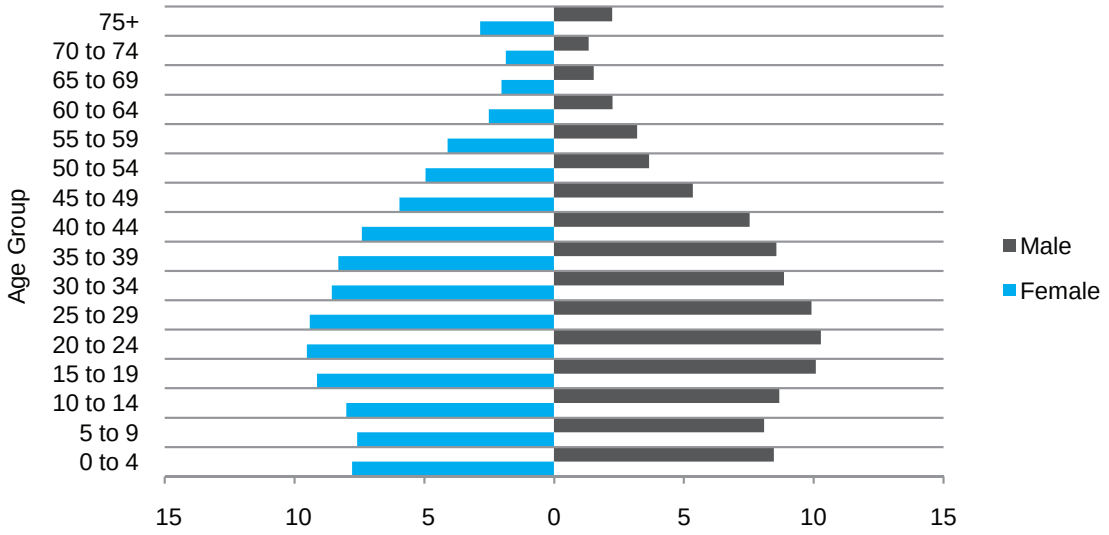
Figure 3. Population pyramid, 1999



Source: Provincial Statistics Office (2010) *Data collected during fieldwork.*

7 Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

Figure 4. Population pyramid, 2009



Source: Provincial Statistics Office (2010) *Data collected during fieldwork.*

Age profile of the population. Over the last decade, there have been shifts in the age profile of the population, comparable to many other provinces in Viet Nam (Figures 3 and 4 and Annex 1.5). Whereas children under the age of 15 made up 32 per cent of the population in 1999, this has reduced to 24.3 per cent in 2009. This is associated with continued reductions in the crude birth rate from 19.2 births per 1,000 people in 2005 to 16.7 births per 1,000 people in 2010, and the average number of births (for women aged 15 to 49 years old) from 2.1 in 2005 to 1.9 in 2010.[8] According to the Viet Nam Household and Living Standards Survey (VHLSS),[9] the average household size remained constant between 2004 and 2008 at about 4.5 persons per household; while the 2009 Census gives a lower average household size of 4.1 persons, as compared to the national average of 3.8 (Annex 1.2).

Widening sex ratio at birth. According to the 2009 Census, An Giang has a comparatively high sex ratio at birth (SRB) of 113.7 male births per 100 female births, with a rate of 115.6 for urban and 113.1 for rural localities (Annex 1.2). This gives An Giang as the 13th highest SRB out of 63 provinces and cities, and is higher than the national SRB of 110.5. The province reported lower SRB figures of 105.6 per cent in 2006[10] rising to 113.7 per cent in 2009.[11] As discussed further in Section 4.3, there is nationwide concern with the rise in the SRB in Viet Nam over the last decade, which has a number of important implications for policy-makers, including in the areas of health and education.

Labour age population and employment skills. The labour force in An Giang has increased substantially in recent years and will continue to do so over the next decade. Whereas in 1999, about 60 per cent of the provincial population was of working age (15 to 60 years), this has risen to 67.5 per cent in 2009 (Annex 1.5). Providing adequate training and generating productive employment for the increasing number of school-leavers and young labourers, particularly those from rural areas, is now a major priority for the provincial authorities. The provincial plan for the National Target Programme on New

8 Sub-Department of Population and Family Planning (2010) *Report on the results of the National Target Programme on Population and Family Planning in the period 2006-2010.*

9 General Statistics Office (2009) *Results of the Viet Nam Household Living Standards Survey 2008.*

10 UNFPA (2007) *Viet Nam Population situation 2006. New Data: sex ratio at birth.*

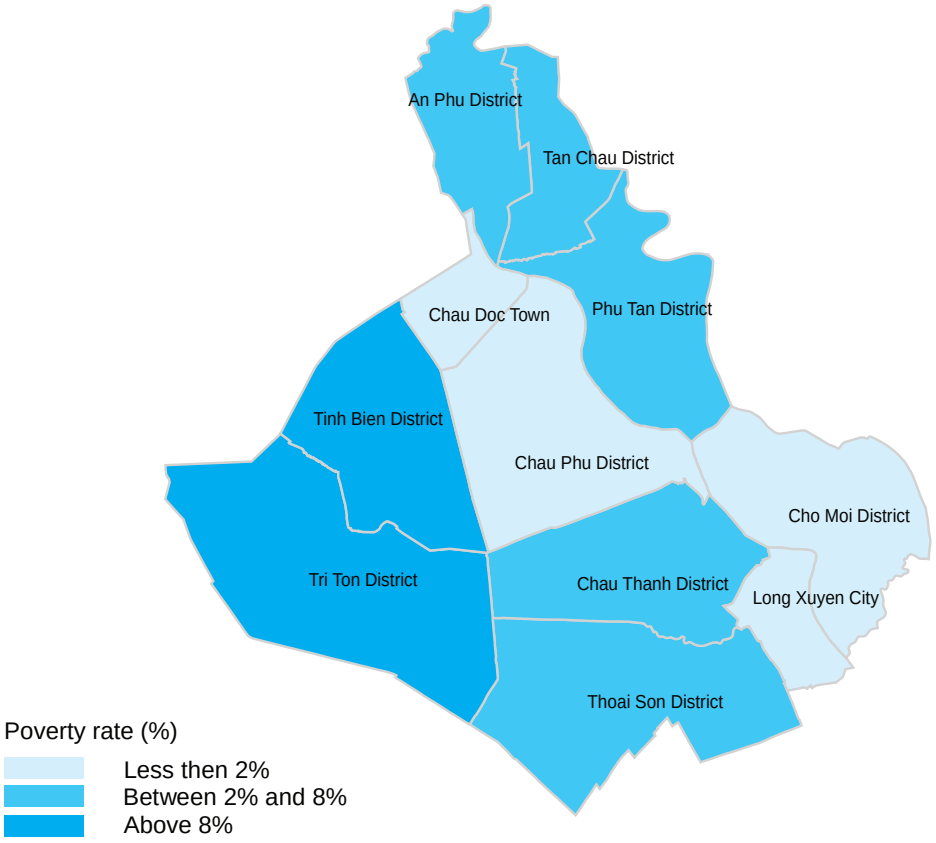
11 Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Completed results.*

Rural Development places a high priority on training for the rural labour force, and aims to provide over 50 per cent of the rural labour force with general training and over 40 per cent with vocational training by 2020.[12] This will be a tremendous challenge. According to the 2009 Census, only 1.8 per cent of the population over 15 years of age in An Giang have currently completed vocational training, which is below the regional rate for the Mekong Delta of 2.2 per cent and the national rate of 4.7 per cent (Annex 1.32).

2.3 Poverty status and trends

There have been steady reductions in poverty in An Giang over recent years. According to the VHLSS, which uses the Government poverty line and is based on household income, the poverty rate declined from 9.7 per cent in 2006 to 8.5 per cent in 2008. This was below the overall rate for the Mekong Delta Region of 11.4 per cent in 2008 (Annex 1.8). Provincial figures indicate further reductions from 7.2 per cent in 2008 to 3.6 per cent in 2010 (Table 2 and Annex 1.9). The intra-provincial poverty rate in 2010 ranges from 0.42 per cent in Chau Doc Town and 1.17 per cent in Long Xuyen City, up to 8.73 per cent in Tri Ton and 12.14 per cent in Tinh Bien, which represent the poorest rural districts (Map 2). As noted above, the latter districts have the highest proportion of Khmer and it is recognised that poverty continues to be concentrated in this ethnic minority group.

Map 1. Poverty rate by district, 2010 (in per centage)



Source: DOLISA (2010). *Data provided during fieldwork.*

12 An Giang Provincial People's Committee, Decision No.1036/2010/QD-UBND (dated 07/06/2010) *Decision on promulgation of indicators for building new rural communes.*

Table 2. Poverty rate and ethnic minority population by district, 2008-2010

Administrative Area	Poverty rate (%)			Ethnic minority population in 2009 (%)		
	2008	2009	2010	Total	Khmer	Cham
Province	7.2	5.8	3.6	5.3	4.2	0.7
Long Xuyen City	2.7	2.0	1.2	1.0	0.2	0
Cho Moi District	3.7	2.6	1.9	0.2	0	0
Chau Thanh District	5.1	3.9	3.1	2.7	2.1	0.5
Thoai Son District	7.9	5.9	3.5	2.8	2.6	0
Tri Ton District	18.9	16.2	8.73	35.4	33.8	0
Tinh Bien District	18.9	16.0	12.1	29.3	29.1	0
Chau Phu District	8.7	7.2	1.9	0.9	0.1	0.4
Chau Doc Town	2.1	1.4	0.4	2.4	0.1	0
An Phu District	9.7	7.9	5.7	4.4	0.1	4.1
Tan Chau Town	4.2	3.8	2.9	2.2	0.1	1.6
Phu Tan District	7.3	5.7	3.1	1.2	0.1	1.0

Source: DOLISA (2010) *Data provided during fieldwork.*

Child poverty. As described in the report on the VHLSS 2008, children have special needs to ensure their physical, intellectual and emotional development.[13] The conventional method used to measure child poverty focuses on children living in households defined as poor, exclusively according to the monetary poverty line. This method has limitations because it does not indicate whether the diversity of children's basic needs is being met. A multidimensional approach is therefore needed to measure and understand child poverty more fully.

Table 3. Multidimensional child poverty rate by domains and region, 2008

Region	Child poverty rate (%)					
	Education	Health	Shelter	Water and sanitation	Work	Social protection
Red River Delta	8.8	55.3	1.4	18.7	5.5	10.9
North East	15.4	58.6	24.8	50.8	14.5	5.0
North West	29.3	67.1	44.7	85.5	27.0	2.4
North Central Coast	13.8	69.1	8.9	38.9	12.7	6.6
South Central Coast	11.1	56.2	8.3	41.0	6.7	5.2
Central Highlands	18.5	48.3	23.3	66.0	11.1	2.7
South East	14.6	42.5	8.1	16.7	6.3	11.7
Mekong River Delta	26.2	43.4	39.2	70.4	10.1	13.6
National	16.1	52.9	17.4	42.9	9.8	8.8

Source: General Statistics Office (2009) *Results of the Survey on Household Living Standards 2008.*

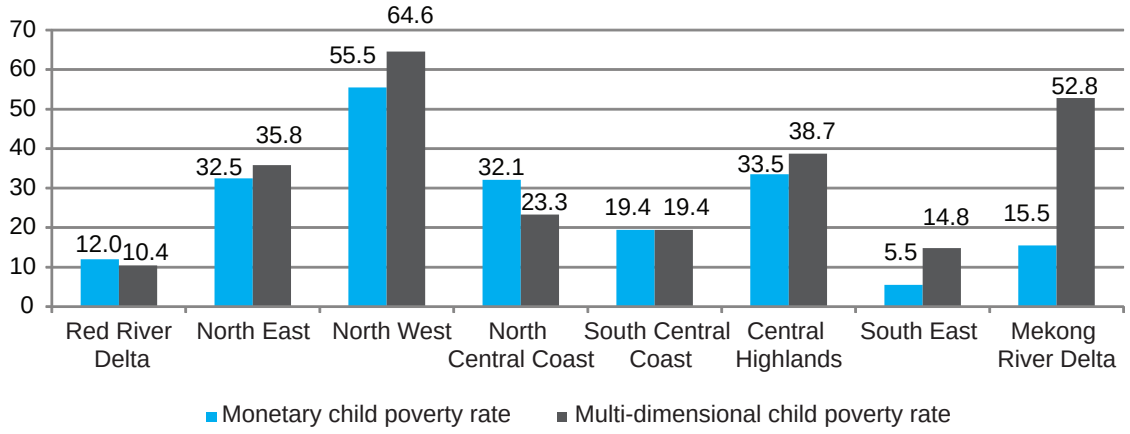
The VHLSS 2008 assessed child poverty as the proportion of children deprived of their basic needs in at least two of the six following domains: education, health, shelter, water and sanitation, child labour and social protection (Annex 1.10). According to this survey, 52.8 per cent of children in the Mekong Delta Region as a whole suffer from multidimensional poverty, whereas only 15.5 per cent of children are poor according to the monetary poverty rate (Table 3 and Figure 5). This is the second highest rate of multidimensional child poverty in the country following the North West Region, and is considerably higher than the nationwide rate of 28.9 per cent. In addition, as Figure 5 illustrates, the gap between the monetary and multidimensional poverty rates is

13 General Statistics Office (2009) *ibid.*

particularly high in the Mekong Delta Region. This demonstrates the added-value of using a broader poverty index in this context, as a monetary index does not adequately capture all dimensions of poverty.

These are regionally aggregated data, which do not provide insights into the child poverty situation at the provincial or sub-provincial level. However, they do give some indication of the domains and causative factors that may be associated with child poverty in each region. For example, it is apparent that child poverty in the Mekong Delta Region is particularly associated with the lack of safe water and sanitation (70.4 per cent). Compared to other regions, the child poverty rates in the region in the domains of social protection, safe water and sanitation, shelter, and education are relatively high. In contrast, the child health poverty rate in this region is lower than a majority of other regions.

Figure 5. Multidimensional and monetary child poverty rates by region, 2008



Source: General Statistics Office (2009). *Results of the Survey on Household Living Standards 2008.*

2.4 Local economy, household incomes and expenditures

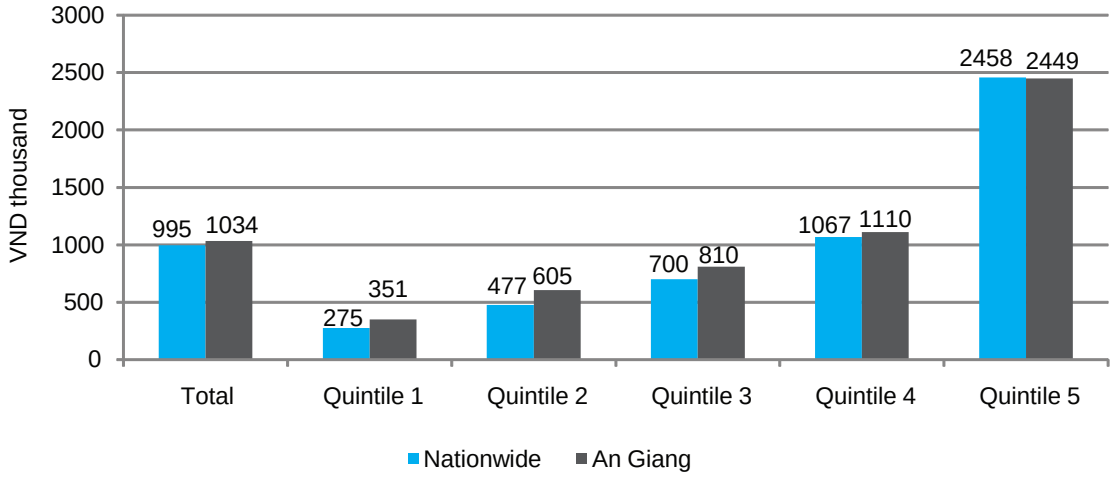
Provincial economy. An Giang has achieved remarkable economic growth over the last decade (Annex 1.11). According to provincial SEDP reports, growth in GDP reached 13.6 per cent in 2007 and 14.2 per cent in 2008, but declined to 8.67 per cent in 2009 and 10.12 per cent in 2010.[14] GDP per capita has nearly doubled from VND 11.36 million in 2007 to VND 21.18 million (or VND 1.76 million per month) in 2010. The agriculture, forestry and fisheries sector represented 34.3 per cent of GDP by current prices in 2009, while industries and construction represented 12 per cent and services 53.7 per cent. However, these figures do not reflect the full value of agriculture and fisheries to the provincial economy, since many economic services and industries are related to these production sectors. Over the last decade, growth in the provincial GDP has been fuelled by the rapid development of aquaculture. Aquaculture outputs at constant 1994 prices increased by 224 per cent from VND 772 billion in 2000 to VND 2,500 billion in 2009, with current production being around 300,000 tonnes per annum.[15] All economic sectors were affected by the downturn in the global economy in 2009. The agriculture and fisheries sector was particularly susceptible, with only marginally negative growth in 2009 (-0.5 per cent); in 2010 this sector began to recover, but only to half the level of growth achieved in previous years.

Per capita incomes. As of 2008, the average per capita monthly income in An Giang was VND 1.06 million or VND 12.77 million per annum (Annex 1.12). According to the

14 Provincial People's Committee (2008 to 2010) *Socio-Economic Development Reports and Plans.*
15 Provincial Statistics Office (2010) *Statistical Yearbook 2009.*

Provincial Ethnic Committee, the per capita income amongst ethnic minorities is generally much lower (VND 6.5 to 7.5 million per annum).[16] It is notable that per capita incomes in An Giang very closely match the national average for each economic quintile (Figure 6 and Annex 1.12). It is also notable that the proportion of household income derived from agriculture, forestry and fisheries in An Giang has continued to rise in recent years, from 35 per cent in 2002 to 40 per cent in 2008 (Annex 1.14). This is a further indication of the value of the agricultural economy in An Giang and the extent to which this has contributed to improving household living standards.

Figure 6. Per capita monthly income by economic quintile, nationwide and An Giang, 2008



Source: General Statistics Office (2010). *Statistical Yearbook of Viet Nam 2009.*

Income gap and targeting. According to national statistics, the income gap between the top and bottom economic quintiles in An Giang is less than the national average, by a factor of seven, as compared to 9.8 nationally (Annex 1.13). However, as noted by the Provincial Statistics Office, it is difficult to obtain accurate household income and expenditure data; richer households may hide assets and incomes, while some households may hide incomes from gambling or private money lending. The income gap is likely to be wider than reported figures. This may influence policy mechanisms that use household income as a benchmark for targeting social or financial assistance, although there is insufficient evidence to substantiate this.

Household expenditures and assets. VHLSS 2008 data indicate that households in the Mekong Delta Region generally spend more on healthcare (8 per cent of household expenditure) than the national average (6.4 per cent) and all other regions of the country (Annex 1.15). On the other hand, households in this region tend to spend less on education (4.2 per cent of household expenditure) as compared to the national average (6.2 per cent), as well as on culture, sport and recreation (0.9 per cent as compared to 1.5 per cent nationally). For all other expenditure categories, including food and fuel, households in this region spend close to the national average. These are regional figures and therefore only give an overall picture of expenditure patterns; nonetheless they are indicative of some important regional differences and characteristics.

In particular, there are notable regional variations in housing standards (Annex 1.17). According to the 2009 Census, only 10.9 per cent of households in An Giang are recorded as having permanent housing, which is higher than the regional rate for the Mekong Delta Region (8.3 per cent) but considerably lower than the national rate of permanent housing (46.7 per cent).

16 Provincial Ethnic Committee (2010) *Report for the Situation Analysis of Children in An Giang Province.*

Increased economic mobility and behavioural change. One of the most salient features of the current socio-economic situation in An Giang is the increased economic mobility of many households. This is associated with increased wealth and with the various forms of economic migration and labour mobility (see below). The evidence suggests that this can also be linked to changes in social behaviour, particularly with respect to healthcare-seeking behaviour, which may have positive or negative consequences. The example was given above of the rapid rise in the sex ratio at birth in An Giang, as this may be linked to behavioural change associated with increased access to sex-selection technology and private health facilities. Another example is in infant feeding practices, as many parents may resort to formula milk rather than breastfeeding with increased wealth. These are negative examples, but there are also many positive examples of recent behavioural change especially in healthcare for children. As noted in Sections 4.2 and 4.3 below, ensuring safe birth delivery at specialised hospital units and ensuring their children are fully vaccinated has become regular practice for a majority of families in An Giang; this represents a significant positive shift in social behaviour.

2.5 Patterns of migration and household mobility

As with other provinces in the region, An Giang has experienced a high rate of out-migration in recent years. Out-migration in the Mekong Delta as a whole increased from 14 per 1,000 inhabitants in 1999 to 46.5 in 2009. Over the same period, the net migration rate (in-migration minus out-migration) quadrupled in absolute value from -10 to -42 (Table 4).[17] In 2009 the out-migration rate in An Giang was 55 per 1,000 inhabitants and the net migration rate was -46. Migration data from the 2009 Census only include permanent or semi-permanent relocation and persons over five years of age; as such, there data do not present the full picture of population mobility including seasonal or occasional migration, or the situation of young children in migrant families.

Table 4. Out-migration and net migration rates, 2009

Region/province	Out-migration rate (‰)		Net-migration rate (‰)	
	1999	2009	1999	2009
Northern Midlands and Mountains	18	27	-10	-18
Red River Delta	21	18	-11	-2
North and South Central Coast	26	45	-19	-38
Central Highlands	17	27	76	9
South East	14	10	49	117
Mekong River Delta	14	46	-10	-42
An Giang	-	55	-	-46
Dong Thap	-	58	-	-45.5
Kien Giang	-	46.5	-	-33.6
Long An	-	49.5	-	-19.7

Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

The patters of migration and household mobility in An Giang are exceedingly complex. They are location-specific to the extent that the migration destinations often vary from commune to commune; groups of migrant workers from one commune often migrate to the same location and type of work through shared communication networks. Several major patterns of intra-provincial and inter-provincial/regional migration and household mobility can be identified, however, each of which may have particular implications for children, as follows:[18]

17 The 2009 Census measures the out-migration and net-migration rate in the five years preceding the census date.

18 Viet Nam Academy of Social Sciences (2009) *Field Report: Participatory Poverty Assessment in An Giang Province.*

1) ***Short-term seasonal movement of rural families to obtain agricultural work, either within the province or in neighbouring provinces***. For instance, this type of seasonal labour movement is common amongst many poorer Khmer farmers in Tinh Bien District to find work harvesting rice. In this situation, the whole family will usually move for the harvesting period, resulting in temporary withdrawal of children from school. However, the availability of this type of seasonal agricultural work has reduced in recent years, due to the mechanisation of rice harvesting.

2) ***Longer-term migration of rural families to find agricultural work in neighbouring provinces and regions.*** For instance, migration to provinces of the South East Region and the Central Highlands to obtain work on rubber and other plantations. In this situation, both parents will often migrate, the first child will often go with them to obtain work, while younger children may be left in the home community with grandparents or relatives. This may have consequences for elder children who are permanently withdrawn from school. Several province and district officials in An Giang also note that this arrangement may adversely affect the care and nutrition of younger children left behind with relatives. In the Khmer communities of Tinh Bien, this type of migration is found amongst young married couples who do not have farmland and/or have incurred substantial debts from marriage. Unskilled labour on rubber and other plantations enables them to save money, but presents difficult circumstances in which to raise a young family.

3) ***Migration of young adult semi-skilled workers to the urban and industrial zones of HCM City and the South East Region.*** The high rate of out-migration from the Mekong Delta provinces in recent years has been primarily due to this type of migration. As noted in the 2009 Census report, almost all migrants from the Mekong Delta chose to relocate to the urban/industrial areas of the South East Region.[19] Previously, this was mainly amongst unmarried Kinh people to obtain manual or semi-skilled work for a period of years on construction sites, in garment factories or housekeeping. Recently, the number of young Khmer people undertaking this type of migration has also increased. While this type of migration enables many young adults to obtain a higher income, there are many reported difficulties they encounter in social living conditions, as well as in establishing a stable base for starting a family and long-term employment prospects.

4) ***Return migration to home areas.*** This aspect of return migration, which is associated with the above categories of out-migration, is often overlooked. The reasons for return migration and the consequences for households and individuals involved are diverse. For example, one study amongst a Khmer community in Tri Ton District found several reasons for return migration.[20] Seasonal migrants returned home because of the need for family labour at home, to bring back earnings or due to health problems. Other Khmer migrant workers sometimes returned home because they could not adapt to the living and working conditions, especially high living expenses, low incomes, language difficulties and pressures of work. This study also found that return migration can have both positive and negative impacts on the migrant workers and their families. Their greatest concern is the lack of regular employment in the countryside and the decrease in income sources.

5) ***Migration and displacement caused by flooding.*** Some temporary relocation or permanent migration is made in response to flooding, especially in peak flood

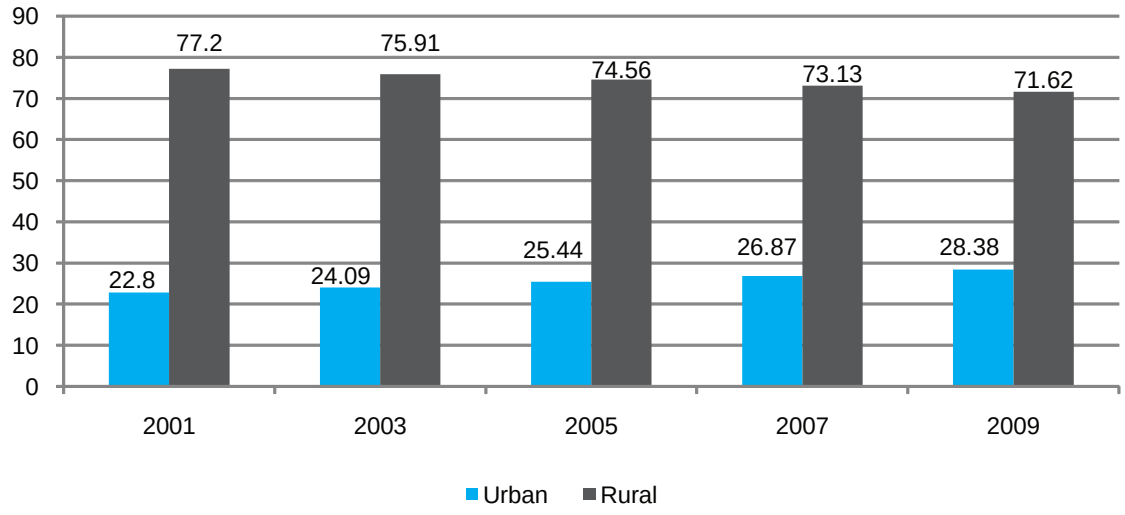
19 Central Population and Housing Census Steering Committee (2010) *ibid.*

20 Ho Thi Ngan (2010) *The Social and Economic Effects of Remigration to Rural Areas in Viet Nam: a case study of Khmer people in O Lam Village, Tri Ton District, An Giang Province.*

years.[21] Seasonal movement to urban centres is important for some people seeking alternative livelihoods. Children and poorer households may seek refuge from flooding in urban centres. Some households may have migrated more permanently if successive flooding has caused the destruction of agricultural assets and if disaster relief aid is exhausted.

6) ***Urbanisation processes.*** Over the last decade, the An Giang population has become increasingly urbanised. Between 2001 and 2009 there has been a 5.6 per centage point shift in the rural-to-urban population, with the rural share declining from 77.2 per cent to 71.6 per cent (Annex 1.4 and Figure 7). This is not primarily due to rural-to-urban migration within the province. Rather, it is associated with the reassignment of rural communes to become urban wards in peri-urban zones, together with the reassignment of Tan Chau from a district to a township in 2009. This reflects the wider process of 'rural urbanisation' that is taking place in the densely populated Mekong Delta Region. As noted in the participatory poverty assessment conducted by the Viet Nam Academy of Social Sciences (VASS) in 2008, this presents particular challenges and vulnerabilities for peri-urban households and labourers as they need to shift away from agriculture-based livelihoods to new forms of employment and income generation. [22]

Figure 7. Proportion of urban and rural population, 2001–2009



Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Completed Results.*

7) ***Relocation of skilled young adults to urban conurbations.*** With increasing wealth and economic mobility, some better-off families in An Giang are sending their children to large cities such as Can Tho and HCM City for higher education and to establish a profession there. Some may invest in housing for their children. One potential consequence of this is that it may reduce the availability of a new generation of skilled professionals to work in local government authorities or professional services in the province in the future.

8) ***Mobile households involved in river trade and transport.*** While not technically referred to as a form of migration, a sizeable proportion of the An Giang population is involved in various forms of river trade and transport. No precise figures are available

21 Dun, O. (2008) *Migration and displacement triggered by flooding events in the Mekong Delta.*
22 Viet Nam Academy of Social Sciences (2009) *Participatory Poverty Assessment: Synthesis Report.*

on the numbers of households involved. However, this 'floating community' does represent a distinct population group with special characteristics and needs. Many province and district officials in An Giang state that the provision of social services to this population group presents special challenges; including family planning and reproductive healthcare services, birth registration and the provision of insurance cards and vaccination for children. As one provincial official stated: "Full monitoring and supervision of this population is very difficult". Due to their mobile or semi-mobile lifestyle, many families find it difficult to ensure full-time school attendance for their children, and school drop-out rates are reported to be higher amongst this population group than others.

Population monitoring and social services amongst mobile population groups. For all of the above population groups, the local government authorities have encountered difficulties in social service provision and population monitoring. As the Provincial Statistics Office and DOLISA suggested during this research, regular administrative data collection in different sectors (e.g. poverty monitoring and child malnutrition surveillance) may not adequately cover these population groups because households are not present during the data collection period.

Furthermore, the design of sample surveys on specialist topics is rarely adequate to capture a full understanding of the particular circumstances and needs of these groups. While a general indication is given above of the particular circumstances and vulnerabilities of children in each of these distinct social groups, there is a lack of empirical evidence to analyse these situations more fully. In this respect, it is recommended that particular attention should be given to improved data collection and understanding the situation of children in: poor rural families engaged in longer-term migration to find agricultural work in neighbouring provinces and regions; and mobile households involved in river trade and transport.

Labour demand, migration and education. Labour shortages have led enterprises in HCM City and the Southeast Region to compete to attract workers, not only in terms of welfare, but also in concessions to the minimum recruitment age and education qualifications (from the junior secondary to the primary level). Some enterprises accept illiterate workers to train them from scratch. Some enterprises target residents in purely agricultural areas, or amongst ethnic minority people who have few livelihood opportunities such as amongst the Khmer community. Some companies give incentives to encourage their staff to pull workers from these rural areas, or they cooperate with local authorities and provide commissions for local cadres to recruit workers. These corporate responses to labour shortages may have implications for educational motivation and attainment amongst children, by increasing early drop-outs especially in communities with ethnic minorities and emerging migrant flows to urban areas for employment (see Section 5.6 below).[23]

2.6 Climate change and environmental vulnerability

Living with the floods. The agricultural economy of An Giang is dominated by the annual flood cycle of the Mekong River. Annual flooding commences in July and peaks in September to October. The flood levels vary from year to year, with extreme floods occurring in 1994, 1995, 1996, 2000, 2001, 2002 and 2011. Although flooding is integral to the agricultural productivity of the region, each year it brings hardship for households

23 ActionAid and Oxfam GB (2009) *The impacts of the global financial crisis on socio-economic groups in Viet Nam: a regular monitoring report.*

exposed to the rising water.[24] Three factors combine simultaneously to create dangerous flooding situations: (i) large volumes of water are received from upstream due to typhoons or low atmospheric pressure systems; (ii) long and heavy rainfall within the delta region; and (iii) high tides that reduce drainage capacity in the delta canals and river channels.[25] The floods in the Mekong Delta in 2000 and 2001 were exceptionally severe, causing huge economic losses, affecting over 1 million households and causing 1,516 deaths, including 642 children. Nearly 1,000 schools were inundated, severely disrupting the education system throughout the region. In Tan Chau District, for instance, the floods of 2000 and 2001 caused 269 deaths, of which 76 per cent were children.[26] The equally severe 2011 floods had a more limited, yet still substantial impact, taking 23 lives, of which 43 were children.

Since the mid-1990s, the Government of Viet Nam has promoted the strategy of 'living with floods' in this region. This strategy has focused on strengthening the system of dykes and transport infrastructure, together with the development of residential clusters aimed at creating stable living for those communities most affected by flooding. This strategy was intensified after the historically severe floods in 2000, and investment in residential clusters was one of the main objectives of socio-economic development in the Mekong Delta Region in the period 2001-2005. An Giang has made considerable investments in flood control and disaster mitigation over the last decade; including the ambitious North Vam Nao Water Control Scheme, which has protected about 300,000 residents and provided controlled water supply to 22,000 hectares of paddy land in Phu Tan and Tan Chau.[27] The province has also taken significant steps to safeguard children in times of flooding (see Section 4.6 below). The limited human impact of the severe 2011 floods demonstrate the results of the province's strategy and preparedness measures.

Climate change impacts. The Mekong Delta Region is recognised as particularly susceptible to the impacts of climate change, including sea level rise and saline intrusion, vulnerability to extreme climatic events, variable rainfall patterns and river flow dynamics.[28] The effects of climate change on the delta's hydrology are projected to be very significant: according to one scenario, total annual runoff through Mekong River basin is forecast to increase by over 20 per cent by 2030.[29] Saline intrusion would adversely impact freshwater fisheries, crop production and clean water supply in some localities. Flooding in tidally inundated areas, and longer flooding periods in the interior part of the delta could affect rice production. The high population density of the delta makes it especially vulnerable to climate change. It is estimated that about 5 million people would be affected by a 1-meter rise in sea level, and that rice production, national food supply and the agricultural economy may be severely affected.[30]

Although the impacts of climate change will vary from location to location within the delta region, it is likely that one of the major consequences and adaptations amongst the human population would be increased levels of displacement and migration. Some household migration patterns in the region are already associated with the loss of livelihoods and displacement caused by flooding. As indicated above, children of migrant households, particularly in households affected by flooding, are vulnerable in terms of child health and survival and loss of education opportunities.

24 Few, R. et al (2010) *Seasonal hazards and health risks in the Mekong Delta: a multidisciplinary approach.*
25 Dun, O. (2008) *ibid.*
26 Pham Xuan Phu (2007) *Livelihood outcomes in the residential cluster and dyke programme in An Giang Province.*
27 AusAID (2007) *North Vam Nao Water Control Project: Independent Completion Report.*
28 International Centre for Environment Management (2009) *Report for the Mekong Delta Climate Change Forum.*
29 Eastham J, et al. (2008) *Mekong River Basin water resources assessment: Impacts of climate change.*
30 International Centre for Environment Management (2009) *ibid.*

Adaptation to climate change will therefore need to become an increasingly important and integral part of social and economic development planning in An Giang and other provinces of the Mekong Delta in the coming years. As noted in the recent report of the Mekong Delta Climate Change Forum, the government strategy of 'living with floods' needs to be more fully elaborated in practice.[31] An integrated approach that combines engineering responses to climate change, with economic and spatial planning, social safeguard policies, and strengthening natural resource management systems and rehabilitation will be required.

2.7 Patterns of intra-provincial disparities

In some rural provinces of Viet Nam, intra-provincial disparities in poverty status and the situation of children is strongly linked to factors of location and ethnicity. For example, as documented in the Situation Analysis of Children in Dien Bien[32] and Ninh Thuan,[33] poverty in these two provinces is clearly concentrated in remote rural districts and communes and amongst certain ethnic minority groups. Indicators of child health, educational attainment and household income all tend to be lower in these particular locations and ethnic groups. While this is true to a certain extent in An Giang, it can be said that the patterns of intra-provincial disparities in An Giang are both more complex and less clearly determined by either location or ethnicity.

Several comparative indicators for the research sites are given in Table 5. These show that poverty rates are highest, per capita incomes are lowest, and child malnutrition rates are higher in Tinh Bien District in comparison to Tan Chau or Long Xuyen. As noted in Section 2.3 above, Tinh Bien and Tri Ton districts are considered to be the most disadvantaged districts in the province, with higher Khmer ethnic minority populations. The poverty rate amongst the Khmer is higher than amongst other ethnic groups. The Khmer still face disadvantages in access to social services, higher education and employment opportunities due to social barriers and difficulties in language. For some other social trends and indicators, though, there is less noticeable disparities according to ethnicity or location. For example, improvements in reproductive healthcare amongst the Khmer population have broadly followed province-wide trends (Section 5.3). On the other hand, differences in rural clean water supply and household sanitation follow different spatial patterns and causative factors (Section 4.5).

31 International Centre for Environment Management (2009) *ibid.*

32 UNICEF/Dien Bien Province (2011) *Situation Analysis of Children in Dien Bien Province.*

33 UNICEF/Ninh Thuan Province (forthcoming) *Situation Analysis of Children in Ninh Thuan Province.*

Table 5. Selected socio-economic indicators for the research locations

Indicator	Research districts, commune and ward						
	Province	Tinh Bien District	Vinh Trung Commune	Tan Chau Town	Chau Phong Commune	Long Xuyen City	My Binh Ward
Poverty rate (per cent, 2010)	3.6	12.1	26.0	2.9	4.3	1.2	2.3
Per capita annual income (VND million, 2010)	21.183	18.975	-	19.319	-	41.0	-
Under-five child malnutrition (per cent, 2010)	17.5	22.5	25.7	19.8	20.6	16.7	10.1
Rural households with quality water supply (per cent, 2009)	44.3	58.0	60.0	67.1	61.3	42.3	N/A
Rural households with sanitary latrines (per cent, 2009)	46.1	48.9	33.1	49.8	49.6	51.5	N/A
Children attending kindergart by five years of age (per cent, 2009)	-	-	94.8	101.2	100	99.5	99.2
Primary school drop-out rate (per cent, 2009)	1.4	1.9	1.7	1.5	0.9	1.5	-
Lower secondary school drop-out rate (per cent, 2009)	7.5	6.3	6.5	5.3	7.3	2.5	-

Source: Compiled from district SEDP reports and provincial department reports.

Furthermore, there are distinct cultural, religious and socio-economic differences between the three main ethnic minority groups in An Giang, such that it would be misleading to draw general conclusions about patterns of disparities according to ethnicity. The Hoa are historically well integrated into the urban economy and are recognised as comparatively prosperous. The Cham population, while being predominantly rural, is recognised to be adept at private sector business activity, as well as having comparatively high standards of educational attainment. The Khmer have strong agricultural traditions and patterns of economic interaction within their community. Underlying these differences are the distinct Neo-Confucian, Islamic and Buddhist traditions of each of these communities respectively.

Household vulnerability. The processes of social and economic change taking place in the Mekong Delta Region today are rapid and far reaching. Economic growth is associated with widespread changes in economic behaviour as people seek out new and better forms of employment, or alternative sources of income, which is resulting in high rates of labour migration and other forms of household mobility and economic mobility. Large numbers of young people are entering the labour market, with a tremendous appetite for the opportunities provided by the modern-day economy. Increased wealth and economic mobility is also resulting in various dimensions of change in social behaviour. All these changes have profound implications for the ways in which families organise their daily lives, for the care and protection of children, as well as for the livelihood opportunities and social prospects of young people.

In this context, the major patterns of intra-provincial disparities that affect the situation of children in An Giang are related to the circumstances of particularly vulnerable households. This is true for both Kinh and ethnic minority households. Spatial patterns of disparities have less to do with broad differences in geographical or administrative areas, and more with ‘micro-level’ spatial differences between households and residential locations or communities.

