

People with Disabilities in Vietnam:

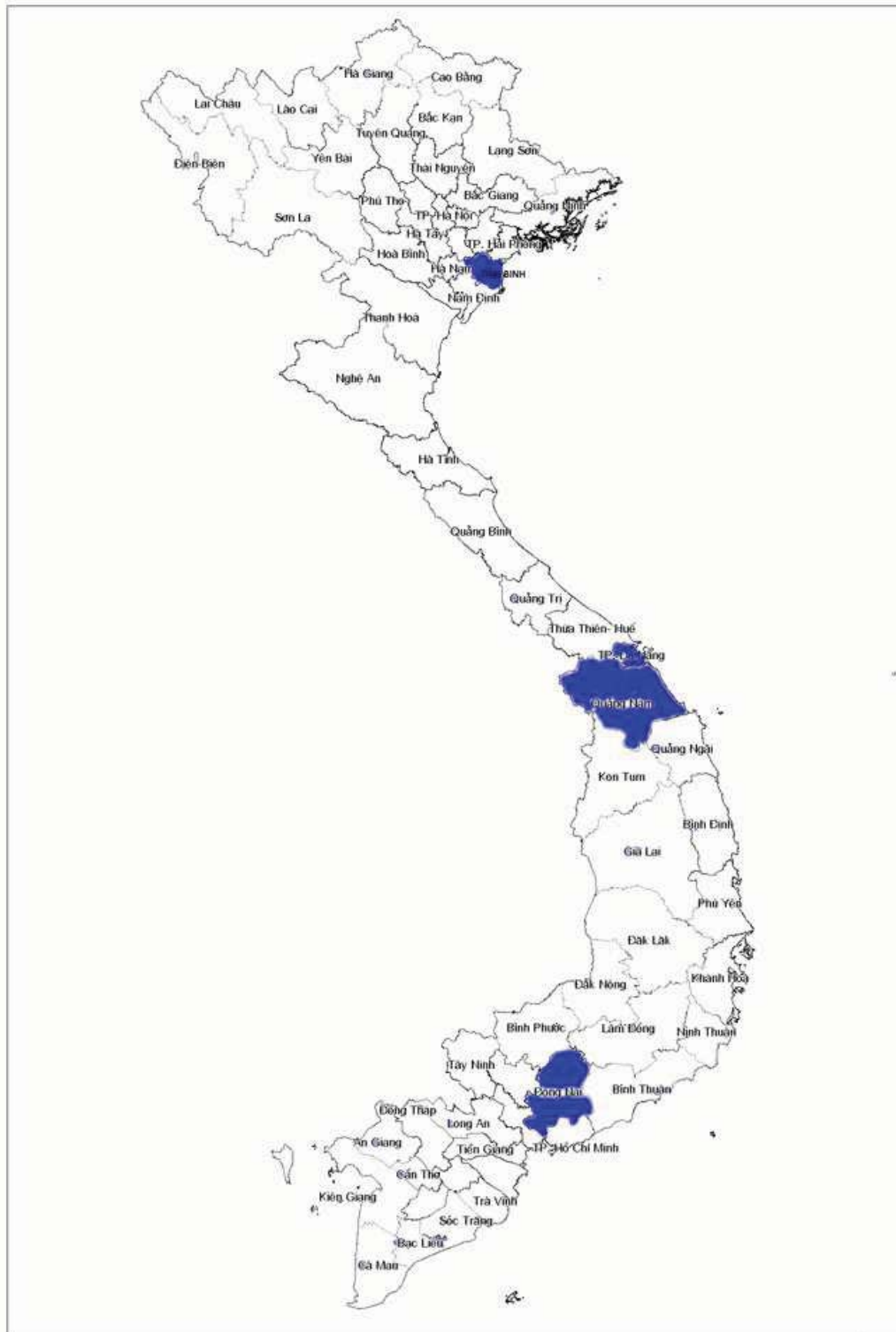
Findings from a social survey at
Dong Nai, Quang Nam, Da Nang, and Thai Binh



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MAP 1. SURVEY PROVINCES IN ADMINISTRATIVE MAP OF VIETNAM



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PART 1. INTRODUCTION

1 BACKGROUND

1.1 Rationale

People with disabilities (PWD) are an important social issue in Vietnam. According to government statistics, as of 2003, there were more than 5 million people with disabilities (PWD) in Vietnam, accounting for 6.3 percent of the total population. Nearly 8 percent of Vietnamese households had members who were PWD and most of these households were poor. Up to 80 percent of PWD are dependent on support from their family or social assistance provided by the state and/or community.

Government policies, concretized most specifically in the 1998 Ordinance on Disabled Persons, often emphasize the importance of care and support for PWD. Budget shortages and poor management, however, limit both the scope and depth of those supports. Efforts to mobilize community resources to help PWD also face many difficulties, such as a low degree of awareness regarding the rights and needs of PWD, or the presence of stigma and discrimination towards PWD's from certain segments of the population.

In 2006, assisted with a grant from the Ford Foundation, the Institute for Social Development Studies carried out a research project that aimed to undertake a comprehensive analysis of the current situation of PWD in a number of high-prevalence provinces in Vietnam. Advocacy for policy enhancement and societal mobilization to support PWD requires a solid evidence base that can be best provided by rigorous social research. At present, however, studies on PWD are relatively few in number and poor in quality. Most are in fact small assessments. In general, these studies focus primarily on environmental/medical/rehabilitation aspects of disability at the expense of a better understanding of its social dimensions, such as the social participation and integration of PWD, gender aspects, or community attitudes, including stigma and discrimination, towards PWD. So far, disability is not yet viewed as a social product, but primarily as the "problems" of a homogenous group of disadvantaged people caused by their 'disabled' status.

This research aims to fill such gaps and in doing so, expand our understanding of the multiple vulnerabilities PWD currently face, thus providing a stronger empirical base for policy formulation and the design of effective interventions. In a particular focus of this research, we examine the situation of a sub-group of PWD: those individuals believed to be affected by dioxin from Agent Orange (AO) as used in the Vietnam War. Dioxin-related disability has been of special concern for the government, scientists, the mass media, and many domestic and international organizations. However, compared to other groups of PWD, the situation of dioxin-affected people is least understood, except for a general consensus of agreement on their socioeconomic hardship, in addition to the severity of their poor health status.

The localities selected for the research are Thai Binh, Quang Nam, Da Nang, and Dong Nai. Geographically, these provinces stretch from the North through the Center to the South of

Vietnam, providing a countrywide panorama of the issues to be covered. These provinces are also localities reporting a very high prevalence of PWD. In particular, these provinces report high numbers of the population affected by dioxin. These ‘Hotspots’ of dioxin contamination have been found in several localities in Da Nang, Quang Nam, and Dong Nai. The province of Thai Binh in the North is also reported to have large numbers of returning soldiers who were exposed and subsequently affected by dioxin during the war. Decades may have since passed, but the destructive and life-long effects of dioxin remain to blight both the environment and the people who reside there.

1.2 International definitions and models of disability

Although definitions of disability vary over time and across countries, essentially it is considered to be a condition, or function, judged to be significantly impaired relative to the usual standard of the general population. Disability is often used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment or mental health problems. A variety of conceptual models have been proposed to explain disability. Of them, the two most important are the medical model of disability, and the social model of disability.

In the *medical model of disability*, disability is the result of a physical condition intrinsic to the individual that may reduce the individual’s quality of life and cause clear disadvantages as a result. Hence, curing or managing disability means identifying, understanding, and controlling the disability as well as altering its course. Thus the government, private sector and society should invest in health care and related services to cure disabilities medically, allowing disabled persons to have a “normal” life.

In contrast, the *social model of disability* proposes that barriers and prejudice as well as exclusion by society (purposely or unintentionally) are the ultimate factors defining who is disabled or non-disabled. The model recognizes that while some people have physical, intellectual, or psychological differences (which may sometimes be impairments) from the generally accepted standard norm, these do not lead to disability unless society fails to accommodate and include them as part of the “normal” mainstream. Thus, a fundamental aspect of the social model concerns equality and often focuses on changes required in society, regarding in particular:

- A more positive attitude toward disability and disabled persons; not underestimating the potential quality of life of those with impairments;
- Increasing social supports that help in dealing with the above barriers;
- More information for disabled people, for example the training and use of Braille;
- More emphasis on the physical structures that would facilitate greater access for disabled persons.

The social model focuses on functioning as an interaction between a person and his/her social environment, highlighting the role of society in labeling, causing or maintaining disability within that society through attitudes or accessibility that favors the ‘normal’ majority. It contends that these negative attitudes stem from the medical model and a subjective value system that can harm the self-esteem and social inclusion of those constantly subjected to it.

The social model of disability often distinguishes between ‘impairment’ and ‘disability’. Impairment is used to refer to the actual attributes (or loss of attributes) of a person, whether in terms of limbs, organs or mechanisms, including physiological. Disability is used to refer to the panoply of restrictions put in place by society when it does not give sufficient attention to accommodating the needs of individuals with impairments.

The social model also relates to economics. It proposes that people can be further disabled by a lack of resources in meeting their needs. It addresses issues such as the underestimation of the potential of people to contribute fully to society and add economic value to society if they are given equal rights and equal access to facilities and opportunities as others.

In addition to the two major models of disability described above, there are some other less commonly-used models, such as: the *moral model* that refers to the attitude that people are morally responsible for their own disability (for example, people have congenital disability as a result of bad actions of parents or grandparents); the *professional model* that provides a traditional response to disability in which an authoritarian, overactive service provider prescribes and acts for a passive client; and the *charity model* that depicts disabled persons as victims of circumstance, and thus deserving of pity. These, alongside the medical model, are the ones most often used by non-disabled people to define and explain disability. And as we will see in later sections of the report, in Vietnam we find that these perceptions and attitudes continue to retain a common currency in contemporary society.

Emerging issues and debates surrounding 'disability' include social and political rights, social inclusion and citizenship. In developed countries, the debate has moved beyond a concern about the perceived cost of maintaining dependent people with a disability to the wider struggle to find effective ways of ensuring that people with disabilities can participate in, and importantly contribute to, society in all spheres of life. Many are concerned, however, that the greatest need is in the developing nations, where the vast bulk of the estimated 650 million persons with disabilities reside.

On December 13, 2006, the United Nations formally agreed on the Convention on the Rights of Persons with Disabilities, the first human rights treaty of the 21st century, to protect and enhance the rights and opportunities of the world’s estimated 650 million disabled people. Countries signed up to the Convention will be required to adapt their national laws so that persons with disabilities would have equal rights as others, for example the right to education, employment, and cultural life; the right to own and inherit property; the right to not be discriminated against in marriage, childbearing, etc.

