DISABILITY-INCLUSIVE SOCIAL PROTECTION RESEARCH IN VIETNAM

A national overview with a case study from Cam Le district

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Abbreviations

aOR	Adjusted odds ratio
CI	Confidence interval
CHI	Compulsory Health Insurance
CSI	Compulsory Social Insurance
DDDC	Disability Degree Determination Council
DPO	Disabled Peoples Organization
GDP	Gross Domestic Product
LMIC	Low and middle income countries
MEC	Medical Examination Council
MOET	Ministry of Education and Training
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalid and Social Affairs
OR	Odds ratio
SDG	Sustainable Development Goals
UN	United Nation
USD	United States Dollar
VHI	Voluntary Health Insurance
VSI	Voluntary Social Insurance
UNCRPD	UN Convention on the Rights of Persons with Disabilities
VND	Vietnam Dong
WHO	World Health Organization

1 Background

Social protection is increasingly used by governments in low- and middle-income countries (LMICs), as a tool for alleviating poverty, enhancing living conditions and reducing inequalities. While a "social protection floor" of basic guarantees for all has been championed as key to meet the Sustainable Development Goals (SDGs), it is also recognised that additional interventions or targeted outreach may be needed for certain individuals or groups who face higher risks of poverty and other forms of marginalisation [1, 2].

Box 1: Disability and poverty

Poverty and disability can be considered to operate in a cycle, with the one re-enforcing the other. In LMICs in particular, conditions associated with poverty such as lack of access to healthcare, inadequate water and sanitation, malnutrition and poor or unsafe living conditions, increase the risk of being born with or acquiring a disability [3, 4]. In turn, disability can lead to exclusion from work, education and healthcare, as well as high healthcare and other expenses, which can further exacerbate both economic and more multidimensional forms of poverty [5-7].

In a systematic review of 150 studies on disability and economic poverty in low and middle income countries, over 80% found that disability increased the risk of poverty and vice versa [8]. This relationship was consistent across regions/countries and impairment types, and was evident in both adults and children. Many studies also found links between disability and multidimensional forms of poverty – such as poorer access to education, healthcare and employment.

People with disabilities are defined in the United Nations Convention of the Rights of Persons with Disabilities (UNCRPD) as including those who have "long-term physical, mental and intellectual or sensory impairments which in interaction with various contextual factors may hinder their full and effective participation in society on an equal basis with others" [9]. As the estimated 1 billion people living with disabilities globally are significantly more likely to be living in poverty (see Box 1) and face a wide range of social, economic and cultural forms of exclusion, they are more likely to need and potentially benefit from social protection [7]. In addition to a needs-based argument, the right to inclusion in all aspects of society – including in social protection – on an equal basis with others is well-established in international treaties such as the Universal Declaration of Human Rights (Article 25) and the UNCRPD (Article 28) [9].

Inclusion of people with disabilities in social protection may be through mainstream schemes (where they are not explicitly specified as intended beneficiaries but may be implicitly targeted due to higher levels poverty and other types of marginalisation) or through disability-specific programmes (i.e. where disability is an explicit criteria for eligibility). Across all types of schemes, however, evidence is lacking on whether people with disabilities are accessing available programmes and whether participation in social

protection leads to the intended outcomes of alleviating poverty, supporting resilience and promoting greater social participation.

From the limited evidence available, there is concern that both mainstream and disability-specific programmes are not reaching and meeting their intended outcomes for people with disabilities [10]. Specific barriers to participation across programmes may include: inaccessibility of administration and service procedures and centres, discriminatory attitudes among administrations, certain conditions attached to receipt of benefits (e.g. school attendance), eligibility thresholds that do not consider extra disability-related costs and limited awareness of the availability of and eligibility for programmes [11]. Additionally, disability assessments to determine eligibility for targeted schemes often use medical model criteria, which may be biased against certain impairments, do not adequately capture the impact of social and environmental factors on functioning and are reliant on specialised resources which may be limited in many LMIC settings [10, 11]. Furthermore, benefits tend to focus more on providing a basic level of subsistence, rather than targeting sources of exclusion and disability-related extra costs; consequently, some evidence suggests that social protection does little to promote more far-reaching participation and equal opportunities for people with disabilities, thereby contributing to exclusion and marginalisation from society [10].

To explore in more depth the degree to which social protection systems are meeting their intended goals of poverty alleviation, development of stronger livelihoods and the reduction of inequalities for people with disabilities, we have conducted research in Vietnam, which is part of a two-country study on disability-inclusive social protection systems (see "Disability-Inclusive Social Protection Research: Evidence from Nepal", for Nepal findings). Vietnam was selected as a study site for this research as it was identified as having a strong social protection system that has made concerted efforts to address the needs of people with disabilities. Vietnam has numerous programmes targeted to people with disabilities that seek to target a diverse range of drivers of poverty and marginalization, such as the Disability Allowance (an unconditional cash transfer programme), subsidized health insurance and supports for education and work. This research explores the degree to which people with disabilities are accessing and benefiting from these and other programmes.

2 Study Aims

The overall aims of this study are (1) to assess the extent to which social protection systems in Vietnam address the needs of people with disabilities; and (2) to identify and document elements of good practice, as well as challenges, in the design and delivery of social protection for people with disabilities. As most social protection programmes in Vietnam are targeted to various vulnerable groups (e.g. orphans, widows, single parents), the research mainly focuses on disability-specific schemes, as they are relevant to a higher proportion of people with disabilities.

Specific objectives of the research include:

(1) To describe the overall social protection landscape in Vietnam, with an emphasis on the Disability Allowance and other disability-targeted schemes.
(2) To explore the need for social protection among people with disabilities in Vietnam.
(3) To measure access of people with disabilities in Vietnam to the Disability Allowance and other social protection schemes.
(4) To explore the experience of recipients in applying for and using the Disability Allowance.

3 Methods

3.1 Study components and their objectives

This research was comprised of three components:

- **National policy analysis**: to describe the current social protection system in Vietnam, namely the Disability Allowance and other disability-targeted programmes, and assess the degree to which it is responsive to the needs of people with disabilities.
- **Quantitative research:** to measure the need for and access to social protection among people with disabilities, and explore the experiences of Disability Allowance recipients in applying for and using the grant.
- **Qualitative research:** to explore people with disabilities' knowledge of the Disability Allowance and their experience of accessing and benefiting from the scheme.

3.2 Study setting

While the policy analysis presents a broad overview of disability and social protection across Vietnam, the qualitative and quantitative components provide a more in-depth exploration of the functioning of the system in practice by focusing on one district.

Location of Da Nang (red), the study setting

The district of Cam Le, part of the province of Da Nang (in Central Vietnam), was selected for this purpose. Since one of the aims of this study is to identify elements of good practice in disability-inclusive social protection, Cam Le was selected after consultation with stakeholders as it has a strong network of Disabled People's Organisations (DPOs) and disability-support services as well as a relatively well-functioning social protection administration.

Cam Le is a predominantly urban district. According to the 2007 census, 68,320 people live in Cam Le. In Da Nang province, 1% of the population – 9,677 people – were receiving the Disability Allowance in 2014 [12].

As Cam Le is urban, relatively affluent, and was identified by stakeholders as having a relatively well-functioning social protection system and adequate availability of disability-related services, the results from this study may not reflect the situation across all of Vietnam. However, this study setting was selected to allow the best opportunity to identify good practices in disability-inclusive social protection. As such, it should be viewed as a case study of the strengths and challenges in the Vietnamese system when it is working relatively well, rather than reflective of the situation across the entire country.

3.3 Study component methodologies

A mixed-methods approach, combining quantitative and qualitative data collection in Cam Le with a policy analysis at the national level, was used to meet the study objectives. The use of mixed-methods combines the strengths of each methodology – while offsetting some of the limitations inherent in each – leading to greater breadth and depth of understanding.

3.3.1 Component 1: National Policy Analysis

A national policy analysis was conducted, in order to describe the overall social protection landscape in Vietnam and highlight the strengths and weakness of the system in addressing the needs of people with disabilities. Given that there were few broader mainstream schemes, the focus was predominantly on disability-targeted schemes.

To achieve these objectives, the following methods were undertaken:

- **Literature review** to identify the relevant legal frameworks, policies and programmes in Vietnam as well as existing research on this issue. This included a review of relevant publications on social protection, national and international legislation, policy instruments, national laws/decrees/circulars, monitoring and evaluation documents, and academic and grey literature in both English and Vietnamese. Literature was identified through key informant provided documents and online searching.
- **Consultative workshop** of stakeholders working in disability and social protection in Vietnam. The workshop was held in May 2016 in Hanoi and brought together more than 50 key stakeholders from government agencies, NGOs, INGOs, and Disabled People's Organisations (DPOs).
- **In-depth interviews** with 16 key stakeholders at national level within responsible Ministries, United Nations agencies, NGOs, and the national federation of organizations of people with disabilities to explore perceptions of the impact of major policies and programmes related to social protection for people with disabilities as well as the challenges they face.

3.3.2 Component 2: Quantitative Research

The quantitative part of this study consisted of three components:

- Population-based survey of disability across Cam Le, Da Nang;
- Case-control study of people with disabilities identified during the population survey and purposively selected Disability Allowance recipients and age-sex-cluster matched controls without disabilities; and
- Survey of recipients of the Disability Allowance, identified both from the survey and from official registers.

3.3.2.1 Population-based household survey

A population-based survey was conducted to estimate the prevalence of disability in the general population, identify participants for the nested case control and compare household level indicators between households with and without members with disabilities. This survey also gathered data on socioeconomic indicators and participation in range of social

protection programmes to enable comparisons between households/individuals with and without disabilities.

Sampling frame: Data from the most recent National Census were used as the sampling frame. A two-stage sampling strategy was employed based on methodology used in other surveys [13]. In the first stage, probability-proportionate-to-size sampling was used to select clusters in Cam Le. Clusters were "Population Groups", the lowest administrative unit in Vietnam (average size: 162 people). In total, 75 out of 710 clusters were selected. In the second stage, modified compact segment sampling was used to select households within clusters to be visited. With this method, maps of each selected cluster were divided into equal segments of approximately 80 people with the assistance of village leaders or staff at nearby health centres. One segment was then randomly selected, and households were visited systematically beginning from a random start point, until the sum of members aged 5+ across households reached 80 people. This method has been used widely for rapid population based surveys [13-15].

Selection criteria: All households in the sampled areas were visited and invited to participate. Household membership was defined based on the following question, from the most recent Census: "How many people, including yourself, live in the household, share meals and share fees for at least 6 months of the previous year?" All members of selected households aged five years and older were screened for disability using the Washington Group Short Set Questionnaire, translated into Vietnamese using recommended protocol [16] (see Box 2).

Box 2: Measuring Disability

Disability was defined using the Washington Group Short Set of Questions on Disability, an internationally recognised, validated instrument that provides robust and internationally comparable estimates of disability [17]. The Washington Group Questions focus on an individual's ability to function within their everyday environment, rather than focusing on the presence of medical disorders or diseases. This approach is more in line with conceptualisations of disability espoused by the World Health Organization's International Classification of Functioning, Disability and Health (ICF) and the UNCRPD [18]. This tool comprises six questions about difficulties with activities (seeing, hearing, walking or climbing stairs, remembering or concentrating, self-care and communicating). For each question, the responder can choose one of four options: no difficulty, some difficulty, a lot of difficulty or cannot do at all. For the purpose of this study, people who answered "cannot do at all" or "a lot of difficulty" for at least one question were considered to have a disability.

This definition of disability encompasses similar domains as the Joint-Circular 37/2012/TTLT-BLĐTBXH-BYT-BTC-BGDĐT, which is used to determine eligibility in Vietnam's disability-targeted social protection programmes. Joint-Circular 37 relies primarily on a functional assessment of disability, similar to the Washington Group. While Joint-Circular 37 includes psychiatric conditions as an eligible disability, which is not

explicitly captured in the Washington Group Short Set, all disability types must lead to limitations in either walking, self-care, understanding or communication, which are captured in the study definition.

Procedures: Questionnaires were administered in Vietnamese by trained data collectors using computer tablets. The survey collected data on the household's composition, the disability status of each member, socioeconomic indicators and the participation of members in a range of social protection programmes. Questionnaires were asked to the head of household or another adult member with detailed knowledge about the household.

3.3.2.2 Case-control study: Exclusion and needs for social protection

A nested case-control study was conducted to compare the living situation between people with and without disabilities.

Selection criteria: *Cases* were any male or female, aged 5 years and above, who had been identified as having a disability based on the Washington Group questions during Phase 1. For each case identified, one *control* was selected as a comparison. Controls were also drawn from the population-based survey in Phase 1 and were the same sex and of similar age (± 5 years) as cases. Controls could not be from a household which included a member with a disability. Additionally, 76 people were selected from registers of Disability Allowance recipients as additional cases and matched to controls from the population-based survey. These individuals were selected based on geographic proximity to the included clusters (i.e. within the same ward/commune – the administrative unit above Population Group), to allow for matching based on area of residence (as well as age and sex) with controls. The addition of the Disability Allowance recipients allowed for higher powered analyses and to compare the experiences of people with disabilities who were and were not receiving social protection.

Variables studied: The case-control questionnaire included sections on: education, employment, health and knowledge of and participation in a range of social protection schemes.

Box 3. Indicators of living circumstances

As a key goal of social protection is to reduce poverty and improve living circumstances, a variety of indicators were used to measure individual and household living conditions across questionnaires. These indicators were derived from data collected in both the household and case control surveys. Almost all are measures of *relative* well-being compared to others in the study sample.

At the household-level, we used the following measures of economic well-being:

- *Household income per capita*: total income from all sources, divided into quartiles.
- *Self-rated wealth*: subjective ranking of the household's wealth relative to neighbours.
- *Socioeconomic status*: derived from principal component analysis of ownership of 18 durable assets and ownership of livestock, divided into quartiles. Assets were

selected based on the 2002 Demographic Health Survey in Vietnam and feedback from local partners.
- *Living below the minimum standard of living (nationally defined)*: Defined as 1,300,000 VND (US$57) per person per month for the period 2016 – 2020 for urban areas.

All household level analyses were adjusted by the household's size and dependency proportion (proportion of the household comprised of children, adults 65+)

At the individual level, we used a variety of measures of well-being, including:
- *Access to education*: school enrolment, attainment.
- *Health:* any serious health event in the last 12 months, diagnosis of chronic conditions, access to health insurance and needed healthcare.
- *Access to work:* employment status, wages.
- *Participation*: in key family and community activities.

All individual-level analyses were adjusted for age, sex and area of residence.

Procedures: The case-control questionnaire was administered in Vietnamese to cases and controls by a trained data collector. For children below 16 years (age of consent) and people with impairments that severely limited their ability to understand/communicate, a carer answered on their behalf as a proxy. In these instances, input from the child/person with a disability was still sought whenever possible and appropriate.

3.3.2.3 Disability Allowance questionnaire: Experiences of recipients

Study design: A survey was given to recipients of the Disability Allowance to learn about their experience in applying for and receiving the grant and the perceived impact of participation.

Selection criteria: All people with disabilities who had reported during the case control or household survey that they were currently receiving the Disability Allowance received this questionnaire. An additional 76 people were selected from the registers of Disability Allowance recipients.