Factors such as household location, living conditions and productive assets, combine with factors of human resource potential, economic capacity and social position of the household, to create patterns of comparative advantage and disadvantage. Household living conditions can have a significant impact on child health, shelter and survival. The household labour profile and employment prospects have a significant impact on the demand for child labour, and hence on school attendance and the educational attainment of children. In an aggregate sense, therefore, it can be said that the 'physical space' and 'socio-economic space' occupied by the household is the major determinant of the well-being and future prospects of children. This is an exceedingly complex socio-economic context, which relates to the high population density and highly competitive local economy of the region.

CHAPTER 3: PROGRAMMING AND BUDGETING FOR CHILDREN

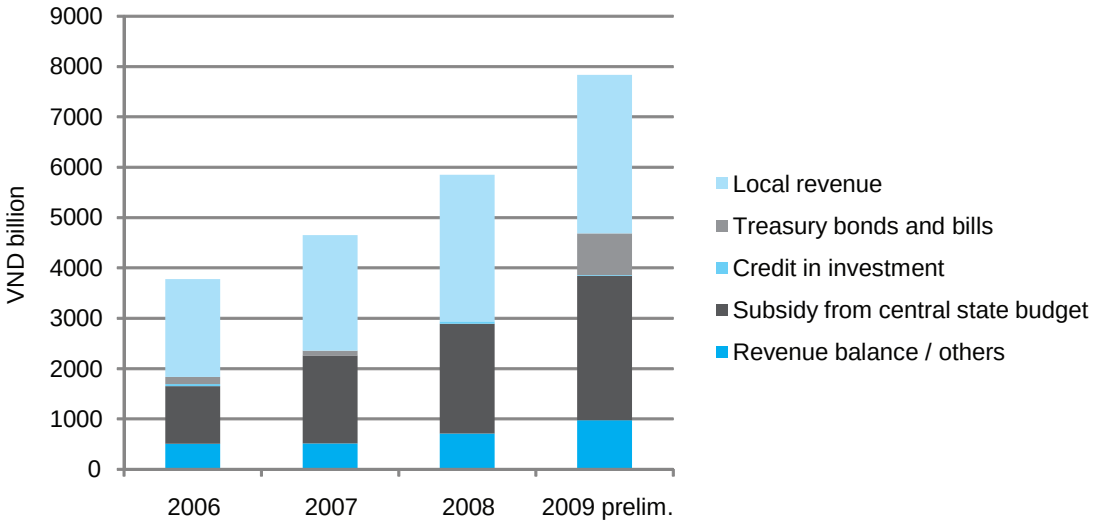
3. Programming and Budgeting for Children

This chapter makes an analysis of social sector programming and budgeting for child-related services in the period from 2006 to 2010. This includes: (i) budget trends in the overall provincial budget and the 'development investment budget' included in the annual Socio-Economic Development Plan (SEDP); (ii) funding allocations to the National Target Programmes (NTPs); (iii) funding for social protection policies and programmes; and (iv) institutional arrangements for cross-cutting child care and protection issues. A presentation is also made of overall progress and outcomes under the National Plan of Action for Children (NPA) in the period 2001 to 2010. This provides the basis for a more detailed analysis of each sector and clusters of child rights in the following chapters.

3.1 Provincial budget and social sector expenditures

Provincial revenue. There has been a 133 per cent increase in provincial revenue from VND 3,362 billion in 2005, to a preliminary figure of VND 7,835 billion in 2009 (Figure 8 and Annex 1.18). In comparison to many other rural provinces in Viet Nam, An Giang has the advantage of having a large and diverse local revenue base. Local revenue constitutes about half the total provincial income, amounting to VND 1,729 billion (51.4 per cent) in 2005 and VND 2,916 billion (49.8 per cent) in 2008; while transfers from the central state budget comprised 32.2 per cent of revenue in 2005 (VND 1,083 billion) and 37.2 per cent (VND 2,181 billion) in 2008.[34]

Figure 8. Provincial revenue sources, 2006-2009



Source: Provincial Statistics Office (2010) *Statistical Yearbook 2009*.

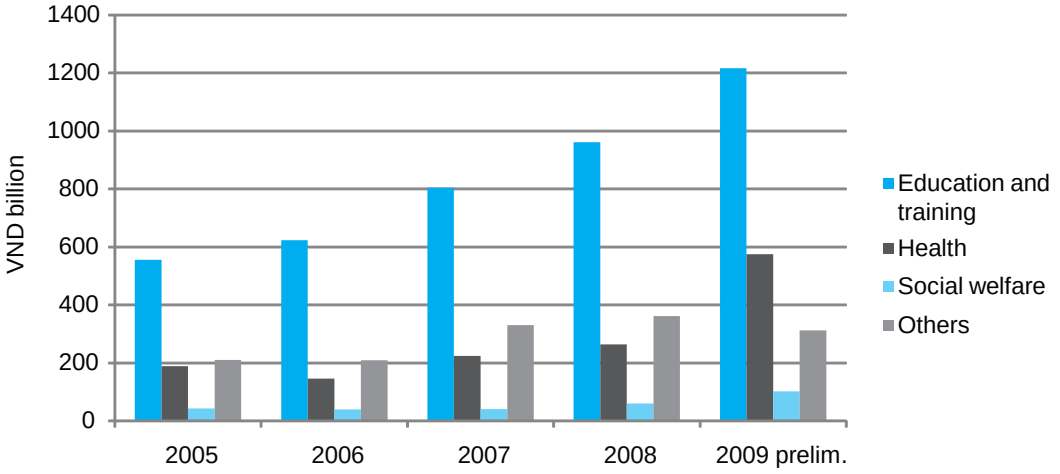
The rapid growth in local revenue has largely come from the private sector. Within the local revenue category, in 2008 the largest share came from non-state sector enterprises (25.5 per cent), followed by lottery revenue (14 per cent) and state enterprises (12 per cent).[35] In the period from 2005 to 2008, local revenue from state enterprises increased by 78 per cent and from non-state enterprises by 106 per cent, while revenue from foreign-invested enterprises declined by 17 per cent. While there have been increases in revenue from income tax 110 per cent and housing and land tax 191 per cent, agricultural land-use tax revenue has declined by 34 per cent, which reflects the preferential policies of the Government towards rural farm producers.

34 This can be compared to Dien Bien and Ninh Thuan provinces, for example, where transfers from the central state budget accounted for 65 per cent and 60 per cent respectively of total provincial revenue in 2009.

35 Provincial Statistics Office (2010) *ibid*.

Social sector expenditures. Overall province expenditures increased by 82.5 per cent from VND 3,092 billion in 2005 to VND 5,643 billion in 2008 (Annex 1.19). Overall social and cultural sector expenditures rose by 133 per cent from VND 854 billion in 2005 to a preliminary figure of VND 1,989 billion in 2009 (Figure 9). In proportional terms, however, this represents a decrease in social sector expenditures from 27.6 per cent of total provincial expenditures in 2005 to 24.25 per cent in 2008. In the period 2005 to 2008, education expenditures increased by 73 per cent and health and social relief each by 40 per cent.

Figure 9. Provincial social and cultural sector expenditures, 2005–2009



Source: Provincial Statistics Office (2010) *Statistical Yearbook 2009*.

In 2008, education and training accounted for about 70 per cent of social sector expenditures and 17 per cent of total province expenditures, while health accounted for about 19 per cent of social sector and 4.7 per cent of total provincial expenditures. It is notable that the education and training sector accounted for less of the proportion of provincial expenditure in An Giang than in less prosperous and mountainous provinces such as Dien Bien, Ninh Thuan or Gia Lai.[36] In the latter provinces, higher per capita education expenditure in recent years is related to the substantial capital investments that have been made in expanding and upgrading the quality of school infrastructure in these remote and mountainous areas.

Local revenue resources for social policies and programmes. As highlighted in later sections of this report, the substantial local revenue base has enabled the provincial authorities in An Giang to devote provincial resources to augment implementation of policies and programmes in ways that have had a beneficial impact on social indicators in some sectors. In particular, the province has supplemented recurrent budgets for service provision. For instance, a significant proportion of local revenue in An Giang comes from

36 Provincial education and training sector expenditure

Province	Education and training sector expenditure in 2008 (VND billion)	Proportion of total provincial expenditure in 2008	Total number of primary, lower and upper secondary school pupils in 2008	Inferred per capita expenditure estimate per pupil (VND million)
An Giang	961	17%	328,790	2.9
Dien Bien	763	28.3%	103,697	7.35
Gia Lai	869	29.3%	273,764	3.1
Ninh Thuan	348	23.6%	117,802	2.9

Source: Provincial statistical yearbooks (2009).

the lottery (VND 402 billion in 2008). This is incorporated into the provincial budget, while provincial officials indicated that about 70 per cent of this lottery revenue is allocated to health and education concerns.

3.2 Socio-Economic Development Plan (2006-2010)

The SEDP provides figures for the province's annual 'development investment budget' (Annex 1.20).[37] The SEDP development investment budget plan primarily includes 'investment capital' *(vốn đầu tư)* and some 'service delivery expenditures' *(vốn sự nghiệp)*, but does not incorporate all recurrent expenditures *(chi thường xuyên)* of the local authorities (such as salaries and regular operating expenditures).[38]

The development investment budget of An Giang further reflects the province's diverse economy and income base. In 2010, locally managed development capital made up 94.6 per cent of the total SEDP budget, with centrally managed capital covering the remaining portion. Within the locally managed development capital category, state budget resources comprised 7.1 per cent of the total budget (VND 1,603 billion), within which Official Development Assistance (ODA) amounted to VND 50 billion; ODA is therefore only a minor proportion of the province's total investment budget, equivalent to 0.2 per cent in 2010. The largest proportion of development investment capital derived from private enterprises and households (ranging from 40-42 per cent in the period 2008-2010), other sources including bank lending (ranging from 35-39 per cent in 2008-2010), and investment capital raised from government bonds and credit (7 per cent in 2010); while investment capital from state-owned enterprises has declined in this period from 0.25 per cent of the total budget plan in 2008 to 0.13 per cent in 2010.

3.3 National Target Programmes

The National Target Programmes (NTPs) are the primary means through which government policies and state budget resources are concentrated on achieving social development objectives and strengthening social service provision; as such, they are an important focus for our analysis of programming and budgeting for children. According to figures provided by the Department of Finance (DOF), total expenditure on the NTPs in An Giang in the period from 2006 to 2010 was in the order of VND 2,289 billion; of which about 93 per cent was for service delivery (vốn sự nghiệp) and 7 per cent for capital investment (vốn đầu tư) (Annex 1.21 and Table 6).

It is notable that according to these figures, about 65 per cent of NTP funding was mobilised from 'other sources' (VND 1.487 billion), while funding from the central state budget and the provincial budget made up 23.5 per cent and 11.5 per cent respectively. This represents a substantial contribution to NTP funding from non-public sources and socialisation policies. In particular, these contributions have been mobilised for the NTP on Poverty Reduction (VND 1,415 billion) and the NTP on Social Diseases, Epidemics and HIV/AIDS (VND 65 billion). Under the NTP on Poverty Reduction, this includes lending to poor households through the Bank for Social Policies and various poverty reduction funds. Under the NTP on Social Diseases, Epidemics and HIV/AIDS, non-public

37 It should be noted that the data referred to in this section are SEDP budget planning figures, and not implemented expenditure or final liquidation figures.

38 There is no direct or precise English language term for 'vốn sự nghiệp', which is an important category in the Vietnamese budgeting system. As suggested by the Viet Nam Institute for Finance Research, the term 'service delivery' may best describe the contents of this budget category. In practice, a proportion of 'vốn sự nghiệp' may be used as recurrent budget *(chi thường xuyên)*. It also includes discretionary funding for sector departments and local authorities for budget items such as: investment in materials, facilities and equipment; operations and maintenance; information and communication activities; testing implementation 'models'; and allowances for local collaborators working at community level. As such, *'vốn sự nghiệp'* is an important category of financing for improving the quality of service provision.

resources have been mobilised primarily for HIV/AIDS prevention and treatment. Non-public funding has also been made to the NTP on Rural Clean Water Supply and Environmental Sanitation, through private sector water supply ventures.

In terms of the state budget resources, about 36.7 per cent of total NTP funding has been allocated to the NTP on Education and Training, followed by the NTPs on Poverty Reduction (17.7 per cent), Population and Family Planning (16.9 per cent) and Rural Clean Water Supply and Environmental Sanitation (14.6 per cent). It appears that comparatively little has been allocated to the NTP on Food Hygiene and Safety (0.2 per cent) even though this is an issue of nationwide concern for the government and general public, as well as having an impact on child health and nutrition.

Table 6. Funding allocations to the National Target Programmes, 2006-2010

National Target Programme	Total (VND million)	Funding sources (VND million)		
		Central budget	Provincial budget	Other budget sources
Total	**2,289,951**	**539,804**	**262,322**	**1,487,825**
Investment budget	156,881	127,117	22,764	7,000
Service delivery budget	2,133,070	412,687	239,558	1,480,825
NTP on Poverty Reduction	1,557,371	17,371	125,000	1,415,000
NTP on Population and Family Planning	135,530	41,978	93,552	-
NTP on Health and HIV/AIDS	120,408	34,172	20,411	65,825
NTP on Rural Water Supply and Sanitation	124,222	111,572	5,650	7,000
NTP on Culture	13,990	13,990	-	-
NTP on Prevention and Control of Crime	4,600	4,600	-	-
NTP on Education and Training	294,530	294,530	-	-
NTP on Employment	22,454	4,900	17,554	-
NTP on Food Safety and Hygiene	4,914	4,914	-	-
NTP on Drug Control	11,932	11,777	155	-

Source: Department of Finance (2010) *Data provided during fieldwork.*

NTP on Education and Training. This programme has received VND 295 billion, of which 96.3 per cent has been allocated to service delivery. However, this does not represent the total funding for this sector. According to figures provided by the Department of Education and Training (DOET), substantial resources for investment in schools infrastructure and facilities have also come from the Concretisation of Schools Programme (VND 294 billion in the period from 2006 to 2010), as well as from various donor-supported projects.

NTP on Prevention of Social Diseases, Epidemics and HIV/AIDS. This programme has received about 120 billion VND, of which 98.3 per cent has been allocated to service delivery. A breakdown of budget allocations under this NTP from 2006 to 2010 is given in Table 7.[39] In total, about 33 per cent of state budget resources have been allocated to those three projects that have the most direct impact on child health and survival, including malnutrition prevention (16.4 per cent), reproductive healthcare (11.4 per cent) and universal vaccination (5 per cent). Considerable resources have also been allocated to dengue fever prevention and treatment (14.7 per cent). The prevalence of dengue fever has been increasing in recent years from 146 per 100,000 inhabitants in 2006 to

39 Department of Health (2010) *Report on Implementation of the NTPs in the period 2006-2010.*

167 per 100,000 in 2009, and children are particularly susceptible.

About 68 per cent of total funding under this NTP has been allocated to the Project on HIV/AIDS Control, of which 80 per cent has been mobilised from non-public sources. This reflects the high priority given to the HIV/AIDS prevention effort by the provincial authorities in recent years and by donors and NGOs working in the health sector in An Giang. This has resulted in reduced rates of new HIV infections (see Section 6.6). There are several donor and NGO-supported projects working on HIV/AIDS. There is a potential risk to continued financing and sustaining these achievements because many of these projects are due to finish in 2012.

Table 7. Funding for the NTP on Social Diseases, Epidemics and HIV/AIDS, 2006–2010

Programme/ component	Funding allocation by year (VND million)					Total 2006 to 2010 (VND million)	Per centage of total	State budget (per cent)
	2006	2007	2008	2009	2010			
Total funding:	**13,534**	**21,495**	**23,273**	**31,204**	**30,622**	**120,296**		
Central state budget	5,290	7,175	5,925	6,989	8,681	34,060	28.3	
Provincial budget	1,020	5,357	4,099	6,480	3,455	20,411	17.0	
Other mobilised sources	7,224	8,964	13,248	17,735	18,486	65,825	54.7	
Project funding:								
TB control	950	950	1,162	2,275	1,389	6,726	5.6	11.0
Leprosy control	140	135	175	190	280	920	0.8	1.7
Malaria control	100	142	139	152	197	730	0.6	1.3
Goitre control	300	0	0	0	0	300	0.2	0.6
HIV/AIDS prevention and treatment	9,224	13,397	16,823	20,168	21,806	81,417	67.7	30.5
Child malnutrition prevention	1,500	1,600	1,750	1,937	2,171	8,958	7.4	16.4
Community mental health	250	310	500	1,540	600	3,368	2.8	5.9
Reproductive healthcare	0	0	1,290	3,262	1,749	6,301	5.2	11.4
Dengue fever control	600	4,437	674	1,018	1,270	7,999	6.6	14.7
Child vaccination	470	475	550	575	645	2,715	2.3	5.0
Diabetes prevention	0	0	0	0	395	395	0.3	0.7
Army cooperation in healthcare	0	50	210	87	120	467	0.4	0.9

Source: Department of Health (2010) *Report on results of the National Target Programmes in the period 2006-2010.*

NTP on Population and Family Planning. It is notable that about 69 per cent of funding for this NTP has come from the provincial budget (Table 6). Similarly, 94 per cent of funding for the Project on Reproductive Healthcare under the NTP Social Diseases, Epidemics and HIV/AIDS has come from the provincial budget (Table 7). This reflects the high priority that the provincial authorities in An Giang have placed on family planning and improving reproductive healthcare services. This is, in turn, reflected in province-wide progress and achievements in reproductive healthcare indicators (Section 5.3). The research team suggests that this is a clear example of where province budget resources have been allocated to augment national programmes with beneficial outcomes for both women and children.

3.4 Funding for social protection policies

Due to the large number of sectors and agencies involved in different aspects of child protection, it is difficult to piece together a comprehensive picture of budgetary allocations for these activities. Nonetheless, since 2007 there has been a consolidation of the financing and fund allocation procedures for social protection, following Decree No.67/ND-CP,[40] supplemented by Decree No.13/ND-CP in 2010.[41] Decree No.67 brought together previously fragmented legislation and sets of procedures for social assistance to families and children. This is for both care in the community and at the provincial social protection centres. For care in the community, the fund allocations are made on a needs assessment basis; the commune/ward authorities submit lists of eligible households to receive support, which are verified by the district Labour, Invalids and Social Affairs Section and Planning and Finance Section.

This research compiled budget allocations under Decree No.67 and Decree No.13 at the provincial level and in the three research districts to give an indication of funding patterns and priorities for social protection (Section 7.3 provides a detailed analysis of the targeting, administration and use of these funds). According to figures provided by DOLISA, about VND 150 billion was allocated between 2007 and 2010 (Table 8), of which each year about 30 per cent comes from the provincial budget and 70 per cent from the central state budget.

Within the province, the budget distribution broadly correlates to the population of each area (district, township or city). In the period covered by Decree No.67 from 2007 to 2009, the annual expenditure was between VND 21.6 billion and VND 27.8 billion. During this period, the support primarily targeted poor households. Decree No.13, introduced in early 2010, has widened the pool of eligible recipients – consequently the preliminary expenditure for 2010 has doubled to about VND 63.7 billion and the number of recipients has increased from about 24,000 persons in 2009 to about 30,460 persons in 2010. [42]

Table 8. Funding for social protection policies by administrative area, 2007–2010

Administrative area	Population (2009)	Total funding (VND million)	Annual funding (VND million)			
			Decree No.67			Decree No.13
			2007	2008	2009	2010
Total		**148,200**	**25,700**	**21,600**	**27,800**	**63,710**
Cho Moi District	345,200	23,300	4,500	4,400	4,400	10,475
Phu Tan District	227,070	18,900	3,500	3,500	3,300	5,880
Chau Phu District	245,102	16,600	2,500	2,500	3,100	8,480
Long Xuyen City	278,658	16,100	2,700	2,700	2,700	3,080
Tri Ton District	133,109	14,000	2,400	2,400	2,600	6,600
An Phu District	177,710	12,100	2,000	2,100	2,500	6,540
Thoai Son District	180,551	11,200	2,200	2,200	2,300	4,800
Tan Chau Town	153,185	10,800	1,700	1,700	2,600	7,400
Tinh Bien District	120,781	10,600	1,700	1,700	1,500	4,905
Chau Thanh District	169,723	9,800	1,700	1,700	1,700	3,000
Chau Doc Town	111,620	5,800	800	700	1,100	2,550

Source: Department of Labour, Invalids and Social Affairs (2010) *Data provided during fieldwork.*

40 Decree No.67/2007/ND-CP (13/04/2007) on policies to support targets under social protection.

41 Decree No.13/2010/ND-CP (27/02/2010) on adjusting and supplementing a number of articles in Decree No.67/2007/ND-CP on policies to support targets under social protection.

42 Department of Labour, Invalids and Social Affairs (2010) *Report on results of social protection and poverty reduction work in 2010.*

Socialisation policies for child care and protection. The province has been active in encouraging local enterprises, individuals, non-governmental and charitable organisations to contribute to child care and protection, especially amongst poor households. One of the main mechanisms is through the Province Child Protection Fund (Box 1), as well as through learning encouragement associations and movements (see Section 5.6).

3.5 Institutional arrangements for child care and protection

The institutional arrangements and responsibilities in An Giang for the main cross-sectoral child care and protection concerns are summarised in Table 9 below.

With the cessation of the Committee for Population, Family and Children (CPFC) in 2008, there has been a reassignment in the institutional responsibilities for child care and protection. In general, the provincial authorities have managed this adjustment well. There appears to be a generally good understanding amongst provincial and district agencies about the new institutional arrangements and their respective roles and responsibilities. The province has also taken steps to augment human resources to help ensure that child care and protection activities at the commune, ward and/or township level are maintained.

Box 1. Provincial Child Protection Fund

In 2010, the Child Protection Fund raised VND 4.341 billion from 32 organisations, agencies and individuals from both inside and outside the country. From these mobilised sources and provincial state budget contributions (VND 1.187 billion), the Child Protection Fund provided VND 5.524 billion for 3,438 children in difficult circumstances and disabled children:

- Support for 2,108 children in difficult circumstances (VND 285 million) such as gifts and material support for homeless children, disabled children, children with HIV/AIDS, abused children and children in mercy centres. These activities not only happened at New Year but also on the International Children's Day, the Mid-Autumn Festival and the Action Month for Children.
- Provision of 162 scholarships for Cham children (VND 145 million).
- Eye diagnosis and operations for 213 children (VND 93 million).
- Diagnosis and operations for 27 children with motor disabilities (VND 76 million).
- Diagnosis and operations for 159 children with cleft palate (VND 330 million).
- In particular, the Child Protection Fund prioritises heart operations for poor children and has sent 92 children with congenital heart problems for successful treatment (VND 4.35 billion).

Source: (i) "Results of the Child Protection Fund in An Giang in 2010". *An Giang Portal. October 13, 2010; (ii)* Department of Labour, Invalids and Social Affairs (2010) *Data provided during fieldwork.*

Decision No.385/QD-UBND (11/03/2008) of the Provincial People's Committee reassigned the responsibilities previously covered by the CPFC to the Department of Labour, Invalids and Social Affairs (DOLISA), the Department of Health (DOH) and the Department of Culture, Sports and Tourism. Child care and protection includes a wide range of issues and additional provincial and district agencies are responsible for various aspects. The main legislative and organisational adjustments that were made are as follows:

- ***Overall state management for care and protection of children.*** Decision No.814/QD-UBND (05/05/2008) established the Child Protection Section under DOLISA at the provincial level and the Labour, Invalids and Social Affairs Section of the districts;

with responsibility for implementation of government policies; and planning of projects and programmes on child care and protection and inspection and monitoring of child rights and legal issues.

- ***Family planning and population monitoring.*** Decision No.1120/QD-UBND (04/06/2008) established the Sub-Department of Population and Family Planning under DOH, followed by Decision No. 1467/QD-UBND (24/07/2008) establishing Population and Family Planning Centres at the district level. These centrer have with responsibility for the implementation of family planning policies and programmes, and population monitoring and reporting.

- ***Commune, ward and township staffing.*** Official Notice No.2573/UBND-VX (11/07/2008) and Official Notice No.892/UBND-VX (19/03/2009) reassigned the population cadre at the commune, ward or township level to fall under the administration of DOH, and created an additional position of a family and children's cadre at this level. The latter is an important step taken by An Giang Province to ensure that family and children's issues continue to be covered at the grassroots level. Currently 115 out of 156 communes, wards and townships have these family and children's cadres.[43]

- ***Child injury prevention and monitoring.*** Overall responsibility for child injury prevention initiatives and reporting is assigned to the Child Protection Section under DOLISA. The Preventative Health Centre under DOH is responsible for compiling statistics on child accidents and injuries from the local health centres and hospitals. The Department of Public Security and local police are responsible for certain aspects of child injury prevention and monitoring (e.g. for child fatalities and road and traffic accidents). DOLISA also works in collaboration with the Department of Culture, Sports and Tourism and DOET on child injury prevention activities (e.g. swimming lessons for children). The Women's Union is responsible at the community level for organising shelter points where vulnerable children are collected during times of flood emergency (diễm giữ trẻ mùa lũ).

- ***Children in conflict with the law, child abuse, and trafficking.*** The Department of Public Security, the Department of Justice, and the People's Court are each responsible for addressing and monitoring respective aspects of children in conflict with the law, child abuse, and trafficking of women and children (see Sections 6.5 and 6.7). The Department of Justice has established a Group for Legal Support for Trafficked Women and Children with the participation of other relevant agencies. The Social Protection Centres are responsible for handling some cases of children in conflict with the law and trafficking. The province has also established a Legal Advisory Centre for Poor People (Trung tâm Tư vấn Pháp lý cho người nghèo) that can assist poor families and children with legal problems.

- ***Birth registration.*** The Department of Justice is responsible for birth registration procedures and records, working through the Legal Aid Cadres at the commune, ward and township level. Experience has shown that the additional family and children's cadres have an important role in encouraging and supporting families to obtain birth registration, as well as helping to coordinate with the local authorities.

- ***Institutional care for children in need of special protection.*** The province has four public Social Protection Centres, and one private centre established by a

43 Propaganda and Education Committee (2010) *Report on 10 years implementation of Resolution No.55/CT-TW of the Party Central Committee on strengthening local party leadership for the care, protection and education of children.*

benefactor in Chau Doc. Each public Social Protection Centre includes care for elderly people as well as for children, including children with severe disabilities, orphans or homeless children, and children in conflict with the law. In addition, there is a school for children with disabilities (in particular children with hearing and sight impairments) under DOET located in Long Xuyen City.

Institutional capacity gaps. Based on this research, there are several key aspects of child care and protection in An Giang that appear to be inadequately covered by the existing institutional arrangements. Some of these relate to the need for closer coordination and collaboration between different sector agencies. Others relate to gaps in service provision, particularly at the interface with local communities, families and children. These will be detailed in later sections of the report, but can be summarised here as follows:

- ***Local collaborators and social workers at the community level.*** In general, health officials in An Giang state that the local healthcare network is adequately staffed in a majority of rural communes and urban wards (see Section 4.1). In contrast, the network of local collaborators dealing with child protection and social issues in the community is still not well developed. The placement of the family and children's cadres has begun to fill this gap. This situation should be further resolved by the Government decision in 2010 on the social work system.[44] Under this decision, by 2015 the number of social work cadres, staff and collaborators will be increased by 10 per cent nationwide, with each commune having one or two social workers with monthly allowances at least equivalent to the minimum wage. This provides an opportunity to develop the social work system in ways that are appropriate to the particular needs and circumstances of vulnerable population groups in the province.

- ***The system of health and social work collaborators amongst the mobile population.*** As indicated in Section 2.5 above, a significant number of households in An Giang are engaged in mobile or semi-mobile lifestyles, which presents particular challenges for the provision of health and social services. It is recommended that special attention should be given to strengthening the system of local collaborators amongst this population group, as part of the overall development of the social system in An Giang. This may be best achieved by recruiting women from within these communities to become more actively engaged in awareness raising and information dissemination with their peers and other families.

- ***Counselling services for children.*** During this research, several agencies indicated the need to strengthen counselling and advisory services, especially for teenagers and young adults. This is mentioned with respect to reproductive healthcare and HIV/AIDS awareness amongst the young population in general and in conjunction with secondary schooling in particular[45] (see Section 4.3). In addition, statistics on child injury in An Giang suggest a high incidence of injury caused by attempted suicide and violence amongst the 14-19 age group, especially amongst teenage boys (see Section 4.6). Providing sensitive and confidential counselling services for children subject to psychological or physical violence or abuse, and for emotionally troubled children, will be an important part of developing the social work system and services in the future. Counselling knowledge and skills also need to be strengthened amongst all respective agencies and staff.

44 Decision No.32/2010/QD-TTg (25/03/2010) on approval of the scheme on development of social work in the period 2010-2020.

45 Sub-Department of Population and Family Planning (2010) *Report on the results of the National Target Programme on Population and Family Planning in the period 2006-2010.*

- ***Coordination and mobilisation of child injury prevention efforts.*** There is currently no provincial committee structure with overall responsibility for child injury prevention; through while the Provincial Transport Safety Committee is responsible for this respective area. In recent years, successful efforts have been made in reducing child injury and deaths caused by flooding in An Giang, through close collaboration between different sectors and agencies (see Section 4.6). At the same time, there are other aspects of child injury prevention that need to be strengthened. In particular, stronger cross-sectoral coordination is required to tackle road and traffic safety for children and to promote behaviour change around this issue, and the mobilisation of child injury prevention plans and activities at the commune or ward level.

- ***Children with disabilities.*** According to DOLISA, there are 15,199 people with disabilities in An Giang, of whom 1,900 are children, and 70% of those children have congenital disabilities.[46] There are many challenges in responding to the needs of people living with disabilities. Firstly, there is inconsistent data because of unclear criteria and standards between concerned sectors in data collection (e.g. DOET gives a much higher figure of 5,000 children with disabilities). Secondly, although the National Assembly passed the Law on Disabilities in 2010,[47] there is a lack of guidance from the central level on healthcare, education, social protection and social services for people with disabilities, together with a lack of coordination between the concerned sectors. Thirdly, while the proportion of children with disabilities attending school in An Giang is quite high and there is provision of institutional care of children with severe disabilities at the Social Protection Centres, there is a lack of advisory support for families caring for disabled children in the community.

3.6 Plan of Action for Children 2001-2010

Table 10 presents the data on progress and achievements under the national and provincial Plan of Action for Children (2001-2010). These data are drawn from the provincial report on implementation of the plan[48] and from other departmental reports. It will be seen that while many of the child survival and health indicators have largely been achieved, some other targets in education, water supply and sanitation, and child protection have yet to be reached.

Data are not available for many of the child protection and child participation indicators. It appears that the reason for this is the difficulties encountered in general population monitoring in An Giang, which makes it difficult to establish rates of reduction or increase over time. For instance, while administrative data are available for the number of orphans and homeless children under care and protection, data are not available on the proportion of the total number of homeless and orphaned children this represents (see Section 6.2 for a fuller analysis of these data gaps).

46 Department of Labour, Invalids and Social Affairs (2010) *Report on results of social protection and poverty reduction work in 2010.*

47 Law No.51/2010/QH12 (17/06/2010) on People with Disabilities.

48 Provincial People's Committee (2010) *Plan of Action for Children in An Giang Province in the Period 2011-2020.*

Table 9. Institutional responsibilities for cross-sector child care and protection issues

Sub-sector/child care and protection issue	**Overall coordinating body and/or mechanism** (under Provincial People's Committee)	**Main responsible and implementing agencies**	**Supporting agencies and socialisation partners**	**Commune or ward staff and local collaborators**
Overall state management for child protection	*Currently no overall coordination mechanism*	Child Protection Section under DOLISA; Labour, Invalids and Social Affairs Section at district or township level		Family and children's cadre (in 115/156 communes and wards)
Care for children in need of special protection	*Currently no overall coordination mechanism*	Child Protection Section and Social Protection Section under DOLISA; Labour, Invalids and Social Affairs Section at district or township level	Provincial Social Protection Centres (four public and one private); school for children with disabilities (under DOET)	Family and children's cadre
Family planning, reproductive healthcare and population monitoring	Population Committee under DOH	Sub-Department of Population and Family Planning under DOH; Population and Family Planning Centres at district or township level		Population cadre (in 100 per cent of communes and wards); midwives and/or junior delivery doctors (in 100 per cent of communes and wards)
Child injury prevention and monitoring	*Currently no overall coordination mechanism (formerly Committee on Child Injury Prevention under DOH)* Provincial Transport Safety Committee	Child Protection Section under DOLISA (with responsibility for state management of child injury prevention initiatives, monitoring and reporting)	Preventative Health Centre (compiling statistics on child accidents and injuries); Department of Public Security and local police; Department of Culture, Sports and Tourism; DOET; Women's Union	Women's Union; Youth Union
Universal health insurance for children under six years of age	*Currently no overall coordination mechanism.* Quarterly review meetings of responsible and supporting agencies	Province Social Insurance (head office and district branches)	DOLISA, DOH, DOF, local health service units (hospitals and clinics)	Family and children's cadre
Birth registration	*Currently no overall coordination mechanism*	Department of Justice and township level	Mobile birth registration teams	Legal aid cadre; Family and children's cadre supporting
Child abuse and children in conflict with the law	*Currently no overall coordination mechanism*	Departments of Public Security and Justice and the People's Court each responsible for addressing and monitoring respective aspects	Province Social Protection Centres; Women's Union; Legal Advisory Centre for Poor People; Labour, Invalids and Social Affairs Section at the district or township level	Women's Union
Trafficking of women and children	Group for Legal Support for Trafficked Women and Children (under Department of Justice)	Department of Justice; Department of Public Security	Peoples Court; Lawyers Association; Fatherland Front; Women's Union; army border guard; Social Protection Centres; Legal Advisory Centre for Poor People	Women's Union

Table 10. Progress under the Plan of Action for Children, 2001–2010

Indicator	Action Plan Targets 2010		An Giang Province						Source
	National	An Giang	2000	2005-6	2007	2008	2009	2010	
Infant mortality rate (per 1,000 live births)	<25	10	33.8	23	18	14	12	10	A
Under-five mortality rate (per 1,000 live births)	<32	<25	48	30/28	26	24	22/20	20/18	A
Maternal mortality rate (per 100,000 live births)	<70	<70	60	28	26/24	22	20	20/18	A
Underweight children under five years of age (%)	<20	<20	32	23.5	22	18.2	17.5	17	A
Stunted children under five years of age (%)	-	<25	36.2	30.4	31.8	30	29.6	28.7	A
Infants with low birth weight (<2500g) (%)	<5	<6	-	5.4	5.7	6.2	5.4	5.8	A
Pregnant women with tetanus vaccination (%)	>90	>85	-	96.1	97.3	100	95.2	96	A
fully immunised children under one of age (%)	>95	>95	-	98.3	98	100	95.7	70	A
Rural population with appropriate clean water (%)	85	90	-	37	40.5	43	61.6	-	B / C
Urban population with appropriate clean water (%)	90	95	-	72.5	78.1	86	89	93.6	B
Rural and urban households with appropriate latrines (%)	70/90	70/95	-	-	-	-	46.1	-	C
Schools with clean water and sanitation (%)	100	-	-	-	-	-	86.7	-	C
Children attending kindergarten by five years of age (%)	95	95	26.8	67.5	96.5	98.7	86.3	91.8	D
Primary net enrolment rate at right age (%)	99	99	-	81	84.9	76.4	86.2	95.5	E
Primary school completion rate (%)	95	-	85.3	99.7	96.3	98.1	98.8	99.4	E
Lower secondary completion rate (%)	75	-	90.4	97.8	95.8	94.7	98.9	97.9	E
Children with disabilities enrolled at school (%)	80	-	-	41.8	48.2	55.6	58.6	61.2	F
Orphans being cared for (%)	100	-	-	-	-	-	-	-	
Children with cleft palates having operation (%)	100	-	-	-	-	-	-	-	
Children with disabilities having operation/rehabilitation (%)	70	-	-	-	-	-	-	-	
Decline in number of children working hazardous conditions (%)	90	-	-	-	-	-	-	-	
Number of drug-using children	90	90	-	-	-	-	-	-	
Number of children in conflict with the law using drugs	90	95	104	-	-	-	412	240	D
Children under six with health cards (%)	95	95	-	-	-	-	-	±95	D
Children with a birth certificate before five years of age (%)	90	95	77	88	-	-	95	95	D
Children receiving a birth certificate on time (%)	-	-	-	39	45	50	54	52	G
Communes or wards with a cultural venue and recreation point for children, outdoor playgrounds or meeting standards for children's recreation (%)	100	100	-	-	-	-	-	-	

Sources: **A.** DOH (2010) *Five-year development plan of the health sector, 2011-2010;* **B.** Provincial Socio-Economic Development Plans (2006-2010); **C.** PCERWASS (2009) *Report on results of survey on rural water supply and sanitation 2009;* **D**. Provincial People's Committee (2010) *Plan of Action for Children in An Giang Province in the Period 2011-2020;* **E.** DOET (2010) *Data provided during fieldwork;* **F.** DOET (2010) *Report on education of children with disabilities in An Giang in 2010-2011;* **G**. *Department of Justice (2010) Data provided during fieldwork.*
Note: Full immunization includes three vaccines against Hepatitis B, Polio, Diphtheria, Pertussis and Tetanus, and one against Tuberculosis and Measles.

CHAPTER 4:
CHILD HEALTH AND SURVIVAL

4. Child Health and Survival

4.1 Access to quality healthcare for children

Overall improvements in healthcare situation. A majority of participants in this research believe that there were positive developments in healthcare provision for children in An Giang over the last decade. Health officials in Tan Chau District, for example, stated that the health status of the population has generally improved in recent years, reflecting province-wide trends in better primary healthcare; full vaccination has been extended to a majority of children, there is now a good understanding amongst parents of the benefits of inoculation, with positive impacts on the incidence of infectious diseases; most clinics are sufficient at following-up on reproductive healthcare activities; regular basic health check-ups are provided for school children; and there is now better management of health statistics. Health officials in other districts made similar overall reflections on progress and achievements.

Local healthcare network and staffing situation. Health officials in An Giang stated that the local healthcare network, meaning the system of village health workers, nutrition collaborators, and health groups in rural villages and urban residential clusters is generally adequate. In Tinh Bien District, for example, 100 per cent of villages have health groups and local collaborators, 100 per cent of communes meet national health standards and many villages meet standards for health in cultural villages. All communes and wards have midwives and/or junior delivery doctors (Annexes 1.22 and 1.23). There is, however, a shortage of allowances for health collaborators, particularly for those working on nutrition. For instance, since 2010 only about one-third of nutrition collaborators working on nutrition in prioritised communes continue to receive monthly incentives from the Child Malnutrition Control Project. It is difficult to maintain the enthusiasm and commitment of the village collaborator network, who mainly work on a voluntary basis and many collaborator leave their jobs each year.

Many localities reported that their major staffing problem is a shortage of doctors. There is a drain on doctors as many move to the private sector due to economic incentives and greater prestige. In some districts, such as Tan Chau and Tinh Bien, it has been necessary to withdraw doctors from commune clinics to the district hospitals. In some localities, this has resulted in a recent reduction in the rate of communes meeting national health standards. The implication of this for child health is a lack of resources for regular diagnosis and treatment at the commune or ward clinics. During this research, some commune health staff complained that the commune clinics were small, with facilities that do not meet required healthcare standards, which may lower service quality despite community and household efforts to increase the use of services.