1.3 An overview of the disability situation in Vietnam

1.3.1 Disability definition

Article 1 of the Ordinance on Disable Persons of the Republic Socialist of Vietnam defines a disabled person, regardless of the cause of their disability, as “a person who lacks one or many parts of body or functions, exposing under different types of disabilities, that decrease working abilities, making their works, living, and study difficult”.

The Ministry of Health (MOH) and Ministry of Labor, Invalids and Social Affairs (MOLISA) are the two key ministries working on policies, rehabilitation, care and treatment, social support and welfare for PWD. The two ministries adopt the following definitions of impairment, disability, and handicap introduced by the World Health Organization.

Impairment (organ level): loss or abnormality of body structure or of a physiological or psychological function. Impairment may be the result of disease or accident, or of congenital or environmental agents.

Disability (individual level): reduced or absence of ability to perform as a result of impairment; the restriction or absence of a function (moving, hearing, or communicating).

Handicap (social level): disadvantages experienced by a person as a result of a disability. The result of an interaction between an individual with impairment or disability and barriers in social, cultural, or physical environment so that this person cannot take part in mainstream community life on an equal level or fulfill a role that is normal.

In the classification of disability, the Vietnamese government adopts the one introduced by the World Health Organization (WHO) in which disabilities are classified into seven main categories as follows:

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

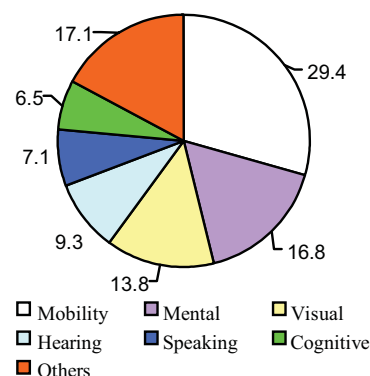
Region	Percentage
Northwest	3.0
North East	13.0
Red River Delta	18.6
North Central	12.5
Central Coast	14.2
Central Highland	3.0
Southeast	16.5
Mekong River Delta	19.2
Total	100.0

This classification is however used inconsistently as definitions of different types of disability vary in different documents (Kane, 1999).

1.3.2 Situations of disability

According to the statistics from the Ministry of Labor, Invalids and Social Affairs (MOLISA), by the early 2000s, Vietnam had about 5.3 million PWD, accounting for 6.3 percent of the population. Of them, 1.5 million were classified as “heavily disabled”. Nearly 8 percent of Vietnamese households included a PWD, and

Chart 1. Types of disability (%)



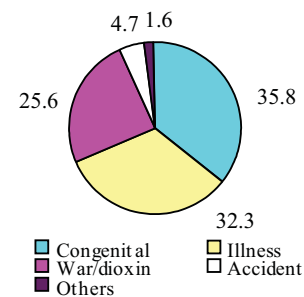
most of these households were poor. However, depending on the definition of the PWD, the figures can vary. For example, the estimation of the WHO indicates that the proportion of PWD's in Vietnam should be 10 percent of the total population.

The proportion of males with disability was higher than that of females, 63.5 versus 36.5 percent. The proportion of PWD among men was 7.5 percent while that for women was 5.1 percent. About 16 percent of PWD are under 16 years old, 61 percent of them are from 16-55 years old, and 23 percent are more than 55 years old. The proportion of PWD living in rural areas was 87 percent while those living in urban areas accounted for 13 percent. The distributions of the PWD nationwide are presented in Table 1.

The major disabilities, as shown in Chart 1, include mobility (29.4%), mental (16.8%), hearing/speaking (16.4%), and visual disabilities (13.8%). Also, 20 percent of the PWD are multi-disabled, e.g., they are both vision-impaired and hearing impaired.

The causes of disabilities are presented in Chart 2. Over one third of disability was congenital. Another one third was caused by disease. It is important to note that war-related causes explained the disability of one quarter of PWD, according to the government's own figures.

Chart 2. Disability causes (%)



The government's projection is that the proportion of PWD in the total population will increase in years to come due to traffic or work accidents, and environmental pollution brought about by rapid industrialization and urbanization.

1.3.3 Disadvantages of people with disability

Regarding social status, 70 to 80 percent of PWD residing in urban areas and 65 to 70 percent of the PWD in rural areas were dependent on support provided by their families (mainly), and social assistance from government and local communities. Only 25 to 35 percent of PWD had any involvement in paid employment.

An assessment by MOLISA conducted in 2005 across eight provinces (Quang Ninh, Hoa Binh, Ha Tay, Thanh Hoa, Quang Nam, Dac Lac, Dong Nai and Can Tho city) reveals that most households with a PWD suffered from low living standards, with 33 percent falling into the category of poor households (the national figure was 22 percent). Indeed, households with multiple PWD's suffered most: 31 percent of households with one disabled person were categorized as poor; the figure for households with 3 PWD rose to 63 percent.

Close to one quarter (24%) of households with a PWD lived in inadequate housing; 65 percent lived in semi-permanent houses. Only 11 percent of households could afford to live in permanent houses.

The educational attainment of PWD was alarmingly low: 41 percent of PWD aged 6 and above were illiterate. Those with an educational attainment of lower secondary level or higher accounted for only 19.5 percent of PWD. Regarding technical and higher education, 93.4 percent of PWD aged 16 or above received none. In general, the education and vocational levels of urban PWD were higher than that of rural PWD; of male PWD compared to female PWD; and of Viet ethnic compared to those of other ethnicities.

The assessment of MOLISA also showed that about 30 percent of the PWD were unemployed but wished they had stable jobs. The proportion varied across the regions: it was highest in the Red River Delta (42%), followed by the Southeastern region (36%). Extremely few PWD were accepted to work in government offices and enterprises. The income of employed PWD was very low (below minimum wage). Most worked in the agricultural sector where income was lowest. Overall, from 70 to 80 percent of urban PWD and from 65 to 70 percent of rural PWD depended on support from their families or social assistance from the government and/or community, respectively. All these above figures in themselves reveal the difficulties that PWD face and their need for social protection.

1.3.4 Disability-related stigma and discrimination

In a recent assessment of the disability situation in Vietnam, the United States Agency for International Development (USAID) stresses an important issue: the critical need to change the overall negative and dismissive societal attitudes that are hampering the advance of PWD. The greatest challenge to an inclusive approach to disability, upon which Vietnam's national disability strategy is based, "is not yet understood by most people in society. As is the case in most countries, most people in Vietnam, including those in public administration, tend to falsely perceive people with disabilities as inherently incapable of significant participation in the social and economic mainstream".

Government reports have already documented how stigma and discrimination have hampered the advancement of PWD. For example, in a survey of 720 PWD in Hanoi, Da Nang, and Ho Chi Minh City conducted by the Committee for Social Affairs of the National Assembly, nearly 7 percent of PWD reported that in their own families, they were treated worse compared to other family members; 13 percent said they were badly treated by the community. The USAID assessment also showed that, in education, children with disabilities (CWD) were occasionally rejected by schools and/or became the target of unkind attitudes from other non-disabled students who exposed CWD to taunts and isolation. In the workplace, the level of stigma and discrimination was even higher, with employers unwilling to take the "risk" of employing workers with disabilities (USAID, 2005).

In fact, tackling stigma and discrimination (S&D) against PWD has now emerged as a core issue where the government wishes to achieve more. However, changing long-held perceptions and attitudes held within society is by no means easy, as it requires monumental efforts from all sections of that society.

1.3.5 Traditional beliefs and cultural values towards PWD

The task is difficult because traditional beliefs and cultural values attribute disability to be the result of bad deeds or sins committed by one's ancestors. This stems from the concept of reincarnation, which holds that life is not a linear continuum from birth to death but cyclical. Only the human body “dies”. The soul never perishes as it reincarnates into another existence and identifies with each life cycle. The life cycle also has its hierarchy of significance, with humans ranking the highest and insects the lowest. People committing evil deeds will not only be punished by being reincarnated as a form of life at a lower level, but their descendants will also suffer disability as a common consequence (Hunt, 2002). Thus, while there is a general sense of pitiful sympathy towards PWD among the population, they can also be the target of social isolation and ridicule regarding their respective disabilities. *Thằng mù* (blind person), *thằng què* (limping person), *con điên* (lunatic person), *đồ dở hơi* (crack-brained person), etc. are the common epithets used to address PWD in a disparaging way. Even the official term, “tan tat” carries a discriminatory message – as “tan” means “finished”. In the South during the Vietnam War, injured soldiers were called “phé binh”, meaning disposed soldiers. In proverbs, PWD were also portrayed negatively, such as:

“Chông còng mà lấy vợ còng
Năm chông thì chật, năm nông thì vừa”
“Crook-backed husband marries crook-backed wives
Bed is narrow for them; only round flat basket fits”

1.3.6 New perspectives on disability

Vietnam is a country that has suffered heavily through continuous wars over the course of its history. The Twentieth Century witnessed two devastating wars, one with the France for national independence and the other with the United States for national unification. The second war (often called the Vietnam War) was particularly severe, resulting in the loss of millions of Vietnamese soldiers and civilians as well as numerous casualties. Even today, people are still suffering with injuries from land mines and bombs left over from that war.

In addition, more and more evidence has emerged linking Agent Orange to a host of diseases, debilitating conditions, and disabilities. Millions of gallons of herbicides were sprayed by the U.S. military over the southern territory of Vietnam during the period 1962-1971 to devastate all the trees, vegetation, and crops in jungles and farmlands where the North Vietnamese Army and the Southern revolutionary forces could hide. The largest volume of herbicide was applied from the air by C-123 "Provider" aircraft in a program code-named Operation Ranch Hand. Agent Orange (AO) accounted for much of the total sprayed. In the United States, following a scientific report in 1969 concluding that exposure to Agent Orange could cause birth defects, use of the herbicide was suspended. In Vietnam, U.S.-authorized herbicide use was also halted in 1971.

Since then, concern about the long-term impact of AO on health has accelerated, partly from Vietnam veterans (in the U.S.) who developed cancer or fathered handicapped children. Some veterans attributed these problems to their exposure to herbicides during their military service in Vietnam. Although thousands of scientific studies have been conducted, the cause-

effect relationship between AO and health remained uncertain. However, a comprehensive study conducted by the National Academy of Sciences' Institute of Medicine under the request of the Congress concluded that there is sufficient evidence of an association between exposure to herbicides and various debilitating health outcomes, such as spina bifida, soft tissue sarcoma, non-Hodgkin's lymphoma, Hodgkin's disease, chloracne and porphyria cutanea tarda. There is also limited/suggestive evidence of an association between exposure to herbicides and respiratory cancers, prostate cancer and multiple myeloma.