Variables studied: The Disability Allowance questionnaire included questions on: the application process, types of benefits received and self-reported impact of participation.

Procedures: The Disability Allowance questionnaire was administered by trained data collectors. For children below 16 years of age (age of consent) and people with impairments that limited their ability to understand/communicate, a carer answered on their behalf as a proxy. In these instances, input from the child/person with a disability was still sought whenever possible and appropriate.

Box 4. A Note on Statistical Tests

Odds ratio (OR): an odds ratio measures how strongly the presence of one characteristic (e.g. disability) is associated with another variable (e.g. poverty). It is calculated by measuring the likelihood of an outcome occurring in a group that has the characteristic of interest compared to its likelihood in a group that does not have the characteristic. Odds

ratios can be adjusted for other characteristics, such as sex and age, which may also be associated with the outcome of interest. Adjusting by these other characteristics gives us a better estimate of the true relationship between the characteristic and outcome of interest. For example, if we give an odds ratio of 4.3 when comparing poverty between people with and without disabilities, this means that people with disabilities are 4.3 times as likely as people without disabilities to be living in poverty. After adjusting for age and sex, the odds ratio reduces to 3.8: this is a more accurate estimate of the influence of disability on poverty than OR=4.3, since it is controlling for these other factors (older age, being female) that are also associated with poverty.

Confidence intervals (CI): a confidence interval is used to indicate the precision of a study measurement (e.g. mean, OR). For a given level of certainty (normally set to 95%), confidence intervals provide a range of values around the sample's estimate that are likely to contain the "true" value of that measure across the entire population. For example, if the prevalence of disability in our sample size is 2.5% (95% CI: 2.1-2.9%), that means we are 95% confident that the "true" prevalence in the entire population is between 2.1-2.9%.

p-value: p-values are used as an indicator of statistical significance. Typically, values of $p \leq 0.05$ indicate statistical significance: this means that there is a less than 5% chance the observed estimate occurred by chance. The smaller the p-value, the greater the confidence that the observed effect is genuine.

3.3.2.4 Data analysis

All quantitative data was collected on computer tablets, using questionnaires created with Open Data Kit (ODK). These mobile data entry forms were pre-coded and had built-in consistency checks to reduce recording errors. Forms were uploaded through a secure server at regular intervals throughout data collection. Data was checked for errors both manually and using STATA 14. Data were analysed using STATA 14.

Household survey: We calculated the prevalence of disability, both overall and by type of functional limitation. A socioeconomic status index was created through principal component analysis of household ownership of assets. Multivariate regression (logistic or linear) was used to compare socioeconomic indicators between (1) households with and without members with disabilities and (2) households with members with disabilities who were and were not receiving the Disability Allowance. Analyses were adjusted for household size, percent female, dependency proportion[1] and average age. Additionally, extra costs were calculated according to the Standard of Living approach described by Zaidi et al [19]. With this methodology, standard of living is measured through asset ownership and is assumed to be positively correlated with income; extra costs of disability are then calculated as the additional income needed to support the same standard of living as a similar household without disabilities, controlling for other factors which may introduce variation

[1] Proportion of the household comprised of non-working age adults in the household, including children (0-14 years) and older adults (60+).

[20]. This approach has been used in a range of contexts, including in LMIC settings, to estimate extra costs of disability [20].

Case control: To explore differences between people with and without disabilities in areas such as health, employment and education, conditional logistic regression was used. If conditional regression was not possible due to incomplete matching, multivariable logistic regression was undertaken, controlling for the matching variables of age and sex. For comparisons between people with disabilities who are and are not receiving the Disability Allowance, multivariate logistic or linear regression was also used.

Disability Allowance questionnaire: responses about application experience, use of the Allowance and self-reported impact were tabulated by frequency.

3.3.3 Component 3: Qualitative Research

Qualitative interviews were carried out with people with disabilities benefiting from the Disability Allowance and those who were not, to understand their knowledge of the programme and their experience of accessing and benefiting from the scheme. District- and community-level stakeholders, including disability service providers, representatives of Disabled People's Organizations (DPOs), and decision makers/administrators responsible for social protection and related services, were also interviewed to understand the ways in which the planning and implementation of social protection programmes includes or excludes people with disabilities.

Research tools: Six sets of in-depth interview guidelines were used to collect information from different categories of study participant:

(1) Commune, District and Province level officials,
(2) Adults with disabilities receiving the Disability Allowance,
(3) Adults with disabilities not receiving the Disability Allowance,
(4) Caregivers of children with disabilities receiving the Disability Allowance,
(5) Caregivers of children with disabilities not receiving the Disability Allowance, and
(6) DPOs and NGOs at the district or province level.

In addition, two focus group discussions were held with 1) parents of children with disabilities and 2) adults with disabilities receiving the Disability Allowance.

Data collection: Data was collected by a team of three qualitative researchers at the same time as the quantitative survey was being carried out. A purposive sample of 25 persons with disabilities was identified during the population-based survey. These individuals were selected to reflect variation in terms of sex, age (children, working-age and older adults) and geographic distribution and included recipients and non-recipients of the Disability Allowance. A total of 20 key informant interviews, identified through snowball sampling, were carried out.

Data analysis: The interviews were transcribed and analysed by the senior Vietnamese researcher, Doan Thi Thuy Duong. A thematic approach was used to analyse findings.

3.4 Consideration of intersectionality

This research focused predominantly on the influence of disability in understanding need for, access to and use of social protection entitlements among people with disabilities. Still, efforts were made to explore the intersection between disability and other sources of marginalisation. For example, all analyses were disaggregated by gender and age group where adequate numbers or sufficient variation in responses allowed for statistical testing. Differences in experiences among particular groups of respondents – for example, people living in poverty or in rural areas – were explored as they emerged organically from the research.

However, it is acknowledged that further research is needed to probe more in-depth into how disability overlaps with other types of marginalisation and its impact on both participation and inclusion in social protection.

3.5 Ethics

This study was approved by the Ethics Committee at the London School of Hygiene & Tropical Medicine in London, UK and the Hanoi School of Public Health in Hanoi, Vietnam. Informed written consent was obtained from all study participants before beginning any interviews. For children below 16 years (age of consent) and people with impairments that severely limited their ability to understand/communicate, a carer answered on their behalf as a proxy. Individuals who reported unmet health needs were referred to available local services.

PART A:

National Overview of Disability & Social Protection Provisions

Overview

Part A describes the national policy framework for social protection and disability in Vietnam. It analyses key policies and programmes related to social protection for people with disabilities in terms of implementation progress, achievements and challenges so as to highlight the strengths and weakness of the system in addressing the needs of people with disabilities.

4 Disability Policy in Vietnam

4.1 Data on disability

Data on disability in Vietnam has been gathered through several surveys and censuses. These have employed a variety of methodologies, resulting in a large but inconsistent body of disability data, with estimates of prevalence ranging from 3.2-15.3% [21, 22]. Despite the difference between the various previous surveys, the most commonly quoted disability prevalence in Vietnam is derived from the 2009 Census, of 7.8% for population aged 5+ or 9.8% for the adult population aged 18+, although even this may be an underestimate. As with this study, the 2009 Census uses the Washington Group short set of questions to measure disability. However, it uses the cut-off of "some difficulty" in performing at least one of the six activities of daily living, which will include more mild forms of disability.

4.2 Policies and legislation on disability

The Government of Vietnam has paid attention to the needs and rights of people with disabilities from an early stage in the country's development. The first Constitution of the Socialist Republic of Vietnam in 1980 stated that, "elderly and handicapped people who have no one to rely on are entitled to support by the State and the society" [23]. In the subsequent 1992 Constitution, another entitlement was added, namely that "the State and society shall create conditions for handicapped children to acquire general education and appropriate vocational training" [24].

The first comprehensive statute for disability – the Ordinance on Handicapped Persons – was issued in 1998. In this Ordinance, the Assembly of Vietnam acknowledged that "*handicapped*[2] *persons are entitled to assistance by the State and society in healthcare and functional rehabilitation, in the procurement of suitable jobs and are eligible to other rights as prescribed by law*" [25]. The Ordinance also mandates the State to encourage and create favourable conditions for people with disabilities to exercise on an equal basis their political, economic, cultural and social rights and to develop their own abilities, to integrate themselves into the community and to take part in social activities.

In 2007, Vietnam signed the UN Convention on the Rights of Persons with Disabilities (UNCRPD). As a party to the Convention, Vietnam is required to ensure that persons with disabilities have the full enjoyment of human rights and full equality under the law. Although the Convention was only ratified by Vietnam in February 2015, the Law on Persons with Disabilities – the first law in Vietnam on this issue – was promulgated in 2010, soon after signing the Convention.

It is notable that, possibly as a result of the delay in ratification, the 2010 Law is not entirely in-line with the provisions of the UNCRPD. In particular, the definition of disability gives inadequate recognition to the importance of the interaction of social or environmental "barriers" with functional impairments to produce disability. People with disabilities are defined in the 2010 Law as those "*who are impaired in one or more body parts or suffer*

[2] The term "handicapped" or "tan tat" was previously used by the Vietnamese Government until the adoption of the UNCRPD.

functional decline manifested in the form of disability which causes difficulties to his/her work, daily life and study".

Nonetheless, the 2010 Law on Persons with Disabilities and the ratification of the UNCRPD were significant milestones in Vietnam's political commitment to promoting and protecting the rights of people with disabilities. Together, they provide the legal foundation for Vietnam's approach to the rights of people with disabilities. In addition, in 2012, the Government approved a National Action Plan to Support Persons with Disabilities for the period 2012-2020. The Plan is designed to support implementation of the Law and contains a range of specific targets for the periods 2012-2015 and 2015-2020 [26].

4.2.1 Key implementing bodies

At the national level, the Ministry of Labour, War Invalids and Social Affairs (MOLISA) assumes overall responsibility for implementation and monitoring of the 2010 Law and other policies concerning people with disability. MOLISA also leads coordination with other ministries, which manage activities specific to their expertise. For example, the Ministry of Health (MOH) has oversight on programmes and policies related to access to health and rehabilitation, while the Ministry of Education & Training (MOET) is responsible for the provision of education to children with disabilities [27].

In 2015, the National Committee on Disability (NCD) was established with the mission to better direct and coordinate between ministries, branches and localities to solve problems related to lack of coordination among policies and programmes for people with disabilities [28]. The Committee Chairman is the Minister of MOLISA. Commissioners are representatives from relevant ministries, civil society organizations and organizations for people with disabilities.

At the local level, overall responsibility for issues related to people with disabilities also fall under the decentralised branches MOLISA. Specifically, it is the Department of Labour, Invalids and Social Affairs (DOLISA) at provincial-level and then the Labour, Invalids and Social Affairs Division under the District People Committee that have responsibility for disability issues within their area. In each commune[3], there is one civil servant in charge of "cultural and social issues". Along with a wide range of other responsibilities, this civil servant manages the distribution of the social assistance allowances, including to people with disabilities.

5 Disability-Targeted Social Protection

There has been a gradual expansion of social protection measures for various sections of the population in Vietnam, particularly in terms of social assistance. Almost all social protection entitlements in Vietnam are targeted to specific groups, including people with disabilities, older adults, single parents and orphans.

Regarding disability-targeted social protection, the Government of Vietnam has specified several social protection provisions for people with disabilities. These include entitlements

[3] Generally, administrative units in Vietnam are subdivided as follows, from largest to smallest: National, provincial, district, ward/commune and Population Group.

for: 1) social assistance, 2) healthcare, 3) education, 4) transportation, and 5) vocational training and employment. [27]. The benefit packages people with disabilities are eligible to receive is dependent on the outcome of a disability assessment.

5.1 Determining eligibility for disability-targeted social protection

5.1.1 Assessment criteria for defining disability and programme eligibility

Joint-Circular 37/2012/TTLT-BLĐTBXH-BYT-BTC-BGDĐT is the primary policy tool used for the majority of assessments to determine if a person is eligible for disability-targeted social protection programmes. The policy contains two tools: one for children under 6 and one for people with disabilities aged 6 or older. Definitions of disability are in line with the 2010 Law on Persons with Disability and focus primarily on functioning, rather than the presence of clinical impairments.

For both tools, there are two steps to determine eligibility. First, a "disability type" is determined. Under Vietnamese law, the following six "disability types" are considered eligible: 1) physical disability; 2) sensory (hearing/speech) disability; 3) visual disability; 4) mental and psychiatric disability; 5) intellectual disability; and 6) other disabilities (related to reduced capacity in working or learning from other causes) [27].

If a person is deemed to have an eligible type of disability, they then undergo an assessment for "disability degree." There are three categories of disability degrees: 1) exceptionally severe disabilities; 2) severe disabilities; and 3) mild disabilities [27]. The "degree" of disability is of considerable importance because most disability-specific entitlements, including social assistance, free health insurance, and access to nursing and care in residential social protection centres are only for people with "exceptionally severe" or "severe disabilities" as confirmed by an official disability certificate [27, 29, 30].

As discussed below, there are several challenges in the content and implementation of Joint-Circular 37. The Government has acknowledged most of these issues and, as a result, Circular 37 is currently under reform. MOLISA is leading the reform process with the collaboration of the MOH and MOET as well as representatives from organizations working in the field such as NGOs, research institutes, and Disabled People's Organisations etc.

5.1.1.1 Children with disabilities under 6 years

Under Joint-Circular 37, children under 6 may have their type and degree of disability assessed from in-person observation by the Disability Degree Determination Council (DDDC) and reporting of parents/care takers on the child's functioning, with referrals for medical evaluations for complex cases.

Typically, only cases of physical and visual disabilities, as well as severe epilepsy (4+ convulsions/month) are assessed solely by the DDDC [31]. Children with other forms of disability typically require an additional medical evaluation from the Medical Examination Council (MEC) to complete their assessment. Although it should be noted that identifying disability in young children is a global challenge [29] – for which there are currently few validated, non-clinical assessment tools – the additional assessment can lead to delays, extra costs and stress for families with young children with certain disabilities. In particular,

children with hearing/speech, learning or intellectual disabilities, autism and very young children or new-borns with disabilities are most likely to require medical evaluation and therefore are perceived to face greater barriers to access.

Consequently, one of the main priorities for reform is to streamline the process and create a more appropriate approach to assess children's degree of disability. In this regard, MOLISA and MOH are currently working together to develop a form which combines an in-person assessment of functioning, the perception of caregivers and evidence from a health assessment in order to provide a more accurate, one-stop assessment.

5.1.1.2 People with disabilities 6 years and over

People with disabilities aged 6 and over receive an assessment from the DDDC that includes an in-person observation of functioning and interviews with the applicant and/or their caregiver to determine their disability degree and form.

For disability degree, the tool in Joint-Circular 37 contains a standardised scoring system based on the ability of people with disabilities to do eight daily life activities[4] with or without help. For each activity, "able to do" scores 2 points, "able to do with help" scores 1 point, and "unable to do" scores 0 points. The total points for all eight activities will be used to determine the degree of disability as following: 1) Extremely serious disability: 0-4 points, 2) Serious disability: 5-11 points, 3) Mild disability: 12+ points.