Universal vaccination. According to provincial figures, between 2006 and 2009 over 95 per cent of infants under one year of age were fully vaccinated, while a dramatically lower figure was reported in 2010 due to a shortage of vaccine supplies (Table 11). In addition to the basic vaccination programme, the rate of children with vaccinations against Japanese encephalitis and measles has been maintained at a high level. There has been a reduction in infectious diseases amongst children due to the vaccination programme and improved environmental sanitation. Many local health officials said parents were much more aware of the importance of vaccination and there has been significant behaviour change around this issue. However, as one province health official noted, one negative consequence is that many parents now wish to get all of the vaccinations at once, while there is a need to spread out the injections to ensure effective inoculation.

Discussions at the commune level confirm these trends. For example, children in Chau Phong Commune said that children were regularly vaccinated at the local health centre, but sometimes the centre's vaccine stocks were insufficient. Some parents and children had to wait a very long time before they could return home because the clinic had run out of vaccines, negatively affecting children rights to healthcare. Similarly, Khmer people in Vinh Trung Commune are now more aware of the benefits of vaccination; awareness raising activities and the dedication of grassroots health staff are listed as major reasons for this achievement. Eligible households now receive invitations for vaccination, which remind them to follow the schedule. In Vinh Trung only about 2 per cent of children have not had vaccinations as they belong to the 'mobile population' who may not be at home during vaccination visits.

"Vaccination for children has now become routine for parents. Before you had to remind parents about this." (Health official, Tinh Bien District)

There is some evidence to suggest that the actual rates of full vaccination may be lower than reported figures. One recent survey conducted by DOH, based on a sample of 1,100 households in four districts, found that the rate of full vaccination of children at 24 months of age was only 57.2 per cent, which is considerably below officially reported figures (Table 12).[49]

49 Department of Health (2010) *Household survey on maternal, infant and child healthcare in four districts under the Provincial Child Friendly Programme in An Giang in 2010.*

Table 11. Population, reproductive health and child vaccination indicators, 2006–2010

Indicators	Year					Target 2010
	2006	2007	2008	2009	2010	
Population						
Population growth rate (%)	1.25	1.24	1.21	1.19	1.17	1.19
Reduction of birth rate (‰)	0.4	0.35	0.3	0.25	0.25	0.3
Total birth rate (number of children per woman aged 15-49)	2.1	2	1.95	1.95	1.9	-
Crude birth rate (‰)	17.6	17.6	17.3	17	16.7	-
Sex ratio at birth (males birth pr 100 female birth)	108	108	109	109	113.7	-
Reproductive health						
Pregnant women with fewer than three maternity check-ups (%)	72.5/62.2	85.3/77.6	76.6/80	98.3/85	84.7	>90
Pregnant women with TT2 vaccination (%)	96.1	97.3	100	95.2	96	>85
Deliveries with professional assistance (%)	-	99.9	99.9	99.9	-	-
Deliveries at health facilities (%)	99.8	99.9	99.9	99.9	99.96	>99
Deliveries at commune/ward clinics (%)	23.3	18.8	16.1	14.6	-	-
Maternal Mortality Rate (per 100,000 live births)	28	26/24	22	20	20/18	<70
Infants with low birth weight (<2500g) (%)	5.4	5.7	6.2	5.4	5.8	6
Infant mortality rate (per 1,000 live births)	23	18	14	12	10	10
Under-five child mortality rate (per 1,000 births)	30/28	26	24	22/20	18	<25
Universal vaccination						
Fully immunised children under one year of age (%)	98.3	98	100	95.7	70*	>95
Children aged six with measles vaccination (%)	99.9	95.4	97	97	-	-
Children aged 3-10 with typhoid vaccination (%)	97.8	97.8	88.5	96.8	-	-
Children with 2nd Japanese encephalitis vaccination (%)	95.6	98.1	97.4	96.7	-	-

Source: (i) Sub-Department of Population and Family Planning (2010) *Report on implementation results of the NTP on population and family planning in the period of 2006-2010; (ii)* Department of Health (2010) *Five-year development plan of the health sector, 2011-2015; (iii)* Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Completed results.*

* In 2010, the child vaccination target was not met due to an insufficient supply of Hepatitis B vaccine.

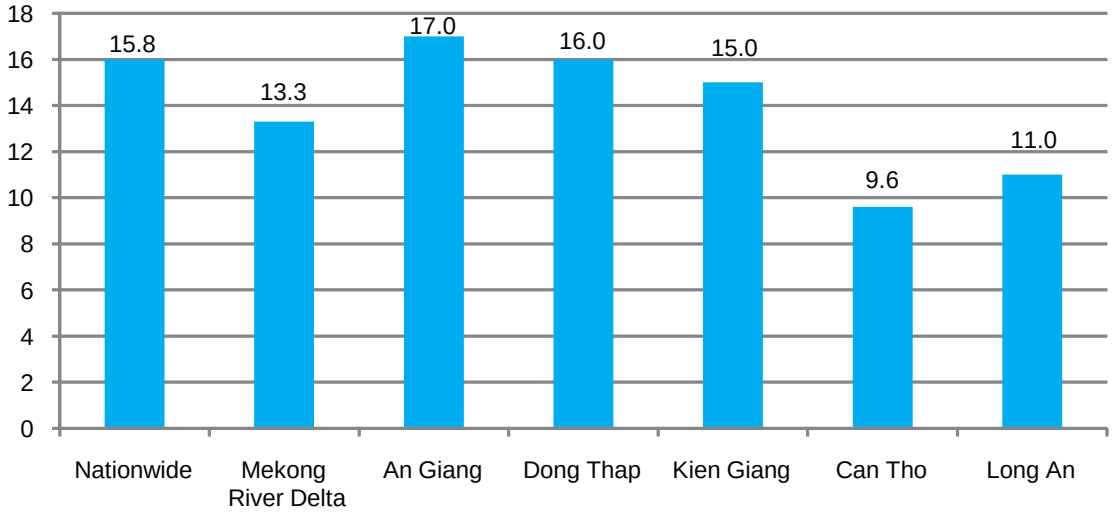
School health check-ups. One noticeable improvement in recent years has been in the provision of regular health check-ups for school children and environmental health checks at schools, through collaboration between DOH and DOET. All schools in An Giang have staff responsible for school health who have received training. Basic health check-ups for children are made at the end of the school year. In 2009, for instance, it was reported that 74 per cent of pupils at 93 per cent of provincial schools received check-ups.[50] Dental checks and advice on oral hygiene were provided to 100 per cent of primary school

50 Department of Health (2010) *ibid.*

pupils. The Preventative Health Centre also monitors light, ventilation and environmental sanitation in schools and these activities are funded by the provincial budget. The funds for school dentistry are sufficient for basic dental checks and preventative health, but not for dental treatment.

Infant and child mortality rates. The improvements in primary healthcare for children are reflected in continued reductions in the infant and under-five mortality rates (Table 11). According to provincial figures, the infant mortality rate (IMR) has fallen from 33.8 per 1,000 live births in 2000 to 23 in 2006 and 14 in 2009. The Ministry of Health reported a higher rate of 17 per 1,000 for 2009 following the 2009 Census, which is higher than the regional rate of 13.3 for the Mekong Delta Region (Figure 10 and Annex 1.25). As Department of Health officials explained, it is difficult to determine an accurate IMR as there are a variety of causes of infant deaths and they are reported through several different channels. The provincial figures primarily record infant deaths that occur in health facilities as officially reported through the health system. The census figures are likely to be more accurate as they also capture mortalities outside health facilities.

Figure 10. National, regional and provincial infant mortality rates: a comparison, 2009



Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

4.2 Child health insurance

Procedures for child health insurance. Since 2008, the universal health insurance system has made several adjustments for children under six years of age, following circulars No.15/2008/TTLT-BTC-BYT [51] and No.09/2009/TTLT-BYT-BTC.[52] Previously, funding for the diagnosis and treatment of children under six followed a receipt-based payment system that was complicated and not fully transparent. Circular No.9 required that automatic payment be made according to the specified entitlements of 100 per cent for regular diagnosis and treatment and insurance premiums for other types of treatment. Circular No.15 also stipulated that for children without insurance cards, a birth certificate or birth confirmation was sufficient to obtain treatment and access funds; if treatment was required before birth confirmation, the signatures of the head of the medical unit

51 Inter-Ministerial Circular No.15/TTLT-BTC-BYT (05/02/2008) on guidelines for implementing diagnosis and treatment, management, utilisation and liquidation of expenditures for diagnosis and treatment for children under six in public health facilities.

52 Inter-Ministerial Circular No.09/TTLT-BYT-BTC (14/08/2009) on guidelines to implement health insurance.

and parents or guardians would suffice. An Giang Province has also adjusted the referral system, and as of January 2010 children under six can be taken directly to any eligible health unit (clinic or hospital) in the local area for treatment.

Health insurance card coverage. Following the changes above, children under six received new health insurance cards from October 2009 onwards. The provincial authorities in An Giang have paid much attention to child health insurance, as well as to health insurance for the poor and nearly-poor (Box 2). In general, the cards have been well distributed. According to the Provincial Social Insurance Department, 223,000 children under six years of age received cards in 2009, and 219,000 received them in the first three quarters of 2010 (Annex 1.24).[53] In addition, a substantial number of school pupils (with 30 per cent subsidy), ethnic minority households (with 100 per cent subsidy), children in charitable institutions and nearly-poor people (with a 50 per cent subsidy) have registered for cards.

Together with almost universal birth registration for children in An Giang, health insurance has been expanded to a majority of children under six years of age. During this research, district authorities reported coverage rates of 90 to 95 per cent. District officials in Tinh Bien report that a limited number of households have not received health insurance because they lack information on application procedures and entitlements as a consequence of language barriers (usually for Khmer people) or failure to attend public meetings (usually for the poor who are too busy). In addition, a number of parents do not request insurance for school children because they do not see the value of this type of insurance, or premiums are too high, especially in the context of recent increases in both school and medical fees. Elsewhere, it is reported that only a few wealthier households have not registered for child insurance.

Box 2. Campaign to provide health insurance cards for nearly poor people

In 2009 and 2010, the Provincial People's Committee worked with the Fatherland Front Committee to organise a campaign to buy health insurance cards for nearly poor people in An Giang. While Decision No.289 requires a 50 per cent insurance premium for nearly poor people, according to the project on supporting health in the Mekong Delta Region (2007-2011) an additional subsidy of 30 per cent is provided (therefore, nearly poor people only pay 20 per cent). However, nearly poor people in An Giang still have many problems when buying health insurance cards. As a result, this campaign was organised to mobilise contributions from charity organisations, associations, businesses and individuals. In 2009, nearly 100 organisations and individuals raised about VND 3.9 billion to support insurance cards for about 52,000 nearly poor people. The campaign was maintained in 2010 to support additional nearly poor people.

Source: "Ceremony to launch the campaign of buying health insurance cards for nearly poor people in An Giang." *An Giang Portal. July 12, 2010.*

Local viewpoints on child health insurance. In several localities, parents' discussion groups revealed that there was a lot of time-consuming paperwork for insurance cards and waiting for treatment or referral when child health insurance was first introduced. The recent changes in procedures have improved this situation. Even so, many parents and guardians, including those from ethnic minorities who are entitled to free health insurance, said that they still prefer taking their children to private clinics and only use health insurance cards at eligible health units in more serious cases that may require considerable costs.

The group discussions revealed that the main reasons for these seemingly contradictory preferences were as follows:

53 Provincial Social Insurance (2010) *Report on child health insurance in An Giang Province in 2009-2010.*

- The difficult attitudes of medical staff at registered public health units (some people said this may result from their work pressures as a consequence of hospital overload);
- The lack of commune medical staff, especially doctors, in some locations, which may reduce service quality and extend patient waiting time;
- Some better-off households are concerned that doctors may prescribe ineffective medicines if health insurance cards are presented; while a few Khmer households still fear the use of Western medicines for injection;
- In some places, it can be difficult to access the hospitals in bad weather or due to a lack of transport; therefore, parents treat minor child illnesses or injuries at home according to the basic knowledge they have received from commune health staff.

Monitoring child health insurance card usage. The Provincial Health Insurance reports that in 2009, children under six used the cards 218,557 times, and school pupils used them about 231,000 times. However, the statistics do not show the proportion of children who have used the health insurance cards one or more times, or not at all; and nor do they show the types of regular or occasional treatment received. In the future, these statistics should be compiled and monitored in more detail to provide a fuller picture of the patterns of insurance card usage, and to identify potential gaps in service provision. Furthermore, neither health insurance nor the National Target Programmes cover all aspects of primary healthcare for children, such as the surveillance and treatment of acute respiratory infections (ARI). It would be instructive to monitor the proportion of clinic or hospital visits related to these types of ailments.

4.3 Reproductive healthcare

Significant improvements in reproductive healthcare. Many provincial and district health officials, commune health staff and parents' groups confirmed that reproductive healthcare services and maternal and newborn care have improved significantly in recent years. This has been underpinned by strong support from the provincial authorities. As indicated in Section 3.3 above, the provincial budget has allocated substantial resources to augment service delivery under the NTP on Population and Family Planning and the Project on Reproductive Healthcare under the NTP on Social Diseases, Epidemics and HIV/AIDS. Figures provided by DOH substantiate these positive developments and outcomes (see Table 11):

- Since 2006, all communes and wards have had midwives and/or junior delivery doctors and this staffing contingent is quite stable. In addition, all provincial and district hospitals now have dedicated paediatric or gynaecological units.
- The proportion of pregnant women receiving three or more antenatal check-ups has increased from between 60-70 per cent in 2006 to over 95 per cent in 2009 and 2010;[54] since 2006, over 95 per cent of pregnant women have received tetanus vaccinations.

54 The Department of Health and the Sub-Department of Population and Family Planning report various figures for the per centage of pregnant women receiving three or more antenatal check-ups. There are several reasons why it is difficult to obtain precise figures on this indicator. Firstly, pregnancies may span over different administrative years, which influences annual reporting. Secondly, recent changes in MOH guidelines have been made to stipulate the need for regular check-ups according to the stages of pregnancy. Thirdly, some public health facilities in An Giang receive women from outside the province for antenatal check-ups. Lastly, some households are choose to obtain antenatal check-ups and screening from private clinics.

- The proportion of pregnant women undertaking voluntary testing for HIV has increased (according to discussions with health officials in Tan Chau District, over 95 per cent of pregnant mothers were contacted and 90 per cent agreed to voluntary HIV testing in 2009).
- Since 2006, the rate of women delivering at health facilities has been over 99 per cent; nearly all deliveries are now with professional staff in attendance and there are few home deliveries.
- The rate of deliveries at commune or ward clinics has been steadily decreasing from 23.3 per cent in 2006 to 14.6 per cent in 2009. This is because a majority now take place at provincial or district hospitals to take advantage of better care and facilities.

The above improvements are reflected in the maternal mortality rate, which has decreased substantially from 60 per 100,000 live births in 2000, to 28 in 2006 and 20 in 2009.

Changes in reproductive healthcare behaviour. These indicators suggest that positive changes have taken place in reproductive healthcare behaviour in recent years. This is associated with increased awareness amongst parents and increased economic mobility, which has enabled parents to access a wider range of public and private services. Moreover, it is significant that these overall changes in parental behaviour appear to be amongst all population groups. This is true even in the more remote rural areas and amongst the Khmer ethnic minority women. For instance, in Vinh Trung Commune, only a few deliveries still take place at home or in the commune clinic, most of which are emergency cases when women cannot reach the hospital in time (Box 3). This suggests that Information, Education and Communication (IEC) activities in reproductive healthcare have been effectively strengthened and expanded.

Box 3. Improved birth delivery practices in Vinh Trung Commune

Most Khmer women in Vinh Trung Commune have stopped using informal village midwives (locally known as mu tu or mu vuon) over the past five years after seeing or hearing about many complications of home delivery. Also, in the past, pregnant Khmer women did not have tetanus injections before giving birth, but the number has increased due to awareness-raising activities and positine role models. Most births now take place at the district hospital. The recently improved transport system, including better roads and transport by hospital ambulances rather than by ox-carts, has also played an important part in the increased number of safe deliveries.

All mothers have breastfed their babies in the first six months. However, some pregnant women are still reluctant to follow periodical check-up schedules. Despite the decline in traditional delivery practices, some mothers from the Khmer and some Kinh households still follow the Khmer tradition of lying over coals for a few months after delivery. According to this tradition, both mother and the infant lie over coals in the belief that it purifies the blood of the mother and avoids 'shaky-hand and cold-feeling symptoms' in later years, as well as strengthening the stamina of the child. Some households may use electric heating instead of coals. Furthermore, after delivery, many Khmer and some Kinh mothers drink herbal alcohol in order to strengthen their health, and may easily get drunk while lying over coals. Therefore, this practice poses the risk of burning for both mothers and infants, as well as for household possessions.

Source: Discussion with commune health staff in Vinh Trung Commune (December 2010).

Quality of services. Despite these improvements in the coverage and utilisation of services, there are still concerns about the quality of services. The recent survey conducted by DOH in four districts found that only 63.1 per cent of pregnant women received at least three pregnancy check-ups, ranging from 54.8 per cent in Tinh Bien to 72.8 per cent in Phu Tan Districts (Table 12). These are significantly lower than the

official figures from the District Health Section. Moreover, only 19.7 per cent of women received full quality pregnancy check-ups according to MOH regulations (only 50 per cent had urine protein tests, 37.9 per cent had blood tests for anaemia and 33.2 per cent had voluntary testing and counselling for HIV). These survey results indicate that continuing efforts are needed to improve the quality of services.

Table 12. Officially reported figures and survey results for maternal, infant and child healthcare indicators in four districts, 2010

Indicator	District							
	Phu Tan		An Phu		Tri Ton		Tinh Bien	
	Reported 2009	Survey	Reported 2009	Survey	Reported 2009	Survey	Reported 2009	Survey
Pregnant women receiving at least three pregnancy check-ups (%)	81.3	72.8	88.9	64.2	86.7	60.6	72.1	54.8
Breastfeeding of infants immediately after birth (%)	89.9	67	94.6	48.9	83.4	50.3	80.1	54.1
Exclusive breastfeeding of infants in first six months (%)	58.3	9.1	14.6	4.1	41.5	11.1	18.2	0
Breastfeeding mothers taking Vitamin A after birth (%)	98	63.9	97	63.1	100	48.5	100	51.4
Full child vaccination by 24 months (%)	107	54.3	96	61.1	98.9	67.3	101.4	46.2

Source: DOH (2010) *Household survey on maternal, infant and child healthcare in four districts under the Provincial Child Friendly Programme in An Giang in 2010.*
Note: survey results are based on a sample of 1,103 households with children under five years of age.

Changes in the role of commune or ward health staff. The reductions in the number of women delivering in commune or ward clinics means that the role of clinic staff needs to be transformed from providing direct assistance in birth delivery to ensuring quality pregnancy check-ups and advice on reproductive health issues. This is an advantageous situation because it will enable DOH to strengthen IEC work at the community level. Higher up the system, future improvements in reproductive healthcare services and facilities will need to take into account factors of cost-effectiveness for both the health service and for parents. For instance, improvements in the regularity and quality of services for antenatal and postnatal check-ups for women and infants may be concentrated at the inter-commune polyclinic level, to allow easy access for parents.

Sex ratio at birth. As noted in Section 2.2 above, there are some potentially negative consequences of these service improvements and behavioural changes. This is particularly the case with regard to the sex ratio at birth (SRB), which has been steadily increasing in An Giang in recent years, from 105.6 per cent in 2006[55] to 113.7 per cent in 2009 (Figure 11).[56] The General Statistics Office first identified the signs of a rising proportion of male births in estimates it derived from annual population surveys in 2000, while indirect estimation techniques can date the beginning of a rising SRB in Viet Nam to 2005.[57] The analysis of 2009 Census data shows that there are strong regional

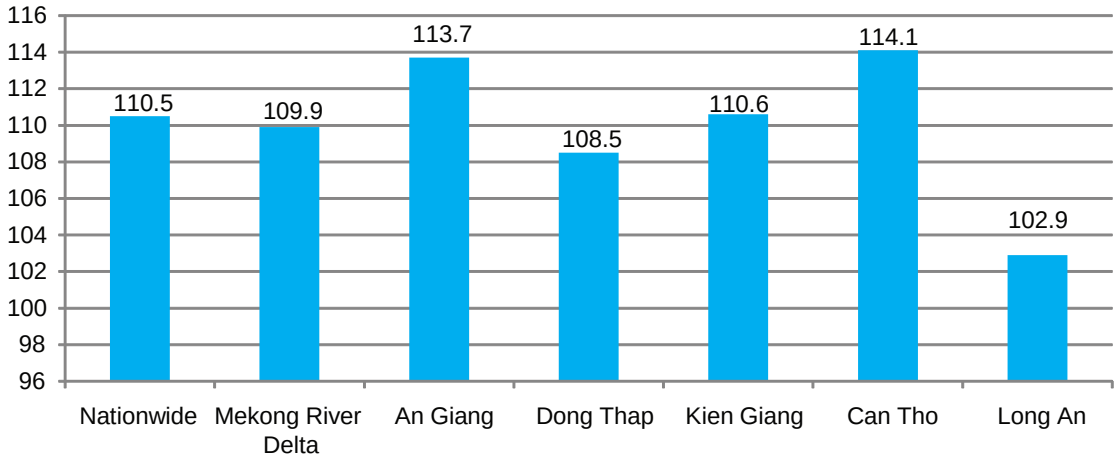
55 UNFPA (2007) *Viet Nam Population situation 2006. New Data: sex ratio at birth.*

56 Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Completed results.*

57 General Statistics Office (2011) *Sex Ratio at Birth in Viet Nam: new evidence on patterns, trends and differentials.*

differences in the SRB. While there are not significant differences between urban and rural areas, higher SRB levels are closely correlated with education levels and with indicators of better housing quality and ownership of household assets. The recent GSO report suggests that while the SRB among the poorest quintile of the population is at a normal biological level, it rapidly increases with better socio-economic conditions among the more prosperous quintiles.[58]

Figure 11. National, regional and provincial sex ratio at birth: a comparison, 2009



Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

According to a recent study by UNFPA, the rapid increase in the SRB in Viet Nam over the last decade appears to be related to 'supply factors' rather than to an increasing preference for sons.[59] That is to say, increased economic mobility has allowed many couples to access modern sex determination technology for the first time, which has in turn allowed them to adapt their reproductive behaviour to their desire to bear sons. As the UNFPA noted, quantitative information from birth registration records and census data is adequate to get an overall picture of the SRB. However, from a qualitative point of view, the practice of sex selection in Viet Nam is still poorly understood. The report recommends that more sociological research is needed to better document and understand the factors lying behind this recent change in sex selection practices. This is true for An Giang, where insufficient information is available on which population groups, within rural or urban areas, are primarily making these changes in reproductive behaviour. This needs to be combined with increased information and awareness-raising on this important issue amongst government agencies, the health service, mass organisations as well as amongst the general public.

The GSO report states that prenatal sex selection is a manifestation of acute gender bias, which may have profound and long-term impacts on society, on family structures and marriage systems, especially as there will be more young men than women in the same generation.[60] The report highlights the difficulties of devising effective policy solutions, but that these need to include a combination of: (i) more regular and intensive monitoring to understand trends and differentials; (ii) the enforcement of ethical practice in both public and private health facilities; (iii) strengthening the legal system to ensure gender equality; and (iv) more active campaigning for gender equality and to target deep-rooted attitudes towards women and discriminatory sex-selection practices.

Vulnerable groups and gaps in reproductive healthcare provision. There are

58 General Statistics Office (2011) *ibid.*
59 UNFPA (2009) *Recent Changes in Sex Ratio at Birth in Viet Nam; a review of evidence.*
60 General Statistics Office (2011) *ibid.*

two major population groups in which reproductive healthcare provision needs to be strengthened. Firstly, amongst young migrant women and those from mobile households. According to provincial and district officials, there are still difficulties in ensuring regular antenatal check-ups, tetanus vaccinations and advice for women from these groups. The second priority is to strengthen reproductive healthcare advice and HIV/AIDS awareness amongst teenagers and young adults, both generally and in conjunction with secondary schooling.[61]

4.4 HIV/AIDS and children

Trends and current situation. In An Giang, HIV/AIDS emerged at an early stage in comparison to some other rural provinces in Viet Nam. The epidemic pattern in An Giang is primarily associated with drug use as well as with sex work, and the geographical situation of the province close to the international border where cross-border population movement and sex work are concentrated. During the early part of the last decade, the province experienced high rates of new HIV infections, such that An Giang still has a high number of people living with HIV/AIDS in comparison to other provinces in the Mekong Delta Region. According to the Ministry of Health, in 2009 An Giang had the 18th highest cumulative rate of HIV infections nationwide (170.6 per 100,000 inhabitants), higher than the average for the Mekong Delta Region (131.6 per100,000) but slightly lower than the national average (Annex 1.26). According to figures provided by DOH, whereas children under 16 years of age accounted for 3.8 per cent of the cumulative number of HIV infections in 2006, this rose to 4.8 per cent in 2009; and there has been a similar proportional increase in the number of children living with AIDS (Table 13).

Table 13. HIV/AIDS indicators in An Giang, 2006-2009

Indicators	2006	2007	2008	2009
Cumulative number of people living with HIV/AIDS	5,270	5,898	6,581	7,112
Cumulative HIV cases among children under 16	203	247	299	342
Cumulative AIDS cases	3,805	4,306	4,791	5,163
Cumulative AIDS cases among children under 16	143	171	208	235
New HIV cases	766	552	531	388
New AIDS cases	346	306	213	179
Rate of new HIV infections per 100,000 people	34.6	24.8	20.9	18.1

Source: Department of Health (2010) *Data provided during fieldwork.*

The province has made considerable efforts to promote the awareness, prevention and treatment of HIV/AIDS. As noted in Section 3.3, in the SEDP period 2006 to 2010, about 68 per cent of total funding under the NTP on Social Diseases, Epidemics and HIV/AIDS was allocated to the Project on HIV/AIDS Control, of which 80 per cent was mobilised from non-public sources. These efforts have resulted in a 50 per cent reduction in the number of new HIV infections from 766 in 2006 to 388 in 2009, and reductions in the infection rate from 34.6 per 100,000 inhabitants in 2006 to 18.1 per 100,000 in 2009 (Table 13). The introduction of anti-retroviral treatment has also reduced the number of new cases of AIDS and mortalities from the disease.

Prevention of mother-to-child transmission. At this point in time, the rate of infections

61 Sub-Department of Population and Family Planning (2010) *Report on the results of the National Target Programme on Population and Family Planning in the period 2006-2010.*

amongst the female population of reproductive age and the prevention of mother-to-child transmission (PMTCT) is a major concern for the province.[62] According to provincial and district health officials, the province has made quite successful attempts to encourage pregnant women to undertake voluntary counselling and testing (VCT) and there has been focused monitoring and targeting of this population group and female sex workers. While the rate of VCT is quite high, this is often conducted at a late stage in pregnancy. Priority should be given to improve the participation of pregnant women in VCT during the first stage of pregnancy. This will require clear guidance and coordination between the district and commune level, as well as more investment and capacity building at the commune level.

A recent study on male partner involvement in PMTCT conducted in An Giang (together with HCM City and Quang Ninh Province), found that men and women generally have high knowledge about HIV transmission routes between partners.[63] On the other hand, the study found that knowledge of prevention of mother-to-child transmission, especially among men, is not high, even in areas where PMTCT services are being offered. In addition, male involvement in HIV testing when offered during routine antenatal check-ups and access to related PMTCT care is minimal. This study stresses the importance of adopting a comprehensive approach to PMTCT, involving both men and women. The most critical behaviour change at the individual level is to encourage couples to test before conceiving, and condom use among men who test positive, which requires more men to undertake voluntary testing. This should be combined with encouraging greater male involvement during pregnancy and childbirth, and strengthening counselling services for women who test positive in order to avoid future transmission.

An Giang has had some success in expanding the array of interventions offered to intravenous drug users, including community-based services, peer education outreach and needle exchange programmes.[64] According to preliminary results from the second round of the Integrated Biological and Behavioural Survey (IBBS 2009), conducted in 10 provinces and cities, exposure amongst drug users to needle/syringe distribution in An Giang increased from 23 per cent in 2006 to 84 per cent in 2008 (Figure 12), while consistent condom use with regular partners amongst drug users has increased from 29 per cent in 2006 to 41 per cent in 2009 (Figure 22).[65]

62 Department of Health (2010) *Five-year development plan for health services, 2011-2015.*

63 Shroff, R. et al (2008) *Male Partner Involvement in Prevention of Mother-to-Child Transmission in Viet Nam: challenges and opportunities for intervention.*

64 Family Health International (undated) *Overview of Peer Education, Outreach and Needle Exchange in Viet Nam supported by PEPFAR/USAID/FHI.*

65 Preliminary results from Integrated Biological and Behavioural Survey (2010), *NIHE/MOH and Family Health International.*

Figure 12. Exposure to needle/syringe distribution amongst intravenous drug users, 2006 and 2008

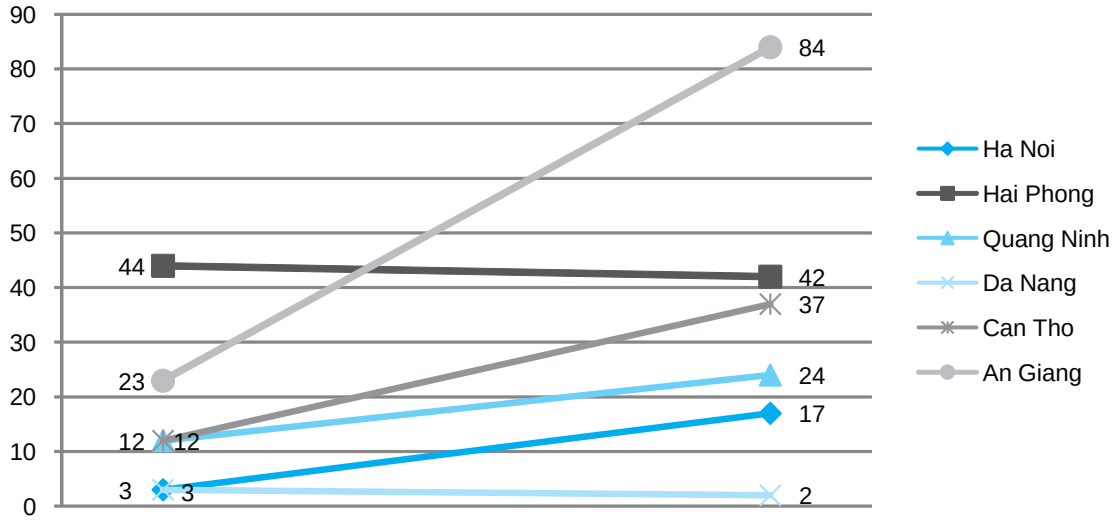
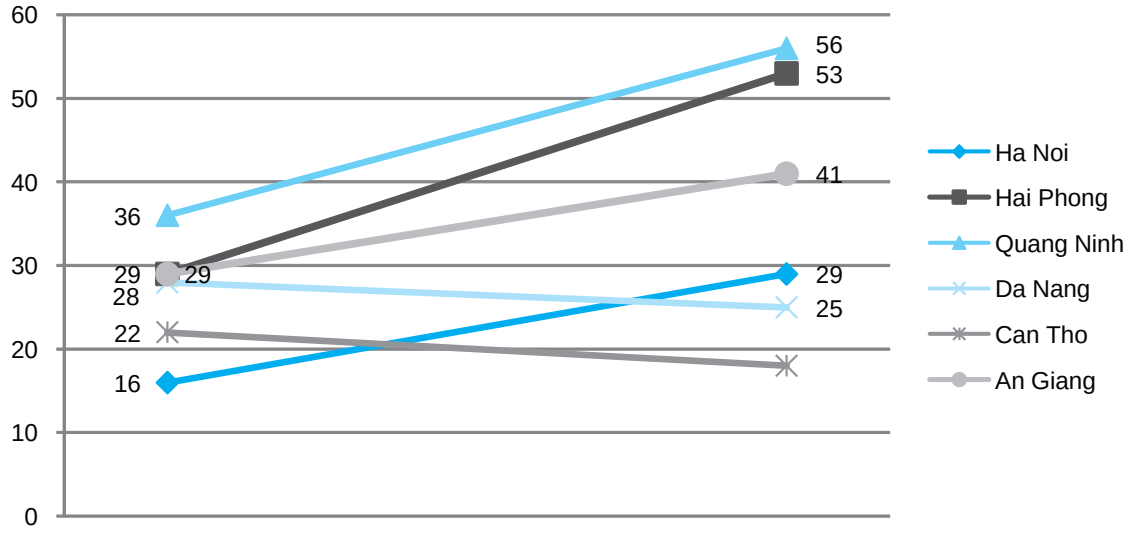


Figure 13. Consistent condom use with regular partners amongst intravenous drug users, 2006 and 2008



Source: FHI (undated). *Overview of Peer Education, Outreach and Needle Exchange in Viet Nam .*

4.5 Maternal and child nutrition and undernutrition

According to the Nutrition Surveillance System, there has been a steady reduction in under-five child malnutrition, as measured by weight for age, over the last decade in An Giang, from 32 per cent in 2000 to 24.9 per cent in 2005 and 17 per cent in 2010. This exceeds the province's target of 19 per cent for 2010 (Table 14 and Annex 1.27). In common with other provinces, however, stunting rates have remained persistently high, showing only a marginal decline from 30 per cent in 2005 to 28.7 per cent in 2010. These high rates are cause for nationwide concern with regard to the health and socio-economic impacts of maternal and infant undernutrition.

Table 14. National, regional and provincial child malnutrition rates, 2005 and 2010 (in per centage)

Region/province	2005				2010			
	Under - weight total	Moderate under - weight	Stunting total	Moderate stunting	Under - weight total	Moderate under - weight	Stunting total	Moderate stunting
Nationwide	21.3	19.5	24.4	17.4	17.5	15.4	29.3	18.8
Mekong Delta	23.6	20.7	28.1	18.2	16.8	14.5	28.2	17.1
An Giang	24.9	21.3	30	18.6	17.0	14.8	28.7	17.7

Source: National Institute of Nutrition (2005 and 2010) *Nutrition Surveillance System.*

Malnutrition status according to locality, population group and age group. District figures show that there are differences in the child malnutrition rate according to locality. Generally higher rates persist in the remote rural districts and communes and amongst the Khmer ethnic minority population, such as in Tinh Bien (Table 15). Circumstantial evidence suggests that children from rural migrant families may be most vulnerable to a lack of adequate nutrition, especially young children who are left behind with grandparents, siblings or other relatives when their parents are away on migrant work. All districts report differences in the malnutrition rate according to age group, with lower rates amongst infants under two years of age than amongst children from three to five years old. This indicates that one of the major problems of child health and development in An Giang is the nutrition of young children of kindergarten and primary school age.

Child stunting results from chronic maternal nutrient deficiencies before and during pregnancy, especially micronutrient deficiencies due to a poor quality of care and services. Moreover, child stunting also results from poor feeding practices and complementary feeding of young children including poor breastfeeding during the first 24 months of age. Other known contributing factors include poor hygienic living conditions, poor water sanitation and infectious disease burden. Stunting is therefore a valuable indicator of the quality of maternal and child healthcare services and living conditions. The recent survey of 1,100 households in An Giang found that less than 10 per cent of mothers practised exclusive breastfeeding during the first six months and only 56.7 per cent of breastfeeding mothers took Vitamin A supplements (Table 12).[66] Another survey in three districts of An Giang found moderate levels of prolonged undernutrition amongst women of reproductive age (19.2 per cent) but high rates amongst young women aged 15 to 19 (33.3 per cent). [67] This survey also found high rates of anaemia among pregnant women (46.6 per cent) especially in the last three months of pregnancy (50.6 per cent), as well as severe rates of anaemia amongst children under five years old (65.7 per cent) especially in Tinh Bien District (84.4 per cent). Moreover, a 2009 survey found that only 58 per cent of households in An Giang are using adequate iodised salt. This caused women of reproductive age and children to be gravely exposed to iodine deficiency, with average values for urine iodine to reach only 58 µg/L (compared to a recommended cut-off point of about 100 µg/L).

66 DOH (2010) *ibid.*

67 Department of Health/Preventive Health Centre/National Institute of Nutrition (2009) *Nutrition and anaemia situation for women and children in three districts of An Giang Province in 2009.*

Table 15. Under-five child malnutrition 'weight by age' by age group and district, 2008 and 2009 (in per centage)

Administrative area	Year	
	2008	2009
Tan Chau District		
Under-five malnutrition (%)	20.6	19.8
Under-two malnutrition (%)	6	7.3
Tinh Bien District		
Under-five malnutrition (%)	24.3	23
Under-two malnutrition (%)	10.3	11
Long Xuyen City		
Under-five malnutrition (%)	17.0	16.7
Under-two malnutrition (%)	7.5	6.3

Source: District Socio-Economic Development Plans

Causative factors of undernutrition. It appears that there are several causative factors associated with undernutrition (Figure 14). Unlike other rural provinces in Viet Nam, undernutrition is not primarily associated with a general lack of availability of either staple or nutritious foods for children in An Giang. This is in contrast to Dien Bien Province, for example, where the Situation Analysis of Children found that basic household food shortages, and limited access to markets to purchase nutritious foods, continues to be a major cause of child malnutrition in this remote province. [68] Several provincial and district officials in An Giang commented on the fact that while the province is a major producer of rice, fish, fruit and vegetables, child malnutrition continues to be a problem.

This suggests that the root cause of this problem lies in behavioural patterns of feeding practices for pregnant women and children. This is partly associated with poverty. As one health official said, *"If some poor farmers catch a bigger fish they have to sell it, while their children only eat rice and fish sauce at home for breakfast."* However, this problem is not confined to poor households, as many local officials confirmed that children from all income groups, and from families of labourers as well as administrative workers, may suffer from a lack of regular meals and adequate nutrition. Time availability due to work pressures on parents is often cited as a contributing factor, together with limited full-day kindergarten school attendance, and constraints and weaknesses in implementation of the malnutrition prevention project.

Future directions and priorities for the malnutrition prevention programmes. In the past, the steady reductions in child malnutrition have been primarily due to the increases in household incomes and food security. The above factors suggest that continued reductions in the child malnutrition rate in An Giang may be difficult to achieve, or will only achieve a slower rate of reduction in the coming years, because this problem now lies primarily in the quality of care services and social and parental behaviour patterns that are more challenging and slower to change. To address the new characteristics of this issue in the current socio-economic context, the child malnutrition prevention programmes may need to shift their emphasis in the next SEDP period, as follows:

68 UNICEF/Dien Bien Province (2011) *Situation Analysis of Children in Dien Bien Province.*

Figure 14. Causative factors and capacity gaps related to child malnutrition in An Giang

Immediate causes	Underlying causes and capacity gaps	Structural and behavioural causes
Lack of adequate regular meals, balanced diets and/or sufficient nutritious meals for all women, pregnant women and young children. Children from migrant families vulnerable to a lack of adequate nutrition, especially young children left behind with relatives when their parents are away on migrant work. Time constraints: work pressures on parents, amongst richer and poorer households, which may limit breastfeeding of infants and preparation of adequate meals for older children.	*Schooling constraints:* limited full-day kindergarten school attendance, which limits the extent that children from three to five years old can receive regular midday meals while at school and parents are at work. *Weaknesses in programme implementation:* (i) limited funds for IEC work on child nutrition; (ii) lack of allowances for local collaborators; (iii) demonstrations of types of foods that poor households cannot afford. *Programme content:* emphasis on 'quantity' rather than on 'food quality' in IEC work and demonstrations on child nutrition.	Social and parental behaviour patterns of feeding practises for young children. Lack of public awareness on constituents of a balanced diet for children.