In Vietnam, many birth defects and congenital disabilities are now attributed to the exposure of parents to chemical agents, particularly AO. In light of this new perspective on Agent Orange, many people with disabilities caused by AO are now viewed as war victims (Hunt, 2002).

2 RESEARCH OBJECTIVE, APPROACH, AND QUESTIONS

2.1 Research objective

The overall objective of this research is to examine the economic and social situations in which PWD, including those who were likely to have been affected by Agent Orange, live and work in high-prevalence provinces in Vietnam. The major purpose is to identify their vulnerabilities and their needs for support.

2.2 Research approach

We conceptualize disability as a status of multiple vulnerabilities experienced by PWD, which can expand to include and adversely affect their families. These vulnerabilities are caused by both physical/mental disabilities as well as by the attitudes of society towards PWD. The ultimate goal of the research is to come up with strong policy recommendations drawing on a good understanding of the real-life experiences of PWD. Based on the research findings, prescriptions for priority support will also be delineated.

Because difficulties and vulnerabilities are, to a great extent, socially constructed, one important strand of this inquiry looks closely at the perceptions and attitudes exhibited by the community towards disability. We are particularly interested in focusing on the problem of stigma and discrimination against PWD. We consider stigma and discrimination to be a major barrier preventing PWD from enjoying equitable and full integration into mainstream society. As such, any effort to support PWD should adopt a rights-based approach.

2.3 Research questions

Specifically, the following questions are addressed in this research, with the empirical data collected from the survey:

1. What socioeconomic difficulties and vulnerabilities are currently faced by PWD? How do various dimensions such as the types and causes of disability, gender, age, geography, etc. affect these difficulties and vulnerabilities?
2. To overcome those vulnerabilities, what coping measures are adopted by PWD? Are these strategies for mere survival or for economic and social integration (e.g. building stronger human capacity, fuller participation in the local economy and community, development of social capital)?
3. What are PWD's perceptions and awareness of their rights? Does the community in which they live also share these? If not, exactly what perceptions and attitudes towards PWD's capabilities, needs, rights, and opportunities are the community harboring?
4. Do PWD face stigma and discrimination (S&D)? If so, what form does S&D take, and from what sources (e.g. family, community, or from themselves, i.e. self-stigma) and in what settings is it most commonly manifested (schools, work place, hospital, public places, etc.)? How does S&D affect PWD in various aspects of their life?
5. What supports and services are available and accessible to PWD and their families? How do PWD view the appropriateness, usefulness and effectiveness of those supports and services? How do communities perceive their role in providing social protection for PWD?

3 RESEARCH METHODOLOGY AND SAMPLE DESIGN

3.1 General concepts

This research on disability relies on both qualitative and quantitative data collected through both a household survey and in-depth interviews to examine various aspects of the Vietnamese experience of disability, including those individuals who were likely affected by Agent Orange. While quantitative data has been utilized to estimate statistically specific measurements that can then be said to be representative of the target population as a whole, the purpose of in-depth interviews is to illuminate certain sensitive and detailed information that is unlikely to be obtained from a solely quantitative survey.

There are a number of technical issues that need to be considered in designing and carrying out the survey on PWD in Vietnam. First, despite the official definitions of disability, a complete and accurate list of PWD in the target population is unavailable. Second, it is difficult for interviewers to assess and identify the disability status of individuals, especially infants and the elderly. Third, many people with certain kinds and levels of disability are unable to participate directly in the interviews. Information about them thus had to be collected from other adult family members. Fourth, some PWD do not live at home, but at special centers or schools. Fifth, although the consequences of Agent Orange are a special focus of the survey, victims cannot be identified with any precision, especially in the case of those people who were indirectly or not seriously affected. In addition, available resources

are certainly not sufficient to carry out a nationally representative survey. Because of these issues, the following definitions and limitations of the survey need to be clearly stated.

Person with disability (or disabled person): The identification of a person with disability in this research is based on the WHO's definition (WHO, 1998), as mentioned above. However in any social survey, many disabilities are difficult to assess and confirm, especially for those that cannot be visually identified. In this research, a person is recognized as *disabled* if being in at least one of the seven groups mentioned above, and his/her disability status is confirmed by local administration, commune, family and/or admitted by oneself.

Household with PWD (or disabled household): is a household having at least one person with disability.

Non-disabled household is a household with no members having a disability.

Target population: As available resources were limited, the survey was undertaken in three provinces of Thai Binh, Quang Nam, Dong Nai and the city of Da Nang to collect all relevant information. The rationale for selecting these provinces and city is that they are all located in three main regions of Vietnam (North, Centre and South). In addition, three of them (Da Nang, Quang Nam and Dong Nai) contain 'Hotspots' of Agent Orange contamination and, moreover, all of them are believed to have a high concentration of affected people. Agent Orange was never sprayed in Thai Binh during the war, but this province is the homeland of many returning veterans who had contact with Agent Orange in wartime and the next generation may still have to bare the consequences of this contact. For convenience and technical suitability, Quang Nam and Da Nang city are combined into one geographical unit (simply called Quang Nam – Da Nang province). In fact, they share boundaries and were once a single province.

Because of some difficulties mentioned earlier, this research only covers the population aged from one to 70 years, and living permanently in households (e.g. not in a special center). As the attitudes of both disabled and non-disabled people (in relation to disability) are of interest in this study, the survey was designed so that the collected data are representative for both these groups. The sample of households without PWD will serve as a control group against which vulnerabilities brought about by disability status of the households with PWD can be isolated

In short, the first target population of this survey includes households including PWD aged 1 to 70 years in three provinces: Thai Binh, Quang Nam – Da Nang, and Dong Nai. The second target population is representative of all non-disabled households.

3.2 Household survey

3.2.1 Questionnaires

The survey used household and individual questionnaires. The household questionnaire was designed for both disabled and non-disabled households but some of its questions were applied to only disabled households and vice versa. It includes six sections: household

demographic and socioeconomic characteristics, knowledge about disability, difficulties of disabled households, supports from community and society for the disabled and their families, information and communication about disability, and awareness of Agent Orange.

The individual questionnaire was applied to collect information from every selected disabled person. If a disabled person was unable to answer questions, information about this person was obtained from another adult householder or his/her assistant. Each individual questionnaire contains a section on disability status, six sections about the difficulties of disabled individuals, a section on sporting-cultural activities and accessibility to public services, and a section on awareness about the rights of the disabled (a set of questionnaires is presented in the Appendix).

3.2.2 Sampling design

On the basis of research objectives and available resources, a multistage probability sampling method was applied. In the first stage, communes/wards, or clusters of sampling units, were selected in each of the three provinces. At the second stage, households were selected separately for disabled group and non-disabled. An over sample was made in relation to disabled households as they account for less than 5 percent of the total population.

The Sampling fraction is the ratio of sample size to population size. In this survey, the sample was designed with a constant sampling fraction in each province in order to avoid weighting in data analyses.

Basically, the sampling design includes the preparation of a sampling frame, estimation of sample and cluster sizes, selection of communes, estimation of urban and rural sampling fractions, and the selection of households and individuals.

Preparation of sampling frame:

In cooperation with provincial administrators, lists of all communes/wards including the most updated figures of disabled and non-disabled households and individuals were obtained in each of the three provinces. These figures were certainly imperfect but were necessary for the selection of communes/wards and households.

Estimation of sample and cluster sizes:

Based on the general cost model (Kish, 1995), the estimated optimum number (most economical) of households to select per sampled commune averages about 65. The number of selected communes in Quang Nam – Da Nang is 17, and in Thai Binh as well as in Dong Nai is 16.

For any proportion p needs to be estimated, the minimum sample size of approximately from 1050 to 1100 households should be sampled in each province to obtain the estimates with the 95%-confidence interval within $p \pm 0.05$. In order to enable some estimates and comparisons between subgroups of disabilities with acceptable standard errors, the sample sizes for disabled households in each province were increased by about 50 percent (i.e. from 1575 to

1650 households). Each of these numbers was split into two groups, which were proportional to urban and rural target populations in the corresponding province.

Table 2. Distribution of the selected wards and communes

	Thai Binh	QN- DN	Dong Nai	Total
Urban (wards)	2	7	4	13
Rural (communes)	14	10	12	36
Total	16	17	16	49

Selection of communes and wards

Based on the lists, 16 communes from Thai Binh, 17 communes from Quang Nam – Da Nang and 16 communes from Dong Nai were randomly selected (Table 2). As the numbers of wards and communes were not very large, the numbers of selected wards and communes were not exactly proportional to the total numbers of communes/wards or households in rural and urban areas. This issue can be resolved by adjusting the sampling fractions of households in urban and rural areas.

Estimations of sampling fractions

From the 49 selected communes and their estimated numbers of disabled and non-disabled households, sampling fractions for these communes were estimated for urban and rural areas in each of the three provinces. They were calculated by dividing the provincial sample size to the number of selected communes and weighting by numbers of households in each commune and by the rate of provincial urban households. In addition, an adjustment for the estimated non-response rate of 5 percent was also applied for the sample of non-disabled households. As it seemed reasonable to predict a higher rate of ineligible returns and non-response in the sample of disabled households, the adjustment rate for this group was 10 percent.

Selection of households

Under the guidelines set out by the research team, the lists of disabled and non-disabled households and individuals of the 49 selected communes/wards were checked and updated by local administrators and collaborators. Then the sampling fractions calculated for the corresponding rural (or urban) area and an equal probability systematic random technique were applied to these updated lists to select disabled and non-disabled households. The assumption was that these lists of households are not changed much by the update. Thus, if the numbers of non-disabled households from the updated list at all communes do not differ from those provided by the provincial administrators, the provincial sample sizes would be just 5 percent higher than the amounts estimated above.

Selection of individuals

From every household in the sample, an adult householder needed to be selected and interviewed by means of a household questionnaire. Every disabled person aged from 1 to 70

years in the selected disabled households should be interviewed directly or indirectly by using an individual questionnaire.

The overall sampling fractions

The estimation of the overall sampling fractions for non-disabled households is as follows. If S denotes the designed sample size for a province and the proportion of rural non-disabled households from total non-disabled households in this province is K , the designed provincial sample sizes of non-disabled households are $S * K$ in rural areas and $S * (1 - K)$ in urban areas.