As with the tool for children under 6, the disability assessment tools for the people aged 6 or over is also perceived to have a number of limitations. For example, the current tool makes it difficult to identify and define the degree of disability for some specific conditions such as developmental and psychosocial impairments and tends to underestimate the severity of the impacts that certain conditions such as restricted growth and profound deafness have in the context of Vietnam. It should be noted that for some people with mental health conditions, it is not necessary to go through this process in full to receive social assistance as they are entitled to apply using documentation supplied to them upon discharge from a mental health facility. However, people who have less severe psychosocial conditions, or those who are never treated in a mental health facility, are likely to face significant challenges in applying through the DDDC. MOLISA and MOH are currently reviewing tools to address some of these challenges.

5.1.1.3 Other assessments: Medical Examination Council criteria

While the majority of assessments are conducted using the criteria outlined in Joint-Circular 37, certain cases are referred to the MEC [27]. The MEC uses a solely medical approach, determining the degree of disability based on the proportion of bodily injury due to disability. Specifically, if that proportion is at least 81%, the person is considered to be suffering from an exceptionally severe disability. If that proportion is from 61% to 80%, the person is considered as having a severe disability [32].

[4] These activities include: walking, eating and drinking, toilet hygiene, personal hygiene, dressing, hearing and understanding what people say, expressing wishes and thinking in speech, participating in housework like folding clothes, sweeping, washing dishes, cooking.

5.1.2 Assessment bodies

5.1.2.1 The Disability Degree Designation Council

Following the introduction of in 2012 of Decree No. 28/2012/ND-CP and Joint-Circular 37, the disability assessment process shifted from the provincial-level MEC to the commune-level Disability Degree Determination Council (DDDC).

The DDDC is composed of men and women from the following bodies: 1) the chairperson of the commune-level People's Committee as its President; 2) the head of the commune-level heath station; 3) the commune official in charge of labour, invalids and social affairs; 4) the heads or deputy heads of the commune-level Vietnam Fatherland Front Committee, Women's Union, Youth Union and War Veterans' Associations; 5) the head of a DPO in the locality, where such an organization exists [27].

Joint-Circular 37 is designed to be used by people without specific medical expertise in disability to allow for greater flexibility in conducting assessments. By not relying on specialists, the pool of potential assessors is broadened, which is important for areas of the country – particularly in rural areas – where availability can be limited. This use of non-specialists allows for most assessments to be conducted locally.

However, there are concerns that DDDCs are inadequately prepared to conduct assessments. For example, there is widespread concern that the current level of training of the DDDC on the implementation of Joint-Circular 37 is insufficient. In combination with a lack of broader knowledge on disability issues and high turnover of DDDC members, the current system can lead to inconsistent implementation and outcomes of the disability assessment across different communes, districts and provinces. Further, although the DDDC is supposed to include the head of the commune-level DPO, in reality very few communes have a legal DPO. For example, Hanoi – the capital of Vietnam – has 584 commune-level administrative units but by 2013 it had only 63 commune-level DPOs [33]. As such, the involvement of people with disabilities in the process of disability determination is very limited in practice.

5.1.2.2 Medical Evaluation Council

In cases where the DDDC cannot reach a conclusion on the presence or degree of disability, a MEC can provide a medical assessment [27]. Additionally, if a person with disabilities wishes to appeal the conclusion of their DDDC assessment, they can go to the MEC to be re-evaluated using the MEC criteria [27].

As opposed to the DDDC, which operates at the commune-level, MECs are located at provincial-level, decreasing the geographic and likely financial accessibility of the process.

5.1.3 Application process

In order to appear before the DDDC, people with disabilities have to submit a simple paper application and VND 50,000 (US$2.20) to the People's Committee of the commune where they live [31]. Applicants are also invited or requested to submit any medical documentation of disability.

Once applications are received, the Chairman of the commune People's Committee has 30 days to set a meeting time and venue for the applicant's disability assessment in front of the DDDC. Typically, times are set to allow for the review of multiple applications at one convening of the DDDC. The venue for the assessment is typically the commune People's Committee or health station. As communes are the smallest administrative unit, using commune-level application points improves geographic accessibility and reduces transport and opportunity costs for applicants.

The DDDC will typically make a decision on an individual's application through the conclusions of the in-person assessment. Decree No. 28/2012/ND-CP specifies that within 15 days of receiving a valid dossier (including the results of the assessment), the DDDC should come to a conclusion on the application, publicly post up its decision at the office of the commune-level People's Committee and announce it in the mass media (i.e. over the loud speaker) within seven days to allow for inquiries or complaints.

In cases where the DDDC cannot determine the degree or form of disability, the individual may be referred for a medical evaluation through the MEC. In these cases, the government budget will pay for the examination fees, although transport, opportunity and other costs are out of pocket. Poorer applicants and applicants with mobility limitations are likely particularly disadvantaged in this regard.

In cases where people with disabilities or their family disagrees with the conclusion of the DDDC, they can appeal the decision and be reassessed through the MEC. However, the Government budget will only pay for the examination fee if the conclusion of the MEC supports the complaint [27, 32]. Otherwise, people with disabilities or their family will have to pay for the fee and, as it is at least 1,150,000 VND (US$50.35), people with disabilities may be reluctant to ask for a second opinion from the MEC [27, 32, 34]. While this fee may help protect against excessive contestations, it unduly affects poorer applicants. Further, as the MEC facility is only available in the capital or in big cities (provincial capitals), it may not be accessible for a large number of people with disabilities, particularly individuals with mobility limitations and poorer applicants due to travel and opportunity costs.

5.2 Entitlements

5.2.1 Social Assistance: the Disability Allowance

People who have been certified by the DDDC as having "severe and extremely severe disabilities" are entitled to receive social assistance in the form of the Disability Allowance, an unconditional regular cash transfer. Under Decree No. 136/2013/NĐ-CP, people with "severe disabilities" receive 405,000 VND (US$18) per month, while people with "extremely severe disabilities" receive 540,000 VND (US$24). Older adults or children with disabilities are entitled to slightly higher amounts, of 540,000 VND (US$24) and 675,000 VND (US$30) per month, for "severe" and "extremely severe" disabilities respectively [30]. Each allotment is disbursed through the commune-level People's Committee, by the civil servant in charge of cultural and social issues or labour, invalids and social affairs, and can be picked up in person by the applicant or an individual designated on their behalf.

Based on the specific conditions of each locality, the Chairman of the People's Committee of the province has the right to decide on a social assistance allowance rate which is higher than the base rates specified in Decree No. 136/2013/NĐ-CP [30]. As of 2014, there were 15 provinces which set the social assistance allowance for people with disabilities higher than the national base rate, such as Hanoi, Quang Ninh and Binh Duong [35]. There is, however, no publicly available data on how much additional budget is provided in each province.

In 2009, fewer than 385,000 people with severe disabilities were receiving the Disability Allowance from MOLISA. By 2014 this number had almost doubled to more than 700,000 people [35, 36] but remains far less than the total number of persons with disabilities (estimated at 6.1 million) or the total of persons with "severe" disabilities (which is estimated to be 1.7 million, giving a coverage of 41% persons with disabilities) [36]. Overall, investment in social assistance in Vietnam is relatively limited: cash transfers from MOLISA for people with disabilities specifically account for only 0.09% of GDP (in 2013), which is well below a number of other middle income countries [37].

In addition to expanded coverage, the rate of the Disability Allowance has increased substantially in the last 10 years ago due to increases stipulated in Decree No. 67/2007/ND-CP). Nonetheless, the draft MOLISA Social Protection Strategy for the period 2011-2020 concludes that the amount may be insufficient to deliver a minimum standard of living for beneficiaries, as the allowance amount is equivalent to only 32.5% of the amount considered to be the minimum living standard level.[5] It puts forward a higher standard level for social assistance in 2011 - 2020 at "*40% of the minimum living standard level*" [38]. As such, even if the allotment amount increases in-line with the vision of the Strategy, it is likely still inadequate to meet minimum living standards for a person with a severe disability and no other means of support.

Given this, there is widespread recognition across Government and civil society that the allowance is insufficient to meet even the basic living costs of people with disabilities. Government officials, including MOLISA officials, often state that the aims of the cash allowance are to pay for some food and basic necessities as well as to "encourage them", meaning that the allowance is intended to give those who receive it a small amount of independence. As the Disability Allowance is only provided to people with "severe" or "extremely severe" disabilities, the amount is likely to be inadequate as the system is supposed to be targeted towards people with highly constrained capacity to support themselves (even before the indirect costs of the care provided by other family members are taken into account). If social assistance was provided to people with less severe disability, this monthly amount may form have greater justification, especially if it was intended to defray the "extra costs" of disability rather than to cover basic needs. However, the social assistance system in Vietnam is currently an "all or nothing" approach whereby

[5] Defined as 1,300,000 VND (US$57) 1,000,000 VND (US$44) or per person per month by the MOLISA for the period 2016 – 2020 for urban and rural areas respectively.

those with less severe disabilities do not receive anything at all in terms of cash support (nor, as will be discussed later, do they receive social health insurance).

5.2.1.1 Other forms of disability-specific social assistance

Certain groups of people with disabilities may receive other types of disability-targeted social assistance in lieu of the Disability Allowance. Notably, people with disabilities who are also war veterans and national heroes are entitled to the considerably higher value War Invalids and Contributors Benefit instead of the Disability Allowance [38]. Similarly, people with disabilities resulting from exposure to Agent Orange can receive a larger cash transfer through Agent Orange Victims programme. Additionally, people insured under Compulsory Social Insurance[6] who become disabled due to a labour accident or occupational disease can receive a monthly allowance if the Medical Assessment Councils of the MOH deem their capacity for work as diminished by over 30%. Finally, for caregivers of people with exceptionally severe disabilities, 405,000 VND/month (US$18) is allotted [30].

5.2.2 Health insurance and access to rehabilitation

People with exceptionally severe and severe disabilities as certified by the DDDC and people with disabilities due to injuries during the war or caused by Agent Orange are entitled to receive Compulsory Health Insurance (CHI). Under CHI, the government fully subsidises the cost of their health insurance premium [29, 30, 39]. People with disabilities who have not been certified by the DDDC or who were certified as only having a mild disability are not entitled to subsidised CHI based on disability, and therefore must meet other criteria for subsidised plans or purchase a plan fully out-of-pocket (see section 6.2) [29, 30, 39]. Without health insurance coverage, they would be at higher risk of catastrophic costs when they get an illness.

For people with disabilities under CHI, 95% of eligible medical expenses are covered (or 100% for children under 6). Eligible medical expenses include costs of medical examination and treatment, functional rehabilitation, regular pregnancy check-ups and delivery [29]. Services not covered include family planning and routine check-ups [40]. Additionally, not all kinds of rehabilitation services are covered by health insurance. To date, MOH has approved 248 technical categories of functional rehabilitation that can be provided at rehabilitation facilities based on their professional capacity. This list is quite comprehensive and aims to raise the quality of rehabilitation services. However, based on Circular No. 11/2009/TT-BYT, only 33 out of the 248 categories (~13%) are covered by the health insurance [41]. While the pace of development of the rehabilitation sector and the demands of patients for services are growing fast, the 7-year-old-Circular 11 is inappropriate and causes difficulties for both health workers and patients, especially in relation to the health insurance. The MOH is therefore working on the development of a new circular, which aims to broaden the coverage of health insurance for rehabilitation services.

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[6] Compulsory social insurance covers sickness, maternity, labour accidents and occupational disease, retirement and survivor allowances and is available only for civil servants and formal sector employees with at least a 1-month contract. Voluntary social insurance, which any Vietnamese citizen can choose to participate in, does not provide coverage for occupational accidents and disease.

Further, CHI does not currently cover the cost of assistive devices except in rare cases.[7] Without financial coverage through health insurance, purchasing devices fully out of pocket imposes major costs on people or prevents them from acquiring devices at all.

5.2.3 Educational supports

The Law on Persons with Disabilities affirms the right to education of people with disabilities. Government policies on education for people with disabilities are defined in Joint Circular 42/2013/ TTLT-BGDĐT-BLĐTBXH-BTC [42].

The Law on Persons with Disabilities describes three possible forms of education for people with disabilities: integrated education, exclusive education and semi-integrated education[8]. For all these forms of education, students with disabilities are entitled to certain benefits including: an individual education plan, which will exempt or reduce the requirements for some subjects compared to the original curriculum; deferred enrolment up to 3 years; and adapted criteria for admission to high schools, vocational schools and university. Additionally, all students with disabilities who come from poor and near poor households – regardless of the severity of their disability – are entitled to exempted tuition fees and a scholarship of 1,000,000 VND (US$43.78) to support the purchase of education materials [43, 44]. However, despite these provisions, a recent study still found a large number of students with disabilities faced financial burdens in relation to accessing education services (around 33.1% of 1,200 students with disabilities) [45].

All of the benefits mentioned above are only given where students have the certificate of disability from the DDDC, though certification can be for any level (i.e. includes mild disability) [42]. However, a common practice of the DDDC at the commune-level is to issue the certificate for only people with exceptionally severe disabilities or severe disabilities but not for people with mild disabilities. This leads to a situation in which eligible students cannot get educational benefits. In addition, as a result of negative perceptions and stigma regarding disability, some parents are reluctant to acknowledge that their child has a disability and thus, do not want to apply for a certificate of disability for their child. To improve the situation, it is therefore necessary not only to reform the system for issuing disability certificates but also to raise awareness and address any negative perceptions of disability among parents and people in the community.

5.2.4 Vocational training and employment

The Decision number 1019/QĐ-TTg of the Prime Minister approving the scheme for assisting people with disabilities in the 2012 – 2020 period includes a target that by the year 2020

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[7] For those with occupational disease and injury cover under the compulsory social insurance scheme, assistive devices are covered.

[8] ***Integrated education*** means a mode of education integrating persons with disabilities with persons without disabilities in educational institutions. ***Exclusive education*** means a mode of education used exclusively for persons with disabilities in educational institutions. ***Semi-integrated education*** means a mode of education combining integrated education with exclusive education for persons with disabilities in educational institutions.

about 300,000 people with disabilities who are of working age and have the ability to work should receive vocational education and have suitable employment.

Vietnam has an extensive nationwide system of vocational training establishments. In 2013, there were 1,339 centres [46], however, as of 2014, there were only 256 vocational establishments offering vocational training for people with disabilities, including 55 specialized establishments providing vocational training specifically for people with disabilities [47]. Not only is the quantity of establishments a problem but also their distribution remains inadequate: as most centres are based in urban settings, distance and difficulties of transport can hinder the participation of people with disabilities.

Despite the availability of free tuition fees, people with disabilities are still not taking up the opportunity to come to public vocational training establishments for a variety of reasons. Firstly, many people with disabilities are still not aware of their rights and entitlements related to vocational training. Additionally, public vocational training centres provide vocational training courses for a limited range of professions and are relatively short, which are insufficient for skill development to meet the demands of the economy. The capacity of trainers is also an issue, with NGOs and DPOs expressing concern that government trainers do not have appropriate skills, knowledge or even the appropriate attitude and enthusiasm to teach people with disabilities.

Given these challenges, it is estimated that only 12% of people with disabilities have taken vocational training courses even though their need is very high [47]. Compounded with low education levels and other barriers, people with disabilities often work in the informal sector and low-skilled jobs such as vendors in small shops, tailors, labourers, agricultural workers, handicraft workers or as masseuses [48]. The income derived from these jobs is low and unstable and often insufficient to meet expenditure needs [48].