- *Improvement in the quality of care and nutrition for mothers and young children.* The high child stunting rate and micronutrient deficiencies amongst women and children continue to be a major health burden in An Giang. The challenge now lies primarily in improving health and nutrition care for women before and during pregnancy, and improving care for children; for instance, by preventing undernutrition and micronutrient deficiencies for pregnant women and by improving breastfeeding, especially exclusive breastfeeding for the first six months, and by appropriate complementary feeding practices. Short-term measures are needed to address micronutrient deficiencies amongst particularly vulnerable groups. There is a need to strengthen knowledge and practice in the preparation of meals for pregnant women and small children to improve their nutritional quality, and to reduce iodine deficiency and nutritional anaemia in children and mothers. This needs to be combined with improving the quality of related healthcare services (prenatal examinations, water and sanitation, personal hygiene and deworming). Child malnutrition prevention efforts should also prioritise disadvantaged areas and population groups.

- *Improvements in data collection.* Given the diverse population characteristics of An Giang, sampling under the regular Nutrition Surveillance System is inadequate to fully monitor these patterns of maternal and child undernutrition. To complement the regular system, more detailed sample surveys are required amongst vulnerable population groups (such as the Khmer ethnic minority and migrant households). More detailed surveys should also be conducted to track the status of iodine deficiency and anaemia amongst women and children, as well as to determine worm infection prevalence in children. Micronutrient deficiency and status should also be included as a key indicator in the SEDP for the health sector.

- *Universal preschool education.* Firstly, according to Decision No.239/2010/QD-TTg,[69] one of the province's major priorities is to expand the provision of full-day

69 Decision No.239/2010/QD-TTG (09/02/2010) approving the scheme on universal preschool education for children

kindergarten attendance over the next few years (Section 5.2 below). Reducing the child malnutrition rate is one of the specific objectives of Decision No.239, including support of VND 120,000/month for lunch at schools for disadvantaged children and in disadvantaged areas. While parents can contribute to this fund in more prosperous localities, the subsidies may need to be expanded in poor rural areas. The upgrading of kindergarten infrastructure, which will be necessary to increase full-day attendance, should include kitchen facilities as necessary. This is not to take responsibility for adequate child nutrition away from parents, but recognises the fact that an integrated strategy is required to increase full-day kindergarten attendance and to ensure adequate nutrition for children from three to six years of age.

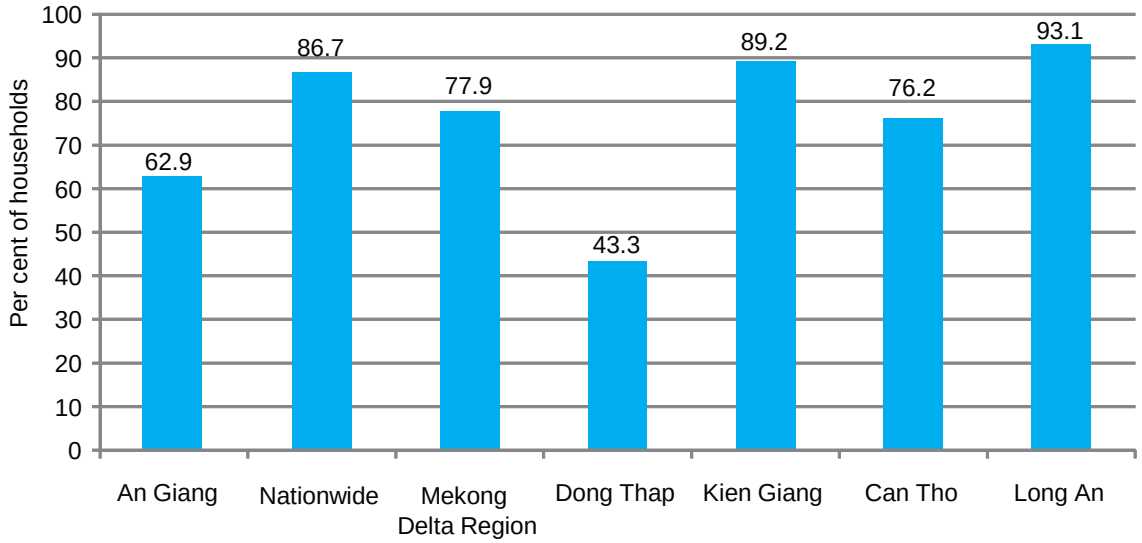
- *Broadening the scope of IEC work on maternal and child nutrition.* This is needed to instil good feeding practices amongst parents and children from an early age onwards (not only focusing on infant nutrition). This needs to concentrate on promoting regularity, diversity and quality of dietary requirements for children of all age groups. According to DOH, there are an increasing number of overweight children amongst some population groups; so far, this issue has not been addressed, but it should be incorporated into a broader approach to IEC. The health sector alone cannot deal with this broad public health concern, so good coordination with DOET, mass organisations and the mass media is essential.

4.6 Water supply and environmental sanitation

Data from the 2009 Census indicate that 62.9 per cent of all households (rural and urban combined) have access to safe water in An Giang (Figure 15). This is below the national rate (86.7 per cent) and that of the Mekong Delta Region as a whole (77.9 per cent). In contrast, 55.3 per cent of all households in An Giang have hygienic latrines, above average for the Mekong Delta Region (42.4 per cent) and slightly higher than the national rate (54 per cent).

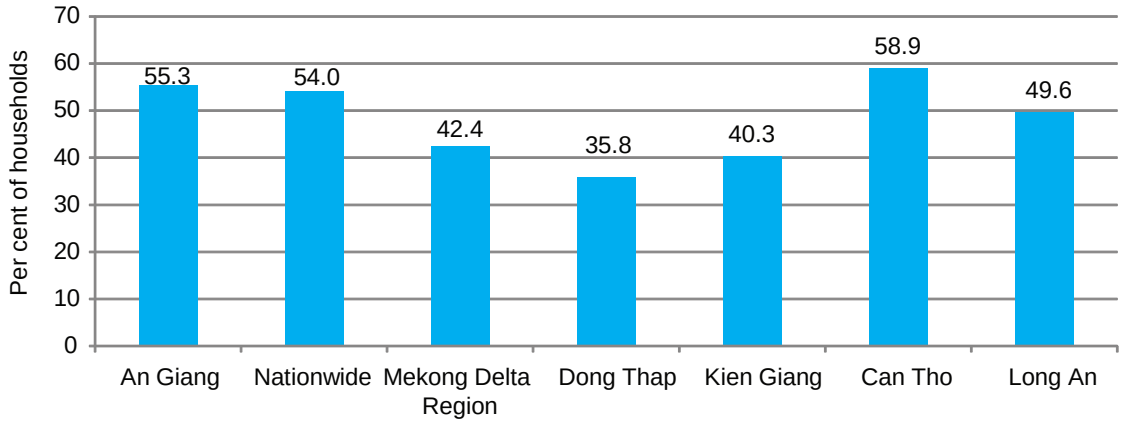
aged five years in the 2010-2015 period.

Figure 15. National, regional and provincial access to safe water: a comparison, 2009



Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

Figure 16. National, regional and provincial use of hygienic latrines: a comparison, 2009



Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

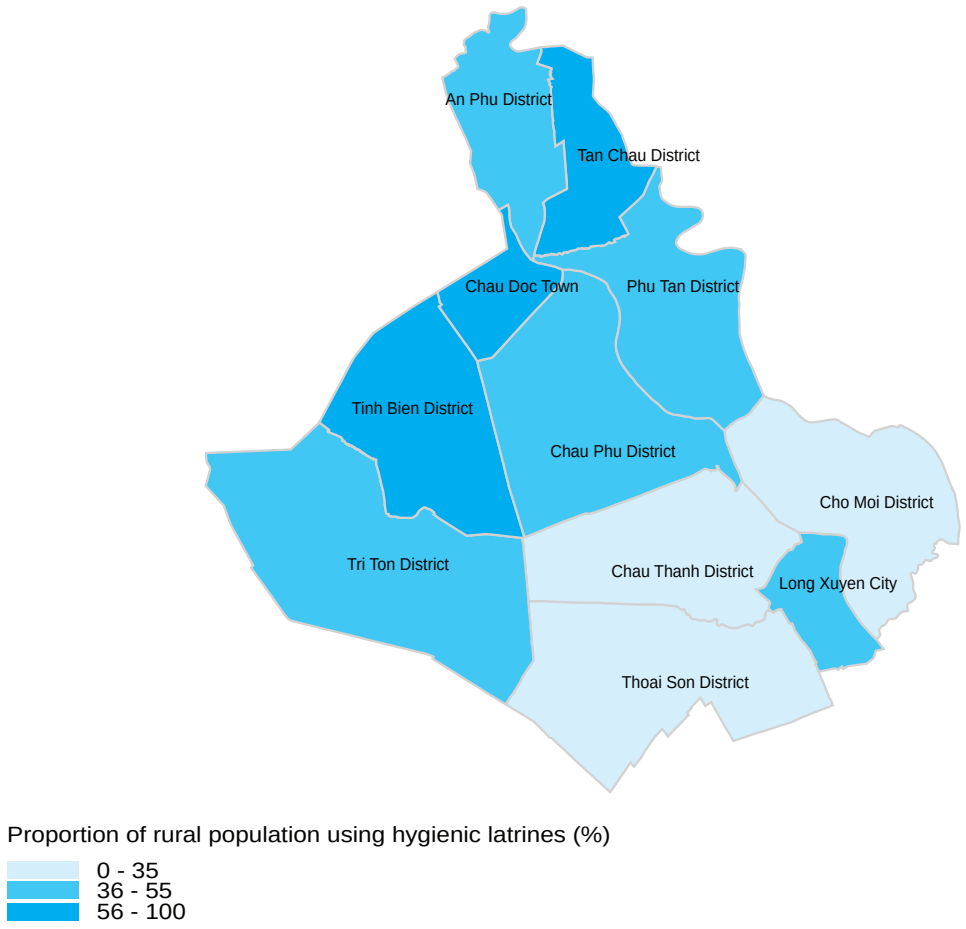
Improvements in data and monitoring systems. In the past, one of the major difficulties in the water supply and sanitation sector in Viet Nam has been the lack of adequate monitoring data; the different agencies monitoring access to improved water supply, water quality and sanitation indicators have used different technical standards. In 2009, An Giang introduced a new set of monitoring indicators, as set out under Document No.3856/2008/BNN-TL[70] of the Ministry of Agriculture and Rural Development and technical standards on domestic water quality issued by the MOH under Circular No.05/2009/TT-BYT.[71] An Giang was one of the first provinces to pilot the new M&E data set through the National Target Programme on Rural Water Supply and Sanitation (NTP-RWSS). The Provincial Centre for Rural Water Supply and Sanitation (PCERWASS) conducted the survey in conjunction with the Preventative Health Centre. The new monitoring system and data sets have been jointly and officially agreed between

70 Document No.3856/BNN-TL (25/12/2008) *on rural water supply and sanitation monitoring and evaluation indicator set.*
71 Circular No.05/2009/TT-BYT (17/06/2009) *on issuance of National Technical Regulations on domestic water quality.*

PCERWASS, the Department of Health and the Provincial Statistics Office. The new indicators have been applied to all rural communes and townships in the province, and to all commune health clinics and schools. For the first time, therefore, a comprehensive data set is available to examine the current situation in rural areas. The results of the 2009 survey are shown in Table 16 and Annex 1.28.

Household water supply and water quality. About 61.6 per cent of the rural population have access to appropriate clean water supply, lower than the rate in urban areas of 89 per cent. In this respect, the province has yet to achieve the respective targets of 90 per cent and 95 per cent, as set out under the National Plan of Active for Children (Table 9 above). Moreover, less than half of all rural population haves clean water according to MOH quality standards (44.3 per cent): by district, the highest rates are in Tan Chau (67.1 per cent), Tinh Bien (58 per cent) and in rural communes of Chau Doc (81.1 per cent), while the lowest rates are found in Chau Thanh (27.5 per cent), Cho Moi (29.3 per cent) and Thoai Son (30.2 per cent). Water quality is a major problem in these latter districts, especially as these average district figures are skewed by the higher rates for the district townships [72]: in 72 per cent of rural communes in these three districts, less than 25 per cent of households have access to adequate quality water (Map 2).[73]

Map 2. Proportion of rural population using sofe water by district, 2009



Source: An Giang PCERWASS (2009) *Report on results of survey on rural water supply and sanitation 2009.*

72 That is, 92.2 per cent for Cho Moi Town and 80.6 per cent for My Luong Town in Cho Moi District, 66.9 per cent for An Chau Town in Chau Thanh District, and 84.5 per cent for Nui Sap Town in Thoai Son District.

73 Provincial Centre for Rural Water Supply and Sanitation (2009) *Report on results of survey on rural water supply and sanitation 2009.*

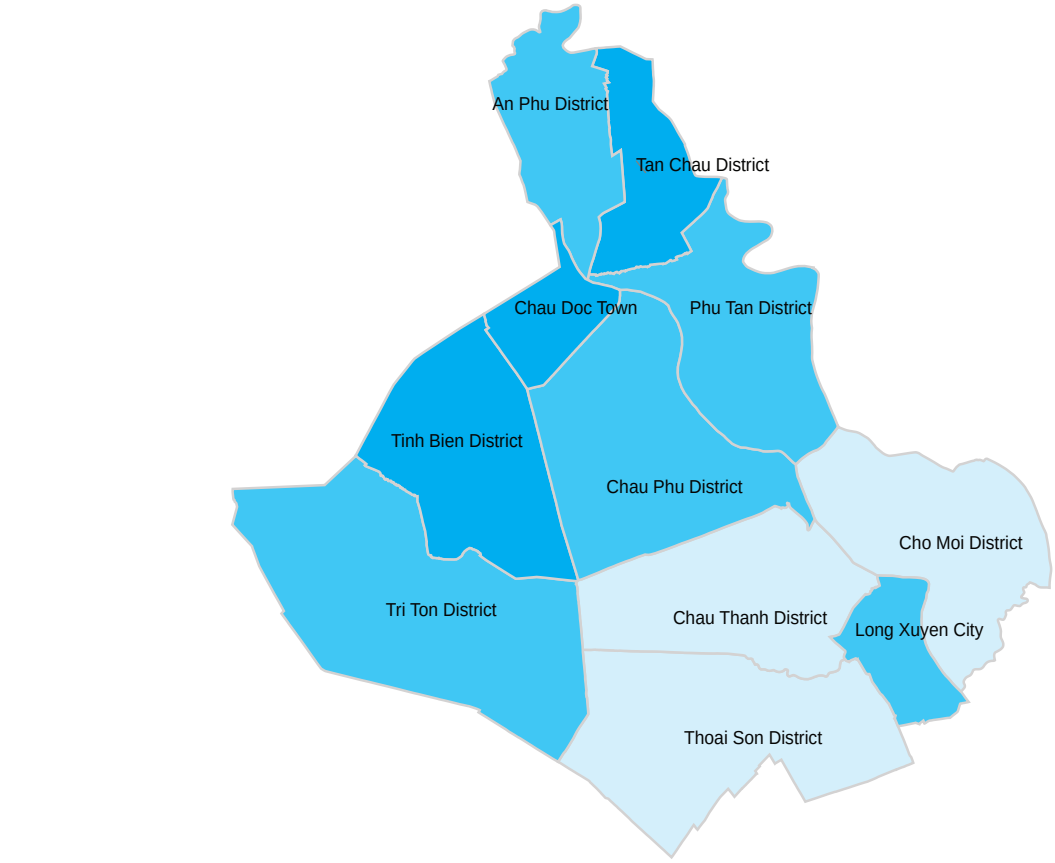
Table 16. Rural water supply and environmental sanitation indicators, 2009

Indicator		Per cent
1	Rural population with access to appropriate clean water supply	61.6
2	Rural population with clean water according to MOH quality standards	44.3
3	Schools with adequate clean water supply and sanitation facilities	86.7
4	Health clinics with adequate clean water supply and sanitation facilities	98.6
5a	Markets with adequate clean water supply and sanitation	49.1
5b	Commune offices with adequate clean water supply and sanitation	97.8
6	Rural and urban households with appropriate sanitary latrines	46.1
7	Households with sanitary livestock housing	36.2
8	Village industries with waste processing system	87.5
9	Water supply systems with sustainable operations	90.1
10	Different models of water supply systems management:	
	• Community managed:	0.5
	• PCERWASS managed	4.7
	• Private enterprise	14.1
	• Business enterprise	80.7

Source: Provincial Centre for Rural Water Supply and Sanitation (2009) *Report on results of survey on rural water supply and sanitation 2009*.

Household sanitation. Nearly half of all households in An Giang now have appropriate sanitary latrines according to MOH standards (at 46 per cent), ranging from 34.5 per cent in An Phu up to 56.8 per cent in Thoai Son (Map 3), while 82.46 per cent of households have some form of latrine. The Preventative Health Centre, the Women's Union and PCERWASS, amongst other agencies, have supported improvements in household sanitation to raise sanitation awareness and promote improved latrine usage through appropriate technology development and credit schemes. Various latrine designs have been adapted to the particular housing conditions found in the region, including raised latrines appropriate to flooded areas and stilt houses along canals, which have been popularly received by many households. These sanitation efforts do need to be maintained in future, to expand the uptake of improved latrines and to increase the proportion of rural households keeping livestock in sanitary conditions (currently at 36 per cent). It should be noted that 17.5 per cent of the rural population in An Giang (76,000 people) still do not have latrines, hence they have to defecate openly in rivers, canals and fields. This results in contamination of water sources and the environment, affecting people's health. Hence, sanitation promotion efforts and initiatives should first target those households that still do not have home latrines.

Map 3. Proportion of rural households with hygienic latrines by district, 2009



Source: An Giang PCERWASS (2009) *Report on results of survey on rural water supply and sanitation 2009.*

Children's access to safe water and sanitation. According to the 2009 Census, 37.1 per cent of children under five years of age in An Giang still do not have access to improved water (placing An Giang in the 14th position amongst 63 provinces and cities). At the same time, 44.7 per cent of children do not have access to improved sanitation (placing An Giang in 45th position amongst 63 provinces and cities).

Sustainable water supply systems in sparsely populated rural areas. One difficulty encountered in An Giang is developing models for sustainable clean water supply in the more remote and sparsely populated rural areas, such as Tinh Bien and Tri Ton districts. As described in Box 4, water supply continues to be difficult for some households in Vinh Trung Commune in Tinh Bien. In many such localities, models for wells and hand pumps, shared by groups of households, failed in the past because of a lack of maintenance and a lack of sufficient ground water. Models for piped water supply, utilising treated or filtered surface water resources, have not been effective because of a lack of technical management capacity at the commune level and because these remote schemes do not cover operating and replacement costs. There are no immediate solutions to this problem; but one way forward may be to introduce improved technologies for simple household water treatment (such as the use of bio-sand filters).

Box 4. Water supply and sanitation in Vinh Trung Commune

In Vinh Trung Commune, the local authorities installed a new water plant in 2008, but it cannot provide sufficient water for local residents due to water shortages and poor pumping capacity, especially in the dry season. Only about 70 per cent of the local population can benefit from the plant, and some households in remote villages do not have access to tap water. They still use river water or underground water from wells built in the past, some of which have deteriorated. According to staff of the commune health centre, about 20 per cent of the commune population do not have access to safe water as they live near or along the river banks and in the fields. They treat their water supply following instructions from the commune health staff. In the rainy season, people are encouraged to use boiled water instead of river water. More people also now use bottled water if economic conditions allow.

Khmer people regard livestock as close possessions that should be kept close to the household. Therefore, despite awareness raising activities on environmental hygiene, some Khmer households still keep animals in their houses, and animal waste may pollute their water sources. Local people report that sanitary conditions in primary school toilets are not satisfactory. According to commune health staff, some waterborne diseases (diarrhoea, dengue fever and skin diseases) still occur, but not at epidemic levels, thanks to awareness raising activities by a network of medical teams and volunteers to clean the environment and control mosquitoes.

Source: Discussion with commune leaders and health staff in Vinh Trung Commune (December 2010).

Schools and clinics. A high proportion of rural schools and clinics now have adequate water supply and sanitation facilities (86.7 per cent and 98.6 per cent respectively). This is a result of investment that has been made in recent years to upgrade these facilities. Studies have shown that the provision of adequate toilet facilities is a good incentive encouraging children, especially girls, to stay at school for the entire school day. At this point in time, the major concern is to ensure adequate operations and maintenance (O&M) of these facilities. In urban areas, schools are able to collect fees to clean, equip and maintain toilet blocks; but this is more difficult in rural areas, and the education sector budget does not provide sufficient funds for O&M.[74] Hygiene education for students, good hygiene practices and proper use of latrines can also help to reduce the costs for school latrine O&M.

Public sanitation and environmental health. Another future priority in An Giang will be to introduce better systems of public sanitation and to increase public awareness around this issue. Currently, only 50 per cent of rural markets have adequate sanitary conditions. Attention will also need to be given to waste management in rural areas. In An Giang, as in many other rural areas of Viet Nam, there is a growing problem of indiscriminate waste disposal around commune centres and district towns. This represents a public health concern, which needs to be tackled at an early stage to change public behaviour and introduce effective waste management systems.

Links between water quality, environmental sanitation and child health. It is common knowledge that there is an association between water quality and health risks such as diarrhoeal diseases. However, recent research undertaken in several communes around Long Xuyen City yielded some interesting results on these linkages.[75] This research adopted a novel methodology to combine information from environmental monitoring, health data and analysis of health behaviour in order to develop a multilayered understanding of seasonal health risks. Some of the main results and conclusions from this research are as follows:

74 For instance, if it is assumed that half a day of cleaning is required for toilet blocks in all 900 rural schools, for 26 days per month over the nine-month school year, at VND 50,000 per day, this comes to a total requirement of about VND 10.5 billion (USD 530,000) per year.

75 Few, R. et al (2010) *Seasonal hazards and health risks in the Mekong Delta: a multidisciplinary approach.*

- *Water quality and seasonal risk of diarrhoeal disease.* Using E. coli levels as an indicator of water quality, water tests from this study suggested that contamination of environmental water is higher in the dry season when river levels are low. This is also the season when there is less access to rainwater as an alternative water source. However, contrary to some prevailing messages from the health service, this study found little evidence of any seasonal impact of water quality as measured by E. coli counts on the incidence of diarrhoeal disease risk. Seasonal impacts of water quality appear to be masked by a complex mix of inter-household variations in water source and treatment methods, hygiene behaviour patterns and other risk factors that influence diarrhoeal disease risk.

- *Water sources and diarrhoeal disease risk.* The study found a close association between whether or not people use an improved water source and diarrhoea. This is strongest in children under five years old. Children under five years who have access to improved water sources (piped or rainwater) suffer only 25 per cent of the amount of diarrhoea as children who drink unimproved water (canal water or river water). The differential vulnerability of young children to diarrhoeal disease throughout the year was especially highlighted in household interviews, suggesting the need for more targeted health promotion to protect this age group.

- *Water quality and skin conditions.* For skin diseases, the evidence of seasonality from various data was stronger. Both self-reported cases of skin complaints and perceptions of risk of skin disease were skewed toward the wet season and flooding period. Most households in the behavioural survey associated skin disease with contact with water, through activities such as washing in river water, swimming or working in ricefields.

4.7 Child injury prevention

Current situation. In recent years the Government has given considerable attention to strengthening child injury prevention programmes. Even so, injury continues to be a leading cause of child morbidity in Viet Nam. In 2009, nearly 7,000 children aged between 0-19 years died as a result of an injury[76]; and this is only the tip of the iceberg in terms of the full social, economic and personal burden and impacts of child injury. This is, therefore, a serious public health concern for all local government authorities and local communities.

Table 17 presents the data on reported child accidents and injuries in An Giang in 2009 and 2010 (Annex 1.29 and 1.30). Compiled by the Preventative Health Centre, the data include child accidents and injuries referred to the health service, but do not include minor unreported accidents that were treated at home, or those child fatalities handled by the police. The total number of injuries and fatalities will therefore be higher. Moreover, while these data provide a good snapshot of child accidents and injuries over a 21-month period, time-series data are not readily available to show reductions or increases over a longer period of time.

76 MOH (2011) *Injury Mortality Statistics in 2009.*

Table 17. Causes of child injuries, 2009-2010

Cause of injury	Age range/per centage of accidents and injuries		
	0-4 years	5-14 years	15-19 years
Total reported accidents	**3,192**	**5,174**	**6,204**
Road accidents	32.0	38.7	38.2
Labour accidents	1.6	5.5	8.7
Animal bites, stings	1.2	2.1	2.0
Falling	48.5	34.4	10.8
Drowning	1.2	1.3	2.3
Burns	6.2	1.6	1.6
Poisoning by chemicals and food	1.1	1.1	1.6
Attempted suicide	0.0	0.2	4.8
Violence and conflict	0.5	3.1	9.3
Other	7.8	11.8	20.6

Source: Department of Health (2009 and 2010) *Reports on Accident Statistics.*
Note: Data for 2010 only include the first nine months.

These statistics raise several important points:

- The major cause of injury to children of all age groups combined is road and traffic accidents (37 per cent), followed by falls (27.5 per cent) and labour-related injuries (6 per cent);
- A majority of injuries to children under 15 years old are due to falls (38 per cent) followed by road accidents (37 per cent), labour-related injuries (4 per cent) and burns (3.9 per cent);
- As to be expected, injuries caused by falls are highest in the 0-4 age group (48.5 per cent) and thereafter decrease steadily with age to 10.8 per cent in the 15-19 age group;
- Injuries caused by labour-related accidents increase with age, rising from 5.5 per cent in the 5-14 age group to 8.7 per cent in the 15-19 age group;
- While only a limited number of injuries related to drowning are reported here (1.3 per cent), 10.2 per cent of all injuries take place in the vicinity of ponds, rivers and waterways;
- It is notable that 5.2 per cent of all reported injuries are due to violence and conflict, rising from 3.1 per cent in the 5-14 age group to 9.3 per cent in the 15-19 age group;
- It is also notable that there is a high reported incidence of injury due to attempted suicide amongst teenagers in the 15-19 age group (4.8 per cent).

Protection against floods and drowning. The extensive network of waterways and frequent floods in An Giang create including the risks of drowning. Following the severe floods of 2000 and 2001, the province introduced a number of measures to safeguard children from these dangers. Firstly, there has been a concerted programme of swimming lessons for children aged five to 11 years of age. DOLISA has organised these lessons in collaboration with the Department of Culture, Sports and Tourism, local government authorities and mass organisations. Primary and secondary school teachers have also been provided with training on the prevention of drowning for their pupils. Since

2002, over 110,000 children have received swimming lessons, while in 2009 there were 634 classes for 18,000 children.[77] Secondly, the province has established shelter points where vulnerable children can gather during times of flood emergency *(diểm giữ trẻ mùa lũ)*. These are organised by the Women's Union in each locality. Depending on the scale of flooding, between 40 to 90 shelter points are established each year (e.g. in 2009 there were 39 points protecting about 1,000 young children). These measures have proven to be effective, as shown by the devastating floods of 2011.

"In the past, children had to cross muddy water to reach school. Now roads and school facilities are in better condition, so they remain safe at school even during storms" (Children's group, Vinh Trung Commune)

Although drowning is a common cause of child fatality in the Mekong Delta, it does not emerge as an outstanding issue in An Giang thanks to these effective preventative measures. The improved local infrastructure, including roads and school facilities, has also led to more convenience and safety for children on their way to remote schools in flood-prone areas. These preventative measures need to be continuously maintained, however, to ensure that each generation of children has the necessary life skills and shelter to cope with flooding.

Road and traffic accidents. As in other provinces, traffic and road safety for children is a major concern in An Giang. Discussions with parent's groups revealed that many parents have to spend considerable time taking their children to school and bringing them home. In addition, many parents are worried about the infringement of traffic laws by some juveniles who drive motorbikes, even though they are unlicensed and do not wear helmets. Provincial and district officials are also concerned about this issue. The number of traffic accidents and fatalities in An Giang has not reduced substantially in recent years, despite awareness raising and law enforcement efforts.

To combat this critical public health issue, stronger efforts are required to promote behaviour change amongst parents and the general public, combined with stronger observance and enforcement of traffic regulations. Recent Government legislation has tightened the regulations and penalties relating to child helmet use through Decision No.34/2010/ND-CP. [78] This stipulates mandatory helmet use for all two-wheel vehicle passengers of six years of age and older, and increased fines for motorbike drivers carrying children without helmets. However, enforcing child helmet use is only one part of the solution. An Giang has narrow roads but with good surfaces and congested traffic which increases the risks of road accidents, especially for children cycling, walking or playing near busy roads. Public education and community mobilisation around all aspects of road and traffic safety is therefore essential.

Suicide and violence. The high reported incidence of injury amongst teenagers in the 15-19 age group caused by violence and by attempted suicide is a cause for concern. The figures indicate that 83 per cent of the injuries by attempted suicide were amongst teenage boys, whereas the injuries caused by violence and conflict were equal amongst girls and boys (Annex 1.29 and 1.30). During this research it was not possible to investigate the circumstances behind these statistics. It is recommended, however, that a focused study should be undertaken to determine which children are most vulnerable and the range of causative factors. In particular, attention should be given to possible links to bullying in schools. As part of the development of the social work system in An Giang, there is a need to increase the provision of appropriate counselling and advisory services

77 Department of Labour, Invalids and Social Affairs (2010) *Report on Implementation of the Plan on Child Injury Prevention in 2009-2010.*

78 Decision No.34/2010/ND-CP (02/04/2010) on administrative fines in the road transport sector.

for teenagers and young adults (see Section 6.6 below).

Institutional capacity. The Child Protection Section of DOLISA takes the lead on planning and implementing child protection activities. It also works with the Preventative Health Centre, which is responsible for compiling accident and injury statistics from the local health units. Several provincial officials stated that the combined effort of DOLISA, DCST, the district authorities and mass organisations to provide regular swimming instruction for children has been an effective example of collaboration and coordination. It is recommended that a similar level of coordination will be required to tackle road and traffic safety for children, for which a multi-stakeholder approach is essential. In addition to the above-mentioned agencies, this needs to involve the Department of Public Security, the local police, parents' associations of schools and possibly the local private sector.

Coordinated action is needed at the commune and ward levels, especially to increase public awareness and community mobilisation around road and traffic safety. Currently, the commune and ward authorities only have a small budget for injury prevention activities. With UNICEF support, a model for safe communities *(mô hình cộng dồng an toan)* was introduced in four communes in 2009 and 2010.[79] This model may be scaled-up to other localities based on a review of successful elements of the model.

79 DOLISA (2010) *ibid.*

CHAPTER 5: CHILD EDUCATION AND DEVELOPMENT

5. Child Education and Development

5.1 Children's viewpoints on rights to education

During this research, children's discussion groups expressed many ideas and expectations about education. Children display a good understanding of their rights to education and are generally more articulate about these particular rights than about their rights to survival and participation. In addition to commenting on their own direct experience of schooling, children are also aware of the wider aspects of creating good educational opportunities for all children. Many children commented on the positive changes in schooling conditions:

> *Many good conditions have been created for children to develop their talents, such as participation in leisure activities and talent-seeking contests.* (Secondary school children's discussion group, My Binh Ward).

> *Nowadays, the government has paid good attention to street children, encouraging children to go to school, and providing material assistance to poor students with good academic achievements.* (Secondary school children's discussion group, My Binh Ward).

At the same time, children expressed a good understanding of the difficulties faced by some children in access to schooling and educational opportunities, due to physical conditions in the locality, poverty, the attitude and demands of parents, or a lack of facilities:

> *Many children stay at home all day, not being allowed to go out to see the outside world.* (Secondary school children's discussion group, My Binh Ward).

> *In rural areas, because of poor conditions, many talented children cannot meet their potential, which has become extinguished.* (Secondary school children's discussion group, My Binh Ward).

> *Because the family is poor, one of my friends doesn't go to school but has to work to support the family. I wish all mothers would understand that schooling is the most important thing for children.* (Secondary school children's discussion group, Vinh Trung Commune).

> *For some children, the right to development is not properly enforced. Some parents who are unaware [of the benefits of education] or did not have a good education themselves have created an unfavourable situation for their children's development. They do not help their children's education, forcing them to work throughout their childhood with no access to leisure activities. Some parents force their children to study and work all the time, creating pressures for the latter who cannot grow up properly like their peers.* (Secondary school children's discussion group, My Binh Ward).

> *Many children in rural areas do not have access to healthy leisure activities like their counterparts in urban areas. Their playgrounds are actually deserted. Some communities have not paid due attention to building healthy playgrounds for children.* (Secondary school children's discussion group, My Binh Ward).

When asked about their wishes and expectations for education, many children spoke of the need to provide greater assistance to disadvantaged children, and to tackle the problem of child labour that can limit schooling opportunities:

I wish all the children on the planet were allowed to go to school. For this, parents have to send their children to school and create the best conditions for their children. The school and society have to create the night conditions for all children. (Secondary school children's discussion group, Vinh Trung Commune).

I wish that mothers were aware that early labour hampers their children's development. (Secondary school children's discussion group, Vinh Trung Commune).

Male and female cadres from the commune come to the households and explain that children should go to school because they are the future of the country. (Secondary school children's discussion group, Vinh Trung Commune).

I wish that cadres from the Commune's Peoples Committee would come and explain to families about [the disadvantages of] children working so that it can be stopped. (Secondary school children's discussion group, Vinh Trung Commune).

I wish enterprises would allocate money for study encouragement funds to provide scholarships for poor students and those living in remote areas. (Secondary school children's discussion group, My Binh Ward).

The following sections begin with a statistical summary of trends and the current situation of preschool, primary and secondary education. These data have been compiled from various sources, including reports provided by DOET from 2008[80], 2009[81] and 2010[82] (Table 18 and Annex 1.31), the province's statistical yearbook[83] and figures from MOET (Annex 1.34 to 1.38).[84] The chapter makes an in-depth analysis of certain aspects of the quality of education and learning and the factors influencing educational attainment and completion.

5.2 Preschool and early childhood education

Nursery schooling. Access to nursery schooling continues to be limited in An Giang, particularly in rural areas. According to DOET, only 5.5 per cent of preschool age children were attending nursery facilities, including private nursery groups and nursery classes in public kindergartens in 2009, of whom approximately 50 per cent attended private nursery groups. According to MOET, in the school year 2009-10 there were 190 nursery groups in An Giang, of which about 61 per cent were public and 39 per cent were private.

Kindergartens. The number of children attending kindergarten by age five has increased substantially over the last decade amongst all population groups, including ethnic minority children in remote communes and villages. The proportion of children attending kindergarten by age five has increased from 26.8 per cent in 2000, to 67.5 per cent in 2005 and 91.8 per cent in 2010, thereby falling just below the provincial target of 95 per cent for 2010 (Table 9 above).[85] According to DOET, the overall proportion of children

80 Department of Education and Training (2008) *Implementation report for 2008 (Report No.261/BC-GDDT dated 28/11/2008).*

81 Department of Education and Training (2009) *Implementation report for 2009 (Report No.258/BC-SGDDT dated 01/12/2009).*

82 Department of Education and Training (2010) *Implementation report for the first nine months of 2010 (Report No.189/BC-SGDDT dated 20/09/2010).*

83 Provincial Statistics Office (2010) *Provincial Statistical Yearbook 2009.*

84 Ministry of Education and Training (2009) *Education and Training Statistics for School Year 2008-2009.*

85 Some other provincial reports give a higher figure of over 98 per cent of children attending kindergarten by age five in 2010; however, as noted by DOET, these figures have been reduced because new estimates are based on the 2009 Census population figures rather than on population estimates.

from three to five years of age attending kindergarten in 2009 was 65 per cent, of which just over 8 per cent attended private kindergartens.[86] However, full-day attendance at kindergarten is currently only about 16 per cent. In many rural communes, kindergarten classes share facilities with the primary school. According to MOET, in the school year 2009-10 there were 144 kindergartens in An Giang, of which 98 per cent were public schools (Annex 1.35). A majority of kindergarten teachers are female (99.7 per cent) and the number of pupils per teacher is 26.9, higher than the nationwide average of 19.8.

Universalisation of preschool education. One main concern for the education sector in the forthcoming SEDP periods (2011 to 2015 and onto 2020) is the universalisation of preschool education.[87] This involves increasing the rate of full-day kindergarten attendance. This emerges as a very high priority for An Giang for a number of reasons. Firstly, actively engaging a larger proportion of preschool age children in the education system will instil a 'learning culture' in the next generations of school children from an early age (see Section 5.6 below). Secondly, as indicated above, the strategy for the universalisation of preschooling should address malnutrition amongst children from three to five years of age.

According to DOET, three main issues will need to be addressed to achieve this. Firstly, the network of schools is currently insufficient, and investment is required to double the number of classrooms and to provide associated facilities. Secondly, the current shortage of qualified preschool and kindergarten teachers is one of the education sector's major gaps in An Giang. Thirdly, supportive policies on investment and staffing will be required to strengthen socialisation of kindergarten schooling by encouraging the private sector to invest in establishing new schools. As an interim measure, DOET proposes the 'renting' of local facilities for kindergartens, and hiring kindergarten teachers on a contract basis. However, this can only be a medium-term solution. Considerable investment from both public and non-public sources will inevitably be required to achieve the targets of universal preschooling in An Giang.

5.3 Primary and secondary education

Primary education:

- According to MOET, there were 393 primary schools for the 2009-10 school year. Of these schools, only 4.3 per cent have met the national standards on infrastructure, the amount of teachers per student, teacher qualification, and so forth. This is considerably lower than the national average of 32.8 per cent (Annex 1.36). According to provincial reports, 100 per cent of communes, wards and towns had met universal primary education standards by 2009-10.
- Of the total number of primary pupils in 2009-10 (178,581), 48.5 per cent were girls and 5.5 per cent were ethnic minority children (Figure 17).
- According to DOET, 94.7 per cent of children aged six were enrolled in primary school at the beginning of the 2008-09 school year, rising to almost 100 per cent in 2009-10. The net primary school enrolment rate increased from 81 per cent in the 2006-07 school year to 86.2 per cent in 2009-10, while the gross enrolment rate declined from 119.5 per cent in 2006-07 to 107.9 per cent in 2009-10 (Table 18).
- According to DOET, the primary school drop-out rate declined steadily from 3.6 per

86 Department of Education and Training (2009) *ibid.*

87 Decision No.239/2010/QD-TTG (09/02/2010) approving the scheme on universal preschool education for children aged five years in the 2010-2015 period.

cent in 2006-07 to 1.57 per cent in 2007-08, and 1.35 per cent in 2008-09. However, this figure represents over 2,000 primary school drop-outs in 2008-09 . In the study locations, the drop-out rate in 2009 ranged from 1.5 per cent in Long Xuyen City and Tan Chau, to 1.9 per cent in Tinh Bien (Table 5 above).