If the estimated numbers of non-disabled households in a commune and in this province are respectively n and N , the sampling fraction of non-disabled households in this commune is:

$$f = \frac{S \times K}{n} \times \frac{n}{N \times K} \times 1.05 = \frac{S}{N} \times 1.05$$

Similarly, the sampling fraction of non-disabled households in a ward is:

$$f = \frac{S \times (1 - K)}{n} \times \frac{n}{N \times (1 - K)} \times 1.05 = \frac{S}{N} \times 1.05$$

If c communes and wards were selected from a province having C communes and wards, the overall sampling fraction of non-disabled households is:

$$F = \frac{c}{C} \times f = \frac{c}{C} \times \frac{S}{N} \times 1.05$$

Thus, as the overall sampling fraction is constant in any of the selected provinces, a weighting procedure would be unnecessary for all estimates at the provincial level.

The same formulas were applied to estimate the overall sampling fractions of disabled households and individuals.

3.2.3 Fieldwork and Interviewing results

The fieldwork was undertaken from July to September 2006. The total numbers of interviewed households and individuals in Thai Binh, Quang Nam – Da Nang, and Dong Nai are presented in Table 3.

Table 3. Numbers of interviewed households and individuals

	Thai Binh	QN – DN	Dong Nai	Total
Households	2653	2711	2704	8068
- Non-disabled households	1085	1078	1079	3242
- Disabled households	1568	1633	1625	4826
Disabled individuals	1822	1806	1869	5497

3.2.4 In-depth interviews and focus group discussions

In addition to the household survey, in-depth interviews were conducted with around one hundred individuals (identified during the survey phase), whose information helped highlight important issues relating to the vulnerabilities of the PWDs/dioxin affected. The respondents included local authority and mass organization cadres, health care workers and teachers, local employers and social services providers, the PWDs/dioxin affected, along with the insights garnered from other individuals. Focus group discussions were also held with different groups of people as well.

PART 2. RESEARCH FINDINGS

4 PROFILE OF THE STUDIED PROVINCES

4.1 Thai Binh

Thai Binh is a coastal province locating in the Red River Delta in close proximity to the so-called Triangle of Development consisting of Hanoi, Hai Phong, and Quang Ninh. The total geographical area of Thai Binh is 1,542 square kilometers, or 0.5 percent of the country area. The province comprises of 7 districts, namely Dong Hung, Hung Ha, Kien Xuong, Quynh Phu, Tien Hai, Thai Thuy, Vu Thu, and Thai Binh city. In total, there are 284 communes and urban wards.

According to 2002 statistics, Thai Binh's population was estimated at 1,827,000, and of them 94.2 percent was rural. The average family size was 3.75 persons per household. Working-aged population was large, 1,073,000; 74.3 percent of the labor force were working in the agricultural sector; 17 percent were in manufacturing and construction; and 8.7 percent were in commerce and service. Regarding the quality of the labor force, less than one quarter (23.5%) were trained in vocational training, (13.5%), middle schools (5.5%), colleges and universities (4.5%).

Map 2. Thai Binh Province



Thai Binh has a relatively large population of PWD. By 2006, the province had about 56,800 PWD, of them more than a half (35,860) were soldiers and ex-soldiers whose disabilities

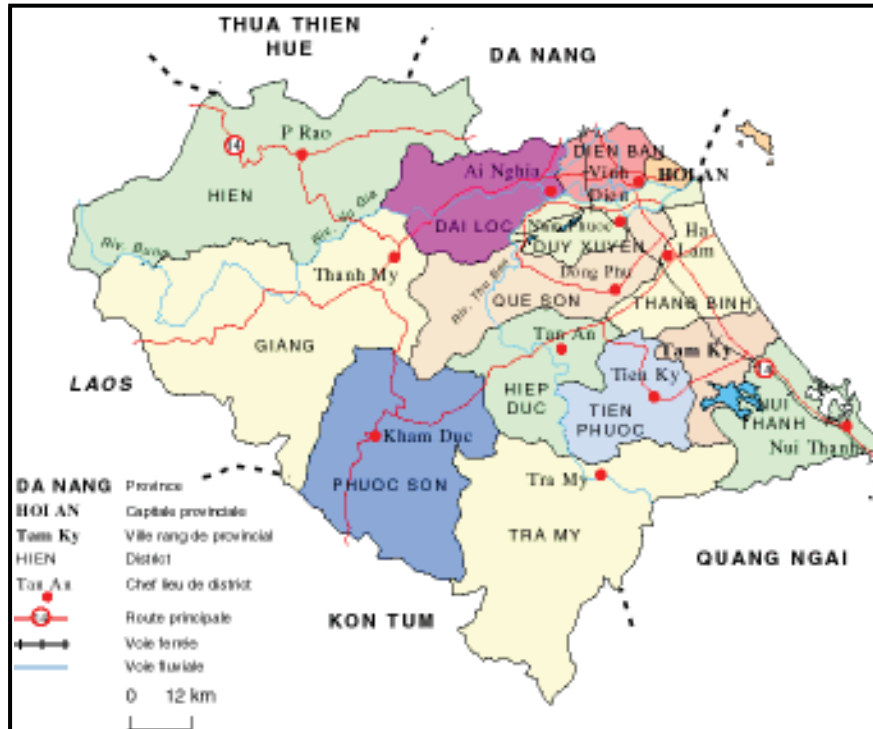
were caused by the war; 20,940 others disabled due to other causes. Overall, PWD accounted for 3.05 percent of the province’s population. During the war for national unification, Thai Binh was among the pioneering provinces in sending a high number of men to fight at the front. “*Thóc không thiếu một cân, quân không thiếu một người*” (Missing not a single kilogram of paddy [for the state] and a single enlisted man [to go to the front]) was a slogan, and an objective, that Thai Binh was committed to follow. Soldiers from Thai Binh were reputed to be tough fighters and thus often assigned to key war zones. Many died, were injured, and were exposed to AO. Back home, the women left-behind turned their paddy field into a national model of 5 tons of rice (per hectare) to support the war efforts.

According to provincial statistics, there are 27,934 PWD who were suspected of being affected by AO, of them 18,828 were directly exposed to AO during their service in the South during the war; 8,547 were their children (second generation); and 559 were their grandchildren (third generation). So far, 1,492 have died.

Of the 18,828 people who were suspected to be AO affected directly, common health problems included liver, lung, bone and skin diseases. Of 9,106 PWD of second and third generation, 56 percent were females, and 44 percent were males. By types of disability, 5,496 (60%) had a mental disability; 2,094 (22.9%) were innately deformed; 1,200 (13.2%) had paralysis; 258 were deaf-and-dumb (2.9%); 58 (0.63%) were blind

4.2 Quang Nam – Da Nang

Map 3. Quang Nam Province



Quang Nam – Da Nang is located in the central area of Vietnam, bordering Thua Thien – Hue in the North, Quang Ngai and Kon Tum in the South, and the People’s Democratic Republic of Laos in the West.

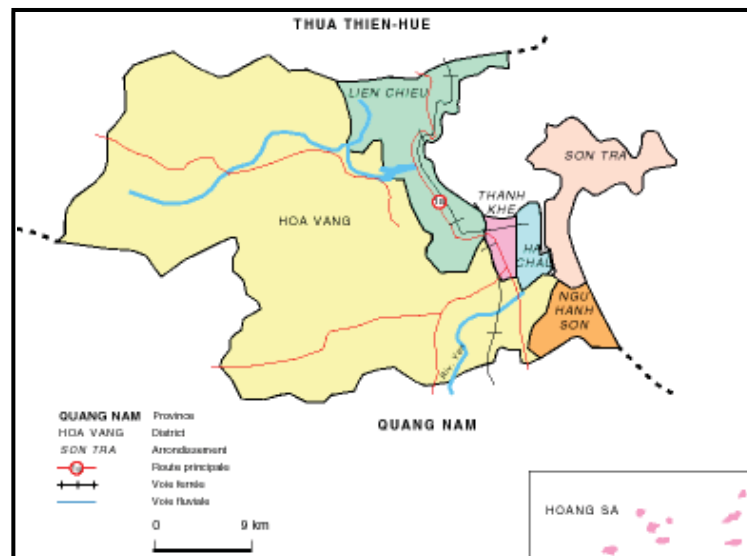
The province had a population of about 1.5 million people by 2004. This is also the home of a number of ethnic minorities, namely *Kato*, *Xê đăng*, *Giẻ Triêng*, *Cor*, and Chinese. The province is divided into 17 districts, namely Phu Ninh, Tam Ky (provincial center), Phuoc Son, Tien Phuoc, Dong Giang, Hoi An, Dai Loc, Duy Xuyen, Bac Tra My, Nam Tra My, Tay Giang, Thang Binh, Nam Giang, Dien Ban, Nui Thanh, Que Son, and Hiep Duc. Most of the province’s geographic area is mountainous, making transportation to and from this region particularly difficult. The province of Quang Nam was among the poorest provinces in the country. The proportion of households classified as poor was 14 percent by 2004 (the national figure was 8 percent).

During the war, fierce fighting took place in the province. Many districts in Quang Nam were heavily bombarded. Even now, unexploded mines, shells and bombs remain inland. They continue to kill and injure many people. Statistics collected at Quang Nam Department of Labor, Invalids and Social Affairs in 2006 show that overall, Quang Nam has 33,437 PWD out of 333,502 households, giving a rate of one person with disability in every ten households.

Many areas in the province were also covered by U.S. herbicide and defoliant spray. During the war, the US military force sprayed over 1.3 million of liters of herbicides in Operation Ranch Hand that lasted from August 1965 to October 1971. According to investigations by the local Red Cross in 2000, in Quang Nam – Da Nang, there were up to 27,500 people who were exposed to AO during and after the war.

In contrast to the province of Quang Nam, Da Nang was one of the five largest urban centers of Vietnam. The city has a geographic area of 1,256 square kilometers, dividing into the 4 urban districts of Hai Chau, Thanh Khe, Son Tra, Ngu Hanh Son, Lien Chieu, one large rural districts of Hoa Vang, and another off land district of Hoang Sa. These districts were composed of 33 urban wards (or sub-districts) and 14 rural communes.

Map 4. Da Nang City



During the war, the city was home to a major American airbase. The population has since increased to over one million inhabitants, mostly refugees. Da Nang’s total population by

2004 was 764,549 people, of them 80 percent (or 607,897 people) were urban and 20 percent (156,652 people) rural.

On January 1st, 1997, Da Nang was separated from Quang Nam to become the country's 4th municipality (Vietnam has 5 independent municipalities). Since then, the city has experienced very fast economic growth and became the third strongest economic city in Vietnam after Ho Chi Minh City and Hanoi. GDP per capita has increased steadily from 7,823,000 dong in 2001 to nearly double, 12,510,000 dong by 2004. The city had a labor force of 451,663 persons, of them 370,978 had stable jobs and income. The unemployment rate in 2004 was 5.16 percent.