To promote more sustainable livelihoods for people with disabilities, the Government offers preferential loans from the State Development Bank for self-employed people with disabilities or households creating jobs for people with disabilities (including in the informal sector) to cover production and business activities. They are also entitled to receive guidance related to production methods and technology transfer and receive support on product sales according to regulations of the Government [27]. There is no national data available on how many people with disabilities have taken up these loans, although there is some evidence that they are popular among people with disabilities [6]. For example, by 2012, 13,000 members of the Vietnam Blind Association had received a loan with a total amount equal to 31 billion VND (US$44,000) [47].

Additionally, businesses which employ people with disabilities (comprising 30% or more of their total staff) are exempt from enterprise income tax; may borrow loans at preferential interest rates; receive priority in land, ground and water surface lease; and may be exempted from rental fees [27]. However, the monitoring and enforcement of this in practice is unclear with no available data to date. Furthermore, incentives for businesses only cover the formal sector. As about 82% of employment across Vietnam is through the informal sector [61], and is likely higher for people with disabilities due to lower levels of

educational attainment as well as discrimination in the workplace, many people with disabilities will not benefit from this scheme. As women and people in rural areas are also more likely to engage in informal employment in Vietnam, they are particularly unlikely to benefit [49].

5.2.5 Transportation discounts

People with disabilities of any degree classification are eligible for subsidised or free fares on public transportation. To utilise this benefit, they must present the "disability card" they received after their disability certification.

However, the limited availability and accessibility of public transportation is a major barrier to uptake. Additionally, awareness of this benefit is perceived to be low, due in part to the limited utility in areas without adequate and disability-friendly public transportation infrastructure.

6 Non-Disability Targeted Social Protection

The majority of social protection entitlements in Vietnam are targeted to specific groups deemed to be at a high risk of poverty or who face other forms of marginalisation, including people with disabilities. People with disabilities may also be eligible for programmes for other targeted groups, if they meet their eligibility criteria. Additionally, other schemes, such as social insurance and health insurance, are open to a broader population.

6.1 Social assistance

Vietnam offers a range of other forms of social assistance to other marginalised groups, such as for older adults in poor households, orphans or single parents. Although these programmes do not specifically target people with disabilities, people with disabilities may nonetheless be eligible.

For example, as disability increases with ageing, many people with disabilities may be eligible for allowances given to older adults. Older adults over 60 living in poor households (according to the poverty line stipulated by the Government in each period) who have no family members to rely on (or where that person is also a social protection beneficiary) are entitled to a monthly allowance of 405,000 VND (US$18). Older adults aged 80 and older with no other source of income may receive 540,000 VND (US$24).

Additionally, as other research has found higher rates of divorce and parental abandonment in families where a child has a disability [50], households with children with disabilities may be over-represented among those eligible for the Single Parents' or Orphans Allowance. The former provides single parents belonging to a poor family an allowance of 270,000 VND (US$12) per month for one child and 540,000 VND (US$24) if they have two children or more, while the latter provides 675,000VND (US$30) to orphans 4 and under and 405,000 VND (US$18) to orphans aged 5-17 [30].

However, it is important to note that any individual who is eligible for more than one form of social assistance is only entitled to receive one, the one of the highest amount. The only types of social assistance which can be received concurrently are the Single Parents'

Allowance and the Allowance for Caregivers of People with Exceptionally Severe Disabilities. The restriction to only receiving one type of cash assistance does not acknowledge additional financial needs stemming from multiple sources of marginalisation. In this regard, older adults with disabilities may be particularly affected, given that disability prevalence increases with age. While older adults may receive the Old Age Allowance to help cover lost earning potential and other age-related expenses, older adults with disabilities cannot also receive the Disability Allowance to cover additional disability-related expenses.[9] They will therefore have to contend with additional disability-related costs from the same allotment. In contrast, since parents can receive both the Single Parents' Allowance and the Disability Allowance concurrently, recipients – most of whom are women – do have access to additional resources to help cover multiple sources of costs.

6.2 Health insurance

People with disabilities who do not receive government-subsidised CHI based on disability may still be eligible for this plan for reasons. For example, children under six, older adults, members of certain ethnic minorities, students and those classified as poor/near poor are eligible to receive full or partial subsidies on their health insurance premium. The percentage of medical expenses covered by CHI for different groups varies, from 80% for students and the "near poor" to 100% for children under six.

Similarly, people with disabilities in formal employment who have a contract of at least 3 months are obliged to participate in CHI. In this case, the premium is set to 6% of the employee's monthly salary. Of the 6% premium, employers contribute 4.5% and employees contribute 1.5% [29, 39]. Given the high barriers to participation in formal sector employment faced by of people with disabilities in Vietnam [49, 51], it is unlikely that this avenue is a widely used option for the vast majority of people with disabilities.

Without CHI subsidised by the government or their employers, people with disabilities could opt into Voluntary Health Insurance (VHI). While this programme is also a form of social insurance run by the State and covers the same types of services as CHI, it has a premium equivalent to 4.5% of monthly minimum salary (from formal or informal work). The insured is responsible for the full payment of this premium, which may be prohibitive to many people with disabilities who have low and unstable sources of income [51].

6.3 Social insurance

Social insurance regimes and policies are set out in the Law on Social Insurance (Law No.58/2014/QH13). In Vietnam, social insurance consists of compulsory social insurance (CSI) and voluntary social insurance (VSI). CSI covers sickness, maternity, labour accidents and occupational disease, retirement and survivor allowances [34]; while, VSI covers only retirement and survivor allowances [34].

Any Vietnamese citizen can participate in VSI. In contrast, CSI is only for civil servants and formal sector employees with at least a 1-month contract. Thus, people with disabilities

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[9] While older adults with disabilities receive a slightly higher allotment amount of the Disability Allowance, it is far from equivalent to the allotments for the two social assistance programmes combines.

who choose to participate in VSI are covered if they pay a monthly amount equivalent to 22% of their self-declared income, which is likely unaffordable for many. For CSI, the contribution is equal to 26% of employee's monthly salary, of which the employers contribute 18% and employees contribute 8% [34]. Given the fact that the informal economy is predominant in Vietnam [61], coverage of CSI is low for all groups, and that includes people with disabilities.

Box 5. Social protection policies: Challenges and examples of good practice

Examples of good practice

- Vietnam offers a wide range of social protection entitlements targeted to people with disabilities aimed at improving access to health, education and work, as well as protecting against poverty.
- Disability assessments have moved away from medically diagnosed impairments, to a more functioning-based approach. Not only is a functioning-based approach more in line with the UNCRPD, but it also reduces the need for medical resources and professionals, which may be limited particularly in rural areas.
- Applications and assessments of disability are conducted at the commune-level, improving geographic accessibility and reducing costs for applicants.
- Assessment bodies comprise individuals from a range of backgrounds and perspectives, and include representatives from local Disabled Peoples' Organizations, where they are present.
- For the Disability Allowance, some consideration has been given to the additional needs of children and older adults with disabilities by increasing the allotment amount. Additionally, provinces have flexibility to increase the allotment amount to account for differences in standards of living and regional barriers to economic inclusion.

Areas for improvement

- The tools for determining the degree of disability focus heavily on physical functioning and self-care. They can therefore underestimate the severity of impact of certain conditions, such as psychosocial and hearing impairments.
- Medical evaluation is still needed for many children under 6, people with psychosocial impairments, complex cases and for appeals. Going to the MECs in provincial capitals involves higher travel and opportunity costs for applicants.
- Health insurance only covers a limited range of rehabilitation services and offers no coverage of assistive devices. Failure to include these items likely limits access to these essential services, or if accessed, high out-of-pocket spending may contribute to financial vulnerability.
- Benefits are not always aligned with the needs of people with disabilities or the contexts in which they live. For example, several employment entitlements are focused on formal sector work.
- With some exceptions, the restriction to only receiving one type of cash assistance may does not acknowledge additional financial needs stemming from multiple risk factors for poverty and deprivation.

PART B

Disability-Inclusive Social Protection in Practice: Evidence from Cam Le, Da Nang

Overview

Part B draws on evidence from qualitative and quantitative research conducted in Cam Le, Da Nang. It provides a more in-depth exploration of the functioning of the system in practice, focusing on the need for, access to and use of the Disability Allowance, as well as other forms of social protection among people with disabilities.

7 Local Policies for the Provision of Social Protection for People with Disabilities in Da Nang

While Da Nang province and its policies for social protection for people with disabilities are under the overall direction of the national government, provincial authorities in Vietnam also have "decision space" to govern policies and their implementation. As such, although the national law sets out a minimum set of entitlements for people with disabilities in Vietnam, in practice the level of benefits and people's access to them vary considerably across different provinces.

In this context, Da Nang is perceived to be a high performing province in relation to public policies and programmes for people with disabilities, in part because of its relative wealth. Consequently, certain social protection provisions for people with disabilities are higher than the national minimum set of entitlements in key areas. Notably, CHI is provided to all children under 17, even if they only have a "mild" disability certification. Additionally, Disability Allowance allotment amounts are topped up for the poor and older adults with a disability, if they receive monthly social assistance of less than 500,000 VND.

8 Need for Social Protection among People with Disabilities

There is mounting global evidence that people with disabilities may experience a greater need for social protection due to an increased risk of poverty and exclusion in areas such as health, education and work. Vietnam's social protection framework for people with disabilities acknowledges and seeks to address these diverse drivers of poverty and marginalisation. To explore the need for social protection, data from the quantitative research was used to estimate the prevalence of disability in Cam Le and compare living conditions between people with and without disabilities.

8.1 Prevalence of disability

Prevalence of disability provides an indication of the number of people who may be eligible for social protection. After screening 6,379 household members for disability, 150 individuals were identified as having a disability according to the study definition ("a lot of difficulty" or "can't do" key daily life activities), giving a prevalence of disability of 2.5% (2.1-2.9%). This estimate reflects more moderate to severe forms of disability, in line with eligibility for social protection eligibility and recent recommendations from the Washington Group on Disability Statistics. A much higher proportion – 20.0% (19.0-21.0%) – reported at least "some difficulty" (the cut-off used in the 2009 Census) in at least one domain.

Prevalence increased significantly with age, ranging from 1.1% (0.6-1.8%) for children up to 13.2% (9.5-18.2%) for adults over 75 (Table 1). Prevalence of disability also increased with decreasing income, with household prevalence in the poorest income quartile almost triple the prevalence in the wealthiest, indicating poverty may either be a cause or an outcome of disability.

		n	Prevalence (95% CI)	Odds Ratio (OR) (95% CI)	aOR (95% CI) $^{\gamma}$
Overall Prevalence of Disability		150	2.5% (2.1-2.9%)	-	-
Sex	Male	66	2.3% (1.8-2.9%)	Reference	Reference
	Female	84	2.6% (2.1-3.2%)	1.2 (0.8-1.6)	1.0 (0.7-1.4)
Age Group	5-18 years	14	1.1% (0.6-1.8%)	Reference	Reference
	19-40 years	38	1.5% (1.1-2.1%)	1.4 (0.8-2.7)	1.4 (0.8-2.7)
	41-60 years	33	2.2% (1.6-3.1%)	2.1 (1.1-4.0)*	2.1 (1.1-4.0)*
	61-75 years	34	6.0% (4.3-8.2%)	5.9 (3.1-11.1)*	5.9 (3.1-11.1)*
	76+ years	31	13.2% (9.5-18.2%)	14.2 (7.4-27.2)*	14.1 (7.4-27.1)*
Income quartiles (monthly, per capita)	1st (wealthiest)	26	1.5% (1.1-2.3%)	Reference	Reference
	2nd	23	1.6% (1.0-2.3%)	1.0 (0.6-1.8)	1.1 (0.6-1.9)
	3rd	32	2.2% (1.5-3.1%)	1.4 (0.8-2.4)	1.4 (0.8-2.4)
	4th (poorest)	69	4.8% (3.8-6.0%)	3.2 (2.0-5.0)*	2.8 (1.8-4.5)*

* Statistically significant
$^{\gamma}$ Adjusted for age and sex

Table 1: Prevalence of disability by key characteristics

8.2 Economic poverty

Protecting households against poverty is a core aim of social protection, which is often defined in terms of basic income security that allows individuals to "secure effective access to goods and services defined as necessary at the national level" [52]. In Vietnam, the Disability Allowance rates have been set to 32.5% of what is considered the minimum standard of living (defined as 1,300,000 VND and 1,000,000 per person per month for urban and rural areas respectively).

However, in Cam Le households with members with disabilities were significantly poorer than households without members with disabilities across all economic measures of poverty (Table 2). For example, their per capita monthly income was almost half of that earned by households without a member with a disability and they were four times as likely to be in the poorest socioeconomic quartile compared to households without members with a disability. Almost two-thirds were living below the level deemed to be the minimum standard of living, indicating a high need for social protection.

There was no significant difference in likelihood of poverty (income or socioeconomic status based) between households where the member with a disability was a woman or man, or if they were a child, work-age adult or older adult.

In addition to poverty, people with disabilities frequently encounter additional disability-related expenses (e.g. extra transport, medical and rehabilitation costs, purchase of assistive devices). Consequently, for a given level of income, households with disabilities may experience lower standards of living compared to households without members with disabilities, who do not have to divert income towards these expenses. These "extra costs" of disability were estimated to be 38.2% of household income. This means that on average, the income of a household with a member with a disability would need to increase by 38.2%

– the equivalent of US$93.66 per month – in order to enjoy the same standard of living as a household without members with a disability. It is important to note that this calculation only takes into account what households with disabilities are *currently spending* on disability-related costs; it does not necessarily represent the amount required for full coverage of the range of disability-related expenses needed to promote full and equal inclusion. In fact, given the findings in the ensuing sections, it is highly likely that potential disability-related expenditures would be much higher, if people could afford (or access) them.

Characteristics	**Households with members with a disability (N=137)[α]**	**Households without members with a disability (N=1,328)**		
Poverty markers			**p-value**	**Adjusted p-value[γ]**
Average monthly household income per capita (1000 VND)	1,248 [US$55]	2,121 [US$94]	<0.001*	<0.001*
	N (%)	**N (%)**	**OR (95% CI)**	**aOR (95% CI)**
Self-rated wealth Average/rich	77 (56.2%)	1,059 (79.7%)	Reference	Reference
Very poor/poor	60 (43.8%)	269 (20.3%)	3.1 (2.1-4.4)*	3.0 (2.1-4.3)*
Socioeconomic status, quartiles[ϕ] 1st (wealthiest)	14 (10.2%)	331 (24.9%)	Reference	Reference
2nd	22 (16.1%)	333 (25.1%)	1.6 (0.8-3.1)	1.5 (0.8-3.0)
3rd	40 (29.2%)	327 (24.6%)	2.9 (1.5-5.4)*	2.9 (1.5-5.4)*
4th (poorest)	61 (44.5%)	337 (25.4%)	4.3 (2.3-7.8)*	4.3 (2.4-7.9)*
Households is below the minimum standard of living[β]	87 (63.5%)	337 (29.9%)	4.1 (2.9-5.9)*	4.0 (2.7-5.7)*
Extra costs of disability	**% income**		**Amount (1000 VND)**	
Household level extra cost	38.2%		2,082 [US$93.66]	

[α] Includes only people with disabilities identified during the population-based survey
*Statistically significant
[γ] Adjusted by household size, dependency proportion
[ϕ] Socioeconomic status was derived through principal component analysis of household ownership of assets
[β] Defined as 1,300,000 VND (US$57) per person per month by the MOLISA for the period 2016 – 2020 for urban areas

TABLE 2: Comparison of economic poverty between households with and without members with disabilities

Given that many people with disabilities already do not meet minimum standards of living and that these disability-related costs are almost four times greater than the amount of the Disability Allowance, social assistance on its own is unlikely to ensure basic income security or an escape from poverty.