- According to MOET, there were 7,094 primary teachers in 2009-10, of whom 56.9 per cent were female. The teacher-to-class ratio was 1.13, which is below the national average of 1.3 (Annex 1.36).

Table 18. Primary and secondary school enrolment rates, 2006-2010

Indicators	School year			
	2006-07	2007-08	2008-09	2009-10
Population				
Ages 6-10	152,300	152,101	152,521	165,561*
Ages 11-14	175,500	174,541	172,154	148,124*
Ages 15-17	110,500	157,661	153,146	116,112*
Number of pupils at beginning of school year				
Primary	182,037	177,127	173,906	178,581
Lower secondary	122,611	112,950	111,190	107,103
Upper secondary	47,181	44,554	43,694	42,839
Gross enrolment rate (%)				
Primary	119.5	116.5	114.0	107.9
Lower secondary	69.9	64.7	64.6	72.3
Upper secondary	42.7	28.3	28.5	36.9
Net enrolment rate (%)				
Primary	81	84.9	74.6	86.2
Lower secondary	42.2	46.3	61.1	54.9
Upper secondary	23.6	24.1	25.8	30.2

Source: Department of Education and Training (2010) Data provided during fieldwork.
** Note: The child population figures for 2009-2010 have been adjusted according to the 2009 Census.*

Lower secondary education:

- According to MOET, there were 154 lower secondary schools for the 2009-10 school year. Of these schools, only 4.55 per cent met national standards, which was lower than the national average of 16.26 per cent (Annex 1.37). As of the 2009-10 school year, 100 per cent of districts and towns and over 96 per cent of communes and wards had met the standards for universal lower secondary education. This is a notable achievement.

- Of the total number of lower secondary pupils in 2009-10 (107,103), 49.3 per cent were girls and 4.6 per cent were ethnic minority children (Figure 17).

- According to DOET, 62 per cent of children were enrolled at lower secondary school at the right age in 2009-10. The net lower secondary school enrolment rate has increased by over 10 per cent from 42.23 per cent in 2006-07 to 54.9 per cent in 2009-10, while the gross enrolment rate showed a marginal increase from 69.8 per cent in 2006-07 to 72.3 per cent in 2009-10 (Table 18).

- The lower secondary drop-out rate decreased from 13.53 per cent in 2006-07, to 7.01 per cent in 2007-08 and 7.45 per cent in 2008-09. For 2008-09, this represents

over 8,000 children dropping out of lower secondary school. In the study locations, the drop-out rate in 2009 ranged from 2.5 per cent in Long Xuyen City, to 5.3 per cent in Tan Chau and 6.32 per cent in Tinh Bien, indicating higher drop-out rates from lower secondary schools in rural areas.

- According to MOET, there were 6,672 lower secondary teachers in 2009-10, of which 56.4 per cent were female, and the teacher-to-class ratio was 2.26, above the national average of 2.09 (Annex 1.37).

Upper secondary education:

- According to MOET, there were 47 upper secondary schools for the 2009-10 school year. Of these schools, 10.6 per cent had met national standards, which was higher than the national average of 8.4 per cent meeting national standards (Annex 1.38). There are 44 public and three private upper secondary schools (this fell from 18 private schools in 2005-06, due to the amalgamation of several private schools with public schools in the vicinity).
- Of the total number of upper secondary pupils in 2009-10 (42,839), 53.6 per cent were girls and 2.8 per cent were ethnic minority children (Figure 17).
- The net upper secondary enrolment rate has increased from 23.6 per cent in 2006-07 to 30.1 per cent in 2009-10, while the gross enrolment rate has shown a marginal decline from 42.7 per cent in 2006-07 to 36.9 per cent in 2009-10.
- In 2009, the province-wide upper secondary drop-out rate declined from 18.23 per cent in 2006-07, to 5.76 per cent in 2007-08 and 6.44 per cent in 2008-09. This represents about 2,800 children dropping out of upper secondary school in 2008-09.
- It is notable that while there has been a 5,0 per cent increase in the total child population of upper secondary school age between 2006-07 and 2009-10 (based on adjusted population figures from the 2009 Census), there has been a 9.2 per cent decrease in the number of upper secondary school pupils in this period. This indicates continuing difficulties in encouraging pupils to complete lower secondary school and continuing on to upper secondary level.
- According to DOET, of the upper secondary school students sitting final exams, the graduation rate ranges from 86 per cent in 2007-08, to 75 per cent in 2008-09 and 82 per cent in 2009-10.
- According to MOET, there were 2,717 upper secondary teachers in 2008-09, of whom 49.7 per cent were female, and the teacher-to-class ratio was 2.48, above the national average of 2.13 (Annex 1.38).

5.4 Quality of education and learning

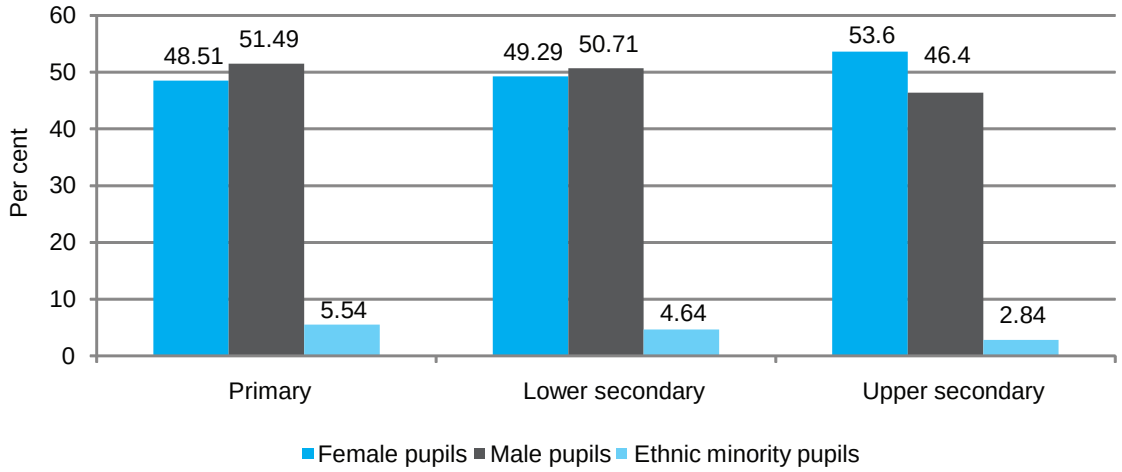
Overall improvements. District education officials in Tan Chau, Tinh Bien and Long Xuyen stated that there have been steady improvements in access to schooling and the quality of education in recent years. Commonly mentioned improvements include: (i) investments made to consolidate the network of primary and secondary schools infrastructure; (ii) enrolment rates have steadily increased at the primary level; (iii) the universalisation of lower secondary education has been achieved and maintained in a majority of locations; (iv) the staffing contingent is generally seen to be adequate in terms of number of staff and their basic qualifications; (v) there is now better provision of teaching equipment and school facilities; and (vi) parental support has been

strengthened, in particular for children in difficult circumstances. As indicated in Section 4.5 above, about 87 per cent of the province's schools had hygienic water supply and sanitation facilities as of 2009. Even so, at the primary and lower secondary level, the proportion of schools in An Giang meeting national standards is below the regional and national average. This indicates that further investment is needed to improve both school infrastructure and facilities and the quality of education.

Primary and secondary school drop-out rates. Good progress has been made in reducing the drop-out rate from primary and secondary school in recent years. Even so, as with other provinces in the Mekong Delta Region, this remains a major problem in An Giang. Based on the figures presented above, it is estimated that over 10,000 pupils dropped out of school in 2008-09. Data from the 2009 Census also revealed that about one quarter (25.9 per cent) of children between five and 15 years old in An Giang had dropped out of school. [88] While the primary school drop-out rate was fairly equally spread across urban and rural areas, the lower and upper secondary school drop-out rate was generally higher in rural areas. In all areas, and amongst all ethnic groups, drop-out rates depend greatly upon parental awareness and household economic conditions.

Gender balance. The gender balance in school attendance at primary and lower secondary level conformed closely to the sex ratio in the population as a whole (Figure 17). The ratio of boys and girls studying widens at the upper secondary level (46.4 per cent boys and 53.6 per cent girls). The 2009 Census also confirmed a higher upper secondary net enrolment rate for girls (36.3 per cent) as compared to boys (29.9 per cent) (Annex 1.33). This may reflect a higher rate of drop-out and discontinued schooling amongst teenage boys, which is a cause for some concern. However, sex-disaggregated data on drop-out rates and completion rates are not readily available. It is recommended that sex-disaggregated data should be compiled to more fully analyse and understand these trends (see Section 5.5 below).

Figure 17. Proportion of girls, boys and ethnic minority pupils at different grades, 2009-2010



Source: Department of Education and Training (2010) *Data provided during fieldwork.*

Education management, inspection and teaching capacities. In recent years, the provincial authorities and DOET have stepped up their efforts to enhance the quality and effectiveness of education management and teaching. Each year, DOET has implemented many measures with these objectives in mind. For example, according to

88 General Statistics Office (2011) *Education in Viet Nam: An Analysis of Key Indicators (Viet Nam Population and Housing Census 2009).*

the sector implementation report for 2008[89], the following specific activities and initiatives were undertaken:

- *Strengthening oversight and inspection.* Includes strengthening the activities of the Technical Subject Councils *(Hội đồng bộ môn)* at different levels; inspection of management of extra-tuition activities; inspection of implementation of MOET guidelines on administrative fines in the education sector; inspection of implementation of the Provincial Party Directive on limiting the number of school drop-outs in selected districts.
- *Improving administrative systems.* Includes application and review of the national administrative standards (ISO 9001:2000) in the provincial education and training sector; training on use of human resources management software (PMIS); inspection of procedures for receipt and liquidation of school equipment; promulgation of regulations on internal expenditure norms.
- *Reviewing teaching content and materials.* Includes organising a review of current curricula and textbooks to provide feedback to MOET; organising a conference to exchange plans of the Technical Subject Councils; organising a workshop on measures to improve education management in information technology (IT) and foreign language teaching centres.
- *Upgrading teacher skills and qualifications.* Includes in-service training to upgrade teacher qualifications in different subjects; improving English-language teaching capacity for secondary school teachers; developing the movement on self-made teaching and learning aids and materials; organising the movement of excellent teachers at different levels; developing the movement on creation and application of innovative experience; organising a competition for teachers on IT applications in teaching and learning.
- *Awareness and application of legal provisions and ethical standards.* Includes issuing guidelines for teachers on the application of child rights; implementation of Decision No.16/2008/QD-BGDDT of MOET on teachers' ethical standards; inspection of the status of teaching and dissemination of law in the education sector with the Department of Justice.
- *External cooperation.* Includes cooperation with Ho Chi Minh City Pedagogic University to provide refresher training for kindergarten teachers; with IBM on IT applications in kindergartens; and with An Giang University to provide coaching for teachers; and developing regional competitions with other provinces on good teaching and learning.
- *Additional teaching activities.* Includes providing extra-tuition to prepare upper secondary pupils for final graduation exams; implementing the scheme on teaching Vietnamese language and mathematics for Grade 1 pupils of differentiated ability; organising study visits in English language subjects for upper secondary schools.
- *Improving extra-curricular activities and the school environment.* Includes organising a wide range of inter-school and extra-curricular sports and cultural activities; promoting a competitive movement on building a child-friendly school environment; organising local quiz competitions for upper secondary school pupils to select An Giang students to take part in the national Route to Olympia Quiz Show, amongst other events and activities.

89 Department of Education and Training (2008) *ibid.*

Information technology. Advancements have been made in expanding access to IT facilities and the use of IT in schools. All schools in the province now have Internet access. Through a two-year programme of cooperation between DOET and the Viettel Group, Viettel has connected 82 per cent of schools to the Internet, while the remaining 18 per cent are covered by other telecom services.[90] However, there is still limited IT equipment and network infrastructure in a majority of schools, and many teachers lack the necessary skills to make active use of IT applications in their teaching. According to DOET, strengthening these capacities will be one of the province's main priorities to enhance the quality of education over the next few years.

Learning outcomes in mathematics and Vietnamese language. MOET has recently made a number of nationwide surveys of education quality based on aptitude tests and learning outcomes. One survey assessed Grade 5 (end of primary school) student achievement in mathematics and Vietnamese language for the 2006-07 school year (Table 19). Student achievements in these subjects were classified into three categories: 'pre-functional', 'functional' and 'independent'. The results of this survey suggest that Grade 5 pupils in the Mekong Delta Region have the second-highest rates of pre-functional ability and the lowest rates of independent ability for both girls and boys, and in both mathematics and Vietnamese language, following the North West Region. For both of these indicators, student ability in An Giang falls in a median position in comparison to other provinces in the Mekong Delta.

Table 19. Grade 5 student achievements in mathematics and Vietnamese language, 2006-2007

Region/province	Pre-functional		Functional		Independent	
	Boys	Girls	Boys	Girls	Boys	Girls
Mathematics						
Nationwide	13.04	12.11	13.08	13.10	73.51	74.43
Mekong Delta Region	19.71	18.02	18.48	19.09	61.59	62.74
An Giang Province	22.50	20.33	16.87	23.16	64.42	56.52
Vietnamese language						
Nationwide	20.39	15.52	12.19	9.80	67.15	74.41
Mekong Delta Region	28.60	22.07	15.34	13.77	55.91	63.88
An Giang Province	29.22	26.32	19.14	13.56	51.64	60.12

Source: Ministry of Education and Training/Primary Education for Disadvantaged Children Project (2008) *Report on study in Grade 5 student achievement in mathematics and Vietnamese language in the 2006-2007 school year.*

These survey results indicate that there are continuing difficulties in ensuring quality outcomes in basic educational skills for children in this region. As many children leave school from grades 5 to 9, many subsequently take up manual or domestic work and may easily lose their functional literacy and numeracy skills. According to the Participatory Poverty Assessment conducted by the Viet Nam Academy of Social Sciences in 2008[91], the lack of functional literacy and numeracy skills is still widespread amongst early school leavers, and can seriously impinge upon their chances for better livelihoods, but are not reflected fully in the available statistics on literacy.

5.5 Ethnic minority education

The proportion of ethnic minority pupils declines from primary to secondary school levels. In the three school years from 2007-08 to 2009-10, ethnic minority pupils constituted

90 "Report on summary conference on bringing the Internet into schools through the cooperation programme between DOET and Viettel An Giang". *An Giang Portal. December 20, 2010.*

91 Viet Nam Academy of Social Sciences (2009) *Participatory Poverty Assessment: Synthesis Report.*

5.5 per cent of primary and 4.6 per cent of lower secondary pupils, but only 2.8 per cent of upper secondary pupils (Figure 17 and Annex 1.31). This is indicative of generally lower levels of educational attainment amongst ethnic minorities at the secondary school level, particularly amongst Khmer teenagers. Even so, it is widely acknowledged that Khmer parents have become increasingly aware of the value of education and therefore pay more attention to the education of their children regardless of gender. Also, they have become more familiar with preschooling as most families have sent their children to kindergartens.

"In the past, few people went to school. But now many more are provided with education. We used to boast about assets, but now about children [with better education]". (Cham parents' group, Chau Phong Commune)

Parental awareness of the value of education and gender equality is generally believed to be high amongst the Cham community. Cham people in Chau Phong Commune, for example, talk about the progress made through "more travel and better connections,". which provides them with opportunities to experience and understand the outside world. Furthermore, the Cham are usually wealthier as many are involved in non-agricultural employment, services and trading, in some cases with partners from Ha Noi, Laos, Cambodia and Malaysia. In Tan Chau, some better-off families, including Cham families, send their children as far away as Chau Doc Town to enjoy higher-quality secondary education. Following the Islamic tradition, the Cham community has also established linkages with foreign sponsorship organisations to send some children abroad for schooling (Box 5).[92]

Box 5. Scholarship to study abroad for Cham students

In Chau Phong Commune, almost 50 Cham students have had the chance to study abroad thanks to religious-based scholarship schemes from Malaysia and Arabian countries and funding from their own clans. They usually study economics, medicine, oil and gas industries or humanities, although a third of the academic schedule is generally devoted to Islamic studies. Upon returning home, many of the students go to work in Ho Chi Minh City or Ha Noi, and thus become good role models for both Cham and Kinh children in their home communities. However, the number of scholarships has decreased as Viet Nam is gaining middle-income country status. According to some people, only Saudi Arabia still provides financial aid for Cham students.

Source: Discussion with commune leaders in Chau Phong Commune (December 2010).

5.6 Factors influencing educational attainment and completion

The 2009 Census revealed the tremendous challenges facing education and training in An Giang and across the Mekong Delta Region. An Giang ranks in a low position for all indicators of the highest level of educational attainment for people aged over five years of age in comparison to other provinces in the Mekong Delta Region and nationwide (Annex 1.32). According to the 2009 Census, 37 per cent of persons over five years of age in An Giang have not completed primary school: this is the highest rate of non-completion in the country, and is considerably higher than the nationwide average of 22.7 per cent (Figure 18). Only 11.8 per cent of people over five years of age have completed lower secondary school, which is the second-lowest rate nationwide, half the national average of 23.7 per cent (Figure 19). Similarly, only 9.5 per cent have completed upper secondary school, somewhat below the regional average (14.3 per cent) and half the national average of 20.8 per cent (Figure 20).

A recent analysis of these census findings by the General Statistics Office[93] stated that:

92 Province Ethnic Committee (2010) *Report for the Situation Analysis of Children in An Giang Province.*
93 General Statistics Office (2011) *ibid.*

"Further research is needed to gain a better understanding of the education situation in the Mekong River Delta. The fact that in this region, the school drop-out rates among the population aged five to 18 years were high and this region had the lowest proportion of the population with completed upper secondary education, with short-term training certificates, vocational training degrees, and junior college or higher degrees is of great concern and indicates an urgent need for the Government to put in place relevant policies to help improve the situation in this region."

Figure 18. People over five years of age with incomplete primary education, 2009 (in per centage)

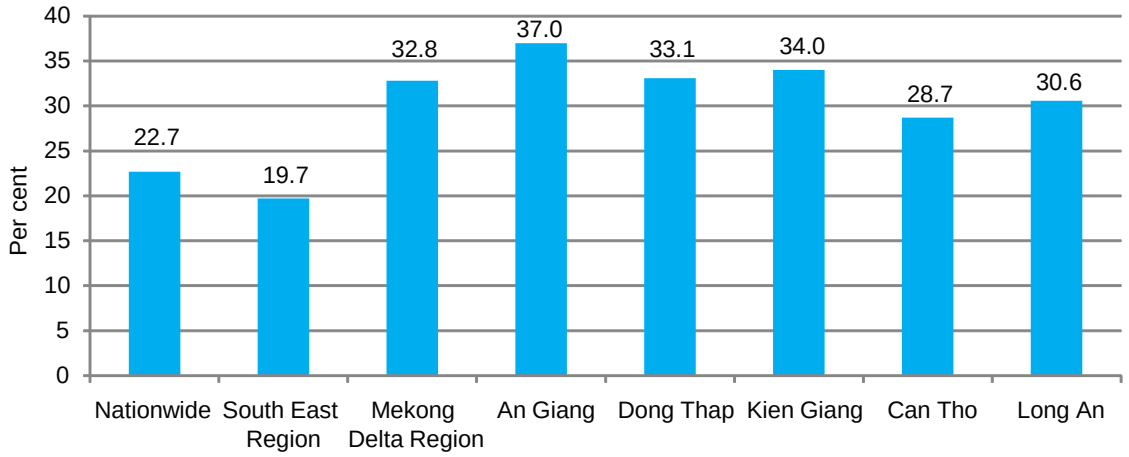
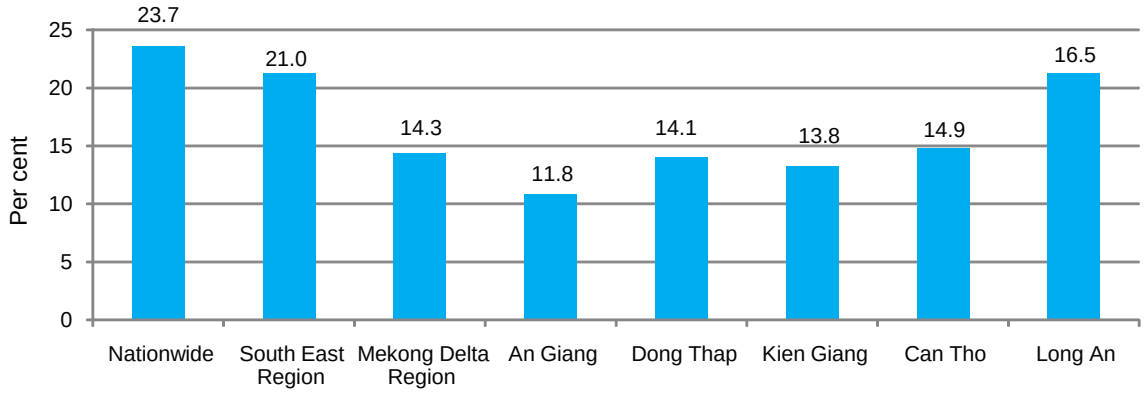
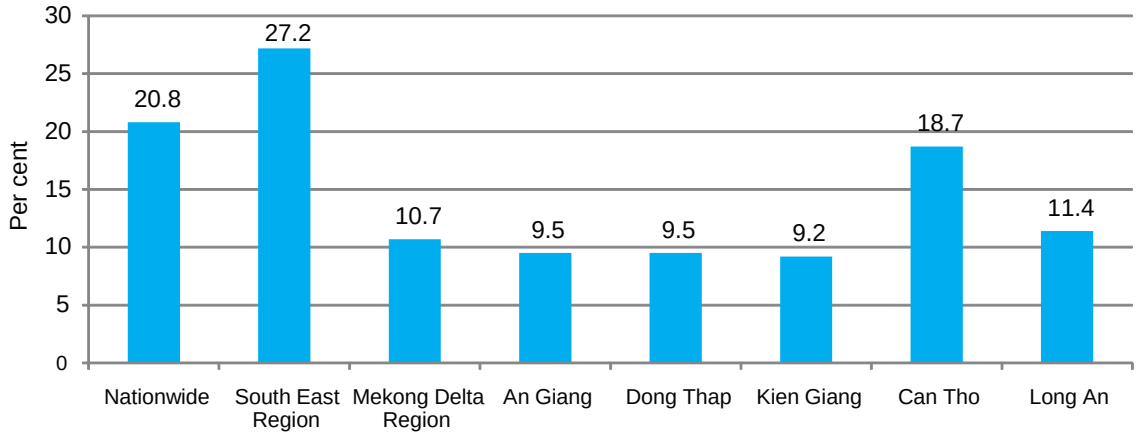


Figure 19. People over five years of age with complete lower secondary education, 2009 (in per centage)



Source: General Statistics Office (2011) *Education in Viet Nam: An Analysis of Key Indicators (Viet Nam Population and Housing Census 2009).*

Figure 20. People over five years of age with complete upper secondary and higher education, 2009 (in per centage)



Source: General Statistics Office (2011) *Education in Viet Nam: An Analysis of Key Indicators (Viet Nam Population and Housing Census 2009).*

Causative factors for discontinued schooling. During this research, discussions with province, district and commune officials, and with school teachers, parents' groups and children, revealed a wide range of reasons for the comparatively high rates of drop-out and discontinued schooling in An Giang. These can be classified as follows (Figure 21):

Immediate causes:

- *Demand for children to work.* Many respondents identified this as the major reason for discontinued schooling. This may be through economic necessity for the household and/or preference amongst children themselves to leave school to obtain work. One recent study found three primary reasons for children dropping out of secondary school in An Giang, all of which are related to labour migration and children's work.[94] Firstly, many children leave school for paid employment, typically in factories near Ho Chi Minh City. Secondly, some children have to stay at home to look after younger children as their parents migrate to other provinces for employment. Thirdly, some children who are temporarily absent from school for more than 45 days because they are needed for harvesting and other domestic work are required to repeat the year, but drop out instead. This study found that the financial cost of education was no longer an important consideration, but the opportunity costs (income not earned) of staying in school were much more important. For young people without university ambitions, and particularly for girls, their working life may last for five years after leaving school until they return to the village and start a family. By leaving school earlier, they increase the number of working years and their income opportunities.

- *Household poverty.* In rural areas, many children drop out in the middle of the school year, following the New Year holiday, because of difficult economic conditions. Their parents chiefly rely on low incomes from agricultural employment.

- *Lack of children's motivation.* Some respondents said that children leave school because of a lack of motivation. This may be due to a range of underlying causes, including weak academic performance, language barriers, a lack of good role models, or negative peer pressures. In Vinh Trung Commune, some children may

94 McCarty, A. and Julian, A. (2010) *Rapid assessment of the effects of the global financial crisis on education in Viet Nam.*

leave school early against their parents' wishes because they lack a genuine interest in education and prefer an outdoor life, such as fishing. However, it is important to interpret such statements with caution. The lack of children's motivation may also be associated with the quality of education, such as how teaching is provided, how capable the teachers are and the learning environment (e.g. students' participation and fair treatment). This aspect of education quality is often neglected but relates to fundamental issues in education provision.

Underlying causes and capacity gaps:

- *Weak academic performance.* Some children discontinue school because they cannot catch up with academic requirements and classmates, which results in a loss of interest and motivation and a preference for domestic or paid labour. Weak academic performance is frequently cited as one reason for the high drop-out rate after the New Year.
- *Language barriers.* Some Khmer children, usually from preschool and primary schools, face great difficulty in understanding their teachers, especially those with a northern accent. Many teachers are from the Kinh ethnicity. However, the number of Cham and Khmer cadres and teachers has increased in recent years. At present, young people aged 25 or less can speak Vietnamese much better than older age groups. While some pupils have language difficulties at the primary level, they may catch up by lower secondary level.
- *Lack of good role models.* Good role models can contribute to increasing school attendance among children. In poor rural communities, and especially amongst the Khmer, however, there are few grown-up children who have graduated from college or university and who can act as role models for younger children. In Vinh Trung Commune, some Khmer girls have graduated to higher education, especially in teacher training, and have a successful career. Some parents say that they have shown these models as positive examples for their children.

Figure 21. Causative factors and capacity gaps associated with discontinued schooling

Immediate causes	Underlying causes and capacity gaps	Structural and behavioural causes
Household poverty; Demand for child labour for domestic work or income-generating activities; Lack of children's motivation due to a range of underlying causes.	Weak academic performance and achievement; Language barriers for some younger ethnic pupils; Lack of good role models for children to follow; Negative peer pressure and influence; Negative impacts of modern lifestyles; Lack of coordination between schools and parents in some localities.	Limited value attached to education amongst some parents; Limited educational completion and attainment amongst parents themselves; Perceptions of limited employment prospects; Prevalent labour migration; Emerging corporate recruitment strategies.

- *Negative peer pressure and influence.* Some people acknowledge the influence of peer pressure in children's behaviour. In particular, in Vinh Trung Commune, more boys than girls have dropped out over the past couple of years, and are said to be involved in antisocial behaviour, such as drinking, fighting and online game addiction.

- *Negative impacts of modern lifestyles.* Some people have expressed their concern at the increasing number of children who are involved in unregulated Internet use, especially online games. This is viewed as one of the major reasons for distraction from schooling, subsequent drop-outs and some other negative behaviour and actions. While primarily an urban phenomenon, this is also emerging as an issue in rural areas.

- *Lack of coordination between schools and parents.* According to some head teachers, in some cases drop-out occurs as a consequence of a lack of close coordination between schools and parents. Parents or guardians may be absent from parent-teacher meetings. At home, they do not pay due attention to school attendance and the academic progress of their children. Consequently, children from such households are subject to negative peer pressures.

- *Consequences of late birth registration.* A small number of Khmer children who are older than school age attribute their dropping out to a sense of inferiority. Often, their late enrolment is a consequence of late birth registration by their parents.

Structural and behavioural causes:

- *Poor parental awareness and education levels.* Some parents do not see the long-term value of education so they don't encourage or support their children to pursue schooling, despite great efforts from schools and commune authorities. Along the border, many parents who grew up during the war with the Khmer Rouge in the late 1970s did not have a chance to access and appreciate the value of education themselves.

> *"We cadres went to their home, persuading them to let their child complete Grade 12, which was only a few months away. We are willing to provide any possible assistance. But they persisted in forcing their boy to leave for Binh Duong to learn some work skills. They listed economic difficulties and the need to support younger siblings. We gave up. They are so determined." (Commune cadres, Vinh Trung Commune)*

- *Perceptions of limited employment prospects.* In a group discussion with parents in Chau Phong Commune, they all expressed their concerns about the employment prospects for their children, which they described as "uncertain and discouraging". Some secondary school, college or university graduates cannot find jobs, which sets a negative example for children.

- *Emerging corporate strategies of recruiting younger, less-qualified rural labourers.* As indicated in Section 2.5, enterprises in the South East Region are increasingly recruiting younger people with lower school qualifications from rural areas. For example, Vinh Trung Commune currently has over 1,000 people working as migrant labourers, primarily in HCM City and Binh Duong Province, of whom 447 are young labourers (and 20 are under-age). Labour migration in this commune began in 2000 but became much more common from 2007 onwards. This correlates to the recent corporate strategies to target young ethnic minority workers to address labour shortages in some labour-intensive industries such as garment and footwear industries, especially after the global financial crisis in 2009.

Inter-linkages between causative factors. Although the foregoing reasons are separated for the sake of analytical clarity and ease of reading, they should not be seen as a sole reason for drop-out and discontinued schooling. In fact, there exists an indivisible analytical connection amongst reasons, either in a cause-effect relationship, or in an equally interactive combination. For instance, in a simple cause-effect relationship, poverty may lead to many cases of household migration, which in turn may result in discontinuation of children's education. The same argument holds true for the linkages between the negative influence of modern lifestyles and children's occasional school absence and academic ability; between language barriers and early school achievement and children's motivation. In an interactive combination, a lack of good role models, negative impacts of modern lifestyles, and negative peer pressures gather force to entice children chiefly from difficult family circumstances to drop out. Difficult family circumstances may include poverty, parental divorce or lack of parental values of education.

This understanding of the causality relationships has important implications for designing effective policy actions and solutions. Classifying them according to immediate causes, underlying causes and capacity gaps, and structural or behavioural causes also helps to make better sense of this complex socio-economic situation.

Addressing immediate causes through learning encouragement. The local government authorities, schools, mass organisations and learning encouragement associations are all involved in helping to activate children's interest and encouraging them to attend school. Mobilising social contributions can also be one of the most important ways of providing short-term financial and material assistance for those children in difficult situations.[95]

The Youth Union is active in these movements.[96] Examples in An Giang include: 'lighting up ambitions' *(Thắp sáng ước mơ)* to support poor pupils; 'fun to learn' *(Vui để học)*; 'weekend playground' *(Sân chơi cuối tuần)*; 'intellectual playground' (Sân chơi tri tuệ); 'helping friends to go to school' *(Giúp bạn đến trường)* with topics such as 'friendly embrace' *(Vòng tay bè bạn)*, 'shirts for friends' *(Tấm áo tặng bạn)*, 'week for poor friends' *(Tuần lễ vì bạn nghèo)*, 'fund for poor friends' *(Qũy bạn nghèo)* and 'fund for poor small children overcoming difficulties' *(Qũy thiếu nhi nghèo vượt khó)*. These types of support are for notebooks, textbooks, clothes clothes, pens and others stationery items. The Youth Union has recently cooperated with DOET and the Youth Newspaper to provide scholarships called 'giving strength to continue school – and stop the flow of drop-outs' *(Tiếp sức đến trường – Ngăn dòng bỏ học)* for pupils in difficult circumstances. The programme 'cultivating green lotus buds' *(Ươm mầm sen xanh)* also cooperates with DOET and the provincial radio and TV to raise funds for leisure activities for children with serious illnesses.

The above are some examples of the considerable efforts that have been made to assist disadvantaged children to attend school. This is in addition to financial support to poor pupils in poor communes under Decision No.112/2007/QD-TTg. [97] The discussion groups in Vinh Trung and Chau Phong communes also acknowledge the significance of support from religious organisations, such as Buddhist pagodas and Muslim networks. Buddhist monks have made some efforts to encourage children to return to school as some of them come to pagodas as a refuge after dropping out from school. During the summer

95 "Social contributions will help to reduce student drop-outs in the Mekong Delta". *VietnamNet,* December 14, 2010.

96 Provincial Youth Union (2010) *Report on results of activities for children in 2010.*

97 Decision No.112/2007/QD-TTg (20/07/2007) on policies to support services, improve and increase people's living standards, and provide legal aid for legal awareness-raising under the Programme 135 Phase II.

vacation, some Khmer students attend Khmer language classes in pagodas. In some pagodas, the number of students that are aware of the benefits of bilingualism, especially for community-related careers, has increased amongst the Khmer community.

Addressing underlying causes through improving the quality of education. It is in the arena of 'underlying causes' that the education and training sector authorities and schools themselves can play the leading role in enhancing the quality and attractiveness of education. Many of the underlying causes mentioned above *(weak academic performance, language barriers, lack of good role models, negative peer pressures and influence of modern lifestyles)* are subjective factors that relate to the quality of education and learning. These need to be addressed through continuing efforts to introduce learner-centred teaching methods, participation in schools, and life-skills and extra-curricular activities related to children's needs and interests. One successful example in this regard is the provision of Mother Tongue Based Bilingual Education, which has been piloted in other provinces to address the language difficulties of ethnic minority pupils at the primary level.

Addressing structural and behavioural causes. These causative factors run deeply in the structure of the local economy in the Mekong Delta Region and in public attitudes towards education and learning. As such, a long-term perspective is required to begin to address these factors. In this regard, the following observations can be made:

Firstly, making concerted efforts to achieve universalisation of preschool education will do much to instil a 'learning ethic' amongst the next generations of school children, and this should receive the highest priority in the forthcoming SEDP period from 2011 to 2015 and onto 2020.

Secondly, as indicated in Section 2.2 above, the provincial authorities prioritise improving the provision and quality of vocational training and employment support for labourers and school-leavers. This is especially the case for training the rural labour force under the provincial plan for the recently introduced NTP on New Rural Development.[98] According to the 2009 Census, only 1.8 per cent of the population over 15 years of age in An Giang has completed vocational training (Annex 1.32). At the same time, 30 per cent of the provincial population is aged between 15 to 29 years old. Providing adequate employment-specific training for the increasing number of school-leavers and young labourers is therefore a major challenge and priority. This will be essential to enhance the competitiveness of the labour force in An Giang.

Various respondents during this research suggested that the quality of available vocational training programmes was still limited. In this regard, the following broad recommendations can be made: (i) strengthening incentives for private sector enterprises and businesses to become directly involved in vocational training; (ii) closely linking vocational training to job-creation schemes; (iii) improving the quality of vocational training in terms of its periodicity, methods of teaching; and (iv) expanding credit for employment under poverty reduction programmes.

98 Decision No.800/QD-TTg (04/06/2010) approving the National Target Programme on new rural areas in the period 2010-2020.

CHAPTER 6:
CHILD PROTECTION

6. Child Protection

6.1 Children's concerns about the rights to protection

In the discussion groups with secondary school children in Vinh Trung and Chau Phong communes and in My Binh Ward, two particular sets of child protection issues stood out as being of most concern for children. Firstly, children are aware that as society is changing, there are many additional pressures on parents, guardians and caregivers, which means that they do not always have the time or capacity to take care of their children fully:

> *As society is getting better, many households become better-off, but parents only care about making money and pay little attention to their children. They think that they can let their children to learn and formulate their personality on their own to obtain an independent character. This is partly true but children with weak determination may easily fall prey to social evils, thus depriving themselves of their future.* (Secondary school children, My Binh Ward)

> *Children who live in orphanages must lack the love and protection of their families. But it seems that in some orphanages, children do not receive the love they need. I myself realise that some carers in orphanages still shout or are not friendly or caring towards orphans.* (Secondary school children, My Binh Ward)

In this respect, the respondents often mentioned friends or classmates who have not received adequate care or attention:

> *A classmate of mine did not receive enough care from his parents who were gambling and drinking all the time, without any attention to their child. So, he dropped out from school, stayed at home, played and was involved in social evils. He is now in jail.* (Secondary school children, My Binh Ward)

> *The mother of my friend does not allow him to go to school and even expelled him from home because, [she says] he cannot do anything – but he is only a fifth grader.* (Secondary school children, Vinh Trung Commune)

The second major concern expressed by secondary school children was about domestic violence and child abuse. They raised the need for better public awareness and measures to safeguard children against abuse. Children raised this topic quite frequently in the discussion groups, which indicates that violence and abuse are aconcern amongst children and are not sufficiently addressed in the public domain:

> *Domestic violence is not good behaviour. I wish that parents were aware that beating their children is not advisable. If their children do something wrong, parents should educate them step-by-step.* (Secondary school children, Vinh Trung Commune)

> *The commune authorities should develop proactive policies to prevent domestic violence.* (Secondary school children, Vinh Trung Commune)

> *I wish that people were educated so that they were more aware of children's rights and would love them more. Then there would be no more violence against children.* (Secondary school children, My Binh Ward)

> *I wish for awareness campaigns for parents to stop violence against children or for support to get people out of poverty to prevent child labour.* (Secondary school children, Vinh Trung Commune)

As the society evolves, awareness and knowledge has improved. Violence and abuse against children has decreased but still exists. More attention is needed from society and the local authorities to protect children. The penalties and the care of child victims are not sufficient, resulting in recurrence. (Secondary school children, My Binh Ward)

6.2 Basic provisions for child rights to protection

Legislative framework and institutional arrangements. As discussed in Section 3.5, the provincial authorities in An Giang have paid much attention to strengthening the legislative framework and institutional arrangements for child care and protection. This includes strengthening the basic provisions for ensuring child rights (such as improving the system of birth registration) and clarifying the sectoral and organisational responsibilities for different aspects of child care and protection (following the dissolution of the Committee for Population, Families and Children). According to DOLISA, this improved awareness of child protection is now reflected in improved policies and better coordinated efforts on the ground.

Institutional capacity gaps. During this research, several institutional capacity gaps and weaknesses in the overall system of child protection were identified, as follows:

- *The network of local collaborators.* According to DOLISA, the network of local collaborators working on social protection and child protection issues have encountered significant challenges, including limited availability of budgetary resources, the absence of a well-established organisational mechanism and weak coordination at the community level. A plan to develop the social work system has been submitted to the Provincial People's Committee, following Decision No.32/2010/QD-TTg.[99] This should be one of the main priorities for the SEDP in the period from 2011 to 2015.

- *Cross-sector coordination.* In recent years, effective cross-sector coordination mechanisms have been established around some child protection issues, including birth registration, and combating trafficking of women and children. However, according to one provincial official, the targets under the National Action Plan for Children that have not been met are primarily those issues around which there has not been such effective coordination.

- *Working children and child labour.* This has emerged as one of the most pressing and yet under-resourced aspects of child protection in An Giang. The responsibilities for monitoring, awareness raising and responding to the child labour situation were transferred to DOLISA in 2008, but so far no specific research has been undertaken on which to base more effective preventative measures. It is recommended that child labour should be a priority in the next few years (Section 6.5 below).

- *Counselling services for children.* Several provincial and district officials suggested that counselling services for children, particularly for children suffering from abuse, will require more attention in future. It is recommended that these counselling services and capacities for children should be developed as an integral part of the overall development of the social work system (Section 6.10 below).