During the war, Da Nang was home to 45 military bases, of them the Da Nang airbase was the most important of the US military forces in the Central Region of Vietnam. The airbase was also the largest storage facility, containing up to 35 percent of the total dioxin chemicals used during the war in the country. Some of the chemical barrels remained untouched decades after the war ended. Over decades, rains have made the chemicals infiltrate into the soil, underground water, or been flushed into nearby Bau Sen pond and the Thanh Binh bay (Le Thanh Thuy, 2005; Anh Binh, 2005). Hatfield Consultants Ltd. listed Da Nang airport to be among the few dioxin hot spots in Vietnam. Essentially, soils at hot spots have very high 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) levels (Dwernychuk, 2005). Da Nang airport is surrounded by crowded civilian areas, making a potentially high number of residents potentially in danger of being exposed to dioxin. According to the statistics of the Da Nang Red Cross, the city has 7,510 persons perceived to be AO affected, of them 2,410 were of second generation and 34 were of the third generation (Nguyen Hong Nga, 2005).

4.3 Dong Nai

Dong Nai is situated on the economic hub of the South. It borders Binh Thuan province in the east, Lam Dong in the northeast, Binh Duong and Binh Phuoc in northwest, Ba Ria – Vung Tau in the south, and Ho Chi Minh City in the west. Thanks to its strategic location and the open policies of the local government, the province has experienced heavy investment from foreign investors in the shipping, food products and manufacturing industries.

Administratively, the province is divided into 11 districts, namely Bien Hoa City, Long Thanh, Nhon Trach, Vinh Cuu, Trang Bom, Thong Nhat, Long Khanh town, Cam My, Xuan Loc, Dinh Quan, and Tan Phu. The province's population (2004) was 1.45 million, of them 48 percent were males and 52 percent were females. Dong Nai had an urban population of 230,000 people, or 16 percent of the province's population, much lower than the national average (25.4% by 2004).

Total PWD in the province, according to local statistics in 2006, was 19,011, of them 11,737 (61%) were males and 7,274 (39%) were females. The number of children with disability (CWD) was 4,264, or 22.4 percent.

The Bien Hoa airport was another dioxin hot spot. It ranks second in terms of contamination level after Da Nang airport, and is followed by Phu Cat airport (in Binh Dinh province).

During the war from 1964 to 1971, 24,000 barrels containing AO were stored at the Bien Hoa airbase. Similar to the situation at Da Nang airport, the heavy contamination of soil and water in the Bien Hoa airport area poses a serious danger to the local population in terms of AO affection.

Statistics provided to the research team from the Dong Nai's Department of Population, Family and Children show that the province has currently 8,852 people considered to be AO affected, of them 4,449 were the first generation and 4,403 were from the second and third generations.

Map 5. Dong Nai Province



5 SOCIO-ECONOMIC CHARACTERISTICS OF HOUSEHOLDS HAVING PEOPLE WITH DISABILITY

5.1 Demography of Disadvantage

In the survey, information on key demographic characteristics (including age, gender, ethnicity, marital status, education and occupation as well as disability status) of all household members were collected. In this section, we pay special attention to these features of household heads, given the important roles household heads play in family's livelihood generation, social relations within the community, and other decision making relating to the household's overall welfare. Comparisons of these attributes of the household heads (that in fact reflect their labor force quality) are made between the households with PWD and the households with no PWD. As shown in the analysis below, these attributes of the heads of households with PWD are disadvantageous regarding their human productive capacity, compared to those from the other households.

Aging household heads

The survey data show that there were more heads of the households with no PWD aged less than 45, compared to the heads of the households with PWD (see Chart 3). This means that more heads of households with no PWD were of active productive age compared to their counterparts in the households with PWD. In contrast, in all the studied provinces, heads of the households with PWD featured more in cohorts aged 55 and above, about 50 percent. For the households with no PWD, the proportion was about one third. As defined by the Labor Law, the age of 55 is the official retirement age for women, while for men it is 60. The aging of the heads of the

Chart 3. Percentage of household heads aged less than 45

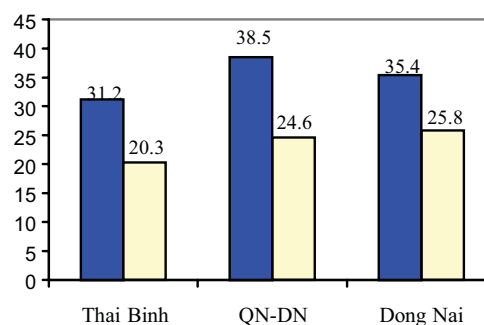


Chart 4. Percentage of household heads aged 55+

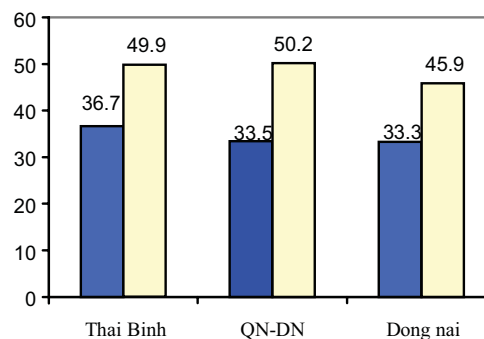
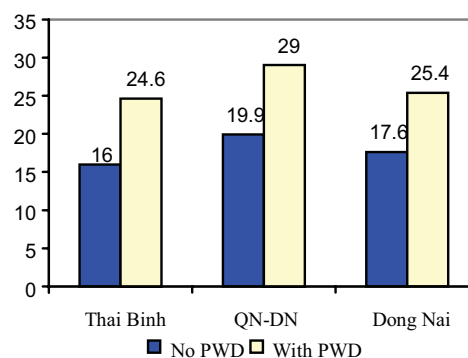


Chart 5. Percentage of household heads aged 65+

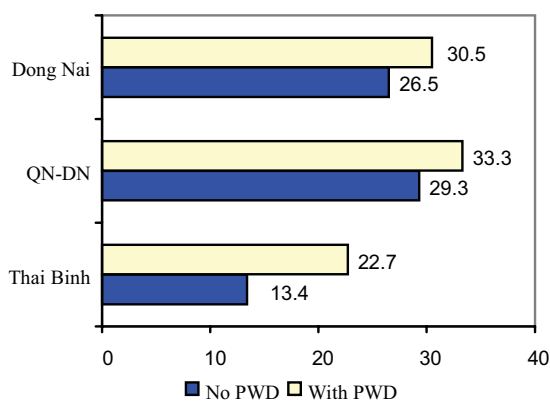


households with PWD is therefore likely to influence their productive capacity and increase their economic dependency on other family members, especially for those aged 65 and above. In the three provinces, the proportion of the heads belonging to this cohort among the households with PWD was from 25 to 30 percent. For the control group of the households, it was from 16 to 20 percent (Charts 4& 5).

Female-headed households

The survey data also showed that overall, more households with PWD were headed by females (Chart 6). One reason for this situation is that in many families, husbands were themselves disabled, thus household responsibilities, including livelihood generation, shifted onto the shoulders of wives. Another reason is that in some other families, disabled women found it difficult, even impossible, to marry, thus making their family single-parent. In the context of pervasive gender inequality, households headed by females may face more difficulties in income generation and social empowerment, compared to households headed by males.

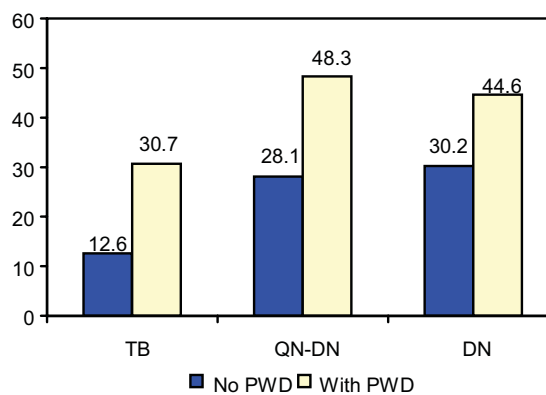
Chart 6. Percentage of female headed households



Low educational attainment

One key indicator of human production capacity is education. In the study, we find considerable lower education attainment of the heads of the households with PWD. For example in Thai Binh, nearly one in every three heads of household with PWD had not completed primary education level or even had no education at all (illiterate). This figure for heads of other households was about one in nine. Similar findings are also found in other provinces, but with higher percentages of the heads with no/below primary education in both groups of the households. In Quang Nam – Da Nang, the percentage was nearly 50 percent for households with PWD, and 28 percent for other groups of households. For Dong Nai, it was about 45 and 30 percent respectively (Chart 7). The lower percentage of household heads with education below primary level, including the

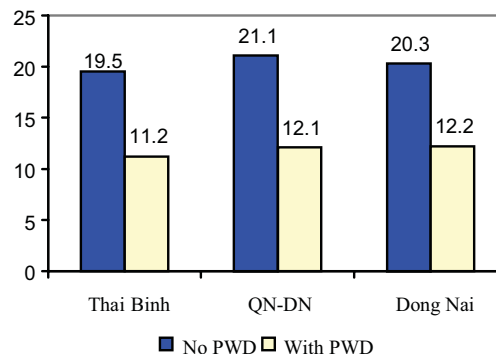
Chart 7. Percentage of household heads with no education or education below primary level



illiterate heads, in Thai Binh, partly reflects more advanced achievements made in education in the North regarding general education, particularly at the primary level.

For higher levels of education, the tendency continued. The proportion of heads of households with PWD achieving upper secondary education or higher in the three provinces were just slightly above 10 percent. For the households with no PWD, the figure was almost double, about 20 percent, in all three provinces (Chart 8).

Chart 8. Percentage of household heads with upper secondary education and higher



Clearly, with a lower level of education, the heads of households with PWD had more constraints regarding employment opportunities and production capacity, thus ultimately limiting chances for the economic and social betterment of their families.

Household heads with disability

Health condition is another indicator measuring human production capability. There was a high percentage of heads of households with PWD who were PWD themselves in all the surveyed provinces. In Thai Binh and Quang Nam - Da Nang, close to half of the household heads (45% and 42% respectively) were PWD. In Dong Nai, the figure was also high, about 30 percent. In general therefore, a household headed by a person with disability would face more difficulties, compared to households whose heads are not.

From all accounts, the above demographic variables show the disadvantages of families with PWD compared to the control household groups, with regard to family economic and social well-being.