8.3 Health

Access to healthcare, including rehabilitation, is a key entitlement outlined in Vietnam's legal framework on social protection for people with disabilities, which is addressed predominantly through the provision of state subsidized CHI. International guidelines

similarly stipulate access to essential healthcare as a central social protection guarantee, with the State responsible for ensuring services are accessible, acceptable and of good quality for all citizens [52]. In particular, guidelines note that no individual should face "an increased risk of poverty due to the financial consequences of accessing essential healthcare."

Still, evidence from Cam Le indicates that people with disabilities may face barriers in accessing needed healthcare, leading to lower health status and potentially greater risk of poverty. For example, people with disabilities were significantly more likely to rate their health as poor compared to people without disabilities: over two-thirds considered their health as "weak" or "very weak" while over 80% of their peers without disabilities considered their health as above average (Table 3).

People with disabilities were also six times more likely to report having experienced a serious health condition in the last 12 months than controls without disabilities. Although almost all people with and without disabilities who experienced a serious health condition sought treatment, people with disabilities paid more for the health services they received. Overall, households with members with disabilities spent on average over twice as much on healthcare a month compared to households without members with disabilities. Financial accessibility of healthcare is therefore a key area to be addressed by social protection for people with disabilities. There were no significant differences on any of the health indicators when findings were analysed separately by sex..

Indicators	Cases (n=222)	Controls (n=222)	aOR (95% CI)$^{\gamma}$
Health			
Self-rated health - Average to very good - Weak/very weak	 78 (35.0%) 145 (65.3%)	 191 (86.0%) 31 (14.0%)	 Reference 17.3 (8.1-37.0)*
Had a serious health condition in the last 12 months	68 (30.6%)	23 (10.4%)	6.1 (2.8-13.7)*
Sought treatment for serious health condition	65 (95.6%)	22 (95.7%)	1.0 (0.1-10.0)
Healthcare spending	**Cases (n=222)**	**Controls (n=222)**	**Coefficient$^{\alpha}$ (95% CI)**
Average monthly household spending on healthcare (1000 VND)	1,626 [US$72.05]	613 [US$27.16]	1011 (50-1972)

*Statistically significant

$^{\gamma}$Adjusted for age, sex and where possible, cluster

$^{\alpha}$ Regression coefficient, which illustrates the difference in monthly household spending on healthcare that can be attributed to disability, after taking into account other factors that may explain differences between cases and controls

TABLE 3: Comparison of health indicators between people with and without disabilities

Additionally, awareness of disability-specific health and rehabilitation services among people with disabilities was overall low (Table 4). Amongst those who were aware of and

reported needing various services, the majority had accessed the required service either currently or in the past.

Women were less likely to have heard of assistive devices and rehabilitation compared to men (p=0.05). Although the difference was not statistically significant, they were more likely to report needing rehabilitation and assistive devices but were less likely to receive them. No differences by age group were found.

	Heard of service/device	Need service/device	Ever received/ used	Currently receiving/using
Medical rehabilitation	101 (45.9%)	55 (54.5%)	45 (81.8%)	16 (35.6%)
Assistive devices	93 (42.3%)	48 (52.2%)	42 (87.5%)	35 (83.3%)
Specialist education	53 (24.1%)	13 (25.0%)	12 (92.3%)	6 (50%)
Vocational training (≥17)	49 (25.4%)	10 (20.8%)	8 (80.0%)	2 (25.0%)
Counselling	51 (23.2%)	11 (21.6%)	9 (81.8%)	1 (11.1%)

TABLE 4: Access to specialist health and rehabilitation services among people with disabilities (n=222)

8.4 Education

People with disabilities – namely children – are entitled to several social protection provisions that aim to improve their access to education, as described in section 5.2.3.

Children with disabilities, however, were significantly less likely to go to school compared to their peers without disabilities, all of whom were currently enrolled (see Table 5). Reasons for not attending included illness, lack of money and negative experiences at school. Even when children with disabilities did attend, many were left behind academically.

Children 5-17			
Indicators	*Cases (n=26)*	*Controls (n=26)*	*aOR (95% CI)¥*
Not currently enrolled	16 (66.7%)	26 (100%)	2.4 (1.2-4.9%)*
Not in same grade as other children	7 (46.7%)	0 (0%)	n/a
Missed school in the past month	3 (12.6%)	2 (7.7%)	2.0 (0.3-13.6)

*Statistically significant

¥ Adjusted for age, sex and cluster

Table 5: Access to education, children with and without disabilities

Adults with disabilities similarly had poor educational outcome: they were more than 4 times more likely to have never attended school compared to adults without disabilities and had lower levels of educational attainment (Table 6). Not surprisingly, reading ability was much lower among adults with disabilities.

Adults 18+			
Indicators	*Cases (n=196)*	*Controls (n=196)*	*aOR (95% CI)¥*
Never attended school	32 (17.2%)	8 (4.1%)	4.6 (2.0-10.4)*
Highest Education			
- Secondary and higher	33 (16.7%)	80 (40.8%)	Reference
- Primary (completed)	82 (41.4%)	75 (38.3%)	2.9 (1.7-5.1)*

- No school/some primary	82 (41.4%)	41 (20.9%)	7.0 (3.5-14.1)*
Reading ability - Can read well - Can read a little - Cannot read at all	 110 (55.6%) 47 (23.7%) 41 (20.7%)	 174 (88.8%) 16 (8.2%) 6 (3.1%)	 Reference 1.9 (1.1-2.6)* 2.5 (1.5-3.5)*

*Statistically significant

¥Adjusted for age, sex and cluster

TABLE 6: Comparison of education indicators between people with and without disabilities

When disaggregating findings on adult's level of education, no significant differences between men and women with disabilities were found.

8.5 Livelihoods

Vietnam social protection policy for people with disabilities outlines several types of entitlements to promote the development of stronger livelihoods, including vocational training and preferential loans to small-business owners with disabilities. Social assistance may also function as income support for individuals who are unable to maintain a sustainable livelihood, due to unemployment or underemployment or – for a minority – incapacity to work.

In Cam Le, there is clearly a need for social protection to foster stronger livelihoods. Among working age adults (18-65 years), people with disabilities were over six times more likely to have not worked in the past 12 months compared to their peers without disabilities (Table 9). The main reasons cited by people with disabilities for not working were that they believed they were incapable of work (64.8%) or that they had had a long illness (21.6%). In comparison, the main reasons for not working among people without disabilities were for childcare/household duties (28.2%), continuing education (20.5%) or due to retirement/continuing education (35.9%).

Indicators	Cases (n=142)	Controls (n=142)	aOR (95% CI)¥
Livelihoods (Ages 18-65)			
Did not work in the last 12 months	91 (64.1%)	40 (27.4%)	6.4 (3.3-12.5)*
Works irregularly (not year-round)ß	16 (29.6%)	10 (9.4%)	4.0 (1.6-9.9)*
Household lacked food in the past month	20 (9.9%)	62 (4.7%)	2.2 (1.2-3.7)*
			CoefficientΩ (95% CI)
Number of months worked in a yearß	9.5	10.9	-1.4 (-2.3, -0.5)*
Average monthly salary (1000 VND), for those paid in cashß	2073 [US$91.20]	4455 [$196.02]	-2142 (-3023, - 1260)*

***** Statistically significant

ß Among people who worked in the last 12 months

¥Adjusted for age, sex and where possible, cluster

ΩRegression coefficient, which illustrates the difference in months worked or monthly salary that can be attributed to disability, after taking into account other factors that may explain differences between cases and controls

Table 7: Comparison of employment indicators between people with and without disabilities

When people with disabilities did work, they earned less than half the salary of people without disabilities, were engaged in less stable work and worked one month less per year on average. Households with members with disabilities were much more likely to experience food insecurity, with twice as many households reporting that they lacked food due to financial reasons in the past month.

In disaggregating the data by sex, both women and men with disabilities were less likely to have worked in the last 12 months than their peers without disabilities of the same sex (Table 8). While both were more likely to work irregularly, this difference was only significant for men with disabilities. Women and men with disabilities who were working earned similar salaries and worked similar number months; they also experienced similar disparities in these areas in comparison to people without disabilities of the same sex.

Indicators	**Women$^{\alpha}$**	**Men$^{\alpha}$**
	aOR (95% CI)$^{¥}$	**aOR (95% CI)$^{¥}$**
Livelihoods (Ages 18+)		
Did not work in the last 12 months	3.6 (1.8-7.5)*	7.3 (3.4-15.5)*
Works irregularly (not year-round)$^{\beta}$	3.6 (0.9-13.9)	4.6 (1.3-15.6)*
	Difference (adjusted p-value) $^{¥}$	***Difference (adjusted p-value)*** $^{¥}$
Difference in number of months worked in a year$^{\beta}$, in comparison to people without disabilities of same sex	1.6 (0.03)*	1.4 (0.07)*
Difference in monthly salary (1000 VND), in comparison to people without disabilities of same sex	-2391 [US$105.20] (p<0.001)*	-2285 [US$100.54] (p=0.008)*

$^{\alpha}$ Comparison is women/men with disabilities to women/men without disabilities

* Statistically significant

$^{\beta}$ *Among people who worked in the last 12 months*

$^{¥}$*Adjusted for age, sex*

Table 8: Comparison of employment indicators, disaggregated by sex

8.6 Participation

The Law on persons with disabilities codifies the rights of people with disabilities to participate on an equal basis in social activities (Article 4.1a) and to live independently and integrate into the community (Article 4.1b). In terms of corresponding social protection entitlements, transportation discounts may address this area directly, while the downstream effects from other entitlements (e.g. inclusion in education, work) may foster increased social participation.

In Cam Le, people with disabilities faced widespread exclusion from social participation. People with disabilities were much less involved on almost all indicator of household and community participation (Table 9). Notably, over 40% of people with disabilities did not vote, with 60% citing their disability as the main reason. Levels of participation did not differ significantly by sex or age group for any indicator.

Indicators	Cases (n=146)	Controls (n=201)	aOR (95% CI)
Participation in household			
Regularly consulted in household decisions	81 (55.5%)	181 (90.1%)	10.0 (5.3-18.9)
Regularly goes with family to family/social events	92 (63.0%)	193 (96.0%)	15.6 (6.9-35.1)
Feels involved and part of household on a regular basis	87 (60.8%)	197 (98.0%)	38.4 (12.9-114.5)
Regularly involved in household conversations	103 (70.1%)	199 (99%)	54.5 (11.8-252.3)
Participation in community			
Regularly participates in community meetings	55 (37.9%)	145 (72.9%)	5.2 (3.2-8.6)
Feels voice is being heard (for those that participate at community meetings)	51 (96.2%)	138 (100%)	n/a
Did not vote in the last election (age 21+)	60 (41.1%)	5 (2.7%)	26.5 (10.1-69.6)
Cases only			
Reason for not voting related to disability	36 (60%)		
Makes important decisions about their lives at least sometimes	102 (67.6%)		
Aware of DPOs	57 (39.0%)		
Is a member of a DPO (if aware)	34 (59.6%)		

* Statistically significant

¥*Adjusted for age and sex*

Table 9: Participation between people with and without disabilities (age 15+)

Box 6. Summary: Need for social protection among people with disabilities

The core goals of social protection are to alleviate poverty, develop stronger livelihoods and reduce inequalities.

In considering these aims of social protection, people with disabilities with disabilities faced a high need for social protection. For example, people with disabilities and their households faced high levels of poverty, as well as barriers from participating in activities that could strengthen their livelihoods such as education and work. Furthermore, people with disabilities experienced poor health and spent more to access healthcare. For almost all of these measures, people with disabilities were worse off compared to people without disabilities.

9 Access to Social Protection

Evidence from Cam Le indicates a clear need for social protection among people with disabilities, given high levels of economic poverty and barriers to developing stronger livelihoods such as lower levels of health and education and less stable livelihoods, as well as persistent inequalities in relation to people without disabilities. Evidence from other areas in Vietnam reinforce that many of these challenges are not unique Cam Le, but are evidence of widespread economic and social exclusion of people with disabilities [53]. While social protection is not the only intervention for addressing these needs, Vietnam's disability-targeted social protection entitlements have the scope to target at least some of them.

In order to potentially benefit from social protection, people with disabilities must first be accessing available programmes. In this section, we explore coverage and uptake of key entitlements, and how the application process functions in Cam Le.

9.1 Experiences of the application process

As noted in Part A, since 2012 the disability assessment process has shifted from the provincial-level MEC to the commune-level DDDC. As commune catchment areas are small, application points are in close proximity to applicants' homes, reducing transportation and opportunity costs, as well as improving communication and outreach. This system also reduces wait times and workloads, as each DDDC is responsible for only assessments in their commune. It is important to note that almost all the officials involved perceived this change to be a positive one:

> *"Now it moves to the People's Committee because the People's Committee is the closest to people in the community, which avoids missing cases. Before the Council was at provincial-level and there were so many severely disabled in the province, they could not cover them all, they could not meet all the people with disabilities."* (3_KI_DD_PC_03)

> *"The empowerment of the Commune authority is one of its advantages. Commune authorities are more active in identifying people with disabilities. They are also closer to the targeted group who need to be identified by the form and level of their disabilities...[as] the [DDDC] needs to directly meet the person to identify the form and level of disabilities. It is much easier and more accessible for a person to visit the commune hall compared with visiting city hall."* (13_KI_DD_DOLISA_11)

The shift of the assessment to the commune-level and the increased role of officials at commune People's Committees in spreading awareness about social assistance and other benefits was mirrored in the quantitative survey with Disability Allowance recipients. Over 85% of respondents indicated that they had learnt of the process through People's Committee staff and 81% had received their assessment at the commune-level (see Table 10).