- *Staff turnover.* Staffing in the social and child protection sector is not fully stable. It is noted that high-calibre staff frequently move on to new positions, due to the

99 Decision No.32/2010/QD-TTg (25/03/2010) on approval of the scheme on development of social work in the period 2010-2020.

priorities of the local authorities, or through promotions or employees seeking better opportunities.

Data coverage and data gaps. The coverage of child protection data in An Giang follows a clear pattern. On the one hand, administrative data coverage is fairly comprehensive. This includes data on birth registration, the number of children in need of special protection that are under care, families and children receiving financial support under social protection policies, and officially reported and handled cases of child abuse and children in conflict with the law. On the other hand, data on the broader child protection situation in the general population are lacking, including information on the numbers and situation of working children, the number of children using drugs, and the overall number of orphaned children, children deprived of parental care and children living on the streets. One of the main reasons for this lack of baseline information is because An Giang has a large and highly mobile population. This makes regular population monitoring extremely difficult. This also makes it difficult to estimate the proportion of children in need of special protection who are currently under adequate protection.

6.3 Birth registration

Birth registration is the cornerstone for ensuring all aspects of child rights are fulfiled for all children. According to the Department of Justice, there have been steady improvements in the system of birth registration in recent years and in the number of children registered on time (within 60 days of birth).[100] In total, 210,000 children had their births registered between 2006 and 2010, of which 48 per cent were registered on time as compared to 20 per cent of children registered on time in the preceding five years. The proportion of children registered on time has increased from about 39 per cent in 2006 to 52 per cent in 2010. Overall, about 95 per cent of children are now registered by five years of age[101], thus meeting the provincial target under the Plan of Action for Children (Table 9 above).

The province has made intensive efforts to tackle the backlog of delayed birth registrations, by organising mobile birth registration teams to work in each locality. However, there are still some delayed registrations in border areas and amongst the Khmer population. Moreover, the improvements in birth registration have been fundamental to progress made in the distribution of health insurance cards for a majority of children under five years of age (see Section 4.2). An Giang has maintained the additional position of family and children's cadres at the commune or ward level. These cadres have been instrumental in encouraging and supporting parents to obtain birth registration and health insurance for their children. Despite this notable achievement, there are still children from ethnic minority groups, mainly Khmer, whose late birth registrations have resulted in latter school enrolments. Further efforts are required to ensure all ethnic minority children register at the right age and before they go to school.

6.4 Children in need of special protection

Funding for social policies. As indicated in Section 3.4, the province allocated about VND 150 billion for social protection from 2007 to 2010 under decrees No.67/2007/ND-CP[102] and No.13/2010/ND-CP.[103] Following the introduction of Decree No.13 in early 2010, the number of recipients has increased from 24,435 people in 2009 to 30,462

100 Department of Justice (2010) *Report on birth registration and legal aid support for children in An Giang Province.*

101 Provincial People's Committee (2010) *Plan of Action for Children in An Giang Province in the Period 2011-2020.*

102 Decree No.67/2007/ND-CP (13/04/2007) on support policies for social protection beneficiaries.

103 Decree No.13/2010/ND-CP (27/02/2010) on adjusting and supplementing a number of articles in Decree No.67/2007/ND-CP support policies for social protection beneficiaries.

people in 2010, with a funding requirement of just over VND 74 billion.[104] The distribution to different target groups is shown in Table 20, based on which the following points can be made:

- Elderly people are the major beneficiary group (63.5 per cent of recipients), with about 58 per cent of the funding allocated to different categories of elderly people in need of support;
- People living with disabilities or HIV/AIDS form the second largest category (28.5 per cent of recipients), covering 35.5 per cent of the total funding;
- Children – as directly targeted recipients (such as orphans and abandoned children, children with disabilities or living with HIV/AIDS) constitute about 12.25 per cent of the total number of recipients and receive about 9 per cent of the total funding;
- Poor single parent households with young children, or with children with disabilities or HIV/AIDS, receive about 3 per cent of the total funding.

Table 20. Recipients and funding for social protection, 2010

Category of recipient according to level of support	Number of recipients	Annual allocation ('000 VND)
Level 1: VND 180,000 per person per month	**24,115**	**52,088,400**
Orphaned and abandoned children	2,171	4,689,360
Teenagers (16-18 yrs) attending literacy and vocational courses	28	60,480
Old people in poor households	1,573	3,397,680
Old people with spouse but without dependent support	1,415	3,056,400
People over 85 years old	15,369	33,197,040
Disabled people without labour capability	2,800	6,048,000
Single parent poor households with young children	759	1,639,440
Level 2: VND 270,000 per person per month	**5,074**	**16,352,280**
Orphaned and abandoned children	376	1,218,240
Children living with HIV/AIDS in poor households	109	353,160
Old people with disabilities	997	3,230,280
People with mental health difficulties and no carers	3,214	10,413,360
People with HIV/AIDS from poor households with no labour	198	641,520
Single parent poor households with young children living with HIV/AIDS or disabilities	153	495,720
Level 3: VND 360,000 per person per month	**1,284**	**5,546,880**
Orphaned and abandoned children	55	237,600
Disabled people with no support	1,118	4,829,760
Foster families with orphaned or abandoned children	67	289,440
Households with two severely disabled members	35	151,200
Single parent poor households with children with severe disabilities or HIV/AIDS	9	38,880
Level 4: 450,000 per person per month	**5**	**27,000**
Foster families with orphaned or abandoned children	5	27,000
Level 5: VND 540,000 per person per month	**11**	**71,280**
Households with three disabled members	11	71,280
Total	**30,484**	**74,085,840**

104 Department of Labour, Invalids and Social Affairs (2010) *Report on results of social protection and poverty reduction work in 2010.*

Source: Department of Labour, Invalids and Social Affairs (2010) *Report on implementation of social protection and poverty reduction work in 2010.*

Targeting and coverage. While the number of eligible beneficiaries under different categories obviously varies from place to place, the diversity of coverage can be taken as a proxy indicator for the effectiveness of targeting. The diversity of beneficiary groups receiving social assistance is generally wider in An Giang than in some other provinces such as Ninh Thuan and Dien Bien.[105] This diversity suggests that the targeting and coverage of eligible beneficiaries is generally more effective in An Giang than in other provinces. District figures confirm this observation (Annex 1.41). Tinh Bien District covers 15 different beneficiary categories, while Long Xuyen City covers 10 different categories.

During this research, several inconsistencies in the targeting criteria and difficulties in implementing these policies at grassroots level were mentioned:

- Firstly, provincial and district officials said that the criteria of only targeting people living with HIV/AIDS in 'poor households' was inappropriate. To ensure equity, this coverage should be extended to all people living with HIV/AIDS.
- It is sometimes difficult to accurately ascertain the status of orphaned or abandoned children and single parent households; for example, in some places single-parent households who are not poor or in a difficult situation are included in the beneficiary list.
- With respect to people with disabilities, certification from the district hospitals is required, which can be difficult if the expertise is not available. In particular, district medical staff are usually not qualified to assess mental health or developmental (cognitive) disabilities.
- As coverage expands under Decree No.13, some district staff expressed their concern about the lack of human resources to meet deadlines for investigative work, payment schedules and updating records. In Tan Chau, quarterly payments are made because of the large number of beneficiaries, while each period of payment may take five to six days.

Orphans and abandoned children. According to DOLISA figures, the number of orphans and abandoned children receiving support in the community has increased from 1,659 in 2008 to 2,547 in 2010, with support ranging from VND 180,000 to 270,000 per person per month (Table 20 and Annexes 1.39 and 1.40). In addition, as of 2010, some 55 orphans and abandoned children were under full-time care at Social Protection Centres (at VND 360,000 per person per month) and 72 were placed with foster families (at VND 360,000 to 450,000 per person per month). No figures are available on the proportion of the total number of orphans and abandoned children this represents, but it is likely that a majority of fully orphaned children in An Giang are covered by social assistance of one kind or other.

The director of the Social Protection Centre in Long Xuyen City said there was a category of children in different situations of partial homelessness and without stable home conditions, or children without adequate parental care, due to various reasons (Box 6). Data on the numbers of such children and information about their circumstances were still lacking. This is an important consideration because these children may not be officially recognised as abandoned or homeless, but are nonetheless in need of special protection.

105 Comparable figures from the Situation Analysis of Children in Dien Bien and Ninh Thuan show a more limited range of recipients according to the categories of eligible beneficiaries identified in decrees No.67 and No.13.

Care of children with disabilities. According to figures provided by DOET, there are around 5,000 children with disabilities in An Giang as of 2009-2010 (Annex 1.42)[106] while DOLISA reports a lower figure of 1,900 (Annex 1.40). The difference in these figures is likely due to differences in the definition of disabilities and criteria used by different sectors. However, these data are insufficient to provide an understanding of the situation in the province as a whole. A more comprehensive survey should be undertaken to ascertain the numbers and situation of children with disabilities in the province. As indicated above, the identification and certification of disabilities continues to be a difficulty and is a weakness in the targeting criteria under decrees No.67 and No.13.[107] The targeting criteria and eligible support for children with disabilities who receive care at home should be clarified at the national level.

It is not possible to extrapolate the number of children with disabilities who are receiving financial support, either through care at home or institutional care, from the data on recipients and funding for social protection (Table 20). Figures are also not available on the number of children with disabilities receiving support, as compared to the total number of children with disabilities who are eligible for this support.

Box 6. Orphaned and homeless children at the Social Protection Centre

The Social Protection Centre in Long Xuyen City caters for different categories of orphaned and abandoned children and children without stable home conditions. Between 2007 and 2010, it has provided care for 15 infants and young children awaiting adoption, and has links with adoption agencies from the United States and Canada. Foreign parents also adopted five children living with HIV/AIDS and undergoing antiretroviral treatment at the centre during this period.

Each year, the Social Protection Centre provides temporary care and accommodation for about 1,000 people (for 30 to 90 days), of whom about 200 may be children. About half of these children have parents but their home life and living conditions were unstable. They may be living with relatives because their parents have moved for work, or are separated or divorced. Some of these children adopt a semi-homeless or vagrant lifestyle, gathering in gangs in public areas. Sometimes they voluntarily want to seek refuge at the centre so they contact the police for referral, especially if they need medical treatment, but they usually do not want to stay long and they may come in and out repeatedly. Some other children visiting the centre do have homes, but they have been referred to the centre because of antisocial behaviour or their parent's inability to cope with their children.

Source: Meeting at the Social Protection Centre in Long Xuyen City (December 2010).

There is a general lack of advice and support services for children with disabilities or for their parents and carers in An Giang. The province is currently building new facilities for the institutional care of children with severe disabilities, for example at the Social Protection Centre in Long Xuyen City. However, this should be combined with a combination of home-based care and institutional support for parents and carers, such as through a specialised service unit that is able to support parents with functional rehabilitation programmes for children with motor disabilities. This should be a priority for the development of the social work system in An Giang.

Education for children with disabilities. Figures provided by DOET indicate that there has been a positive and steady increase in the proportion of children with disabilities attending school, from about 41 per cent in 2005 to 61 per cent in 2010 (Table 21 and Annex 1.42). Moreover, these improvements have been equally amongst both girls and boys. The proportion of children with sight, hearing and speech disabilities attending

106 Department of Education and Training (2010) *Report on education of children with disabilities in An Giang in 2010-2011.*

107 The categories under decrees No.67 and No.13 only identify: (i) poor single parent households with children with disabilities or HIV/AIDS; (ii) disabled people without labour capability; (iii) old people with disabilities; (iv) people with mental health difficulties but lacking carers; and (v) households with two or more severely disabled members.

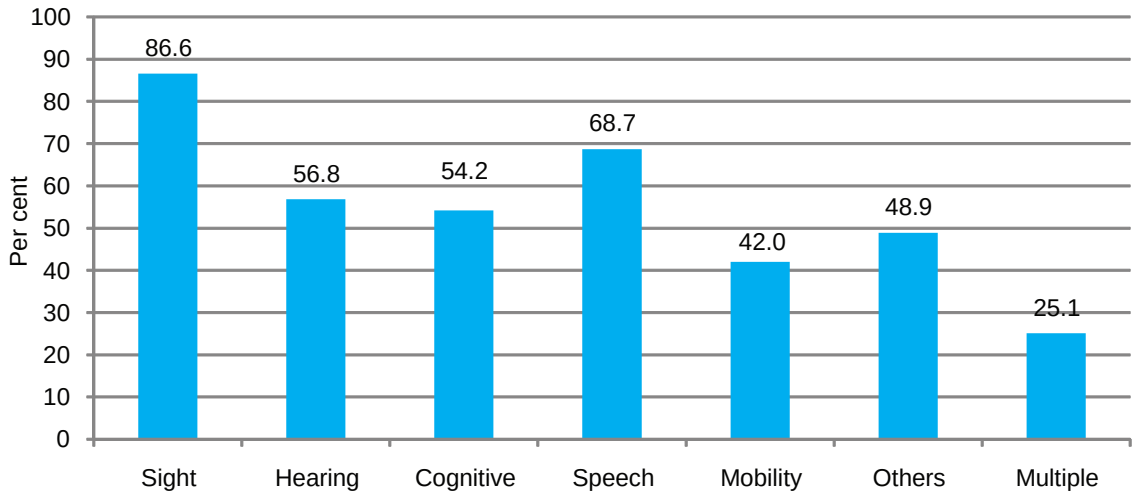
school is comparatively high, while the proportion of children with motor disabilities attending school is still low at 42 per cent in 2010 (Figure 22). Appropriate facilities and teaching provision for children with motor disabilities are still lacking in all schools in An Giang, and it is recommended that this should be one priority for enhancing access to schooling for children with disabilities in the next few years.

Table 21. Children with disabilities attending public schools, 2005-2010

School year	Total number of CWD	Number of CWD in public schools	Per centage
2005	5,038	2,055	40.8
2006	4,393	1,873	41.8
2007	4,995	2,406	48.2
2008	6,520	3,126	55.6
2009	5,149	3,017	58.6
2010	4,987	3,051	61.2

Source: Department of Education and Training (2010) *Report on education of children with disabilities in An Giang in 2010-2011.*

Figure 22. Proportion of children with disabilities in school, 2009, per disability



Source: Department of Education and Training (2010) *Report on education of children with disabilities in An Giang in 2010-2011.*

6.5 Working children and child labour

Internationally, a distinction is made between child work and child labour. Child work includes helping parents with domestic duties, assisting the family business or farm work, or earning money outside school hours and during holidays. Child labour, on the other hand, is defined in the Convention on the Rights of the Child as economic exploitation. It includes work likely to be hazardous, or to interfere with a child's education, or to be harmful to a child's health or physical, mental, spiritual, moral or social development. Whether or not particular forms of work can be called 'child labour' depends on the child's age, the conditions and hours under which the work is performed, as well as on the particular socio-economic context.

At various points in this report, it has been indicated that the situation of working children is an important socio-economic development issue in An Giang and the Mekong Delta

Region as a whole. Due to the highly competitive local economy, there is a strong demand on children to become engaged in various types of income-generating activity from an early age. According to the cultural work ethic of people in this region, many see it as a good thing for children to help their families. As described in Section 5.6, the demand for children to work is cited as one of the main reasons for the comparatively high rates of temporary withdrawal from school or permanently discontinued schooling. Amongst migrant families, the relocation of household labour resources often necessitates that one or more children become involved in work from an early age. Amongst children themselves, there may be significant peer pressure and other types of social influence that make it attractive for them to leave school early, to obtain work and an income to satisfy their expectations for consumer items.

In Tinh Bien District, it is reported that the children who are engaged in paid work to support their families chiefly come from rural areas. Many Khmer children assist their parents in domestic chores or take up some paid agricultural work. Some start working at six or seven years old, usually harvesting rice or looking after cattle. Some sell lottery tickets in urban areas around district and township markets. Some are involved in trading goods across the border. Some work in brick kilns, which is considered the heaviest and most harmful type of work for children.

One provincial official said there was no forced child labour in An Giang, but a large number of children are working. The distinction between these categories is, however, difficult to determine because there are many types of work that may put children in a vulnerable situation and expose them to exploitation. According to the analysis made in this research, there are several groups of working children who are potentially highly vulnerable:

- Children working in brick kilns, carpentry shops and waste collection who may be exposed to harmful environmental conditions, machine use and/or unsafe working practices;
- Children involved in cross-border trading of goods who may be particularly vulnerable to money lenders and economic exploitation;
- Children, often teenage girls, crossing the border to obtain work who are especially vulnerable to sexual exploitation and work in the sex industry;
- Children of migrant families who are left behind with relatives, or to look after younger siblings, who may face especially difficult economic and domestic demands;
- Children involved in work on the streets, selling lottery tickets or other goods, who may be exposed to casual economic exploitation, violence or abuse.

Lack of data on the child labour situation. There is a lack of statistical information and detailed understanding of these patterns of children's work and child labour in the province. For instance, data on the numbers of rural or urban children involved in different types of wage labour in agriculture or in local enterprises and industries are not available. The Government has clearly specified legislation on child labour regulations including the most hazardous forms of work that are prohibited for children [108]; however, there are no data available on the numbers of children in An Giang involved in potentially hazardous forms of work.

108 Inter-Ministerial Circular No.9/1995/TT-LB (13/04/1995) lists 81 occupations prohibited for young workers, and 13 harmful working conditions in which the employment of young workers is prohibited.

This is an important priority for improved data collection. DOLISA took over the responsibility for the compilation of statistics on child labour and for overseeing implementation of protection policies and measures in 2008. DOLISA plans to undertake a baseline survey of children in 2012 that should include child labour as a priority. The survey should pay close attention to determining: (i) the numbers and circumstances of children involved in hazardous forms of work; and (ii) the numbers and circumstances of children involved in types of work that leave them vulnerable to exploitation and abuse, such as cross-border trading of goods. It will be most beneficial to concentrate survey work on gaining a better understanding of these most serious forms of child labour, rather than gathering general statistics on the numbers of children engaged in unpaid domestic work for their families.

The recommendations from a recent study on children's work in Viet Nam are relevant to the situation in An Giang.[109] Firstly, combined with better data on the number of children involved in hazardous form of work, direct intervention is needed to ameliorate this situation if it exists. Secondly, strengthening 'prevention measures' to reduce the flow of children into child labour, including (i) continued improvement of secondary school access and opportunities especially for girls; (ii) enhancing remedial measures whereby children temporarily removed from school can catch up and complete schooling; and (iii) continued awareness raising amongst local communities and parents. Effective implementation of these measures requires reliable information, an appropriate legal and regulatory framework, functioning coordination structures, capable and committed institutions and a mobilised and aware society.

6.6 Trafficking of women and children

The border areas of An Giang, Dong Thap and neighbouring provinces have been a hotspot for the commercial exploitation and trafficking of women and children. Large numbers of Vietnamese people have migrated to Cambodia in recent decades, whose children remain largely stateless and vulnerable to exploitation. [110] There is a demand in Cambodia for Vietnamese migrant workers, and specifically for Vietnamese women working as sex workers. Studies conducted in Cambodia in the early part of the last decade indicate that about 50 per cent of the trafficked persons of Vietnamese origin identified in Cambodia were from An Giang Province, and that up to 30 per cent of sex workers in Cambodia are of Vietnamese origin.[111]

It is difficult to obtain precise figures on trends over time in the numbers of women and children involved. There are several reasons for this. Firstly, there is extensive cross-border flow of labour, including people involved in cross-border trade, and labour relations between rural communities along the border, especially amongst the Khmer. In particular, poor young women from rural communities may seek labour opportunities across the border. It is difficult, therefore, to separate out legitimate forms of labour movement and cases in which people become victims of commercial or sexual exploitation. Secondly, this border zone is a corridor for trafficking of some people from other parts of Viet Nam, not only from within these border provinces. As illustrated by the case described in Box 7, there may be multiple complex linkages involved. Thirdly, because of the illicit nature, victims of commercial exploitation and trafficking are often unwilling to voluntarily report their situation to the local authorities.

109 UCW (2009) *Understanding Children's Work in Viet Nam.*

110 United Nations Inter-Agency Project on Human Trafficking (2008) *Strategic Information Response Network (SIREN): human trafficking data sheet.*

111 University of Miami/AusAid (2003) *Measuring the Number of Trafficked Women and Children in Cambodia: A Direct Observation Field Study.*

Through regular cross-border coordination and collaboration, and with support from a number of international organisations and projects[112], the provincial authorities in An Giang have put in place a number of measures to comprehensively address this situation. Cross-sector coordination within the province, as well as international cooperation, is reported to be good. In June 2009, the Department of Justice established a Cross-sectoral Group for Legal Support for Trafficked Women and Children *(Nhom ho tro phap ly da nganh ve phong, chong buon ban phu nu, tre em)*, with representatives from the People's Court, the Lawyers' Association, the Fatherland Front, the Women's Union, the provincial police and border guards. [113] The activities of this group have included coordinating public awareness and mobilisation campaigns in particularly susceptible locations along the border, and legal advice and support to affected persons.

The main project activities have included: (i) multimedia information campaigns focusing on awareness-raising and fostering community actions to combat trafficking; (ii) economic empowerment to reduce the flow of migrant women; (iii) support for returnees including scholarships and training for disadvantaged girls and young women; (iv) establishing a hotline to respond to questions from vulnerable women and children; and (v) the provision of shelter, counselling and legal advice for victims and returnees through the Social Protection Centres (under DOLISA), the Women's Union and the Centre for Legal Aid for Poor People.

Box 7. Inter-provincial and international trafficking of children through An Giang Province

The following case highlights the complex linkages that are sometimes involved in the trafficking of children and the importance of inter-provincial and international cooperation to address the issue of child tracking in a border province like An Giang.

BVT, born in 1994, is an ethnic minority child from a province in the North Central Coast Region of Viet Nam. In 2009, he dropped out of school at Grade 7 because of frequent bullying at school. In February 2010, a neighbour promised to secure a job for him to look after pigs in the south. But in fact, he was employed as bonded labour to work in a coffee plantation in Lam Dong Province. He did not receive any cash for this period of employment as his wage was deducted to cover living costs and to pay the advance of VND 1.5 million that the neighbour had paid his parents.

Afterwards, he was transferred (sold) to another employer to grow vegetables in a province in the Mekong Delta. After a couple of months, BVT, together with five other teenagers from Quang Ngai and Binh Dinh provinces, was sold again to Cambodia to work in rice fields. He spent five days there but was able to escape back to Viet Nam, together with two girls. BVT was detained at Tinh Bien border gate in An Giang. Border guards referred him to the Customs Service and then to the Department for Prevention and Control of Social Evils under DOLISA. He was sheltered at the Social Protection Centre while responsible officials contacted his family in his home province.

Source: Meeting at the Social Protection Centre in Long Xuyen City (December 2010).

6.7 Children affected by HIV and AIDS

Social protection and counselling for children living with HIV/AIDS. The National Plan of Action sets out ambitious objectives and targets to strengthen the protection and care of children living with HIV/AIDS.[114] During this research it was not possible to make a comprehensive assessment of the extent to which these objectives and targets have been reached in An Giang. It appears, however, that while good progress has been made in extending medical services and treatment for people living with HIV/AIDS, social

112 Including the International Office of Migration (IOM), the An Giang Dong Thap Alliance for the Prevention of Trafficking (ADAPT) and the Asia Foundation.

113 Department of Justice (2010) *Report on birth registration and legal aid support for children in An Giang Province.*

114 Decision No.84/2009/QD-TTg (04/06/2009) approving the National Plan of Action for HIV/AIDS affected children up to 2010, with a vision toward 2020.

protection and counselling services are still lacking. As of 2010, 109 poor children living with HIV/AIDS received social protection funding support under Decree No.13 (Table 19). However, this represents only about 20 per cent of the total number of children living with HIV/AIDS. As noted above, the criteria of only targeting 'poor' people living with HIV/AIDS under this decree excludes a sizeable proportion of the affected population. Many province and district officials in An Giang also say that strengthening the provision of counselling services for families and children living with HIV/AIDS is a high priority.

HIV/AIDS discrimination and confidentiality. The National Action Plan addresses the need to combat discrimination against children living with HIV/AIDS and their caregivers when accessing healthcare, education and other social services. During 2010, the province conducted anti-discrimination awareness-raising activities. At the same time, confidentiality for families and children living with HIV/AIDS emerges as a concern. During this research, three situations were encountered in which the rights to confidentiality may conflict with the implementation of social policies:

- Firstly, under Decree No.67 (2007) and Decree No.13 (2010) on support policies for social protection beneficiaries, provision is made for financial support for families and children living with HIV/AIDS. On the one hand, implementation of these policies at the community level requires transparency in decision-making so that local people see that eligible households for social assistance are being treated equally and fairly. On the other hand, this may conflict with the desire for confidentiality amongst those families living with HIV/AIDS.

- Secondly, clubs for the prevention and awareness of HIV/AIDS have been organised with the participation of children affected or not affected by HIV/AIDS, which is a positive step towards integration of children living with HIV/AIDS into their communities. However, some cases of discrimination or a sense of inferiority have been reported, which raises a practical need to protect the identities of children affected by HIV/AIDS as strictly as possible. During this research, it was found that the lack of confidentiality could affect the participation of children living with HIV/AIDS in school and community affairs to some extent.

- Thirdly, some parents do not want to see commune cadres visit their children who are believed to be living with HIV/AIDS. As one district Women's Union cadre observed: *"Some people ask us not to come back again."* The Law on HIV/AIDS has been enacted, but in practice no written regulations on protecting children's identities have been circulated at the grassroots level, for example on who has the right to know the identities of these children and what obligations they have to protect their identities. Only some verbal instructions have been provided at training courses. Therefore, responsible cadres at the district, commune or village levels, who know the identities of children living with HIV/AIDS, keep those identities confidential because they feel it is the right thing to do, rather than because of legal requirements.

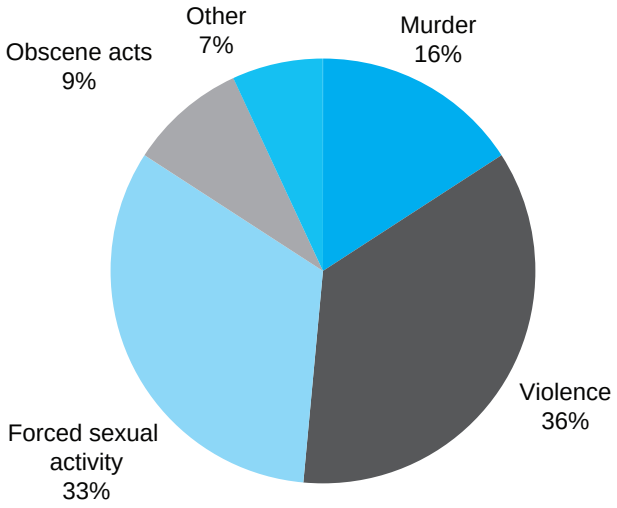
6.8 Child abuse and violence at school

The number of officially reported cases of abuse against children in 2009 are given in Figure 23 and Annex 1.43. Of the 45 cases of abuse handled by the Department of Public Security in this period, about 36 per cent were for violenca against children and 42 per cent were for obscene acts and forced sexual activity with children. It is likely that these officially handled and reported cases do not give an indication of the magnitude of child abuse and that there is significant under-reporting and non-reporting of child abuse, either by families, neighbours or children themselves. Families often prefer to go

through an informal reconciliation process rather than officially reporting to the police or local authorities. This highlights the need for increased awareness-raising amongst local communities on the importance of addressing different forms of child abuse. Little is known about the efficacy of informal reconciliation procedures, or reconciliation procedures according to customary law of different ethnic minorities, in dealing with child abuse. Similarly, it is not clear to what extent the 'commune reconciliation boards' can deal with such cases. This is an important area for future research to help strengthen community-based child protection mechanisms.

A number of reasons suggest that there is a nascent or growing problem of children who suffer from various forms of physical or psychological abuse at home, bullying at school or conflict between children. Firstly, as described in Section 6.1, during this research secondary school children themselves frequently raised concerns about these problems. Secondly, statistics on child injury in An Giang indicate fairly large numbers of teenagers (from 15 to 19 years old) suffering injuries from violence or conflict (see Section 4.7 and Table 17 above). These statistics also show incidence of self-harm through attempted suicide, particularly amongst teenage boys, which may be indicative of various pressures and problems faced by this age group. Nationwide, there has also been increasing public awareness and concern about the rise in school violence across the country[115], and about the lack of counselling services to help children who suffer from psychological or physical violence and abuse.

Figure 23. Cases of abuse against children, 2009 (in per centage)



Source: Department of Public Security (2010) *Data provided during fieldwork.*

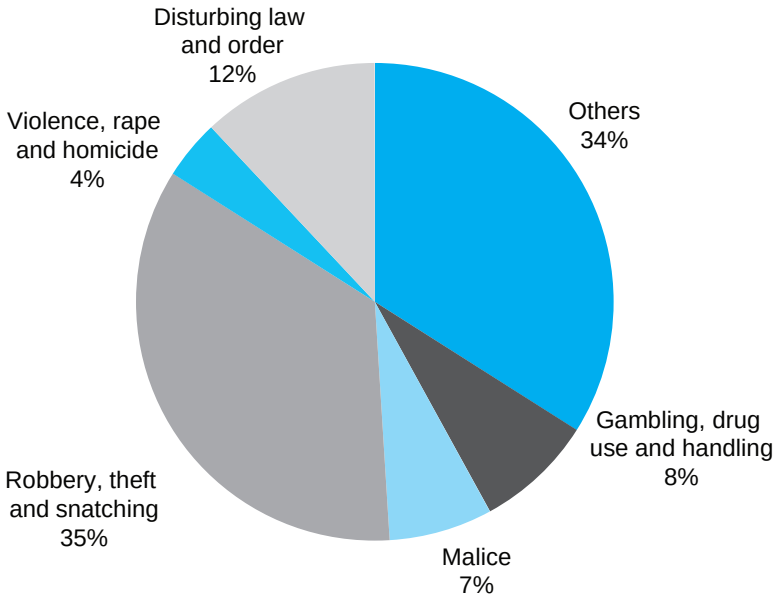
There is insufficient information, however, to quantify the magnitude of this problem in An Giang, or to fully understand the circumstantial factors. Circumstantial evidence suggests that child abuse may be more prevalent in migrant families where children are left with relatives or others while their parents are away. It is recommended that steps should be taken to fill this gap in understanding. In this respect, a useful starting point would be to further verify and analyse the statistics on child injuries caused by violence and self-harm. A range of different preventative measures are be required to address the circumstances of domestic abuse on the one hand, and violence or bullying at school on the other. This would be through a combination of increased public awareness around these issues, appropriate preventative measures against violence in schools, better counselling services for children, and continued strict enforcement of judicial sanctions against perpetrators of child abuse.

115 "Despite major efforts, school violence still continues." *VietnamNet.* November 1, 2010.

6.9 Children in conflict with the law

The circumstances of children in conflict with the law in An Giang are broadly similar to those in other parts of the country (Figure 24 and Annex 1.44). A majority of cases handled by the Department of Public Security and the People's Court are concerned with robbery, theft and snatching (35 per cent) and disturbance of law and order (12 per cent). According to officials from the Department of Public Security, the number of cases fluctuates from year to year but there has been no significant increase in the number of cases over time. In rural areas, theft of assets is the major cause of infringement of the law by children, while in urban areas theft and robbery, drug handling and drug use, and general disturbance of law and order are more common.

Figure 24. Cases of children in conflict with the law, 2009 (in per centage)



Source: Department of Public Security (2010) *Data provided during fieldwork.*

6.10 Development of the social work system

Over the next few years, the introduction of the social work system following Decision No.32/2010/QD-TTg will provide an important opportunity to build a more comprehensive system of child care and protection. However, there are several issues that will need to be carefully considered to develop the social work system in the most cost-effective ways. These relate to: (i) the types of social work service capacities and staff skills that are most required in each locality; ii) the integration of the roles and responsibilities for those aspects of child care and protection that require a coordinated and multi-sectoral approach at the grassroots level; and (iii) the most appropriate organisational set-up and mechanisms to fulfil these needs.

Adapting the social work system to local needs and circumstances. Decision No.32 requires one or two social workers to be employed at the commune or ward level, while strengthening the network of local collaborators working on social protection issues in the community. At the same time, we suggest that the social work system will need to be adapted to the particular demographic and socio-economic circumstances, and to the priority social protection issues, in each locality. These circumstances and priorities differ from province to province. For instance, social work amongst the sparsely populated and largely ethnic minority population in a province such as Dien Bien, will obviously differ from the type of social work system that is most appropriate and cost-effective for the

densely populated and increasingly urbanised population such as in An Giang and other parts of the Mekong Delta.

Capacity building needs. Based on the analysis made in this report, it is recommended that the social work system for child protection should be developed along the following main lines in An Giang:

Specialised service units. Firstly, not all child care and protection services can or should be provided through the regular contingent of commune staff and local collaborators. There are some aspects requiring specialised capacity that cannot be provided by these local staff, and neither would it be most cost-effective. Examples of these types of specialised service units include: (i) counselling services for children suffering from abuse and bullying; and (ii) support and advisory service units for children with disabilities and their parents or guardians.

Local collaborators and peer educators. The network of local collaborators will need to be adapted to the particular population characteristics of the province, such as amongst the mobile or migrant population. It is recommended that particular attention should be given to recruiting social work collaborators from within these population groups to work as peer educators (along the same lines as peer educators within the community living with HIV/AIDS). Similarly, social work collaborators amongst the Khmer ethnic minority population should be primarily trusted men and women from within these communities.

Commune or ward social work cadres. An Giang is in a good position to further develop the capacity of commune or ward-level social work cadres, by already having in place the part-time family and children's officers (in 156 communes or wards), in addition to the population officers. These family and children's officers may later become the commune social workers.

However, during this research it was recognised that there are still considerable gaps in the qualifications, skills and experience of these family and children's officers, and some inconsistencies in their roles and responsibilities. These are as follows:

- *Unclear job description.* These officers are supposed to deal with all child-related work. However, in practice, they have so far been mainly involved in the delivery of health insurance cards for children in conjunction with the Provincial Social Insurance.
- *Unsuitable qualifications.* Only some of these officers have professional social work qualifications. In Chau Phong Commune, for instance, the family and children's officer has recently been transferred from the public security forces, and now studies part-time administration at the Ton Duc Thang Provincial Political Academy.
- *Limited practical social work training.* These officers still lack the necessary skills and experience to deal with complex and sensitive child protection issues and to communicate with families and children. In Vinh Trung Commune, for instance, the family and children's officer has only attended a few training courses organised by DOLISA and the district on injury prevention, domestic violence and child care. In Chau Phong Commune, the officer has only attended one course on child rights and communication skills. The officers also say that they have a lack of reference documents or time to study.
- *Inability to be proactive in work.* So far, these officers have mainly been assisting the activities of other organisations whenever support is required, rather than taking

the lead of child protection activities in the community. This suggests that clearer work assignment is required, combined with appropriate incentives to become more engaged in their work.

- *Weak monitoring.* In Chau Phong Commune, it was noted that the former officer had passed away, but did not leave any records, which meant that the new officer had to start from scratch to collect basic statistics with support from the village heads.

Training and coaching programme. The above observations are indicative of the challenges of strengthening the social work system and capacities at grassroots level. An intensive 'training and coaching programme' is required to equip these commune officers and local collaborators with the necessary knowledge and social work skills, combined with appropriate incentives (including monetary incentives and other types of incentives) to encourage them to become fully engaged with their work. Particular attention should also be given to what types of data are required for monitoring child protection issues in the community, and the reporting system for this. In 2012, DOLISA plans to undertake a baseline survey of children in the province to update its child care and protection statistics (using the 2009 Census as a population baseline). This will be a good opportunity to fully establish the regular administrative monitoring system for child protection.

CHAPTER 7:
CHILDREN'S PARTICIPATION

7. Children's Participation

7.1 Defining children's participation

The 2010 Situation Analysis of the Children of Vietnam suggests that children's rights to participation is a relatively new concept in Viet Nam.[116] Traditionally, the Vietnamese family provides a good protective environment for children. While gender and age define a person's status, girls are traditionally in a weaker position than boys. In local communities, there is often a strong emphasis on meeting the needs of children, through the organisation of various clubs and social events, but in many ways children's rights to participation have not been institutionalised. Considerable efforts have been made in introducing more child-centred teaching methodologies in schools, but this requires more teacher-training and capacity building. The Situation Analysis concluded that while significant efforts have been made, these initiatives remain generally ad-hoc and there is a general lack of awareness amongst children and adults on how to facilitate child participation processes. The findings of this research generally confirm these observations.

Children's participation needs to be considered from a variety of perspectives. Most provincial and district leaders and officials are familiar with a rights-based approach, for instance, as related to the Convention on the Rights of the Child (CRC). However, these concepts are still new to a majority of grassroots officials and local people. Expressions of children's participation are still very much linked to neo-Confucian norms and conceptions of society that underlie Vietnamese society as a whole. This necessitates understanding the ways in which rights are articulated according to these norms, and how they are evolving in the modern-day context.

Secondly, children's participation needs to be considered from the perspective of the culture of different ethnic groups. This includes the opportunities that ethnic minority children and young adults have to engage with wider society on the one hand, and to maintain their involvement with their own culture and society on the other. There has been little research amongst young ethnic minority people on how they perceive their futures, and are adapting to new opportunities and social pressures in the modern world. There is a need for such research to inform approaches to enhance child participation in ethnic minority communities.

Thirdly, children's participation needs to be understood in terms of the interrelationships with the other clusters of child rights to survival, development and protection. For example, the rights to participation and development are closely connected – by enabling children to develop their skills and interests and fulfil their aspirations they will be able to more meaningfully participate in society. There are also important gender considerations in these linkages between the clusters of rights; for example, by providing young women with the knowledge and information they need to self-determine their reproductive healthcare behaviour and safety.

7.2 Children's viewpoints on rights to participation

Children express a diversity of personal experience and contrasting opinions about their rights to participation. While some children believe that they do have opportunities to raise their viewpoints and aspirations in the family, others say that many children are not allowed to do so. The respondents mentioned friends or classmates who were not allowed to participate in social activities of the community or extra-curricular activities at

116 UNICEF (2010) An Analysis of the Situation of Children in Vietnam, UNICEF, Ha Noi.

school because their parents do not think it is beneficial for them. They also said that it is important for the local community to cooperate to make sure that all children have these opportunities:

> *To be able to raise one's voice is important. My right to participation has been enforced. I have many chances to express my views. So do other children*. (Secondary school children, My Binh Ward)

> *I am allowed to express my aspirations to my family in choosing school, things to do and discuss what I consider right or wrong.* (Secondary school children, Vinh Trung Commune)

> *Many children from my neighbourhood are not allowed to express their views or aspirations as the adults think that they, as small children, know nothing to voice their opinions.* (Secondary school children, Vinh Trung Commune)

> *Parents should pay more attention to their children's thoughts and views in order to avoid domestic conflicts.* (Secondary school children, My Binh Ward)

> *A friend from my neighbourhood always stays at home, his parents don't allow him to participate in any activities. His father says: you should not go because participation in [social] activities does not bring any benefits.* (Secondary school children, Vinh Trung Commune)

My grandma hates me, and considers me the 'outcast' in the family just because I am a girl and she prefers boys.(Secondary school children, Vinh Trung Commune)

A friend of mine lost her parents and lives with her paternal family members who do not like girls so they beat and shout at her. I wish that I could tell her family that they should not discriminate against girl. (Secondary school children, Vinh Trung Commune)

I wish that every family would love their children, regardless whether they are boys or girls. (Secondary school children, Vinh Trung Commune)

> *The community should cooperate so that all children can go to school and have the right to participate in collective activities.* (Secondary school children, My Binh Ward)

> *I wish that teachers would come to households to explain the benefits of school activities so that parents will support and no longer prevent their children from participation.* (Secondary school children, Vinh Trung Commune)

Some children also expressed their unhappiness about favouritism and discrimination against girls that still exists in some families:

7.3 Gender and participation

Gender is a fundamental aspect in advancing children's rights to participation, through understanding the respective obligations that are placed on girls and boys within the family, and the opportunities they are provided within education and in wider society.