5.2 Poor Assets

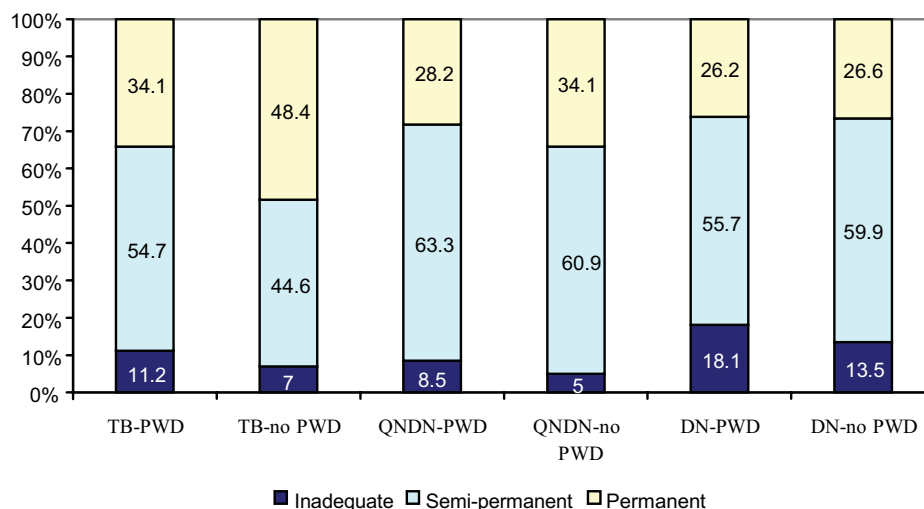
For any household, the house itself is an important asset. Better housing means better living conditions for health, which is related directly to human capability, as discussed above. A house can also be used for economic purposes, for example as a venue for income generating activities. Banks and credit institutions also often consider the value of a house as a pre-condition for offering a loan to a household. Finally, in itself, house is a commodity with a market

“It is very difficult for disabled people to borrow money from a bank or a credit institution to open a business. There is no disability fund and it is not easy at all to borrow money from a bank as there are many requirements and complex procedures. Basically they have to have a collateral, for example land and houses. What disabled people can have as a collateral? Now we have only poverty reduction fund. Disabled people who are not in listed as the poor cannot have access to poverty reduction fund”
(Local government official, Da Nang)

value.

In the study, it is found that housing quality was markedly contrasted between the two groups of households. While nearly half of the households with no PWD (48%) in Thai Binh could afford permanent houses built in brick with a solid roof (tile/concrete roof), for households with PWD, the figure was only one third (34%). The contrast is also found in Quang Nam – Da Nang, with 34 percent of

Chart 9. House type of disabled and non-disabled households (%)



households with no PWD living in permanent houses, compared to 28 percent of households with PWD. For Dong Nai, while the proportion living in permanent houses were not so markedly different between the two groups, more households with PWD were found residing in inadequate housing. Similar situations were also found in the other provinces (Chart 9).

Table 4. Mean and median of home living areas of households

	Thai Binh		QN-DN		Dong Nai	
	With PWD	No PWD	With PWD	No PWD	With PWD	No PWD
Living area						
Mean	49.7sqm	57.7sqm	75.3sqm	79.5sqm	73.7sqm	80.3sqm
Median	40sqm	50sqm	60sqm	72sqm	60sqm	60sqm
Living area per person						
Mean	14.6sqm	17.2sqm	18.9sqm	20.5sqm	16.4sqm	18.8sqm
Median	13sqm	15sqm	15sqm	17sqm	12sqm	14sqm
N	1,568	1,085	1,633	1,078	1,625	1,079

In general, living space (house area) of the households with PWD was about 10 sqm smaller than that in households without PWD (in median: 40 versus 50 sqm in Thai Binh; 60 sqm

versus 72 sqm in Quang Nam – Da Nang). For Dong Nai, while there was no difference in house area median between the two groups of households, the mean of house area of the later group was about 7 sqm higher than that of the former group. In terms of average living area per person, it was 2 sqm less for the former households across the three provinces. Houses of PWD were also located farther from key economic and social service infrastructures compared to houses with no PWD (see sub-section below). This greater distance means more difficulty accessing infrastructures and services. It also means weaker economic and social status, as houses located nearer to community centers are often more expensive and harder to get (Table 4).

Two variables that can be used to measure household well-being are types of latrine found in house and cooking combustibles. Better latrine facilities, especially a septic tank, are costly, thus can partly reflect the economic status of households indirectly. Similarly, better-off households often use electricity and gas for cooking. These two variables are also closely related to health as well. A septic tank results in better hygiene conditions, thus positively contributes to the improved health of household members. The use of gas and electricity for cooking, unlike the use of coal, firewood or straw, produces less toxic fumes that are harmful to health.

As found, there were fewer households with PWD using a septic tank compared to the other household group: 12 versus 22 percent in Thai Binh. In the southern provinces, although the percentage was higher for both household groups, the gap between them also existed. The proportion of households using a septic tank was highest in Quang Nam – Da Nang (for both groups) due to the inclusion of Da Nang city in the sample (Chart 10).

In contrast, half of the households with PWD in Thai Binh used a simple latrine, which is highly unhygienic. Many even did not have a latrine in the house. In Quang Nam – Da Nang and Dong Nai, the figures were about one third and one

Chart 10. Percentage of households with septic tank

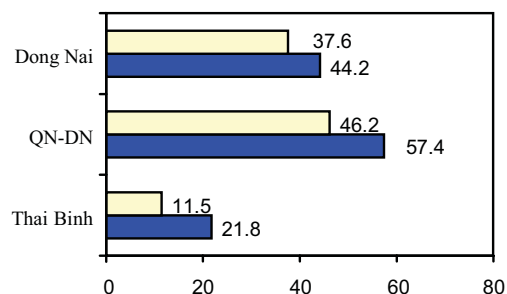


Chart 11. Percentage of households with simple/no latrine

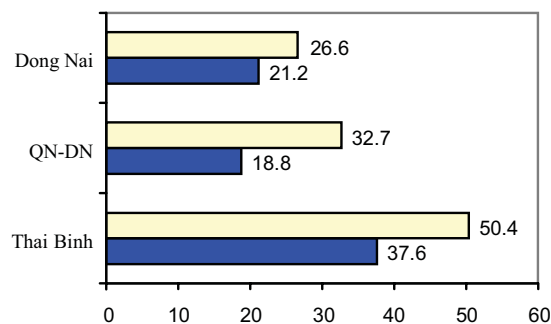
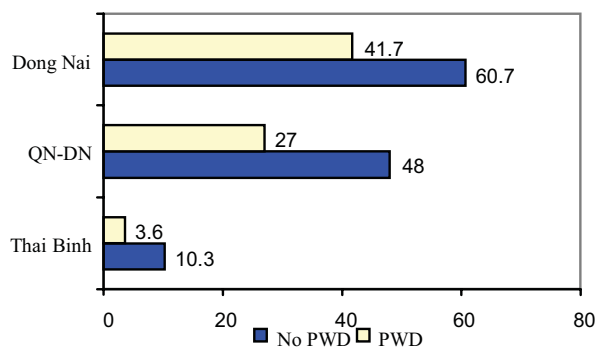


Chart 12. Percentage of households using electricity/gas for cooking



fourth, respectively. For households with no PWD, the situation was much better, with only one fifth or less using unhygienic latrines in these two provinces (Chart 11).

Regarding cooking combustibles, extremely few households with PWD (less than 4 percent) in Thai Binh used electricity and gas, given the high cost. Although the figure was higher for the other provinces, much more households with no PWD used these combustibles for cooking (27 versus 48 percent in Quang Nam – Da Nang; and 42 versus 61 percent in Dong Nai) (Chart 12).

Finally, houses having PWD were poorly furnished in comparison to houses without PWD. In the survey, sets of key consumer durables were compared between the two groups of households. Included in the list are a television, radio/VCD/DVD set, refrigerator, bicycle and motorcycle as well as telephone. These are not only goods that are of relatively high value (especially in rural areas), but also an essential means for people to get instant access to information, better transportation, and faster connections to people and market opportunities. Data analysis shows substantial disparities between the two household groups regarding possession of these durables (see Table 5) with houses of PWD being poorly equipped compared to houses with no disabled people.

Table 5. Facilities in house (%)

	Thai Binh		QN-DN		Dong Nai	
	With PWD	No PWD	With PWD	No PWD	With PWD	No PWD
Television	76.8	92.5	80.6	91.1	85.0	90.7
Radio/VCD/DVD	36.0	55.6	35.0	46.5	42.0	47.5
Refrigerator	5.9	13.7	13.0	26.6	21.2	34.8
Telephone	12.5	25.9	29.0	48.0	32.7	48.8
Motorbike	24.0	54.5	55.6	78.8	64.6	80.4
Bicycle	84.2	95.2	79.7	83.9	68.0	71.1
N	1,568	1,085	1,633	1,078	1,625	1,079

5.3 Poor accessibility

Regarding access, it is no accident that the residences of households with PWD were often located farther from key infrastructure, economic and social service centers of the community compared to those households with no PWD. For example, *on average* the distance from the house of a household with the PWD to any motorway could be 200 meters farther than that of a house with no disabled person. Similar findings are found for distance to local People’s Committee, 400 meters; to local health center, 300 meters; to nearest school, 200 meters; and to major market, 300 meters. Indeed, some houses with PWD were located much farther than these average figures quoted above. While a few hundred meters is not a problem for people with no disability, for PWD, these extra distances can create problems for them in accessing economic opportunities and available services, particularly for those with motor and vision disability (Table 6).

Table 6. Distance from key infrastructure, economic and social service centers (km)

	Thai Binh		QN-DN		Dong Nai	
	With PWD	No PWD	With PWD	No PWD	With PWD	No PWD
Motorway	0.4	0.3	0.4	0.3	0.5	0.3
People Committee	1.1	1.0	1.4	1.2	2.0	1.6
Health care center	1.2	1.1	1.5	1.3	1.9	1.6
School	1.1	1.0	1.0	0.8	1.2	1.1
Major market	1.4	1.3	1.5	1.3	1.8	1.5
N	1568	1085	1633	1078	1625	1079

5.4 Low Income and Expenditure

Income and expenditure are among the most useful indicators of household well-being. Data collected shows that the income per capita of households with PWD was considerably lower than that of households without PWD. The median for annual income per capita for the former households in Thai Binh was 3.4 million Dong (slightly more than 200USD (1USD = 16,000 Dong by the time of the survey in summer 2007) compared to 4.8 million Dong (300USD) for the latter households. An annual income of 3.4 million Dong means a monthly income of 283,000 Dong, or about 18USD. The situation was similar across the other studied provinces. Annual income per capita for Quang Nam – Da Nang was 3.1 million for households with PWD versus 4.6 million Dong for the other households. For Dong Nai, the figure was 3.8 versus 5.7 million Dong. Thus, households with PWD also spent less due to their limited income. The median annual expenditure per capita for the studied provinces was: 2.9 versus 4.2 million in Thai Binh; 2.6 versus 3.7 million in Quang Nam – Da Nang; and 3.2 versus 4.1 million in Quang Nam (Table 7).