Learnt about the Disability Allowance from:	
- People's Committee (ward/commune-level)	115 (85.2%)
- Media	16 (11.9%)
- Disabled People's Organisations	16 (11.9%)
- Friend/relative	15 (11.1%)
- Population group leader	9 (6.7%)
- District People's Committee	4 (3.0%)
- Health centre	7 (5.2%)
- NGO	3 (2.2%)
Where certification took place (new and old system)	
- Commune/ward level committee	109 (81.4%)
- District-level committee	6 (4.4%)
- Hospital/medical facility	8 (5.9%)
- Unknown	13 (9.6%)
Average number of visits required to complete application:	2.3
Wait time to receive Disability Allowance after certification	
- Less than a month	10 (19.2%)
- 1 to 6 months	21 (40.4%)
- 6 months to a year	13 (25.0%)
- One year or more	8 (15.4%)
Difficulties experienced during the application process:	
- Getting to application office (or other application points)	22 (16.3%)
- Understanding the application process	22 (16.3%)
- Accessibility of facilities or application points	19 (14.1%)
- Gathering the necessary documents for the application	19 (14.1%)
- Paying for transport	14 (10.4%)
- Communicating with staff/officials	12 (8.9%)
- Attitudes of staff	11 (8.2%)
- Meeting application deadlines	8 (5.9%)
- Receiving disability assessment	7 (5.2%)

Table 10: Experiences during the application process for Disability Allowance among recipients (n=135)

While the introduction of the new assessment process has undoubtedly improved many of the difficulties experienced during the previous system, particularly around accessing application offices, some challenges remain. Among Disability Allowance recipients[10], challenges during the application process reported by survey respondents are listed in Table 10. The most common difficulties included getting to and around application points, understanding the application process and gathering necessary documentation, experienced by 16% of applicants. These issues were highlighted in some of the qualitative interviews:

> *"From 2003, the district authorities asked me to apply for social protection for my child. I had tried many times. But I don't know why I cannot receive it. They told me to add those documents, add that document. I cannot remember how many times, but I visited the commune hall back and forward many times. There was always some*

[10] Only one person in the study was classified as having a "mild disability", so analyses are restricted to Disability Allowance recipients (i.e. individuals who are certified as having severe or extremely severe disabilities by the DDDC.

> *documents lacking each time or something wrong. Then, they guide me to the mental hospital for getting certification, and I have it now, finally, in 2014.”*
> (2_PWD_MW_02, mother of a child with Down Syndrome)

Furthermore, contrary to official guidelines, there is a perception that only those eligible for social assistance should apply for assessment by the DDDC. This reflects the lack of information about the additional benefits that all people with disabilities, including those classified as having “mild disabilities”, are entitled to – such as transportation discounts and educational supports. Most of the interviewees who did know about these additional benefits were officials or DPO representatives rather than people with disabilities among the general population, although those who did also perceived these benefits to be relatively unattractive. However, officials involved in the process can perpetuate this perception, as some play a “gate keeper” role. Several respondents indicated that officials either don’t encourage people to apply if they are perceived to be ‘mildly’ disabled, or in some cases may actively discourage people from submitting applications.

> *“If Mr H [a LISA officer at the commune People’s Committee] recognized my case as one of severe disabilities or extremely severe disabilities, he will guide me in how to make a dossier and receive social assistance, otherwise he will not. As for my case, he told me I am not qualified and should not make a dossier.”* (16_KI_MW_05)

The low value placed on the “mild” classification by either officials or potential applicants was also reflected in the quantitative, as only one person had received this certification.

In addition to people with mild people being discouraged from applying, older adults with disabilities may also be excluded: the DDDC is thought to have problems related to its understanding of “ageing” and “disability” – their perception is that both have difficulties in functioning but where the main reason is ageing, it is perceived that “this is not disability”. Older adults themselves may not consider themselves to have a disability, leading to self-exclusion.

Overall, the data in Da Nang suggests that there has been a steady increase in the number of people with disabilities registering since the new assessment process was introduced – a 2011 survey found only around 1,800 people with severe disabilities in the province, but by 2014 9,677 were registered and receiving social assistance [2, 9] - and this matches people’s perception within the province.

9.1.1 The Disability Assessment

Among the 5-7 members of the DDDCs across Cam Le, the chairperson of the commune-level People's Committee, the head of the commune heath station, and the LISA officer were reported to have received training for using the disability assessment forms.

Disability assessments in Cam Le typically take place at the Commune People’s Committee hall. The presence of the person with disabilities at the meeting is compulsory. However, if they cannot come to the specific venue due to their condition, the DDDC members visit their household or other convenient location for the applicant:

"The elderly, stroke patients, myocardial infarction cases, for example, cannot visit the Commune People's Committee. They submit their dossier with photos. [The DDDC] will visit their household. It is compulsory. There was a case of a person with mental health problems, when the Council visited his house, he went out and family members agreed another time for the Council to visit." (3_KI_DD_PC_03)

Decree No. 28/2012/ND-CP specifies that within 15 days of receiving a valid dossier, the DDDC must reach and announce their decision on the application. In practice the process may take significantly longer, depending upon the number of dossiers received, and the availability of members of the DDDC. Members of the DDDC could not remember the exact timeline involved, but estimates varied from 30 to 45 days:

"It is about 45 days to identify a case of disability. But we cannot hold a meeting of the impairments assessment council more often. If there are more than 20 dossiers, we can organize two meetings per month but mostly it is one per month and then we publicly post up its conclusions for 15 days." (4_KI_DD_LS_04)

"One meeting could assess one or more dossiers. After receiving a qualified dossier, we need to process it within 30 days. We usually hold from 4 – 5 meetings to assess dossiers per year." (19_KI_HC_01)

As mentioned in Part A, people with disabilities can appeal the decision of the DDDC, in which case they will be re-evaluated by the provincial MEC. In practice, there are very few appeals, around 4 to 5 each year in Da Nang province on average. This reflects some problems with the appeals process itself. Firstly, while the assessment of the form and degree of disability at commune-level is free of charge, citizens who request a re-assessment at the MEC need to pay the fee out-of-pocket if the conclusion of the MEC is similar to the conclusion of the DDDC (if it is not, the DDDC pays for it). Secondly, people with disabilities and their caregivers appeared to have limited information about the MEC and the appeals process.

A: They gave me a decision that my child is classified as having severe disabilities, not extremely severe disabilities. They explained that my child had a lot of disabilities but that he was able to stand alone, so he could not be classified as having extremely severe disabilities. So I did not ask any more".

Q: If you don't agree with the Decision of the [DDDC] you can request for reassessing at higher level, have you ever heard about that?

A: No

Q: Has no one told you about the Medical Examination Council?

A: No (FGD_MW_2)

Finally, people may be reluctant to make a formal complaint against DDDC given that it is composed of a variety of key local officials and other authority figures.

After receiving input from the district-level LISA Division the district-level People's Committee chairperson makes the final decision on the provision of social assistance, which officials reported usually takes from 3 – 5 months to receive social assistance after the initial application. This timeline is in line with the responses from surveyed Disability Allowance recipients, as over two thirds reported that they began receiving social assistance within 6 months of their assessment.

9.1.1.1 Criteria for assessing degree of disabilities

As noted in Part A, Joint circular No. 37/2012 is used by the DDDC to conduct disability assessments. In general, officials involved in carrying out the assessment found the forms easy to use:

> *"It's quick, only about 10 minutes for a dossier. Before, a dossier needed to be consulted by experts and it was more difficult to assess. Now it's simple and we can assess by seeing."* (19_KI_HC_01)

> *"It depends. Some cases are so easy to assess by seeing but some cases need to be more careful, mental and psychiatric disability, for example. It takes 15 minutes, at least 15 minutes."* (4_KI_DD_LS_04)

However, officials and disability advocates all recognised that the forms have some limitations. Some conditions, they noted, are excluded by the form, for example people with autism or with Down's Syndrome may not always be classified as having a disability. Additionally, as the disability degree criteria puts a strong emphasis on mobility and self-care, some forms of disability are frequently classified as mild disabilities, even though they have a significant impact on people's functioning and ability to support themselves in the local context (e.g. paralysis of one leg or hand, visual, hearing and communication impairments).

> *"It is because of one of the criteria to assess the ability to move around of people with disabilities. For people with vision impairment, they are acquainted with everything in their house and they can walk around without help, but they actually need a stick or something to help them to move around." (8_KI_MW_01)*

> *"The criteria for assessing level of disabilities is the worst point of the new procedure. Because the form is used to assess all forms of disability so some forms of disabilities are excluded. Deaf people, for example. Deaf people receive nothing from social welfare because they can walk, eat, have a bath, etc. without help. They can do all of this. Some cannot speak but it is not enough for receiving social welfare. So they are excluded."* (8_KI_MW_01)

In a small number of cases this resulted in a change in approach at the province level. In particular, due to guidance from the provincial DOLISA, a person who is both deaf and has a communication impairment, can now be assessed as having a severe disability and is thus eligible for social assistance.

> *"We classified those cases as mild disabilities [before]. However, the vice head of DOLISA attended that Medical Examination Council and he said that these cases*

should be classified as severe disabilities. He or she [applicant] could do nothing. We need to provide social welfare for him/her. I suggest that this is a "case law". From now on, the [DDDC] at commune-level needs to classify this as severe disabilities. Without his decision, we would classify as mild disabilities those forms of impairment." (7_KI_DD_PMI_07)

It is important to note that DDDC members reported that they did not strictly use the disability degree scoring system to determine certification outcomes, as they could use some personal discretion to decide to put an individual into a higher classification. In particular, they singled out poor living conditions or children with disabilities as reasons to exercise some flexibility:

"We did score degree of disability using the forms, all of members were using those forms. But we were considering others factors, not only using the forms. Those forms are too rigid." (2_KI_DD_HW_02)

"Using forms in Decree 28 and the joint circular sometimes is difficult. Children for example, if they are children and cannot be in the severe category, we need to flexible, for children to receive social welfare." (19_KI_HC_01).

"We consider about living conditions, if they are in economic difficulty, we can be more flexible. It is not in the guideline but we can adjust it in practice." (19_KI_HC_01)

The positive aspects and challenges in applying Joint circular No. 37/2012 to assess degree of disabilities as well as in implementing the Decree 28 were recently reported to national level by provincial DOLISA staff to feed into the national level reform process [54].

9.2 Coverage and uptake of social protection

9.2.1 Coverage of social assistance

According to reports from DOLISA in Da Nang, there were 9,677 people with disabilities (1% of the population) receiving monthly social assistance in 2014 [9]. The number of recipients has been steadily increasingly since the introduction of Circular 28/2012/ND-CP.

From our research in Cam Le, 64 (42.7%) of the people identified as having a disability[11] in the household survey were currently receiving the Disability Allowance. An additional 15 were receiving cash transfers through either the Agent Orange Victim fund or the War Invalids and Contributors Benefit (52.7% coverage for any disability-targeted social assistance) (Table 11). Furthermore, almost two-thirds of Disability Allowance recipients belonged to households receiving any type of social assistance (disability-targeted or otherwise). Households with members with disabilities were significantly more likely to be receiving social assistance, predominately through the disability-targeted schemes as well as the allowance for older adults in poor households.

[11] As the study definition of disability was people who reported experiencing "a lot of difficulty" or could not do certain daily life activities, it focuses on more moderate to severe impairments, which would be more in line with Disability Allowance eligibility criteria of "severe or extremely severe disability".

Programme[a]	Households with members with disabilities (n=137)	Households without members with disabilities (n=1,328)	aOR (95% CI)[¥]
Social Assistance			
Any type of social assistance	86 (62.8%)	152 (11.5%)	13.6 (9.1-20.4)
Disability Allowance	60 (43.8%)	1 (0.08%)	
Orphans or Adopted Children	0 (0%)	3 (0.2%)	
Single Parents	4 (2.9%)	8 (0.6%)	
Older Adults in Poor Households	23 (16.8%)	72 (5.4%)	
Agent Orange Victims	4 (2.9%)	4 (0.3%)	
War Invalids and Contributors Benefit	11 (8.0%)	66 (5.0%)	
Emergency Social Assistance	2 (1.5%)	1 (0.08%)	
Charitable gifts to poor	1 (0.7%)	7 (0.5%)	

[a] Any member of the household is a participant
[b] Covers sickness, maternity, labour accidents and occupational disease, retirement and survivor allowances
* Statistically significant
[¥] Adjusted by household size, and the dependency proportion of the household

TABLE 11: Participation in other social assistance programmes

Only one person who did not meet the study definition of disability was receiving the Disability Allowance; however, with the programmes for War Invalids and Contributors and the Agent Orange Victims, the number of people without disabilities as per the study definition receiving these allowances was much higher (66 individuals for the War Invalids Benefit and 8 for Agent Orange).

People with disabilities who were receiving the Disability Allowance did not differ from non-recipients with disabilities in terms of sex, but were much more likely to be younger in age (Table 12). Coverage for the allowance ranged from 88.9% for children (5-18 years) down to 20.5% for older adults (76+ years). Coverage of the Disability Allowance was lowest for people with limitations due to sensory functions (hearing/seeing), with less than a third receiving the Allowance, and was highest for people with difficulties remembering or communicating.

	Receiving Allowance[a]	Not receiving Allowance[b]	aOR (95% CI)[c]
General characteristics			
Female	70 (52.2%)	50 (56.8%)	1.1 (0.6-2.1)
Age group			
- 5-18 years	24 (88.9%)	3 (11.1%)	Reference
- 19-40 years	48 (76.2%)	15 (23.8%)	0.4 (0.1-1.5)
- 41-60 years	36 (63.2%)	21 (36.8%)	0.2 (0.06-0.8)*

- 61-75 years	19 (46.3%)	22 (53.66%)	0.1 (0.03-0.4)*
- 76+ years	7 (20.5%)	27 (79.4%)	0.03 (0.01-0.1)*
Functional limitation			
- Physical	30 (56.6%)	23 (43.4%)	Reference
- Sensory (visual/hearing)	6 (28.6%)	15 (71.4%)	0.2 (0.4-0.5)*
- Remembering	15 (79.0%)	4 (21.1%)	1.2 (0.3-4.5)
- Self-care	6 (75.0%)	2 (25.0%)	1.2 (0.2-6.7)
- Communication	5 (83.3%)	1 (16.7%)	2.7 (0.2-28.5)
- Multiple	46 (39.0%)	72 (61.0%)	0.8 (0.4-1.7)

[a] N=124 for household analysis, 134 for individual
[b] N=78 for household analysis
[c] Adjusted by age, sex
* Statistically significant

Table 12: Characteristics of Disability Allowance recipients compared to non-recipients with disabilities

Lower coverage for the Disability Allowance among older adults may reflect perceptions that impairments as a result of ageing do not count as 'disability' or are less deserving of support. As mentioned in the national policy analysis, these perceptions may be held by the DDDC, which can influence their decisions in deciding an individual's disability level and thus eligibility for the Allowance. Additionally, these perceptions may be internalised by potential beneficiaries, who do not consider themselves to have a disability and thus do not think they are eligible for the Allowance:

> *"Now the amount of social support depends on government. We only know what they give to us, we don't know how much is enough. The Government should support children with congenital abnormalities not elderly people like us. It is good if the government has social support for elderly people like us, we are getting old and weak, often being sick and difficult to move around. However, I don't make a dossier [to apply for the Allowance]. I think it should be for people who are living in poorer living conditions than me. It is ok if they come to see me and make a dossier for me, if not, I am not going to ask for it."* (10_PWD_MT_04)

Likely the major reason for lower coverage among older adults, however, is participation in other social assistance programmes, notably the allowance given to older adults living in poor households. As individuals can only participate in one scheme, individuals receiving this form of social assistance could not also receive the Disability Allowance. While the Disability Allowance amount with the top up for older adults is higher, the application process for the allowances to older adults can be more attractive, as it does not involve a disability assessment or the potential stigma of identifying as a person with a disability. In Cam Le, 17% of older adults with disabilities were receiving the older adult allowance, precluding them from receipt of the Disability Allowance. Still, as mentioned in part A, the restriction to one type of assistance does not acknowledge additional costs associated with overlapping sources of marginalisation. While the Disability Allowance amount is slightly higher for older adults (and children) than for working-age adults, it is not nearly equivalent to the combination of the two separately.