Gender differentials in child indicators. There are only minor gender differences in some of the most important indicators of child health and education in An Giang. Girls as well as boys have benefited from the improvements to primary healthcare for children. In education, while girls constitute 48.5 per cent of primary school pupils, this increases to 49.3 per cent for lower secondary and 53.6 per cent for upper secondary level (as of

2009-10).[117] While the proportion of ethnic minority pupils transitioning from primary to secondary school is lower than amongst Kinh students in An Giang, this is true amongst both girls and boys; the differentials between ethnic minority girls and boys education are not as extreme amongst the Khmer and Cham in An Giang as compared to some other ethnic minority groups in Viet Nam.

Gender and ethnicity. While significant gender differentials are not apparent in these children's indicators in An Giang, there are underlying and culturally important gender differences which influence child participation. These inter-relationships vary according to the kinship structures and social norms of different ethnic groups. Amongst the Khmer and Cham, as well as amongst the majority Kinh population, kinship systems are organised 'bilaterally'; that is to say, people who are related to either the bride or groom are considered to be relatives in the extended family structures (as distinct from purely patrilineal or matrilineal kinship systems).

Amongst the Khmer, gender is only one of a range of factors that influence where a person is situated in society; other factors including wealth, reputation of the family, religious observance, employment and patron-client relationships being equally important.[118] At marriage, a substantial bride price is transferred from the groom's family to the bride's family. Newly married Khmer couples will often live with the bride's family, but traditional inheritance laws allow property to be divided equally amongst men and women. Khmer women are often the major income earners in the family as well as usually controlling household finances. One implication of this is that children, especially girls, may be given responsibility for domestic duties and looking after younger siblings, which means they have to withdraw from school. On the other hand, some Khmer families will choose to withdraw boys from school to look after cattle (which are an important element in the bride price). Because Khmer women are often the major income earners, they may be given preference for following opportunities to obtain paid employment (e.g. through migrant labour or through training to become teachers and health workers).

The example given above shows how important it is to avoiding drawing general conclusions about gender differentials or patterns of gender discrimination. Moreover, understanding the opportunities for children to participate in wider society needs to be matched by appreciating ways in which families and children choose to maintain their own cultural and social systems.

Specific social issues affecting girls and boys. There are several contemporary social development issues in which gender is an important aspect. Firstly, the increasing sex ratio at birth in An Giang is a fundamental concern that reflects underlying aspects of gender discrimination. Secondly, according to emerging corporate recruitment strategies of export-oriented enterprises in the South East Region, there is a trend to attract girls, including under-age children, from the Khmer community to address their labour shortages, especially after the global financial crisis in 2009. Thirdly, some of the concerns over emerging moral degradation amongst children, such as antisocial behaviour and uncontrolled Internet usage, are more related to boys. Some other problems, such as a lack of appreciation of the value of education, have emerged amongst both boys and girls.

117 This is in contrast to Dien Bien Province, for example, where in 2008-09 girls constituted 46.3 per cent of primary school pupils, but only 39.7 per cent of lower secondary and 41.5 per cent of upper secondary school pupils, while the rate of drop-off for ethnic minority girls is much steeper (*Source:* UNICEF/Dien Bien Province (2010) *Situation Analysis of Children in Dien Bien Province*).

118 Ledgerwood, J. (1990) *Changing Khmer Conceptions of Gender: Women, Stories and the Moral Order.*

7.4 Recreation and out-of-school learning opportunities for children

When asked about the needs for children's participation, a majority of respondents in An Giang spoke about the need to provide more recreation facilities. Indeed, this emerged as a major issue, and was highlighted by provincial and district officials, as well as by community leaders, parents and children themselves (Figure 25). Our analysis of this topic can be expanded to cover not only recreation facilities (such as playgrounds, sports and cultural facilities), but also various extra-curricular or out-of-school learning opportunities and sources of information for children.

Figure 25. Factors contributing to the lack of recreation facilities and out-of-school activities

Immediate causes	Underlying causes and capacity gaps	Structural and behavioural causes
Lack of physical space for recreation facilities (playgrounds and parks); Limited budget allocations to establish recreation facilities; Limited range of available recreational, sports and cultural facilities as well as sources of information (especially for teenagers and young adults); Only about 50 per cent of kindergartens currently have playgrounds with toys or equipment.	Unregulated Internet access and usage causing behavioural problems amongst some children; Limited capacity to involve all children in extra-curricular and out-of-school activities (such as clubs of various kinds).	Limited 'reading culture' amongst families and children; Strong work ethic and lack of time and energy amongst parents to cater for the wider developmental needs of children.

Lack of space and funds for recreation facilities. The immediate causes cited for the lack of recreation facilities for children include a lack of space and funding. Indeed, in the heavily populated environment in the Mekong Delta Region, there is a severe shortage of physical space in which to construct safe playgrounds and parks for children to gather and play in. Public playgrounds, where they exist, are often located in the grounds of government buildings and remain underutilised. Some local officials stated that the lack of budget allocations for recreation facilities was the major constraint. However, others said that the lack of funds was less important than the lack of attention in local planning decisions.

Lack of recreation facilities and behavioural problems amongst children. Some parents, teachers and local officials said that the lack of alternative and safe recreation facilities leads some children into patterns of antisocial behaviour. In particular, this relates to unregulated Internet access and usage. An increasing number of students, usually from both lower and upper secondary schools, regardless of gender, have been playing online games and other Internet applications. Some play on credit, which may lead to negative behaviour and debt obligations, such as the wrongful use of tuition fees and breakfast allowances.

Youth clubs and organised out-of-school activities. The Youth Union and other agencies organise a wide range of learning-promotion groups amongst disadvantaged children, and summer vacation activities for school children. Buddhist pagodas organise community activities for Khmer children to meet up and communicate with each other on the Lunar New Year, the summer festivals and the July Pardon Festival. The UNICEF-supported Provincial Child Friendly Programme has convened healthy living and

life skills clubs for children in 14 communes. These are just some examples of the types of structured events and activities for children. However, as DOLISA officials noted, only a limited number of children can be involved, and their success depends on the capacity and enthusiasm of the local staff who facilitate these types of activities.

Underlying social behavioural factors. Several underlying factors may contribute to the lack of recreation opportunities for children. The strong work ethic amongst the Mekong Delta population means that some parents may not have the time or energy to devote their attention to the wider developmental needs of children. More widely, some commentators have noted the limited 'reading culture' amongst parents and children in Viet Nam, which may also influence these patterns of recreational behaviour amongst children. As suggested at a recent workshop on this topic, solutions for the development of reading culture may include encouraging the setting up of family bookshelves, creating a reading habit in families, learning how to conduct a reading in schools, and strengthening the facilities and performance of libraries to become a more attractive destination for the general public.[119]

Policy solutions. To develop effective policy responses and solutions to this shortage of recreation facilities and out-of-school learning opportunities for children, a distinction needs to be made between the needs of young children (those of preschool and primary school age), and those of teenagers of secondary school age and young adults. In general, it can be said that addressing the needs of the former group is much easier than the latter.

For younger children, the provision of safe recreation facilities in kindergartens and primary schools should be the priority. Physical space is generally more available in school grounds than in other public places. According to Decision No.239/2010/QD-TTg on the universalisation of preschool education[120], there needs to be adequate equipment and toys for realisation of the new preschool education curricula, and the application of information technology at preschool institutions needs to be stepped up so that at least 30 per cent of preschools have access to information technology by 2015. This will create an opportunity to instil favourable learning attitudes amongst children from an early age.

For older children, attention should be paid to diversifying the options available for teenagers to become more actively and directly involved in organising and conducting their own recreation activities. One option is to increase the resources made available to youth clubs of various kinds to strengthen and diversify their activities, by designing their own entertainment and learning programmes; for example as producing their own videos that can be used in peer-education and outreach programmes. A second option is to support the establishment of 'healthy Internet clubs' in urban areas, where a variety education friendly and Internet-based learning activities are provided for children. These may be established through small grants to promote collaboration between local secondary schools and residential clusters, with possible support and sponsorship from local businesses and enterprises.

7.5 Information, public education and communication activities

At the community level, a variety of meetings are organised that are sometimes attended by local children. In Phong Chau Commune, for example, some children aged 14 or 15 said that they are invited to community meetings, such as meetings about 'people's

119 "Workshop on the current situation and solutions for the development of reading culture in Viet Nam." General Science Library of HCM City Portal. September 2010.

120 Decision No.239/2010/QD-TTg (09/02/2010) approving the scheme on universal preschool education for children aged five years in the 2010-2015 period.

solidarity' *(Toàn dân đoàn kết)* and 'people taking part in protection and national security' *(Quần chúng bảo vệ an ninh quốc phòng)*. Although they attend these conventionally 'adult-only' meetings chiefly as passive listeners, a few may express their opinions on reasons for school drop-out, and community cadres may seek ways to mobilise resources to help them to return to school.

According to many local officials, better public information and education in different forms has been one of the most significant interventions in the enforcement of different aspects of child rights in An Giang. Examole, not it is believed to have contributed to mitigating cross-border trafficking, sex abuse, and juveniles in conflict with the law. Awareness raising activities are also believed to have contributed to improvements in the rates of school enrolment, child vaccinations, as well as knowledge of child rights and healthcare for pregnant women and environmental sanitation, particularly amongst the Khmer ethnic group.

In some communes, healthcare communication staff and teachers have made concerted efforts to disseminate information to children who are supposed to relay such knowledge to their parents. This strategy usually works more effectively with children from Grade 7 and above. Usually, commune health station staff talk with children and their parents together at joint meetings at schools. Many parents acknowledge the practical impacts of this communication approach.

The major barriers to this grassroots communication include poor equipment and geographical remoteness. Although most villages have loudspeaker systems, these are often degraded, which makes it hard for villagers to receive the information. Furthermore, information cannot reach residents in remote areas. In these places, information is usually spread through village and mass association meetings, many of which are held at night. The night work creates a burden for local staff. An additional difficulty in the Khmer communities is the limited number of staff who are able to speak the Khmer language. Communication staff are mainly Kinh people, and interpreters are mobilised free-of-charge only for urgent matters. In addition, IEC materials are produced in Vietnamese only as it is more costly to translate these documents into Cham and Khmer languages. The foregoing barriers require further concerted efforts among multiple agencies in raising public awareness, especially in disadvantaged areas.

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Annex 1.1 Demographic characteristics (Nationwide 2009 and 2010)

	2009								2010
	Total population 2009	Female population (persons)	Female population (%)	Sex ratio (Males/100 females)	Urban population (persons)	Urban population (%)	Rural population (persons)	Rural population (%)	Total population 2010
Whole country	**85,789,573**	**43,307,024**	**50.48**	**98.1**	**25374262**	**29.58**	**60415311**	**70.42**	**86747807**
Urban	-	-	-	95.3	-	-	-	-	-
Rural	-	-	-	99.3	-	-	-	-	-
Northern Midlands and Mountains	11,064,449	5,534,925	50.02	99.9	1,772,059	16.02	9,292,390	83.98	11,150,794
Red River Delta	19,577,944	9,930,227	50.72	97.2	5,721,184	29.22	13,856,760	70.78	19,729,612
North and South Central Coast	18,835,485	9,503,886	50.46	98.2	4,530,450	24.05	14,305,035	75.95	18,911,046
Central Highlands	5,107,437	2,523,936	49.41	102.4	1,419,069	27.78	3,688,368	72.22	5,203,606
South East	14,025,387	7,180,709	51.20	95.3	8,009,167	57.10	6,016,220	42.90	14,484,403
Mekong River Delta	17,178,871	8,633,341	50.26	99.0	3,922,333	22.83	13,256,538	77.17	17,268,346
An Giang	**2,144,772**	**1,077,627**	**50.24**	**99.0**	**608,732**	**28.38**	**1,536,040**	**71.62**	**2,148,240**
Long An	1,436,914	723,326	50.34	98.7	251,386	17.49	1,185,528	82.51	1,445,871
Dong Thap	1,665,420	833165	50.03	99.9	287,075	17.24	1,378,345	82.76	1,670,399
Kien Giang	1,683,149	833,639	49.53	101.9	452,574	26.89	1,230,575	73.11	1,703,325
Can Tho	1,187,089	597,572	50.34	98.7	781,481	65.83	405,608	34.17	1,196,694
Hau Giang	756,625	375,931	49.69	101.3	149,399	19.75	607,226	80.25	758,746

Source: (i) Central Population and Housing Census Steering Committee (2010) The 2009 Viet Nam Population and Housing Census: Major Findings; (ii) General Statistics Office (2011) Population and Family Planning Survey 2010

Annex 1.2 Demographic characteristics (Nationwide 2009) continued

	Population density (persons/ km²)	Average household size (persons)	Average annual pop' growth rate (%)	Sex ratio at birth (male births / 100 female births)	Infant mortality rate (infant deaths / 1000 live births)	Population aged 15 and over (persons)	Population aged 15 and over (%)	Population aged under 15 (persons)	Population aged under 15 (%)
Whole Country	**259**	**3.8**	**1.2**	**110.5**	**16.0**	**64,330,730**	**75.0**	**21458843**	**25.01**
Urban	-	3.7	3.4	-	9.4	-	-	-	-
Rural	-	3.9	0.4	-	18.7	-	-	-	-
Northern Midlands and Mountains	116	4.0	1.0	108.5	24.5	8,039,502	72.7	3,024,947	27.34
Red River Delta	930	3.5	0.9	115.3	12.4	15,053,614	76.9	4,524,330	23.11
North and South Central Coast	196	3.8	0.4	109.7	17.2	13,885,444	73.7	4,950,041	26.28
Central Highlands	93	4.1	2.3	105.6	27.3	3,437,025	67.3	1,670,412	32.7
South East	594	3.8	3.2	109.9	10.0	10,921,725	77.9	3,103,662	22.13
Mekong River Delta	423	4.0	0.6	109.9	13.3	12,993,420	75.6	4,185,451	24.36
An Giang	**606**	**4.1**	**0.5**	**113.7**	**17.0**	**1,612,241**	**75.2**	**532,531**	**24.83**
Long An	320	3.8	1.0	102.9	11.0	1,085,644	75.6	351,270	24.45
Dong Thap	493	4.0	0.6	108.5	16.0	1,255,794	75.4	409,626	24.60
Kien Giang	265	4.2	1.2	110.6	15.0	1,239,562	73.6	443,587	26.35
Can Tho	847	4.1	0.7	114.1	9.6	920,468	77.5	266,621	22.46
Hau Giang	473	4.0	-	107.6	12.0	571,093	75.5	185,532	24.52

Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

Annex 1.3 Population by administrative area, age group and ethnicity (An Giang 1999 and 2009)

Administrative Area	1999						2009						Area	Pop. density
	Ethnic groups (person)						Ethnic groups (person)							
	Total population	Children <16 yrs	Kinh	Khmer	Cham	Others (Hoa)	Total population	Children <16 yrs	Kinh	Khmer	Cham	Others (Hoa)		
Whole province	**2,044,376**	**705,308**	**1,940,996**	**78,706**	**12435**	**11256**	**2,142,709**	**558,944**	**2,029,887**	**89,971**	**14209**	**8075**	**3536.76**	**605.84**
Long Xuyen City	248,126	74,745	245,126	219	80	2613	278,658	64,943	275,894	562	122	2048	115.43	2414.09
Chau Doc Town	104,835	34,303	101,382	37	53	3248	111,620	28,419	108,944	120	50	2470	104.68	1066.30
Tan Chau Town	151,853	52,583	148,157	77	2407	1159	153,185	39,710	149,853	131	2472	714	170.45	898.71
An Phu District	167,565	63,069	160,855	104	6018	440	177,710	48,425	169,969	156	7367	201	217.78	816.01
Phu Tan District	232,585	76,231	229,573	153	2236	535	227,070	56,449	224,405	146	2185	315	328.06	692.16
Chau Phu District	234,924	82,505	232,487	559	947	776	245,102	65,735	242,947	366	1027	441	451.01	543.45
Tinh Bien District	106,329	40,475	74,644	31,325	9	318	120,781	34,882	85,392	35,142	17	211	355.50	339.75
Tri Ton District	111,149	42,037	71,068	39,106	21	934	133,109	38,434	87,220	44,969	37	810	600.40	221.70
Chau Thanh District	159,386	57,195	155,556	2,950	621	180	169,723	46,130	165,099	3,579	874	160	355.11	477.94
Cho Moi District	353118	117085	352346	63	13	563	345200	87948	344654	158	21	356	369.62	933.93
Thoai Son District	174506	65080	169802	4113	30	490	180551	47869	175510	4642	37	349	468.72	385.20

Source: Province Statistics Office (2010) *Data provided during fieldwork.*

Annex 1.4 Population by administrative area, sex and urban/rural location (An Giang 2009)

Administrative Area	Total	Male	Female	Urban	Urban %	Rural	Rural %
Whole province	**2,142,709**	**1,064,483**	**1,087,226**	**608,273**	**28.39**	**1,534,436**	**71.61**
Long Xuyen City	278,658	135,147	143,511	245,699	88.17	32,959	11.83
Chau Doc Town	111,620	54,426	57,194	92,667	83.02	18,953	16.98
An Phu District	177,710	88,940	88,770	21,149	11.90	156,561	88.10
Tan Chau District	153,185	75,857	77,328	34,198	22.32	118,987	77.68
Phu Tan District	227,070	112,888	114,182	37,323	16.44	189,747	83.56
Chau Phu District	245,102	122,382	122,720	18,244	7.44	226,858	92.56
Tinh Bien District	120,781	59,511	61,270	34,191	28.31	86,590	71.69
Tri Ton District	133,109	66,082	67,027	30,967	23.26	102,142	76.74
Chau Thanh District	169,723	85,881	83,842	24,214	14.27	145,509	85.73
Cho Moi District	345,200	172,296	172,904	26,567	7.70	318,633	92.30
Thoai Son District	180,551	91,073	89,478	43,054	23.85	137,497	76.15

Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Completed Results*

Annex 1.5 Population age structure (An Giang 1999 and 2009)

Age groups	1999				2009			
	Population 1999	Total (%)	Male (%)	Female (%)	Population 2009	Total (%)	Male (%)	Female (%)
0-4	173,645	8.49	8.95	8.05	173,988	8.12	8.47	7.78
5 – 9	225,897	11.05	11.64	10.48	167,999	7.84	8.09	7.59
10 – 14	254,507	12.45	13.09	11.83	178,654	8.34	8.68	8.00
15 - 19	239,873	11.73	11.85	11.62	205,779	9.60	10.08	9.14
20 - 24	207,654	10.16	10.18	10.14	212,210	9.90	10.28	9.53
25 - 29	196,084	9.59	9.76	9.42	207,043	9.66	9.92	9.41
30 - 34	173,114	8.47	8.66	8.29	186,637	8.71	8.86	8.56
35 - 39	131,347	6.42	6.16	6.68	180,651	8.43	8.56	8.31
40 - 44	99,557	4.87	4.27	5.45	160,059	7.47	7.53	7.41
45 - 49	85,317	4.17	3.81	4.52	121,150	5.65	5.34	5.96
50 - 54	58,263	2.85	2.79	2.90	92,339	4.31	3.66	4.95
55 - 59	45,420	2.22	2.00	2.43	78,275	3.65	3.20	4.10
60 - 64	45,346	2.22	1.94	2.49	51,167	2.39	2.25	2.52
65 - 69	43,194	2.11	2.10	2.13	38,145	1.78	1.53	2.03
70 - 74	30,977	1.52	1.42	1.61	34,193	1.60	1.33	1.86
75+	34,181	1.67	1.38	1.95	54,420	2.54	2.23	2.85
Total	**2044376**				**2,142,709**			

Source: Province Statistics Office (2010) *Data provided during fieldwork.*

Annex 1.6 Population of ethnic groups (An Giang 2009)

	Total	%	Male	Female
Whole province	**2142709**		**1064483**	**1078226**
Kinh	2029888	94.73	1009308	1020580
Tay	31	-	17	14
Thai	50	-	23	27
Muong	52	-	26	26
Khmer	90271	4.21	43984	46287
Hoa	8075	0.38	4074	4001
Nung	18	-	12	6
Mong	9	-	5	4
Dao	7	-	4	3
Gia Rai	2	-	1	1
Ê De	25	-	17	8
Ba Na	2	-	2	0
San Chay	3	-	2	1
Cham	14209	0.66	6977	7232
San Diu	2	-	1	1
Hre	1	-	1	0
Mnong	5	-	3	2
Tho	3	-	0	3
Xtieng	1	-	0	1
Bru - Van kieu	2	-	0	2
Co Tu	1	-	0	1
Co	1	-	0	1
Cho Ro	2	-	1	1
Xinh Mun	1	-	0	1
Lao	36	-	17	19
La Chi	1	-	0	1
Khang	1	-	1	0
La Hu	1	-	1	0
Ngai	1	-	1	0
Pu Peo	1	-	0	1
Foreigners	7	-	5	2

Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Completed Results.*

Annex 1.7 Proportion of households by household size (Nationwide 2008)

Per centage

Region / Province	1 person	2 persons	3 persons	4 persons	5 persons
Whole Country	**6.2**	**13.0**	**20.2**	**29.6**	**31.0**
Northern Midlands and Mountains	3.7	11.5	20.4	30.8	33.7
Red River Delta	7.9	16.6	20.2	31.2	24.1
North and South Central Coast	6.8	13.5	18.7	28	33
Central Highlands	3.6	8.9	17.6	29.1	40.8
South East	6.4	12.1	21.4	28.6	31.5
Mekong River Delta	5.3	10.4	21.8	29.7	32.7
An Giang	**4.1**	**8.6**	**20.3**	**30.2**	**36.9**
Long An	6.6	12.3	21.3	31.3	28.4
Dong Thap	4.3	8.9	19.6	30.8	36.4
Kien Giang	3.7	7.7	20.5	30.5	37.6
Can Tho	3.9	9.4	20.1	29.2	37.5
Hau Giang	5.4	10.7	22.1	30.6	31.2

Source: General Statistics Office (2009) *Population Change, Labour Force and Family Planning Survey 2008.*

Annex 1.8 Poverty rate (Nationwide)

Per centage

Region / Province	Income poverty rate (a)				General poverty rate (b)			
	2006	2007	2008	2009	2002	2004	2006	2008
Whole country	**15.5**	**14.8**	**13.4**	**12.3**	**28.9**	**19.5**	**16.0**	**14.5**
Red River Delta	10	9.5	8.6	7.7	21.5	11.8	8.9	8.0
Northern Mountains	27.5	26.5	25.1	23.5	47.9	38.3	32.2	31.6
North and South Central Coast	22.2	21.4	19.2	17.6	35.7	25.9	22.3	18.4
Central Highlands	24	23	21	19.5	51.8	33.1	28.6	24.1
South East	3.1	3.0	2.5	2.1	8.2	3.6	3.8	2.3
Mekong River Delta	13	12.4	11.4	10.4	23.4	15.9	10.3	12.3
An Giang	**9.7**	**9.2**	**8.5**	**-**	**-**	**-**	**-**	**-**
Long An	8.7	8.3	7.7	-	-	-	-	-
Dong Thap	12.1	11.5	10.6	-	-	-	-	-
Kien Giang	10.8	10.3	9.3	-	-	-	-	-
Can Tho	7.5	7.1	7.0	-	-	-	-	-
Hau Giang	15	14.3	13.4	-	-	-	-	-

(a) Poverty rate is calculated by household income. The Government's poverty line for 2006-2010 period is 200.000 VND per capita per month for rural areas and 260.000 VND per capita per month for urban areas.

(b) General poverty rate is calculated by monthly average expenditure per capita accordiong to the general poverty line provided by GSO and the World Bank.

Source: (i) General Statistics Office (2010) Statistical Yearbook of Viet Nam 2009; (ii) General Statistics Office (2011) Statistical Handbook of Viet Nam 2010..

Annex 1.9 Poverty rate (An Giang 2008-2010)

	2008				2009				2010			
Administrative Area	Total number of households	% poor households	Number of poor households	Number of poor ethnic minority households	Total number of households	% poor households	Number of poor households	Number of poor ethnic minority households	Total number of households	% poor households	Number of poor households	Number of poor ethnic minority households
Whole province	**480211**	**7.20**	**34536**	**5993**	**522624**	**5.81**	**30388**	**4581**	**522624**	**3.59**	**18756**	**4346**
Long Xuyen City	55735	2.68	1493	-	67932	2.02	1369	-	67932	1.17	795	11
Cho Moi District	81144	3.67	2978	-	84125	2.62	2200	-	84125	1.93	1620	-
Chau Thanh District	34372	5.14	1766	120	40705	3.91	1591	-	40705	3.05	1241	127
Thoai Son District	36063	7.85	2831	79	42082	5.87	2472	216	42082	3.88	1634	244
Tri Ton District	30907	18.94	5667	2991	32829	16.29	5349	2180	32829	8.73	2865	772
Tinh Bien District	27905	18.94	5284	2506	29637	16.04	4754	2054	29637	12.14	3598	2960
Chau Phu District	55937	8.14	4555	65	58197	7.17	4173	-	58197	1.92	1111	-
Chau Doc Town	26102	2.10	547	-	28175	1.44	407	-	28175	0.42	119	-
An Phu District	38991	9.70	3783	157	42696	7.85	3351	98	42696	5.66	2415	221
Tan Chau Town	38028	4.21	1600	12	38483	3.75	1442	-	38483	2.86	1099	-
Phu Tan District	55027	7.33	4032	68	57763	5.68	3280	33	57763	3.91	2259	11

Source: Department of Labour, Invalids and Social Affairs (2010) *Data provided during fieldwork.*

Annex 1.10 Child poverty estimates using VHLSS and MICS (Nationwide 2006 and 2008)

Per centage

Region / population group	2006			2008	
	VHLSS (i)		MICS (ii)	VHLSS (i)	
	Monetary child poverty rate	Multi-dimensional child poverty rate	Multi-dimensional poverty rate	Monetary child poverty rate	Multi-dimensional child poverty rate
Whole country	**22.6**	**30.7**	**36.65**	**20.7**	**28.9**
Urban	5.4	11.3	12.04	4.9	12.5
Rural	27.6	36.3	43.40	25.9	34.3
Red River Delta	13.2	9.7	11.26	12	10.4
North East	34.1	36.2	58.76	32.5	35.8
North West	58.9	63.1	77.65	55.5	64.6
North Central Coast	38	25.8	30.95	32.1	23.3
South Central Coast	16.7	18.5	28.79	19.4	19.4
Central Highlands	37.2	39.3	40.53	33.5	38.7
South East	9.1	20.2	22.63	5.5	14.8
Mekong River Delta	12.6	56.3	59.95	15.5	52.8
Male	22.4	30.5	36.86	19.2	28.4
Female	22.9	31.0	35.42	22.3	29.5
Kinh / Chinese	14.5	24.1	28.27	12.7	22.4
Other	61.3	62.3	78.09	60.7	61.5

Source: (i) General Statistics Office (2009) *Results of the Survey on Households Living Standards 2008;* (ii) UNICEF / MOLISA (2008) *Multiple Indicator Cluster Survey 2006.*

Annex 1.11 Gross Domestic Product by economic sector (An Giang 2007–2010)

Year	GDP growth rate	GDP growth at current prices (%)			GDP at current prices (%)		
		Agriculture, forestry and fishery	Industry and construction	Sevices	Agriculture, forestry and fishery	Industry and construction	Sevices
2007	13.63	9.03	15.55	15.8	35.29	12.37	52.34
2008	14.2	8.14	15.57	17.25	39.56	11.95	48.48
2009	8.67	-0.5	6.5	14.29	35.51	12.31	52.18
2010	10.12	4.2	12.2	12.4	33.46	12.82	53.72

Source: (i) Province Socio Economic Development Plans (2008-2011); (ii) Province Statistics Office (2010) *Results of Socio-Economic Statistics in the 10 Year Period 2001-2010 An Giang Province.*

Annex 1.12 Average monthly income by economic quintile (Nationwide 2008)

VND thousand

Region/ Province	General average	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Whole country	995	275	477	700	1067	2458
Red River Delta	1065	332	539	757	1136	2559
North Mountains	657	219	334	464	709	1558
North and South Central Coast	728	237	403	555	802	1647
Central Highlands	795	222	391	605	926	1829
South East	1773	550	925	1287	1791	4286
Mekong River Delta	940	301	502	704	1012	2183
An Giang	1064	351	605	810	1110	2449
Long An	938	331	534	733	1018	2077
Dong Thap	890	279	448	619	932	2169
Kien Giang	1018	327	497	675	986	2600
Can Tho	1131	381	624	954	1268	2426
Hau Giang	886	294	462	682	966	2022

Source: General Statistics Office (2010) *Statistical Yearbook of Viet Nam 2009.*

Annex 1.13 Difference in monthly income between the lowest and highest economic quintiles (Nationwide 2008)

Region / Province	Quintile 1 (VND thousand)	Quintile 5 (VND thousand)	Factor difference between Quintile 1 and Quintile 5
Whole country	**275**	**2458**	**9.8**
Red River Delta	332	2559	7.7
North Mountains	219	1558	7.1
North and South Central Coast	237	1647	7.0
Central Highlands	222	1829	8.2
South East	550	4286	7.8
Mekong River Delta	301	2183	7.3
An Giang	**351**	**2449**	**7.0**
Long An	331	2077	6.3
Dong Thap	279	2169	7.8
Kien Giang	327	2600	8.0
Can Tho	381	2426	6.4
Hau Giang	294	2022	6.9

Source: General Statistics Office (2010) *Statistical Yearbook of Viet Nam 2009.*

Annex 1.14 Monthly average income per capita at current prices by income source (Nationwide 2008)

Region / Province	2004					2008				
	Monthly average income (VND thousand)	Income source (%)				Monthly average income (VND thousand)	Income source (%)			
		Salary and wage	Agriculture forestry and fisheries	Non agriculture, forestry and fisheries	Other		Salary and wage	Agriculture forestry and fisheries	Non agriculture, forestry and fisheries	Other
Red River Delta	488.2	-	-	-	-	1048.5	-	-	-	-
North East	379.9	-	-	-	-	768.0	-	-	-	-
North West	265.7	-	-	-	-	549.6	-	-	-	-
North Central Coast	317.1	-	-	-	-	641.1	-	-	-	-
South Central Coast	414.9	-	-	-	-	843.3	-	-	-	-
Central Highlands	390.2	-	-	-	-	794.6	-	-	-	-
South East	833.0	-	-	-	-	1649.2	-	-	-	-
Mekong River Delta	471.1	-	-	-	-	939.9	-	-	-	-
An Giang	518.2	25.9	35.2	26.8	12	1064.0	25.1	39.9	25.2	9.8
Long An	473.9	39.2	31.6	16.3	12.9	937.7	37.5	32.6	15.4	14.5
Dong Thap	499.7	22.0	36.7	23.9	17.5	889.6	23.7	44.9	21.3	10.2
Kien Giang	513.4	26.8	38.7	22.1	12.3	1017.6	23	42.6	19.5	15
Can Tho	523.9	29.9	26.1	29.5	14.5	1130.8	32.1	23.4	30.8	13.8
Hau Giang	449.0	20.3	46.6	18	15.2	885.9	23.2	41.8	15.7	19.3

Source: General Statistics Office (2009) *Results of the Survey on Household Living Standards 2008.*

Annex 1.15 Structure of household consumption expenditure (Nationwide 2008)

Per centage

Consumption expenditure items	Region								
	Total	Red River Delta	North East	North West	North Central Coast	South Central Coast	Central Highlands	South East	Mekong Delta
Eating, drinking and smoking	53.0	53.4	57.9	59.9	56.7	54.1	53.7	47.1	55.8
Food	12.8	12.7	17.1	21.6	17.8	12.6	16.0	7.8	14.0
Foodstuff	27.3	29.2	29.9	27.9	27.4	26.5	26.4	24.2	29.1
Fuel	2.9	2.7	3.6	4.7	3.4	2.8	2.9	2.5	3.0
Non-eating, drinking and smoking	47.0	46.6	42.1	40.1	43.3	45.9	46.3	52.9	44.3
Garment, hat, shoes, sandals	4.2	4.5	4.5	4.7	4.0	4.4	5.1	3.7	4.1
Housing, electricity, water, sanitation	3.9	4.0	3.1	2.3	3.2	3.6	2.3	5.3	3.2
Furniture	8.3	8.8	8.7	8.8	8.0	8.2	8.8	8.0	8.6
Healthcare	6.4	6.0	5.4	5.2	7.0	6.3	7.2	5.9	8.0
Travel and communication	13.9	13.2	13.3	13.8	10.7	13.7	14.1	17.3	11.1
Education	6.2	6.7	5.1	3.8	8.5	7.7	6.4	6.3	4.2
Culture, sport, recreation	1.5	1.5	0.5	0.4	0.4	0.8	0.6	3.2	0.9
Others	2.6	2.0	1.5	1.1	1.5	2.4	2.0	3.2	4.1

Source: General Statistics Office (2009) *Results of the Survey on Household Living Standards 2008.*

Annex 1.16 Household living conditions (Nationwide 2009)

Per centage households

Region / Province	Safe water	Hygienic toilet facilities	Network electricity for lighting	Television	Motorbike
Whole country	**86.7**	**54.0**	**96.1**	**86.9**	**72.3**
Urban	96.3	87.8	99.6	91.3	83.2
Rural	82.5	39.0	94.6	84.9	67.5
Northern Midlands and Mountains	61.5	26.1	87.1	79.8	69.6
Red River Delta	98.3	60.4	99.7	91.2	70.3
North and South Central Coast	89.7	47.3	97.3	86.2	70.2
Central Highlands	78.5	46.5	93.0	85.1	83.5
South East	97.1	89.9	98.2	88.8	88.0
Mekong River Delta	77.9	42.4	95.1	85.4	62.5
An Giang	**62.9**	**55.3**	**92.3**	**82.3**	**66.5**
Long An	93.1	49.6	97.0	89.5	76.3
Dong Thap	43.3	35.8	97.1	86.7	70.2
Kien Giang	89.2	40.3	91.2	81.8	53.6
Can Tho	76.2	58.9	98.1	88.1	73.0
Hau Giang	64.3	27.1	95.6	84.7	52.0

Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

Annex 1.17 Housing conditions (Nationwide 2009)

Per centage households

Region / Province	Permanent housing	Semi-permanent housing	Less-permanent housing	Simple-permenant housing
Whole country	**46.7**	**38.2**	**7.8**	**7.4**
Urban	41.4	52.7	3.3	2.6
Rural	49.0	31.7	9.8	9.5
Northern Midlands and Mountains	45.5	27.1	15.4	12.0
Red River Delta	89.7	9.5	0.60	0.2
North and South Central Coast	63.0	29.7	3.4	3.9
Central Highlands	19.7	68.8	7.7	3.7
South East	14.4	78.9	2.9	3.8
Mekong River Delta	8.3	48.5	21.4	21.8
An Giang	**10.9**	**49.7**	**24.4**	**15**
Long An	16.9	53.1	13.6	16.4
Dong Thap	10.7	44.2	25.4	19.7
Kien Giang	3.4	40.6	23.5	32.6
Can Tho	6.9	60.9	15.4	16.8
Hau Giang	2.1	42.7	16.7	38.4

Source: Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

Annex 1.18 Province budget revenue (An Giang 2000 – 2009)

VND million

		2000	2005	2006	2007	2008	2009 (prel.)
	Total revenue of state budget	**1,575,194**	**3,362,437**	**3,778,812**	**4,652,352**	**5,853,306**	**7,835,215**
1	Local revenue from different sources	792,585	1,729,411	1,944,883	2,293,258	2,916,645	3150,852
2	Revenue balance	66,895	209,334	136,281	104,483	124,149	102,972
3	Revenue subsidy from central state budget	438,090	1,083,886	1,149,614	1,745,683	2,180,973	2,872,225
4	Revenue of credit in investment	273,000	68,682	143,200	100,000	-	823,369
5	Revenue from treasure bill and bond	4,624	46,079	35,035	-	46,859	15,368
6	Carried over from previous year	-	225,045	369,799	408,928	584,680	870,429

Source: Province Statistics Office (2010) *Statistical Yearbook 2009.*

Annex 1.19 Province budget expenditure (An Giang 2000–20089)

VND million

		2000	2005	2006	2007	2008	2009 (prel.)
	Local expenditure of state budget	**1,307,479**	**3,092,213**	**3,579,278**	**4,475,831**	**5,642,940**	**7,880,571**
I	Capital expenditure	427,575	652,060	800,858	675,288	731,083	2,268,282
II	Working capital	25,802	6,121	148	41,205	-	-
III	Expenditures of credit in investment	186,450	21,250	18,450	25,075	128,334	185,900
IV	Recurrent expenditures	667,652	1,463,607	1,507,531	1,877,241	2,274,248	3,031,674
1	Administrative expenditures	85,010	293,029	328,343	386,110	427,215	503,705
2	Expenditures of economic sevices	55,179	106,334	92,342	112,303	116,474	226,305
3	Expenditures of social and cultural services	383,284	854,338	877,933	1,139,274	1,368,636	1,989,979
3.1	Education and training	224,559	556,143	623,785	805,082	961,412	1,216,251
3.2	Health	89,065	188,814	145,690	224,728	264,179	574,849
3.3	Social subsidy	34,943	42,638	40,176	41,197	59,649	101,746
4	Others	144,179	209,906	208,913	239,554	361,923	311,685

Source: Province Statistics Office (2010) *Statistical Yearbook 2009.*

Annex 1.20 Province development investment budget (An Giang 2008 – 2010)

VND billion

Budget categories		SEDP Year		
		2008	2009	2010
	Total	**16000**	**20500**	**22494**
1	**Locally-managed development capital**	**15200**	**19500**	**21294**
1.1	State budget	1025	1233	1603
	National budget sources	995	1200	1553
	- lottery revenue	280	380	490
	- focused investment	-	-	248
	- revenue from land use	-	-	350
	- investment for specific objectives	-	-	353
	Official Development Assistance (ODA)	30	32.9	50
1.2	Government bond	-	-	333
1.3	Government credit for development	695	1052	1220
1.4	Investment capital of state-own enterprises	41	32	30
	From basic depreciation (downgrading) of assets	15	14	11
	From profit after tax	14	10	10
	Commercial loans	12	9	9
1.5	Investment capital of non-public enterprises and households	6460	8779	8818
1.6	Foreign Direct Investment (FDI)	450	800	700
1.7	Other sources	6309	7605	7961
	Bank loans	4181	4785	4755
	Outside-province capital, NGO	2128	2820	3206
2	Centrally-managed development capital	800	1000	1200

Source: Province Peoples Committee (2008 010) *Socio Economic Development Plans 2008 to 2010.*

Annex 1.21 Funding for National Target Programs (An Giang 2006-2010)