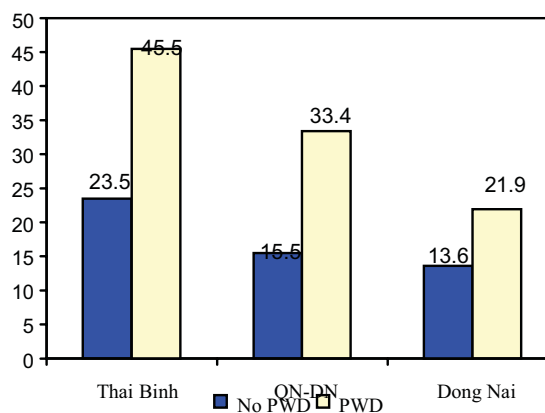
Table 7. Annual income and expenditure of households

	(Thousand VND)					
	Thai Binh		QN-DN		Dong Nai	
	With PWD	No PWD	With PWD	No PWD	With PWD	No PWD
Annual income per capita						
Mean	4914.2	6870.1	4417.6	6555.3	5156.2	4417.6
Median	3405	4767	3085	4588	3770	3085
Annual expenditure per capita						
Mean	4351.5	5902.8	3722.4	5356.3	4327.1	3722.4
Median	2930	4163	2635	3656	3194	2635
N	1568	1085	1633	1078	1625	1633

5.5 Disability as Constraints of Livelihood Improvement

Improving livelihoods for any household (with or without PWD) is hard, particularly because of the common difficulties such as the lack of arable land (for rural households), production means, labor and capital, knowledge and know-how, market access difficulties, as well as health problems. However, two key difficulties specifically faced by the households with PWD compared to other households are the lack of labor resulting from the health problems of household members, mostly the PWD themselves.

Chart 13. Percentage of households reporting the lack of labor as cause of difficulty in improving income



Comparison between the two groups of households shows clearly how disability has become a inhibiting factor for households with PWD in improving their economic status. Disability means fewer family members are able to work, or work effectively, to raise income. Nearly a half (46%) of the households with PWD in Thai Binh reported that the lack of labor (mainly because of disability) prevented them from improving their income. For households without PWD, the proportion was less than one quarter (24%). Similarly, in Quang Nam – Da Nang, one in every three households with PWD (or 34%) faced labor insufficiency. This proportion in households without PWD was about one in every seven (16%). Figures for Dong Nai are one fifth (22%) versus one seventh (14%) respectively (see Chart 13).

The disability status of a household member also directly affected work and labor efficiency of other members who are not disabled, as reported by three quarters of households with PWD

in Thai Binh and about a half of the households with PWD in the other provinces. Caring for one or more family members with disability means that some others in the family must work

Table 8. Effect of disability on employment of other household members (%)

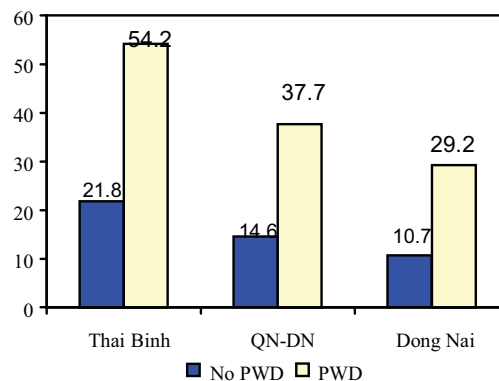
	Thai Binh	QN-DN	Dong Nai
Having negative effect	74.7	48.2	44.5
Do not work/Quit job	21.1	12.7	17.3
Work less	58.7	36.4	25.0
Limit job option	24.6	7.2	7.1
N	1568	1632	1625

less than they should in order to support their disabled relatives. It also means fewer job opportunities for those members. For example they may have to refuse to take a job or an employment opportunity that requires more time or travel, since they need to be available to help the PWD in their family when needed. Some even

decided not to work or had to quit their job to undertake the full time care of disabled members. Table 8 lists in detail the proportion of households where employment of non-disabled members was adversely affected by the disability of one or more other family member.

The second marked difficulty that affects household livelihood is poor health status. As presented in Chart 14, nearly one third of the households with PWD in Dong Nai and more than half of the households in Thai Binh reported health problems, mainly relating to the disabled member, as producing difficulties for their family in improving their economic situation. Figures for the households without PWD were indeed much lower, ranging from one tenth in Dong Nai to about one fifth in Thai Binh. Health problems mean a lower production capacity, fewer opportunities for livelihood generation, higher costs for health care etc., that, in combination, drive down the overall welfare of families.

Chart 14. Percentage of households reporting health problems affecting household welfare



For example, poor health and disability not only affect PWD themselves but the general health of other household members as well (directly as non-disabled members’ health may be affected in taking care of the PWD, and indirectly as disability can cause an overall decline in family welfare, thus affecting the health of everybody). In the survey, respondents of nearly half of the households with PWD in Thai Binh told interviewers that the disability of household members was a significant cause in the deteriorating health of other members who themselves were not PWD. The figure for Quang Nam – Da Nang and Dong Nai was also high, though lower than that of Thai Binh.

“She lies motionlessly, noticing nothing. She has teeth but can not chew so I have to chew rice for her to swallow, lying to swallow because if she sits, rice will fall out.... She lives like vegetable, having no feeling..... I have to be at her side all the time, do not dare to leave home”
 (Male respondent, father of a disabled child, Quang Nam)



A house of PWD by a dirt road



A house of PWD made from brick with thatched roof



A house of PWD made from wood with metal roofing



A PWD in his house



Some furniture of a disabled household



Kitchen of a disabled household

6 SOCIAL AND ECONOMIC CHARACTERISTICS OF PEOPLE WITH DISABILITY

An analysis of the data collected directly from PWD in all the sections of this report are taken along three major dimensions. The first dimension is provincial, i.e. data are analyzed separately for each province, as each provincial sample is representative for the PWD population of that province only. Here, however, we also want to identify commonalities and variations, if any, of the comparative situation relating to PWD across the studied provinces of Thai Binh, Quang Nam – Da Nang, and Dong Nai.

The second key dimension in the analysis is between a group of PWD whose disability was probably caused by AO exposure, and another other group of PWD whose disability was caused by other factors (see the sub-section on the causes of disability). As mentioned earlier, one important aim of the study is to identify the difficulties and vulnerabilities of PWD who are considered (subjectively by the local authorities, communities, families and themselves) to be affected by Agent Orange. However, since it is not the purpose of this study to identify with any degree of certainty who precisely are victims of AO, we adopt here an alternative approach: examining the situation of people whose disabilities are reportedly (by local authority, community, family and themselves) caused by AO, and also those whose disabilities are congenital. As has been previously documented, contact with AO mostly led to birth defects and children with congenital disabilities. Thus, the difficulties of those with congenital disability are likely to be similar to those of AO-affected PWD. For convenience of analysis therefore, the PWD included in these two categories are hereafter named Group A. For PWD of other types, they are included in Group B for the purpose of analysis.

The third dimension is between three cohorts of PWD aged between 1 and 29, 30 and 49, and 50 and above. The purpose here is not only to see if there is any cross-generational difference regarding the situation of PWD in the samples. It also serves the purpose of giving us a clearer picture of the disability situation of each PWD cohort in the context of his or her specific historical periods of pre-1957; 1957-1976; and 1977-present. It should be noted that the second cohort were born during a period coinciding with the Vietnam War. AO was used in Vietnam during the decade spanning 1961-1971. In this survey, the majority of the cases whose disability was claimed to be AO-affected were located in the second and mostly the third cohort. We thus expect to see differences in terms of disability-related difficulties among the three cohorts as well.

Indeed, in the course of our analyses, any additional gender differential will be clearly noted.

6.1 Demographic characteristics

6.1.1 Age

Table 9 presents the age structure of PWD in the three provinces at the time of the survey (From July through September 2006). We can see that there was a rather even distribution of

PWD across age cohorts, except for the case of Quang Nam – Da Nang and Dong Nai where there were higher proportions of PWD aged 19 or younger.

6.1.2 Gender

There were more male PWD in the samples across the provinces, compared to female PWD: 60 versus 40 percent in Thai Binh; 62 versus 39 percent in Quang Nam-Da Nang, and 58 versus 42 percent in Dong Nai. In general, we can say that male PWD accounted for about 60 percent of the samples. These proportions are relatively in line with the national figures in 2003 (63.5% of PWD were male and 36.5% were female).

Table 9. Age structure of PWD (%)

	Thai Binh	QN-DN	Dong Nai
1-19	16.4	23.0	29.9
20-29	14.3	11.0	17.4
30-39	15.0	14.6	14.3
40-49	18.8	15.8	14.8
50-59	19.3	18.9	13.1
60+	16.2	16.7	10.5
Total	100.0	100.0	100.0
N	1,822	1806	1869

6.1.3 Marital status

For PWD aged from 15 and above, questions on marital status were asked during the survey. While the Marriage Law requires that the minimum age for marriage should be 20 for a man and 18 for a woman, in fact, many people got married at much earlier ages, especially in rural and remote areas. Our survey data show a very high proportion of PWD at the studied provinces who were unmarried (Table 10). This high figure shows clearly how disadvantaged the PWD were regarding marriage. As shown in Section 8 of the report, PWD are considered by the community to be “unsuitable” for marriage, as they will not be able to support their own family; having and raising children; even creating further “burdens” for their spouses and other family members. For PWD with congenital disability, mental health problems, or considered dioxin-related disability, there was even a fear that their disability would be transmitted across generations.

There was a tremendously sharp disparity in marital status between male and female respondents, as shown in Table 11, with much higher proportions of married males compared to married females. For example, while nearly 70 percent of male respondents aged 15 and above in Thai Binh were married, the figure for females was just about 20 percent. A similar situation was also found in Quang Nam – Da Nang and Dong Nai.