From the survey, the main reported reasons for not receiving the allowance were lack of awareness of the programme and uncertainties about eligibility (61.6% and 27.9%, among non-recipients respectively).

9.2.2 Health insurance

All people certified as having severe disabilities or extremely severe disabilities receive State-subsidized CHI. As mentioned previously, in Da Nang, additional provisions have been made so that children with mild disabilities aged 6 – 16 years, a provincial policy covered by the Da Nang City budget:

> *"Children age of 6 – 16, who live with mild disabilities, are not eligible for receiving health insurance card by national social protection policies, so the Da Nang government budget covered for this group."* (12_KI_DD_SW_10).

The health insurance card is provided with the monthly social assistance book once a decision on the provision of social assistance has been made by the commune-level People's Committee chairperson. In 2014, 9,409 persons with disabilities in Da Nang had a health insurance card [55]. The health insurance was very well known in Da Nang and all people receiving social assistance reported knowing about health insurance and how to use it. Similarly, in the quantitative survey, almost all Disability Allowance recipients reported receiving free health insurance.

Overall, compared to people without disabilities, people with disabilities were almost four times more likely to have any type of health insurance, and three times more likely to have the insurance premiums subsidised by the government (due to disability or other qualifying characteristics) (Table 13). There were no differences between men and women with disabilities in terms of their likelihood of having health insurance, overall or subsidized.

	Disability	**No disability**	**aOR (95% CI)**
Has any type of health insurance	144 (96.0%)	130 (86.7%)	3.8 (1.4-10.2)*
Health insurance government subsidized (among those with health insurance)	82 (56.9%)	42 (32.3%)	2.8 (1.7-4.7)*

Table 13: Coverage of health insurance among people with and without disabilities (population-based survey only) (n=300)

9.2.3 Uptake of other entitlements

Uptake of other disability-targeted entitlements was very low, mainly due to lack of awareness (Table 14). For example, less than 5% of Disability Allowance recipients were aware of transportation discounts and only a quarter of caregivers of children with disabilities were aware of educational discounts. However, among the small group of individuals who were aware and reported needing the benefits, coverage was generally high.

	Transportation discounts	Education discounts (≤ 17)	Health insurance	Carer allowance	Preferential loans
Aware of benefit	6 (4.6%)	5/21 (23.8%)	126 (94.0%)	14 (10.5%)	19 (14.2%)
Needs (among aware)	5 (83.3%)	5 (100%)	126 (100%)	13 (92.9%)	18 (94.7%)

Receives (among those who need)	2 (40.0%)	2 (40%)	123 (97.6%)	12 (92.3%)	14 (77.8%)

Table 14: Receipt of other entitlements among Disability Allowance recipients (n=158)

A key challenge influencing uptake was the lack of knowledge about these discounts and services, by officials involved in the disability assessment process and people with disabilities alike. Interviews with key informants involved in the process indicated that they were unaware of other services for people with disabilities in which they were not directly involved. LISA officers, for example, only knew about their work on assessing the form and degree of disability, monthly social assistance and health insurance. As such, there is a lack of knowledge regarding the availability of vocational training, rehabilitation and education entitlements and how to access them. As such, most officials were unable to guide people with disabilities to access others these services that they are eligible to receive:

> *"I don't know about it [rehabilitation policies for persons with disabilities]. I only deliver the health insurance card."* (19_KI_HC_01).

> *"The [Vietnam Assistance for the Handicapped] project did train us about social integration, we will introduce people with disabilities to the job centre. We are working as the referee...However, there are only a few people. I don't remember the address of job centre. I think I left it at home."* (6_KI_DD_HW_06)

Most interviewees who were aware of these entitlements received information about them from DPOs, rather than commune officials. For example, in qualitative interviews, only one person was referred for vocational training during the certification process. Similarly, for parents of children with disabilities, none cited the Commune officials as being the source of information about special or integrated education.

> *"She was blind since she was born. There was someone from the blind association, he came here and gave me a paper to fill in and then to submit to district-level. They accepted her for studying at the blind school. Studying is for nothing but they still ask her to go."* (5_PWD_MT_02)

In addition to low awareness of the benefits themselves, there was also confusion about how to utilize them. For example, to use transportation discounts, an official 'disability card' is needed to prove that the person has a disability. Although all people who have been certified as having a disability through the disability assessment are supposed to have received this card, most people receiving the disability allowance did not have a 'disability card' even though officials insisted they were given them. As few had attempted to access other entitlements and thus have a reason to use the disability card, this at least in part seems to reflect the lack of value people placed on entitlements other than social assistance and health insurance.

> *"Why don't they have it? They have it all, they did not show it up but all of them have it. Maybe because they never use it, they travel to nowhere, they think it useless so they left it home, they don't know about it and they forget it."* (8_KI_MW_01)

The importance of addressing better linkages to and increasing knowledge of services and benefits is reflected in the positive attitudes of officials towards a case management approach, that was part of a previously trialled project. This project brought together staff from health, education and social welfare to ensure people with disabilities could access the broader range of services to which they are entitled.

> *"Da Nang started piloting case management under the support of the USAID project in the 2009 – 2015 period. It created a network of DOLISA, DOH and DOET staff to work together to manage the case, connecting and referring to services within the network. Until now I think it is the most effective support for people with disabilities. In 2014 – 2015 we opened 2000 new entries of case management. Using experience from the pilot in Da Nang, MOLISA has issued a Circular to guide others provinces to implement case management for people with disabilities."* (13_KI_DD_DOLISA_11)

Still, even when people with disabilities are aware of benefits and how to use them, they still may not useful due to other barriers. For example, the lack of available, accessible transportation can be a barrier to using transportation discounts.

> *"For people with exceptionally severe disabilities or people with severe disabilities, they can have an exemption for using a public bus. However, there was no way for people with a wheel-chair to get onto a public bus. It's a problem."* (8_KI_MW_01)

Finally, there is a lack of monitoring the utilisation for many of these benefits, making it difficult to measure the effectiveness.

Box 7. Access to social protection: challenges and examples of good practice

Examples of good practice:

- Coverage of social assistance and health insurance has been increasing. In Cam Le, over 50% of people with disabilities receive any type of disability-targeted cash transfer or subsidised health insurance. Moving the application process to the commune-level has helped increased coverage, due to improved geographic accessibility and increased involvement of local officials in spreading awareness.
- Da Nang has expanded eligibility of certain entitlements, namely CHI for children under 17 with mild disabilities.
- Most Disability Allowance recipients reported that the application process was straightforward. Almost 80% of applications were conducted in their commune and fewer than 20% experienced any challenges during the application process. Home visits were available to people with severe functional limitations if they could not go to the designated venue for assessment by the DDDC.

Areas for improvements:

- DDDC members appear to play a gate-keeping role, only encouraging applications from individuals they believe will be classified as severe or extremely severe. This means many people who might be classified as having a mild disability are being excluded from needed benefits. Similar issues were reported for older adults.
- Uptake of benefits other than CHI and the Allowance was very low: most people were either unaware of these additional benefits or did not perceive them to be

useful/of good quality. DDDC officials also had little knowledge of these other benefits, and so they could not refer recipients to relevant services after the application process.

- While moving the application process to the commune-level was reported to improve awareness, many people with disabilities were still unaware of social protection benefits they were entitled to.
- Due to challenges with the assessment criteria or lack of training of assessors, people with sensory impairments, autism, and other conditions were reported to be more likely to be excluded from receiving social protection.
- While social protection may address financial barriers to accessing existing services, the quality and accessibility of the services themselves may still limit use. For example, transportation may be limited or inaccessible, while not all schools offer disability-specific resources or instruction.

10 Use of the social protection: satisfaction, spending and self-reported impact

Among people with disabilities who were accessing social protection, the main entitlements that were used were social assistance and health insurance. This section will explore people with disabilities' experience in using these benefits and consider the adequacy of them in meeting the intended aims of social protection.

10.1 The Disability Allowance

Once people had gone through the application process and been approved, receiving the monthly social assistance payment was reported to be easy and accessible:

> *"They provide me this record and I visit there every month for receiving social assistance. It is on 10th of the month but if there are many people, I can come someday after. I give them my record, I sign, and then they give me the money, nothing to complain about." (9_PWD_MT_03)*

Respondents noted the flexibility of the process in accommodating the needs of beneficiaries. For example, for people with extremely severe disabilities who face difficulties visiting the collection point themselves, family members of beneficiaries can receive the monthly social assistance on their behalf instead:

> *"It is my nephew-in-law, he collects the monthly social assistance and brings it to me every month. It has been the case for 3 – 4 years."* (12_PWD_MT_06, person with stroke and have to bedridden)

> *"He is nice, he knows me and is friendly. Sometimes I get ill and he reminds me that I can ask someone to visit the hall to receive social assistance instead."* (15_PWD_MT_09)

From the survey of Disability Allowance recipients, almost 70% were at least somewhat satisfied with the Disability Allowance (Table 15). The majority had no issue with any elements of the collection process and were satisfied with the amount received. The lowest level of satisfaction was in access to other linked services, with more than 40% indicating neutrality.

	Level of satisfaction				
	Very satisfied	*Somewhat satisfied*	*Neutral*	*Unsatisfied*	*Very unsatisfied*
The amount you receive from the Disability Allowance	19 (14.1%)	62 (45.9%)	47 (34.8%)	5 (3.7%)	2 (1.5%)
Frequency/regularity of grant instalments	29 (21.5%)	74 (54.8%)	32 (23.7%)	0 (0%)	0 (0%)
Collection procedures for receiving benefits	24 (17.8%)	69 (51.1%)	42 (31.1%)	0 (0%)	0 (0%)
Distance to collection site	25 (18.5%)	69 (51.1%)	38 (28.2%)	3 (2.2%)	0 (0%)
Access to other linked services	23 (17.0%)	48 (35.6%)	58 (43.0%)	5 (4.4%)	0 (0%)
Overall satisfaction with the Disability Allowance	15 (11.1%)	77 (57.0%)	43 (31.9%)	0 (0%)	0 (0%)

Table 15: Level of satisfaction with various aspects of Disability Allowance among recipients

10.1.1 Spending and self-reported impact

In about two-thirds of households, the Disability Allowance was reported as being primarily used for the recipient's personal expenses (Table 16). The main expenditures were for basic needs (food, clothing), household expenses and access to general health services. Most spending decisions were made by the recipient, either alone or in consultation with other household members. However, in over 40% of recipient households another household member was the sole decision-maker. Even among adults, 37% had no input into decision-making, which may indicate a limited role of the Allowance in promoting household participation and independent living for people with disabilities.

The breakdown of who makes decisions on how to spend the Disability Allowance and on what expenses did not differ markedly between male and female recipients.

	N (%)
On whom Allowance is mainly spent on:	
- Recipient's individual expenses	94 (69.6%)
- Household expenses	41 (30.4%)
Who makes spending decisions	
- Recipient	60 (44.4%)
- Recipient in consultation with others	17 (12.6%)
- Someone else	58 (43.0%)
Frequency of reported items Disability Allowance is mainly spent on:	
- Household food expenses	112 (83.0%)
- Non-food household expenses	58 (43.0%)

- Clothing	27 (20.0%)
- General health services	21 (15.6%)
- Rehabilitation, assistive devices, specialist health services	15 (11.1%)
- Education	11 (8.2%)
- Transport	6 (4.4%)
- Caregiving support	4 (3.0%)
- Recreation/leisure	1 (0.7%)

Table 16. Spending decisions of the Disability Allowance among recipients

While people with disabilities appreciated the receipt of the Disability Allowance, when asked about the impact of receiving it, most survey respondents indicated more modest benefits (Table 17). The greatest reported impact of the Disability Allowance was in the recipient's household's ability to meet basic food needs, with over half indicating at least some positive impact. Over a third of respondents reported that the Allowance helped them to get medical care. For the remainder of categories, however, the vast majority indicated that receiving the Disability Allowance had no impact.

	Self-reported impact		
	Any positive	*No impact*	*Any negative*
Basic food needs	73 (54.1%)	61 (45.2%)	1 (0.7%)
Non-food household essential expenses	37 (27.4%)	96 (71.1%)	2 (1.5%)
Non-essential household expenses	22 (16.3%)	111 (82.2%)	2 (1.5%)
Recipient's education, skill development	11 (8.1%)	117 (86.7%)	1 (0.7%)
Education of other children in the household	9 (6.7%)	122 (90.4%)	1 (0.7%)
Ability to get medical care	54 (40%)	79 (58.5%)	1 (0.7%)
Recipient's ability to work	12 (8.9%)	120 (88.9%)	1 (0.7%)
Other household member's ability to work	5 (3.7%)	127 (94.1%)	1 (0.7%)
Relationship with other household members	9 (6.7%)	124 (91.9%)	1 (0.7%)
Participation in community	8 (5.9%)	125 (92.6%)	1 (0.7%)
Socialisation with other people with disabilities	7 (5.2%)	126 (93.3%)	1 (0.7%)

Table 17: Self-reported impact of the Disability Allowance among recipients

These findings on the perceived impact of social assistance were mirrored in the qualitative research. Most of the people with disabilities or caregivers stated that they spend the monthly social assistance mainly on food and essential supplies. Although it is valued, the amount of monthly social assistance is clearly not enough to meet the basic living costs and other needs of people with disabilities. This is especially the case for families caring for people with extremely severe disabilities, who require full-time care:

Q: What do you think about the amount of monthly social assistance?

*A: To me it contributes towards his breakfast, part of his breakfast, however, it is an encouragement and care of government (*2_PWD_MW_02)

Qs: Is monthly social assistance enough for his living cost?

A: No, just for some food. (4_PWD_MT_01)

"It is partly to help my child, even though it is so small. Thanks to the government. The amount of money is so small. He is often ill. He needs milk for example. It costs a lot but I think the amount of money is fine. I spend it all to buy milk for him." (5_PWD_MT_02)

However, in common with many government officials, people with disabilities and caregivers said they valued the assistance they received and often used the language of "motivation" or "encouragement":

"It is more about encouragement, to please people with disabilities more than for economical practical reasons. For economical purposes, it is never enough." (2_PWD_MW_02)

"I think it is ok because it is a subsidy from government, it is good that government take care of people with disabilities. Whatever amount of money is good for me....The amount of money is increasing year by year, that's good enough. Because of the limited budget of government, we should share responsibilities with government." (23_PWD_MT_17)

Because of the perception that social assistance is such a small amount, the Disabled People's Organization of Da Nang City and other civil organizations advocated for a higher level of regular social assistance:

"The level of regular social assistance defined by national policy was minimum level, that applied for all province in Vietnam. However, it is not appropriate for Da Nang city where it has higher living expense comparing to others province. So we suggest the People' committee for increasing the minimum level." (8_KI_MW_01)

While the amount provided in the Disability Allowance has increased in recent years, it is clearly insufficient to meet the basic needs of a person with disabilities who cannot find work or is unable to do so, or who incurs extra expenses in daily living. This was reflected in the quantitative survey to a degree, as there were few differences between recipients and non-recipients on most socioeconomic indicators, which may indicate that the size of monthly cash transfer is insufficient to offset the underlying drivers of poverty, including "extra costs" of disability.