VND million

National Target Program	Total investment in period of 2006 - 2010						
	Total	Central budget	Local budget	Other mobilsed sources	% total funding	% state budget resources	% recurrent budget
TOTAL	2,289,951	539,804	262,322	1,487,825			
INVESTMENT BUDGET	156,881	127,117	22,764	7,000			
BUDGET FOR SERVICE DELIVERY	2,133,070	412,687	239,558	1,480,825			
Poverty reduction program	**1,557,371**	**17,371**	**125,000**	**1,415,000**	**68.0**	**17.7**	
- Investment budget	3,500	3,500	-	-			
- Recurrent budget	1,553,871	13,871	125,000	1,415,000			99.8
Population and family planning	135,530	41,978	93,552	-	5.9	16.9	
- Investment budget	1,445	1,445	-	-			
- Recurrent budget	134,085	40,533	93,552	-			98.9
Prevention of Social Diseases, Dangerous Epidemics and HIV/ AIDS	**120,408**	**34,172**	**20,411**	**65,825**	**5.3**	**6.8**	
- Investment budget	2,000	2,000	-	-			
- Recurrent budget	118,408	32,172	20,411	65,825			98.3
Rural water supply and environment sanitation	**124,222**	**111,572**	**5,650**	**7,000**	**5.4**	**14.6**	
- Investment budget	113,822	101,172	5,650	7,000			
- Recurrent budget	10,400	10,400	-	-			8.4
Cultural program	13,990	13,990	-	-	0.6	1.7	
- Investment budget	4,000	4,000	-	-			
- Recurrent budget	9,990	9,990	-	-			71.4
Prevention and control of crimes	**4,600**	**4,600**	**-**	**-**	**0.2**	**0.6**	
- Recurrent budget	4,600	4,600	-	-			100.0
Education and training program	**294,530**	**294,530**	**-**	**-**	**12.9**	**36.7**	
- Investment budget	10,900	10,900	-	-			
- Recurrent budget	283,630	283,630	-	-			96.3
Employment program	**22,454**	**4,900**	**17,554**	**-**	**1.0**	**2.8**	
- Investment budget	21,214	4,100	17,114	-			
- Recurrent budget	1,240	800	440	-			5.5
Food safety and hygiene program	**4,914**	**4,914**	**-**	**-**	**0.2**	**0.6**	
- Recurrent budget	4,914	4,914	-	-			100.0
Anti-drug program	**11,932**	**11,777**	**155**	**-**	**0.5**	**1.5**	
- Recurrent budget	11,932	11,777	155	-			100.0

Source: Department of Finance (2010) *Data provided during fieldwork.*

Annex 1.22 Healthcare service indicators by administrative area (An Giang 2008 and 2010)

	2008					2010				
Administrative area	Number of district hospital beds	Number of doctors per 10,000 people	Commune/ ward clinics with delivery nurse/ midwife (%)	Commune/ ward clinics with doctor (%)	Communes reaching national health standard (%)	Number of district hospital beds	Number of doctors per 10,000 people	Commune/ ward clinics with delivery nurse/ midwife (%)	Commune/ ward clinics with doctor (%)	Communes reaching national health standard (%)
Long Xuyen City	80	14.77	100	84.61	92.3	80.00	16.37	100	84.61	100
Chau Doc Town	50	10.68	100	42.85	100	50.00	12.25	100	14.28	100
Tan Chau Town	170	3.86	100	54.50	100	210	4.25	100	50.00	85.70
An Phu District	150	1.78	100	35.71	92.86	180	2.70	100	35.71	100
Chau Phu District	100	1.34	100	69.23	92.30	120	1.46	100	84.61	100
Chau Thanh District	110	1.84	100	76.92	100	130	2.64	100	76.92	100
Cho Moi District	170	1.39	100	66.67	100	170	1.65	100	66.67	100
Tan Phu District	170	2.83	100	78.95	100	190	2.83	100	72.22	100
Thoai Son District	140	1.66	100	52.94	100	150	3.43	100	58.82	100
Tinh Bien District	140	3.83	100	78.57	100	140	4.02	100	71.43	100
Tri Ton District	120	3.38	100	66.67	86.67	140	3.77	100	53.33	86.67

Source: Department of Health (2010) *Data provided during fieldwork.*

Annex 1.23 Health service delivery indicators (Nationwide 2009)

Region / Province	Total budget 2009 (VND million)	Health budget per capita (VND thousand)	Number of beds in provincial hospitals	Number of beds in district hospitals	Total hospital beds	Number of commune / ward clinic beds	Commune / ward clinics with delivery nurse/ midwife (%)	Commune / ward clinics with doctor (%)	Communes reaching national health standard (%)
Whole country	**13754318**	**159.9**	**85520**	**55190**	**140710**	**47092**	**67.5**	**95.7**	**65.4**
Red River Delta	2789896	142.2	17770	12110	29880	10421	73.2	96.3	78.6
Northern Midland and Uplands	2369785	213.6	9645	9368	19013	10570	58.2	94.0	55.4
North and South Central Coast	2894721	153.4	14181	15359	29540	12550	65.9	96.2	61.0
Central Highlands	942737	184.0	3750	2759	6509	2864	49.5	95.4	48.1
South East	2580590	183.1	25694	5035	30729	2707	78.4	97.2	72.5
Mekong River Delta	2176589	126.4	14480	10523	25003	7980	80.1	96.1	72.7
An Giang	**261171**	**121,5**	**1450**	**1250**	**2700**	**630**	**74.0**	**100**	**97,4**
Long An	189058	131,4	1130	850	1980	732	76,3	84,2	76,8
Dong Thap	193470	116.0	1950	950	2900	788	100	100	52,1
Kien Giang	244120	144,6	1350	1260	2610	630	53,1	84,8	26,2
Can Tho	166804	140,2	1020	570	1590	214	84,7	100	70,6
Hau Giang	95346	125,8	450	760	1210	168	49,3	91,5	80,3

Source: Ministry of Health (2011) *Health Statistics Yearbook 2009.*

Annex 1.24 Health insurance coverage (An Giang 2009–2010)

	2009				2010			
	Number insurance cards	Budget (VND million)	Number of turns of card use	Expenditure (VND million)	Number insurance cards	Budget (VND million)	Number of turns of card use	Expenditure (VND million)
Number of children under 6 with support from state budget and with health insurance cards	223,020	13,046	218,557	8,148	219,808	61,291	316,659	23,705
Number of poor people with support from state budget with health insurance cards including children	241,754	51,392	-	-	247,768	69,403	-	-
Number of school pupils with health insurance cards and with 30% budget support	148,271	7,962	231,226	11,041	195,346	15,202	163,677	10,145
Number of ethnic minority pupils with health insurance cards with 100% budget support	15,509	2,363	-	-	14,050	2,584	-	-
Number of Khai Tri schools pupils with health insurance cards with 100% budget support (provided by DOLISA)	139	47	-	-	128	50	-	-
Number of nearpoor people with health insurance cards with budget support (50% and 30%)	62,770	13,278	-	-	44,370	11,945	-	-

Source: Province Social Insurance (2010) *Report on child health insurance in An Giang Province in 2009-2010.*

Annex 1.25 Selected child health indicators (Nationwide 2009)

Region / Province	CBR (‰)	Sex ratio at birth	IMR (‰)	Vaccination				
				BCG (%)	OPV (%)	DPT (%)	Measles (%)	Fully vac. (%)
Whole country	17.6	110.5	16.0	97.0	96.6	96.3	97	96.3
Red River Delta	17.6	115.3	12.4	99.0	98.7	98.7	98.5	98.5
Northern Midlands and Uplands	19.6	108.5	24.5	97.0	94.9	95.0	95.3	94.3
North and South Central Coast	16.9	109.7	17.2	97.3	96.8	97.0	96.5	95.8
Central Highlands	21.9	105.6	27.3	95.9	96.4	96.5	96.8	96.2
South East	17.8	109.9	10	95.3	95	93.2	97.4	95.9
Mekong River Delta	16.0	109.9	13.3	96.1	96.4	96.3	96.6	96.1
An Giang	**17.6**	**50.2**	**17.0**	**99**	**97.3**	**97.3**	**96.9**	**95.7**
Long An	15.8	50.3	11.0	96.7	97.3	97.4	96.5	96.3
Dong Thap	16.0	50.0	16.0	94.4	97	97	95.8	93.7
Kien Giang	16.7	49.5	15.0	93.5	93.5	93.5	93.5	92.7
Can Tho	15.9	50.3	9.6	97.4	97.2	97.2	97.4	97.3
Hau Giang	17.0	49.7	12.0	97.1	96.5	96.5	96.8	96.8

Source: Ministry of Health (2011) *Health Statistics Yearbook 2009.*

Annex 1.26 HIV/AIDS indicators (Nationwide 2008)

Region / Province	Cumulative number of HIV infected (persons)	Cumulative rate per 100,000 persons	Cumulative caser of AIDS	Rate of new HIV infections per 100,000 persons
Whole country	**179735**	**208.48**	**71119**	**23.5**
Red River Delta	41127	221.77	14148	25.97
North East Region	26341	272.9	10487	36.8
North West Region	10003	375.33	2403	49.34
North Central Coast	9342	86.54	3757	12.06
South Central Coast	4382	60.41	2320	6.67
Central Highland	2700	53.95	776	10.81
South East Region	55330	378.95	24411	33.5
Mekong Delta Region	29854	168.71	12817	18.95
An Giang	**7226**	**321.07**	**4576**	**17.68**
Long An	1766	122.74	991	8.55
Dong Thap	3271	194.39	1019	20.27
Kien Giang	2372	137.3	576	25.18
Can Tho	3920	334.73	1653	36.63
Hau Giang	845	104.51	312	22.02

Source: Ministry of Health (2009). *Health Statistics Yearbook 2008.*

Annex 1.27 Child malnutrition rates (Nationwide 2005, 2007 and 2010)

Per centage

	2005				2007				2010			
	Underweight total	Moderate underweight	Stunting total	Moderate stunting	Underweight total	Moderate underweight	Stunting total	Moderate stunting	Underweight total	Moderate underweight	Stunting total	Moderate stunting
Whole Country	**21.3**	**19.5**	**24.4**	**17.4**	**21.2**	**18.3**	**33.9**	**19.2**	**17.5**	**15.4**	**29.3**	**18.8**
Red River Delta	21.3	19.5	24.4	17.4	18.3	17.0	29.8	18.9	17.5	15.4	29.3	18.8
North East	28.4	24.3	33.6	21.1	23.8	20.8	36.2	23.6	22.1	19.7	33.7	20.9
North West	30.4	24.8	35.6	17.9	27.2	22.4	37.6	21.8				
North Central Coast	30.0	26.0	35.1	23.7	25.0	22.4	36.2	23.4	19.8	17.6	31.4	19.3
South Central coast	25.9	22.6	29.3	19.0	20.7	18.1	33.2	21.4				
Central Highlands	34.5	28.2	41.5	21.5	31.0	25.6	42.3	25.0	24.7	20.6	35.2	21.4
South East	18.9	16.8	21.6	13.0	17.9	15.8	28.1	16.8	10.7	9.5	19.2	10.7
Mekong River Delta	23.6	20.7	28.1	18.2	20.7	18.7	30.8	18.6	16.8	14.5	28.2	17.1
An Giang	**24.9**	**21.3**	**30.0**	**18.6**	**22.0**	**20.2**	**31.8**	**19.1**	**17.0**	**14.8**	**28.7**	**17.7**
Long An	21.4	18.9	22.1	14.8	18.2	15.8	27.4	16.3	14.4	13.2	24.5	15.0
Dong Thap	24.5	20.4	33.8	19.5	21.7	18.4	34.0	20.2	17.3	14.6	29.8	16.6
Kien Giang	23.4	21.2	25.3	18.9	20.8	19.2	29.9	18.4	17.3	14.8	26.9	15.7
Can Tho	21.9	19.5	23.7	17.4	19.1	17.2	29.2	18.1	13.9	13.4	26.4	15.2
Hau Giang	22.2	18.9	30.7	21.2	19.5	16.8	34.0	22.8	16.4	13.6	31.0	22.2

Source: National Institute of Nutrition, Nutrition Surveillance System.

Annex 1.28 Rural water supply and sanitation (An Giang 2009)

Administrative area	Domestic water and household sanitation				Schools			Health Clinics		
	Total number of rural households	Total rural population (persons)	% rural population using	% rural households with hygienic latrines	Number of schools	% schools with standard clean water (QCVN 02)	% schools with hygienic latrines	Number of clinics	% clinics with standard clean water	% clinics with hygienic latrines
Whole province	**433877**	**1809575**	**44.34**	**46.08**	**903**	**86.71**	**86.71**	**139**	**98.56**	**98.56**
Long Xuyen City	7561	32558	42.28	51.47	19	100	100	2	100	100
Cho Moi District	84429	347726	29.31	49.4	143	83.21	83.21	18	100	100
Chau Thanh District	39810	166551	27.52	46.06	91	72.52	72.52	13	92.31	92.31
Thoai Son District	41582	192263	30.21	56.78	87	81.61	81.61	17	100	100
Tri Ton District	32754	132829	50.33	39.71	92	89.13	89.13	15	100	100
Tinh Bien District	27721	118352	57.95	48.88	78	96.15	96.15	14	100	100
Chu Phu District	57903	248104	52.59	42.78	119	84.03	84.03	13	100	100
Chau Doc Town	4636	18802	81.15	52.52	14	100	100	3	100	100
An Phu District	40952	170908	51.66	34.56	79	78.48	78.48	14	92.86	92.86
Tan Chau Town	38564	152583	67.12	49.8	65	100	100	11	100	100
Phu Tan District	57965	228899	48.47	43.63	116	94.83	94.83	19	100	100

Source: Province Centre for Rural Water Supply and Sanitation (2009) *Report on results of survey on rural water supply and sanitation 2009.*

Annex 1.29 Accidents and injuries (An Giang 2009)

Location and type of accident	Total (all age groups)		0 - 4 yrs		5 - 14 yrs		15 - 19 yrs	
	Number of accidents	Female	Number of accidents	Female	Number of accidents	Female	Number of accidents	Female
Location of accident	**22021**	**9268**	**1944**	**1025**	**3115**	**1452**	**4259**	**2167**
On the road	9565	3970	694	376	1266	614	1751	959
At home	6023	2874	867	427	1075	488	604	396
At school	516	286	58	50	221	92	88	82
At work	1375	383	5	5	18	8	235	110
At public places	2291	968	97	85	234	134	661	301
Lakes, ponds, rivers	2251	787	223	82	301	116	920	319
Type of injuries	**22021**	**9268**	**1944**	**1025**	**3115**	**1452**	**4259**	**2167**
Road accident	8409	3554	644	345	1221	572	1510	735
Labour accident	2408	735	20	15	183	175	253	126
Animals (bites, stings,…)	327	97	24	6	76	29	108	26
Falling	4322	1978	935	481	991	396	272	138
Drowning	219	35	21	9	53	7	139	15
Burns	399	148	145	56	54	25	93	36
Poisoning by chemicals or food	322	93	16	8	51	3	97	4
Suicide	545	114	0	0	7	5	246	22
Violence and conflict	2429	771	9	5	85	47	354	207
Others	2641	1743	130	100	394	193	1187	858

Source: Department of Health (2009) *Report on Accident Statistics 2009.*

Annex 1.30 Accidents and injuries (An Giang first 9 months of 2010)

Location and type of accident	Total (all age groups)		0 - 4 yrs		5 - 14 yrs		15 - 19 yrs	
	Number of accidents	Female	Number of accidents	Female	Number of accidents	Female	Number of accidents	Female
Location of accidants	**16379**	**4841**	**1248**	**437**	**2059**	**705**	**1945**	**577**
On the road	7315	2059	443	146	937	324	885	264
At home	4933	1676	634	209	652	224	440	124
At school	711	290	62	40	281	92	216	95
At work	1118	190	3	2	33	9	152	18
At public places	2082	557	99	35	135	48	239	69
Lakes, ponds, rivers	220	69	7	5	21	8	13	7
Number of injuries	**16379**	**4841**	**1248**	**437**	**2059**	**705**	**1945**	**577**
Road accident	6033	1799	377	116	780	286	857	248
Labour accident	2726	526	30	3	103	30	284	63
Animals	188	59	13	1	35	10	19	7
Falls	3528	1421	614	262	791	277	401	154
Drowning	74	21	16	8	13	6	5	0
Burns	128	52	52	20	31	14	7	1
Poisoning by chemicals or food	111	33	18	6	8	3	5	5
Suicide	237	93	1	0	4	3	54	29
Violence and conflict	1950	453	7	1	75	19	221	50
Others	1404	384	120	20	219	57	92	20

Source: Department of Health (2010) *Report on Accident Statistics 2010.*

Annex 1.31 Number of pupils at different education levels (An Giang 2007–2010)

	School year								
	2007-2008			2008-2009			2009-2010		
Education level	**Total pupils**	**Ethnic minority pupils**	**Female pupils**	**Total pupils**	**Ethnic minority pupils**	**Female pupils**	**Total pupils**	**Ethnic minority pupils**	**Female pupils**
Total pupils	334,631	16,303	164,239	328,790	16,103	161,101	328,523	16,089	162,383
Primary	177,127	9,740	85,937	173,906	9,850	83,846	178,581	9,900	86,631
Lower Secondary	112,950	5,252	55,588	111,190	5,072	54,620	107,103	4,974	52,792
Upper Secondary	44,554	1,311	22,678	43,694	1,181	22,635	42,839	1,215	22,960

Source: Department of Education and Training (2010) *Data provided during fieldwork.*

Annex 1.32 Highest educational attainment and literacy rate (Nationwide 2009)

Per centage

	Highest educational attainment of persons over 5 years old						Literacy rate of persons over 15 years old		
	Never attended	Incomplete primary education	Completed primary education	Completed lower secondary education	Completed upper secondary and higher education	Completed vocational	Literacy rate of persons over 15 total (%)	Literacy rate of males over 15 (%)	Literacy rate of females over 15 (%)
Whole country	**5.5**	**22.7**	**27.6**	**23.7**	**20.8**	**4.7**	**93.5**	**95.8**	**91.4**
Urban	2.5	16.7	23.0	20.4	32.4	7.6	97.0	98.0	96.0
Rural	6.8	25.3	29.6	25.1	13.8	3.5	92.0	94.8	89.3
Northern Midlands and Mountains	10.4	22.7	25.6	23.2	18.2	6.4	87.3	92.0	82.8
Red River Delta	2.2	15.8	18.9	33.0	30.1	6.8	97.1	98.7	95.6
North and South Central Coast	4.3	22.2	28.6	25.9	19.1	4.8	93.9	96.3	91.7
Central Highlands	8.9	25.7	30.9	20.8	13.7	-	88.7	92.3	85.1
South East	3.1	19.7	29.1	21.0	27.2	3.8	96.4	97.4	95.4
Mekong River Delta	6.6	32.8	35.6	14.3	10.7	2.2	91.6	93.9	89.5
An Giang	**10.3**	**37.0**	**32.2**	**11.8**	**9.5**	**1.8**	**88.2**	**90.7**	**85.7**
Long An	3.9	30.6	37.7	16.5	11.4	2.4	94.9	96.7	93.1
Dong Thap	7.5	33.1	36.4	14.1	9.5	1.8	90.8	93.1	88.4
Kien Giang	7.5	34.0	35.3	13.8	9.2	2.2	91.4	93.6	89.3
Can Tho	4.9	28.7	32.8	14.9	18.7	3.2	93.5	95.2	91.9
Hau Giang	6.4	33.0	38.0	14.0	8.8	1.7	91.9	94.3	89.5

Source: (i) General Statistics Office *(2011) Education in Viet Nam: An Analysis of Key Indicators (Viet Nam Population and Housing Census 2009); (ii)* Central Population and Housing Census Steering Committee *(2010) The 2009 Viet Nam Population and Housing Census: Major Findings.*

Annex 1.33 Net enrolment rate by education level (Nationwide 2009)

Per centage

	Primary			Lower secondary			Upper secondary			Junior college or university		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Whole country	**95.5**	**95.5**	**95.4**	**82.6**	**81.4**	**83.9**	**56.7**	**53.1**	**60.6**	**16.3**	**15.1**	**17.5**
Urban	97.2	-	-	88.8	-	-	68.4	-	-	36.2	-	-
Rural	94.9	-	-	80.6	-	-	52.8	-	-	6.7	-	-
Northern Midlands and Mountains	92.0	-	-	77.2	-	-	48.6	-	-	5.7	-	-
Red River Delta	97.8	-	-	93.9	-	-	74.9	-	-	27.1	-	-
North and South Central Coast	96.4	-	-	86.8	-	-	61.9	-	-	14.2	-	-
Central Highlands	93.1	-	-	74.9	-	-	48.7	-	-	7.0	-	-
South East	96.8	-	-	83.5	-	-	52.7	-	-	23.5	-	-
Mekong River Delta	94.3	-	-	71.5	-	-	40.4	-	-	8.1	-	-
An Giang	**92.3**	**91.7**	**92.9**	**64.4**	**62.6**	**66.3**	**33.0**	**29.9**	**36.3**	**6.0**	**5.6**	**6.4**
Long An	97.0	96.9	97.1	82.3	80.3	84.6	49.5	43.7	55.7	8.5	7.2	9.8
Dong Thap	95.4	95.1	95.8	73.4	71.1	76.1	43.5	39.6	47.6	7.9	7.3	8.5
Kien Giang	92.5	92.2	92.9	64.6	63.1	66.3	32.8	30.8	35.0	4.2	3.8	4.7
Can Tho	95.5	95.1	96.0	74.6	72.2	77.2	44.8	41.0	48.8	25.3	24.1	26.6
Hau Giang	94.7	94.6	94.8	68.6	65.1	72.3	35.3	32.1	39.1	6.7	6.0	7.4

Source: (i) General Statistics Office (2011) *Education in Viet Nam: An Analysis of Key Indicators (Viet Nam Population and Housing Census 2009); (ii)* Central Population and Housing Census Steering Committee (2010) *The 2009 Viet Nam Population and Housing Census: Major Findings.*

Annex 1.34 Nursery education statistics (Nationwide 2009–2010)

Region / Province	Nursery pupils							Teachers and pupil-teacher ratio		
	Total number pupils	Pupils in public schools	Pupils in non-pupil schools	Number girl pupils	% girls	Number ethnic minority pupils	% ethnic minority pupils	Number teachers	Number female teachers	Pupils per teacher
Whole country	**508190**	**183643**	**324547**	**236757**	**46.59**	**53013**	**10.43**	**49256**	**47960**	**10.32**
Northern Mountains	84965	42635	42330	40438	47.59	37626	44.28	9564	8747	8.88
Red River Delta	212568	57771	154797	96594	45.44	1540	0.72	20092	19999	10.58
North and South Central Coast	105954	26495	79459	50758	47.91	9922	9.36	10239	10111	10.35
Central Highlands	18900	7630	11270	8345	44.15	1749	9.25	1658	1426	11.40
South East	60263	33167	27096	29251	48.54	1730	2.87	5575	5567	10.81
Mekong River Delta	25540	15945	9595	11371	44.52	446	1.75	2128	2110	12.00
An Giang	**3424**	**1799**	**1625**	**1486**	**43.40**	**32**	**0.93**	**270**	**270**	**12.68**
Long An	1630	1026	604	801	49.14	-	-	170	169	9.59
Dong Thap	2638	2638		939	35.60	-	-	313	313	8.43
Kien Giang	1804	705	1099	806	44.68	66	3.66	118	118	15.29
Can Tho	4369	2200	2169	1992	45.59	69	1.58	359	358	12.17
Hau Giang	871	695	176	409	46.96	9	1.03	81	75	10.75

Source: Ministry of Education and Training (2010) *Education and Training Statistics: School Year 2009–2010.*

Annex 1.35 Kindergarten education statistics (Nationwide 2009–2010)

	Kindergarten publis						Teachers and pupil-teacher ratio		
Region / Province	Total number pupils	Pupils in public schools	Pupils in non-pupil schools	Number girl pupils	% girls	Number ethnic minority pupils	% ethnic minority pupils	Number teachers	Number female teachers	Pupils per teacher
Whole country	**2901633**	**1609634**	**1291999**	**1374341**	**47.36**	**452539**	**15.6**	**146596**	**144435**	**19.79**
Northern Mountains	476058	289241	186817	226459	47.57	250342	52.59	27580	26474	17.26
Red River Delta	733278	289292	443986	353537	48.21	11815	1.61	37338	37133	19.64
North and South Central Coast	652154	200318	451836	306018	46.92	79337	12.17	34202	33904	19.07
Central Highlands	200591	160482	40109	95988	47.85	75835	37.81	9490	9455	21.14
South East	390804	257564	133240	181489	46.44	10510	2.69	20387	20237	19.17
Mekong River Delta	448748	412737	36011	210850	46.99	24700	5.5	17599	17232	25.5
An Giang	**52932**	**48691**	**4241**	**25011**	**47.25**	**2382**	**4.5**	**1968**	**1963**	**26.9**
Long An	40552	38638	1914	18223	44.94	-	-	1852	1849	21.9
Dong Thap	49395	49395	-	21756	44.04	-	-	2077	1925	23.78
Kien Giang	26990	23380	3610	13704	50.77	2212	8.2	1073	1060	25.15
Can Tho	35735	27892	7843	17105	47.87	477	1.33	1358	1358	25.8
Hau Giang	23209	19190	4019	10854	46.77	369	1.59	879	825	26.4

Source: Ministry of Education and Training (2010) *Education and Training Statistics: School Year 2009–2010.*

Annex 1.36 Primary education statistics (Nationwide 2009–2010)

Region / Province	Total number schools	Number schools meeting national standards	% schools meeting national standards	Total number pupils	Number girl pupils	% girls	Number ethnic minority pupils	% ethnic minority pupils	Number teachers	Number female teachers	Teacher-class ratio
Whole country	**15172**	**4975**	**32.79**	**6922624**	**3271858**	**47.26**	**1203860**	**17.39**	**347840**	**270912**	**1.30**
Northern Mountains	2843	761	26.77	934377	443443	47.46	577375	61.79	64897	50706	1.25
Red River Delta	2715	1738	64.01	1374634	657821	47.85	23490	1.71	67070	60293	1.46
North and South Central Coast	3798	1739	45.79	1547795	741304	47.89	182277	11.78	81128	65545	1.32
Central Highlands	1137	202	17.77	563792	263899	46.81	244756	43.41	26061	21914	1.19
South East	1488	184	12.37	1032200	485599	47.05	64421	6.24	39945	33287	1.26
Mekong River Delta	3191	351	11.00	1469826	679792	46.25	111541	7.59	68739	39167	1.25
An Giang	**393**	**17**	**4.33**	**178413**	**86631**	**48.56**	**9900**	**5.55**	**7094**	**4039**	**1.13**
Long An	247	48	19.43	118026	56552	47.91	25	0.02	5346	3724	1.24
Dong Thap	317	27	8.52	142781	52866	37.03	9	0.01	6821	3513	1.25
Kien Giang	295	39	13.22	161011	73802	45.84	21334	13.25	7925	4440	1.31
Can Tho	178	20	11.24	89711	38161	42.54	1111	1.24	4262	2842	1.40
Hau Giang	169	29	17.16	65282	31347	48.02	2068	3.17	3512	1835	1.36

Source: Ministry of Education and Training (2010) *Education and Training Statistics: School Year 2009–2010.*

Annex 1.37 Lower secondary education statistics (Nationwide 2009–2010)

Region / Province	Total number schools	Number schools meeting national standards	% schools meeting national standards	Total number pupils	Number girl pupils	% girls	Number ethnic minority pupils	% ethnic minority pupils	Number teachers	Number female teachers	Teacher-class ratio
Whole country	**10060**	**1636**	**16.26**	**5214045**	**2598267**	**49.83**	**800301**	**15.35**	**313911**	**216961**	**2.09**
Northern Mountains	2312	265	11.46	724732	435411	60.08	422557	58.31	52152	35843	2.10
Red River Delta	2426	655	27.00	1116506	538896	48.27	19125	1.71	70473	54320	2.20
North and South Central Coast	2542	512	20.14	1369399	659874	48.19	135838	9.92	80945	56415	2.08
Central Highlands	671	37	5.51	405149	198751	49.06	132645	32.74	21303	13973	1.88
South East	728	74	10.16	701163	334374	47.69	36418	5.19	35692	25712	1.99
Mekong River Delta	1381	93	6.73	897096	430961	48.04	53718	5.99	53346	30698	2.14
An Giang	**154**	**7**	**4.55**	**106301**	**52792**	**49.66**	**4962**	**4.67**	**6672**	**3766**	**2.26**
Long An	122	1	0.28	82456	40661	49.31	24	0.03	4801	3387	2.15
Dong Thap	137	10	7.30	90189	42009	46.58	1	-	5086	2672	2.16
Kien Giang	130	12	9.23	91111	44420	48.57	10951	12.02	5360	3010	1.97
Can Tho	62	7	11.29	56306	27455	48.76	1251	2.22	3148	2134	2.10
Hau Giang	54	6	11.11	36492	17761	48.67	1295	3.55	2130	1247	2.15

Source: Ministry of Education and Training (2010) *Education and Training Statistics: School Year 2009 – 2010.*

Annex 1.38 Upper secondary education statistics (Nationwide 2009–2010)

Region / Province	Total number schools	Number schools meeting national standards	% schools meeting national standards	Total number pupils	Number girl pupils	% girls	Number ethnic minority pupils	% ethnic minority pupils	Number teachers	Number female teachers	Teacher-class ratio
Whole country	**2242**	**189**	**8.43**	**2886090**	**1521326**	**52.71**	**282983**	**9.81**	**142432**	**90488**	**2.13**
Northern Mountains	397	17	4.28	355117	182044	51.26	161411	45.45	17849	11280	2.08
Red River Delta	547	69	12.61	719703	377565	52.46	8058	1.12	35822	24061	2.20
North and South Central Coast	564	64	11.35	817825	439566	53.75	49445	6.05	36564	26938	2.05
Central Highlands	149	4	2.68	191623	101927	53.19	32531	16.98	9628	5190	2.09
South East	221	22	9.95	379823	205457	54.09	15728	4.14	19796	11443	2.19
Mekong River Delta	337	13	3.86	421999	214767	50.89	15810	3.75	22773	11576	2.17
An Giang	**47**	**5**	**10.64**	**42833**	**22960**	**53.6**	**1209**	**2.82**	**2717**	**1351**	**2.48**
Long An	31	-	-	42617	23293	54.66	9	0.02	1910	1131	1.96
Dong Thap	42	-	-	46291	17272	37.31	1	-	2586	1231	2.27
Kien Giang	26	-	-	39504	20138	50.98	3627	9.18	2116	1014	2.17
Can Tho	17	1	5.88	27491	14354	52.21	661	2.40	1335	715	1.97
Hau Giang	16	1	6.25	17152	8796	51,28	339	1.98	1007	453	2.27

Source: Ministry of Education and Training (2010) *Education and Training Statistics: School Year 2009–2010.*

Annex 1.39 Children in need of special protection (An Giang 2008–2010)

Category	Total children		
	2008	2009	2010 (prel.)
Total children < 16 years old	598.716	599.165	598.843
Homeless orphans and abandoned children (2 categories)	1.659	1.860	2.171
Children with disabilities	1.889	1.900	1.900
Children of Orange Agent's victims	79	79	85
Children with HIV/AIDS	108	108	110
Children having to work in heavy and hazardous environments	-	-	1.107
Homeless children	-	103	33
Sexually abused children	35	36	33
Drug addicted children	-	-	9
Children in conflict with the law	358	412	333
Trafficked and kidnapped children	5	4	3
Children having injuries	-	4.726	3.307

Source: Department of Labour, Invalids and Social Affairs (2010) *Data provided during fieldwork.*

Annex 1.40 Care of children in need of special protection (An Giang 2008–2009)

Category	2008					2009				
	Total children	Children in protection centers	Children adopted by families	Children under community care	Children under support from Decree 67	Total children	Children in protection centers	Children adopted by families	Children under community care	Children under support from Decree 67
Total abandoned and orphaned children	1659	50	-	-	1659	1860	47	-	-	1860
Fully orphaned children	34	37	-	-	-	-	34	-	-	-
Abandoned children	22	22	6	-	-	-	19	19	2	-
One parent orphaned children	1608	-	-	-	-	-	-	-	-	-
Total children with disabilities	1889	-	-	-	75	1900	-	-	-	153
Children with disability	-	-	-	-	-	-	-	-	-	-
Children with congenital disability	14	14	-	-	-	16	16	-	-	-

Source: Department of Labour, Invalids and Social Affairs (2010) *Data provided during fieldwork.*

Annex 1.41 Funding for social protection policies in Tinh Bien Districts and Long Xuyen City (2008 and 2009)

	Social protection target group	Tinh Bien District						Long Xuyen City					
		2008			2009			2008			2009		
		Number recipients	VND million	%	Number recipients	VND million	%	Number recipients	VND million	%	Number recipients	VND million	%
	Total	**1814**	**2585**	**100%**	**1631**	**2499.1**	**100%**	**1457**	**194.94**	**100%**	**1586**	**215.04**	**100%**
1	Article 4 / Paragraph 1 above 18 months old	122	175.68	6.46	88	126.72	5.16	15	1.8	0.92	17	2.04	0.95
	Article 4 / Paragraph 2 & 3 and people without labour capacity as in Paragraph 4	569	819.36	30.12	588	846.72	34.45	1254	150.48	77.19	1337	160.44	74.61
	Article 4 / Paragraph 9 raising children from 18 months old	28	40.32	1.48	16	23.04	0.94	2	0.24	0.12	3	0.36	0.17
2	Article 4 / Paragraph 1 under 18 months old; above 18 months with disabilities or HIV/AIDS	1	2.16	0.08	-	-	-	-	-	-	1	0.18	0.08
	Article 4 / Paragraph 2 with serious disabilities	12	25.92	0.95	7	15.12	0.62	2	0.36	0.18	1	0.18	0.08
	Article 4 / Paragraph 5 & 6	45	97.2	3.57	67	144.72	5.89	62	11.16	5.72	72	12.96	6.03
	Article 4 / Paragraph 9 raising children under 18 months old and above 18 months old with disabilities and HIV/AIDS	10	21.6	0.79	6	12.93	0.53	-	-	-	-	-	-
3	Article 4 / Paragraph 4 without self-caring capacity	38	54.72	2.01	30	86.4	3.51	53	12.72	6.53	54	12.96	6.03
	Article 4 / Paragraph 7 adopting children from 18 months old	10	28.8	1.06	10	28.8	1.17	62	14.88	7.63	93	22.32	10.38
	Article 4 / Paragraph 8 with two family members with serious disabilities	3	25.92	0.95	1	8.64	0.35	1	0.72	0.37	1	0.72	0.33
4	Article 4 / Paragraph 7 adopting children under 18 months old and above 18 months old with disabilities and HIV/AIDS	-	-	-	-	-	-	5	1.5	0.77	6	1.8	0.84
	Article 4 / Paragraph 8 having three family members with serious disabilities	1	12.96	0.48	2	25.92	1.05	1	1.08	0.55	1	1.08	0.5
5	Article 4 / Paragraph 1, 2 and 6	382	559.44	20.57	266	394.56	16.05	-	-	-	-	-	-
6	Article 4 / Paragraph 1 from 18 months old	123	177.84	6.54	88	126.72	5.16	-	-	-	-	-	-
	Article 4 / Paragraph 2 and 4	425	675.36	24.83	395	473.04	19.24	-	-	-	-	-	-
7	Article 4 / Paragraph 5 and 6	45	2.7	0.10	67	144.72	5.89	-	-	-	-	-	-

Source: District Labour, Invalids and Social Affairs Sections (2010) *Data provided during fieldwork.*

Decree No.67 (2007) on support for social protection policies / Article 4:

Paragraph 1. Orphans, children who are abandoned or have nobody to rely on; fatherless or motherless children whose living parent is missing according to Article 78 of the Civil Code or is incapable of raising his/her child(ren) according to law; children whose parents or whose mother or father are/is serving imprisonment sentence and who have no person to rely on; and children HIV/AIDS infected in poor households.

Minors aged between full 16 years and under 18 years who are still following general education or vocational training and have the same circumstances like the above-stated children.

Paragraph 2. Lonely elderly people in poor households; elderly people in poor households (according to the poverty line stipulated by the Government in each period) whose spouse is old and weak and who have no child, grandchild, or relative to rely on.

Paragraph 3. People aged 85 or older who have no pension or social insurance allowance.

Paragraph 4. Seriously disabled persons in poor households who have no working or self-serving capacity.

Paragraph 5. Mental illness patients suffering from schizophrenia or mental disorder who have been treated many times by psychiatry institutions but show no sign of recovery and filed chronic disease records, live alone without any support or are members of poor households.

Paragraph 6. HIV/AIDS-infected persons in poor households who have lost their working capacity.

Paragraph 7. Families and individuals adopting orphans or abandoned children.

Paragraph 8. Households having two or more seriously disabled persons who have no self-serving capacity.

Paragraph 9. Single persons under the poor household category who are raising child(ren) under 16 years of age; if their child(ren) is (are) following general education or vocational training, they are entitled to the allowance until their child(ren) reach(es) 18 years of age.

Annex 1.42 Children with disability (CWD) in public school (An Giang 2009)

	Total CWD		Types of child disability													
			Sight		Hearing		Cognitive		Speech		Mobility		Others		Multiple	
	Total	Female	Total	Female	Total	Female	Total	Female	Total	Female	Total	Female	Total	Female	Total	Female
Total CWD	5149	2131	1046	515	271	102	1412	593	824	247	696	299	450	182	450	193
CWD in school	3017	1201	906	427	154	64	766	298	566	169	292	114	220	85	113	44
% of CWD at school	58.6	56.4	86.6	82.9	56.8	62.7	54.2	50.3	68.7	68.4	42.0	38.1	48.9	46.7	25.1	22.8

Source: Department of Education and Training (2010) *Data provided during fieldwork.*

Annex 1.43 Crinmes against children (An Giang 2009–2010)

Year	Total cases	% Cases								
		Killing children	Violating children	Raping children	Having sex with children	Obsence acts with children	Malice	Sale, abduction, illicit transfer of children	Harbouring guilty children	Others
2009	45	15.56	35.56	0	33.33	8.89	0	0	0	6.67
2010 (9 months)	29	3.45	51.72	0	27.59	13.79	0	3.45	0	0

Source: Department of Public Security (2010) *Data provided during fieldwork.*

Annex 1.44 Children in conflcit with the law (An Giang 2009–2010)

Year	Total cases	% Cases											
		Homicide	Robbery	Extortion	Violation, rape	Malice	Theft	Snatching	Disturbing law and order	Gambling	Drug use	Drug handling	Prostitution	Others
2009	358	0.84	1.4	0	3.07	7.26	31.84	1.96	11.73	4.19	3.35	0.56	0	33.8
2010 (9 months)	259	0.39	1.93	0	0.77	6.18	38.61	3.09	25.48	3.86	1.16	0.39	0	18.15

Source: Department of Public Security (29010). *Data provided during fieldwork.*

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UNICEF Viet Nam
Add: 81A Tran Quoc Toan, Ha Noi, Viet Nam
Tel: (+84.4) 3.942.5706 - 11
Fax: (+84.4) 3.942.5705
Email: hanoi.registry@unicef.org
Web: www.unicef.org/vietnam