10.2 Use of health insurance

In contrast to social assistance, most people with disabilities think that that the provision of health insurance is very useful in providing financial protection for them and their family:

> *"I think that health insurance brings a lot of benefit, we should buy a health insurance card in case of illness. My entire family bought health insurance because of having fears about being ill."* (25_PWD MT_19)

> *"My wife had an operation, having health insurance saved a lot of money, I had to spend only some million VND. Without health insurance, I would have to spend more than 90 million VND."* (18_PWD_MT_12)

The benefit of health insurance in decreasing financial vulnerability among people with disabilities and their households was apparent in the survey results. In comparing recipients to non-recipients of the Allowance (all of whom had free health insurance), household out of pocket spending on healthcare was two-thirds less (US$ 38.90 vs $120.69 per month, respectively). As healthcare spending appears to be a major contributor to the extra costs of disability, health insurance can be an important tool for both improving level of health among people with disabilities and decreasing risk of poverty.

However, some challenges remain. Most importantly, as discussed previously, there are limitations in the coverage for rehabilitation and assistive devices. The MOH has approved a comprehensive technical set of functional rehabilitation services that can be provided at different types of rehabilitation facilities based on their professional capacity. However, only 13% of these technical categories are covered by the health insurance [56] and, importantly, these categories are only covered by the health insurance where staff have adequate professional training. Assistive devices are not covered with health insurance and people with disabilities who need support to access devices must seek these through other channels.

> *"Hearing aids are paid for out of pocket – most people I know who use them have had to pay and it hasn't been cheap"* (KI_MB_01)

> *"No, prosthetics were from another [non-government] programme, it is not a regular assistance from government. There were some programmes that lasted about 5 or 10 years. They supported a part of the cost and called for a share from people with disabilities. They asked for a contribution of about 1 million* [about $50]." (24_PWD_MT_18)

Availability is another barrier, even when services are covered. For example, rehabilitation is not available at the commune health station so to receive these treatments, beneficiaries need to be referred to higher level facilities. Furthermore, there are a lot of people with disabilities who do not know about rehabilitation services:

> *"Q: Have you ever heard about rehabilitation services or health promotion for people with disabilities?*
>
> *A: No, I have not"* (18_PWD_MT_12)

> *"Q: You were prescribed drugs for your kidney...and for your lung operation. Have you heard that your muscle are going to weaken in the long term and you will need rehabilitation?*

A: No" (6_PWD_MW_04)

Given that most rehabilitation is provided at district-level or higher, people with disabilities may face barriers to lack of available, accessible or affordable transportation. Opportunity costs from travel and the need for accompaniment may also be a barrier:

> *"Before he had rehabilitation in the rehabilitation centre in Nguyen Hue, it was free of charge. Children under 6 years with disabilities can receive rehabilitation services for free. However, when he was one year old, I became pregnant and I could not bring him there. My husband works far away from home. No one can bring him there"* (19_PWD_MT_13)

Given these challenges, district officials have noted the need for community-based services. Some efforts are being made to decentralise the provision of certain specialist services, so as to improve accessibility for people with disabilities. For example, drug treatments for mental and psychiatric illness are covered under the National Targeted Programmes for Health and are provided at community health stations. As these are close by the Commune People's Committee Hall, people with mental and psychiatric disabilities visit the Commune People's Committee Hall and Community Health Station every month on the same day to receive both monthly social assistance and treatment drugs. They may also use these visits to address other healthcare needs:

> *"For mental health treatment, drugs are delivered for beneficiaries monthly. The community health station receives drugs from the district-level and deliveries every month. Beneficiaries come to take drugs on the 10th of the month; they take monthly social welfare and then pass by to take their drugs. They use the health insurance card for supplemental drugs such as vitamins, brain enhancing drugs, etc."* (2_KI_DD_HW_02).

Since people with mental and psychiatric conditions often visit the commune health station, they may be more likely to use the health insurance card for mild illness, such as having a cold or flu, than other people with disabilities. People with others types of impairment mostly reported only using the health insurance card when they need to be hospitalized rather than for regular check-ups and less severe conditions, in some cases because of difficulties with transportation and costs:

> *"No, I am not going for healthcare check-ups. It's very difficult to access hospital. If I go for a health check-up now, I should have a lot of health problems. However, thinking about economic reasons, transportation, if I knew about my health conditions, I would be more worried. So, I should not know about it. I am old and have lived long enough. If I die, I have no regret"* (23_PWD_MT_17)

> *"No, only when I have a severe health condition, otherwise I just leave it there. It's only a few times I have used it. My child used it only once last year, when he had a stomach ache that needed him to be hospitalized. It's just one time since he had it."* (4_PWD_MT_01)

Finally, some people also reported that they did not use the health insurance card as they think that drugs covered by health insurance are not of good quality:

> *"My child is hospitalized only when he gets high fever, other small health issues such as coughing I let him visit the private doctor; supplements are bought at the private pharmacy shop, too. When he was younger, he took mental health drugs in hospital [covered by the health insurance] but it is not good for him, he was in discomfort so I bought drugs from the private sector"* (FGD_MW_2)

10.3 Adequacy: is social protection meeting the needs of people with disabilities in Cam Le?

Due to high levels of poverty and marginalisation in areas that affect the development of sustainable livelihoods (e.g. lower access to education and decent work, poorer levels of health), it is clear that there is a high level of need for social protection among people with disabilities in Cam Le. However, among individuals who are accessing social protection, it appears there is still a shortfall in meeting the intended aims of social protection.

In comparing people with disabilities who were and were not receiving disability-targeted social protection, there were few tangible differences across any of the indicators of living standards measured in Section 9. Notably, over two-thirds of Disability Allowance recipients were still living below what is nationally defined as the minimum standard of living. Similarly, Disability Allowance recipients faced barriers to decent work, access to education and poor health – all of which impact the ability to develop stronger livelihoods. While health insurance was helpful at reducing out-of-pocket healthcare spending – a key source of disability-related extra costs – barriers to accessing rehabilitation and assistive devices limit the potential for improving levels of functioning and participation.

On their own, the Disability Allowance and health insurance – while helping to close the gap – are nonetheless insufficient in ensuring people with disabilities are meeting adequate standards of living, let alone developing stronger livelihoods. Increasing the uptake and improving the quality of other entitlements (e.g. transportation discounts, vocational training) may help to further improve the living situation of people with disabilities, as would increasing the value of the Disability Allowance and the coverage of disability-specific health services in health insurance. Similarly, increasing linkages to other programmes and services is likely needed.

Box 8. Use and adequacy of social protection: challenges and examples of good practice

Examples of good practice:

- Subsidised health insurance is a key benefit. The use of CHI lead to a two-thirds decrease in healthcare-related spending between recipient and non-recipient households with members with disabilities, targeting a key source of extra costs.
- No respondent indicated any challenges in collection of the Disability Allowance allotments and were satisfied with the procedures that allow for in-person collection (no bank account needed) and through a nominated proxy.

Challenges:

- Many social protection recipients still faced high levels of poverty and barriers to developing stronger livelihoods, meaning that the current content and delivery of social protection is unlikely to have transformative power to meet the living costs or additional needs of people with disabilities.
- Most of the money from the Disability Allowance contributed towards household basic needs, and was not sufficient to cover even that. Additionally, few accessed other entitlements that could alleviate poverty or help develop stronger livelihoods.
- Almost 40% of adult Disability Allowance recipients had no input into how the allotment was spent, indicating that its receipt is not necessarily supporting people with disabilities to live independently.

Conclusions & Recommendations

11 Conclusions

Given high levels of poverty and deprivation among people with disabilities (e.g. lower access to education, poorer levels of health and decreased participation in decent work) found in this study, and also reflected in other research from other areas in Vietnam [53], it is clear that there is a high level of need for social protection among people with disabilities in Vietnam.

The social protection system in Vietnam includes a wide range of benefits for people with disabilities. Entitlements in health, education and employment, combined with the cash transfer acknowledge multiple elements of potential social and economic vulnerability. Vietnam – and the province of Da Nang – have made strides in recent years to improve the provision of social protection and other core services for people with disabilities. Notable improvements include moving the application process from provincial capitals to the more local commune-level, introducing more functioning-based disability assessment criteria and increasing the value of the Disability Allowance. As a result of these changes, coverage of key social protection entitlements has increased: coverage of the Disability Allowance doubled in the last 5 years to an estimated 40% national coverage.

Still, as with any system, challenges remain. Key issues include inadequate training of assessors in the DDDC, biases in either the assessment criteria or assessors that lead to the exclusion of certain types of disability (e.g. sensory impairments, mental health conditions), low uptake of benefits other than social assistance and health insurance and improper alignment of benefits with the needs of people with disabilities and the contexts in which they live. Overall, there is a concern that, while social protection may help to improve living circumstances for people with disabilities, at present it is insufficient to ensure people with disabilities meet adequate standards of living.

11.1 Strengths and limitations of the research

There are several limitations that should be considered when interpreting the findings of this study. Notably, as Cam Le is urban, relatively affluent, and was selected to highlight best practices in Vietnam's social protection system, the results from this study may not reflect the situation across all of Vietnam. Additionally, the Washington Group questions used to define disability in the quantitative surveys do not capture all forms of functional limitations. In particular, no questions ask about mental health, such as depression/anxiety – however the experience of people with these types of disabilities is explored through the policy analysis and qualitative research. Due to the recruitment of Disability Allowance recipients, the cases in the study had relatively more severe forms of disability, and skewing findings to representing the experience of people with more severe forms of disability.

Strengths include the use of mixed methods, which allows for a more comprehensive investigation into our research questions. The use of qualitative and quantitative research in addition to a policy analysis enables us to corroborate and contrast findings across different methods and respondents, which ultimately both broadens and deepens our understanding of the strengths and weaknesses of social protection provisions for people with disabilities

in Vietnam. For the quantitative surveys, the study sample was large and predominately population-based, which improves generalisability of results. We also used a variety of tools to measure both need for, access to and use of the Disability Allowance and its linked benefits, as well as ways to compare the situation of recipients to non-recipients

12 Recommendations

The recommendations outlined below are the result of consultation between the London School of Hygiene & Tropical Medicine, the Hanoi School of Public Health and stakeholders in disability and social protection in Vietnam, including representatives from government, NGOs, DPOs and other experts, who were consulted as part of a dissemination workshop in Hanoi on March 15, 2017.

12.1 For national policy-makers

- Consider ways to update social protection benefits so that they better enable people with disabilities to at least meet basic needs, accounting for both ordinary and disability-related costs. This may include increasing the value of the Disability Allowance allotments in line with or above current MOLISA recommendations, as well as improving the content and delivery of other entitlements (e.g. for transport, vocational training) that target some sources of extra costs and drivers of poverty.
- Adapt the criteria and procedures used for disability assessments in Joint Circular 37 to increase inclusion of people with certain impairments who are often excluded (e.g. of deaf people, those with mental health conditions) or who face additional challenges to access (e.g. people living in rural areas, people who are poorer). This may include trialling alternative assessment tools for regularly excluded groups or implementing outreach programmes for people facing barriers to access.
- Conduct standardised, rigorous training of assessors to ensure they implement assessment procedures properly and consistently. For example, challenge biases related to ageing and disability and encourage applications that are likely to result in mild certifications.
- Align benefit packages with the needs of people with disabilities more effectively, taking into consideration differences in contexts and individual characteristics. For example, vocational training programmes should be better tailored to meet the needs of the local job market and the skills of the participant. Similarly, more focus is needed on employment in the informal sector, where many people with disabilities, particularly women, work.
- Increase availability and quality of rehabilitation, assistive devices and other disability-specific health services and expand coverage for these items in health insurance programmes. For example, increase the number of services that are covered by health insurance and the availability of trained providers who are able to offer them.
- Improve awareness of and expand the quality and quantity of benefits available for people with more mild disabilities. In particular, consider expansion of CHI to people

with mild disabilities to reduce out of pocket healthcare spending, a dominant source of disability-related extra costs.
- Promote greater inclusion of people with disabilities in the design, implementation and monitoring of all social protection schemes.
- Ensure non-disability targeted programmes are inclusive of people with disabilities. Notably, remove limitations that individuals can only receive one type of social assistance or adapt eligibility criteria and benefit levels to adequately reflect and address overlapping sources of marginalisation.
- Collect statistics on the coverage and use of all disability-targeted social protection entitlements as well as the participation of people with disabilities in non-disability targeted programmes.

12.2 For local implementation

- Increase awareness about the range of social protection entitlements available. For example, DPOs, as well as NGOs working in disability or social protection, should be trained to engage with their membership to encourage and support applications. In particular, benefits available to people with mild disabilities need to be more broadly publicised to encourage applications amongst those ineligible for social assistance as well as increase their uptake among already certified people with disabilities and encourage enrolment of people with less severe disabilities.
- Provide information about available entitlements and how to access them once a person has been certified.
- Strengthen referral strategies to link people with disabilities with other services and programmes, including rehabilitation, vocational training and educational services. For example, increasing the role of DPOs in the disability assessment process could enable them to reach out to a wider range of people with disabilities and increase their awareness of the variety of services they can access.
- Ensure social protection entitlements are delivered in a way that fosters choice and autonomy for people with disabilities. For example, provide Disability Allowance allotments directly to adults with disabilities except in rare situations, to promote greater control over its use.

12.3 For research

- Longitudinal, impact evaluation studies are needed to explore the effectiveness of social assistance, health insurance and other social protection provisions in promoting the economic and social inclusion of people with disabilities. Measuring changes pre and post-enrolment, and at different time points over the duration of support, can determine more fully if social protection improves living circumstances and well-being for people with disabilities.
- Identify best practices and tools for assessing disability, including for mental health conditions and in young children, in the context of social protection eligibility. Evaluate the consequences of different approaches in terms of human and material resources required, experience of the applicant and resulting coverage for different subgroups (e.g. by impairment type, age groups, sex). Additionally, explore and trial

monitoring strategies that governments can implement to make use of information collected during the disability assessment process to better understand support needs of people with disabilities and plan adequate policy responses.

- Conduct similar research across other areas in Vietnam (particularly rural and less affluent areas) and internationally to explore how the need for and access to social protection varies in different contexts. Analyses on the strengths and challenges of other social protection systems in responding to the needs of people with disabilities would broaden a currently limited evidence base.
- Across all research, disaggregate data to account for the heterogeneity of experiences of people with disabilities, due to factors such as sex, age, impairment types. Explore in targeted research the impact of intersectionality on need for, access to and use of social protection.
- Conduct research focusing on the inclusion of people with disabilities in large-scale mainstream schemes and consider the merits and disadvantages to targeted or mainstream approaches to social protection for people with disabilities.

12.4 For donors

- Mainstream disability across all programmes. For example, include indicators on disability (disaggregated by sex, age group, impairments type and other characteristics) in monitoring and evaluation frameworks to ensure projects are disability-inclusive in terms of access and impact.
- Support more research on disability and social protection to improve the evidence-base in this field. In particular, impact evaluations of existing programmes and trials of new interventions are needed to establish "what works". This could include consideration of contexts where disability-specific approaches are appropriate or effective, and those where an approach of improving the inclusiveness of and access to mainstream services is appropriate.
- Work with governments and other stakeholders to promote and enact evidence-based policy for disability-inclusive social protection.
- Advocate for full inclusion of DPOs and people with disabilities within all stages of policy and programme development, for social protection or otherwise.

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