Table 10. Marital status of PWD (%)

	Thai Binh	QN-DN	Dong Nai
Married	48.8	46.2	34.7
Widow	3.8	7.1	5.3
Unmarried	44.3	43.0	57.0
Divorced/separated	3.0	3.7	3.1
Total	100.0	100.0	100.0
N	1643	1521	1492

Table 11. Marital status of PWD by gender (%)

	Thai Binh		Quang Nam-Da Nang		Dong Nai	
	Male	Female	Male	Female	Male	Female
Married	68.1	19.9	60.7	22.1	43.8	21.5
Widow	1.6	7.2	3.2	13.7	2.6	9.1
Unmarried	27.2	70.0	33.2	59.4	51.0	65.6
Divorced/separated	3.1	2.9	2.9	4.9	2.6	3.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	986	657	950	571	879	613

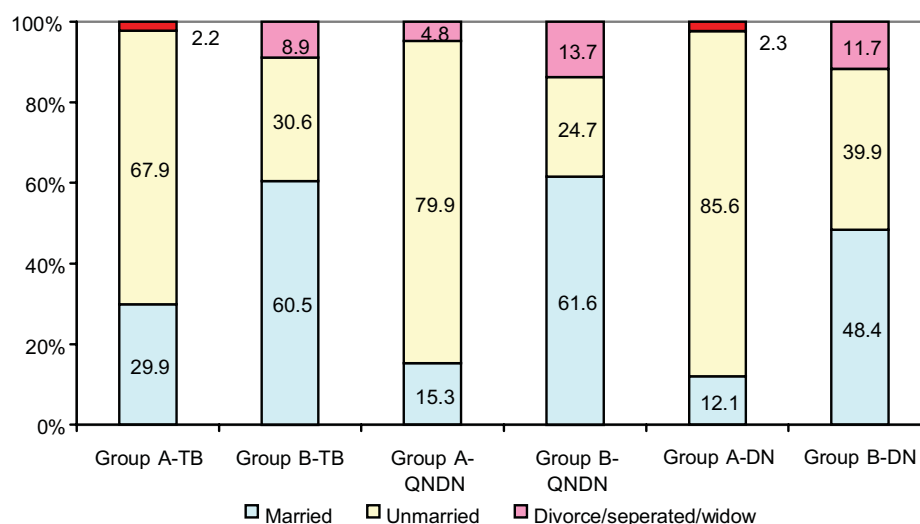
Conversely, unmarried respondents featured predominantly among females. In Thai Binh, the gap was between 70 percent of the females versus 27 percent of males. For Quang Nam – Da Nang, the gap was 59 percent for females compared to 33 percent of males. In Dong Nai, it was 66 versus 51 percent.

Clearly, the community’s perception of marriage needs for males with disability and their female counterparts were different. Marriage was, to some extent, a taboo for females with a heavy disability. Section 8 of the report pursues further analyses of such perceptions on marriage and having children of PWD from families and communities.

Marital status of PWD in Group A

It is quite clear from the data that the PWD in Group A are more likely to be unmarried, due to the severity of their disabilities. There is a common fear among community people that those PWD will produce children with congenital disability genetically. Thus, as presented in Chart 15, the proportion of married individuals in Group A was extremely low, particularly in Quang Nam – Da Nang and Dong Nai. Conversely, the proportion of unmarried PWD in this group was much higher than that of the other group. In Quang Nam – Da Nang, it was almost 80 percent. In Dong Nai, it was almost 86 percent.

Chart 15. Marital status of PWD aged 15+ by Groups A and B (%)



6.2 Educational attainment

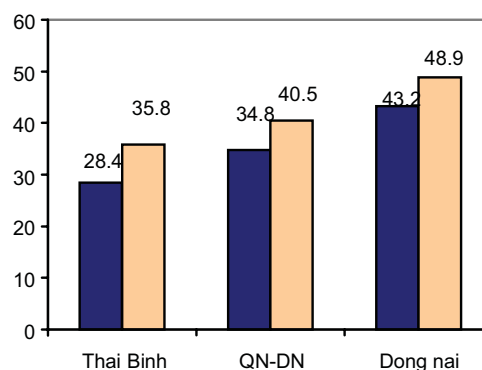
Disability is a clear obstacle for PWD in attaining an education. In the survey, questions regarding education and difficulties at school caused by disability were put to all the PWD aged between 6 (starting age for schooling) and 30 (age when most education, including higher education should be completed). The data shows that one in every three PWD in this cohort in Thai Binh and Quang Nam-Da Nang never attended school. The figure in Dong Nai province was much higher, close to one in every two (Table 12).

There is a gap in education between males and females. Compared to their male counterparts, more females with disability had never attended school at the time of the survey, and this differential was found in all the surveyed provinces. Thus, in Thai Binh, while the percentage of males with disability who had never attended school was already high, 28 percent, for females with disability, it was much higher, 36 percent. Similarly, in Quang Nam, the proportion was 35 percent for males and 41 percent for females. In Dong Nai, the figures are highest: 43 percent for males and 49 percent for females. In other words, of nearly every two females with disability we met in Dong Nai, one had never attended school at the time of our survey. Gaps in education between males and females were already found in other national surveys for the general population. It was reintereinted with our representative samples of PWD in the selected provinces (Chart 16).

Table 12. School attendance of the PWD aged 6 to 30 (%)

	Thai Binh	QN-DN	Dong Nai
Currently in school	24.9	27.4	21.3
Attended	43.4	35.3	33.0
Never attend	31.7	37.3	45.7
Total	100.0	100.0	100.0
N	542	558	822

Chart 16. PWD who never attend school by gender (%)



Regarding levels of educational attainment, at the time of the survey, about 40 percent of PWD in the three provinces had achieved only education that was lower than primary level. This means they could at best know how to read, to write and do the most basic arithmetic only. Some had finished primary education but did not complete the lower secondary level of education. Those who achieved upper education attainment were very few, less than 10 percent in all the provinces. Those who got and completed higher education levels were particularly rare. For example in Quang Nam – Da Nang, there were only 4 PWD with a college degree. In Dong Nai, the number was only 2. None of the PWD in our survey of Thai Binh province had graduated from college or university (Table 13).

Table 13. Educational attainment of PWD (%)

	Thai Binh	QN-DN	Dong Nai
Below primary	39.7	40.9	41.5
Below lower secondary	27.0	29.1	32.3
Below upper secondary	18.9	17.4	16.1
Upper secondary	8.6	7.1	7.8
Vocational/under college	5.7	4.3	1.8
College graduate	0.0	1.1	0.4
Total	100.0	100.0	100.0
N	370	350	446

Education of PWD in Group A

The educational situation of PWD in Group A was even worse. Thus, while the proportion of PWD of other disability types who had never attended school was already high, the figure for PWD of the group of AO-suspected and/or congenital disabilities was about double in all three provinces (Chart 17).

Education attainment levels of PWD in Group A were also frustrating, compared to the other group of PWD. Similar to the above situation, the proportion of PWD from group A who

only achieved an education that is below primary level was more than double in Quang Nam – Da Nang and Dong Nai. In Thai Binh, the gap was also large, 43 versus 29 percent (Chart 18).

Chart 17. Percentage of PWD who never attended school by Group A/B

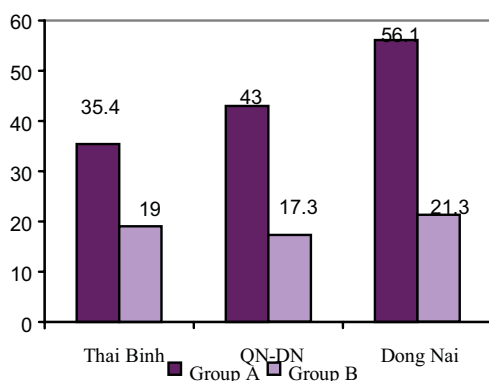
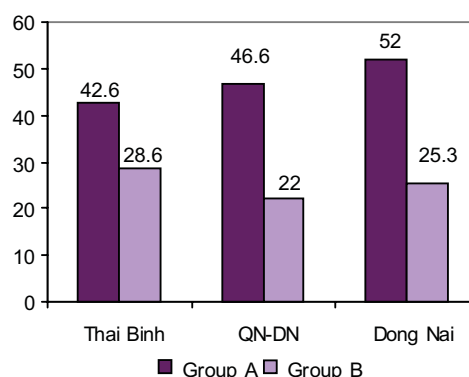


Chart 18. Percentage of PWD in Groups A and B having education below primary level



6.3 Employment

For the cohorts of PWD aged 15 and above, the proportion of those currently working was low across all three provinces. One third of PWD interviewed in Thai Binh used to be employed, but by the time of the survey, they were no longer employed. Indeed, disability was the main reason given why they could no longer work. For Quang Nam – Da Nang and Dong Nai, the proportion was 30 percent and 27 percent. There were quite high percentages of respondents who had never worked in all of the three provinces. In Dong Nai, almost one in every two PWD aged 15 and above has never been in employment. In Quang Nam – Da Nang, it was one in every three. In Thai Binh, the proportion was almost 40 percent. As explained in the next section, disability was the major cause of their unemployment (Table 14).

Table 14. Employment status of PWD aged 15+ (%)

	Thai Binh	QN-DN	Dong Nai
Currently employed	28.0	35.9	25.4
Used to be	33.7	29.8	26.9
Never be employed	38.3	34.3	47.7
Total	100.0	100.0	100.0
N	1643	1521	1492

Compared to males, females in the samples had a more disadvantaged employment status, with less currently working, used to work, and never been employed. For example, in Quang Nam – Da Nang, while 41 percent of male PWD in the cohort were working by the time of the survey, for female PWD, the ratio was just 27 percent. Similarly in Dong Nai, 30 percent of males were working versus 19 percent of females. In Thai Binh, the gap was 31 percent for males and 24 percent for females.

Also, fewer females had been employed before the time of the survey. The data indicate that, except for Quang Nam – Da Nang, the proportion of

Table 15. Employment status of PWD by province and gender (%)

	Thai Binh		QN – DN		Dong Nai	
	Male	Female	Male	Female	Male	Female
Currently employed	30.9	23.6	41.1	27.3	30.0	18.8
Used to be	38.6	26.3	30.0	29.4	31.2	20.7
Never be employed	30.4	50.1	28.9	43.3	38.8	60.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	986	657	950	571	879	613

females who had been employed were about 10 percent less compared to their male counterparts in Thai Binh and Dong Nai. The gap between males and females was largest regarding the proportion of those who were never employed: 30 versus 50 percent in Thai Binh, 29 versus 43 percent in Quang Nam – Da Nang, and 39 versus 61 percent in Dong Nai (Table 15).

All these above figures suggest serious inequalities in employment between males and females. Analysis of the current occupational structure of PWD further highlights their employment disadvantage. As we can see in Table 16, there were quite a few PWD working as skilled workers in enterprises, employees of the government sector, teachers, intellectuals, or employers (here named

Table 16. Occupational structure of PWD (%)

	Thai Binh	QN- DN	Dong Nai
Farmers	70.0	51.6	29.6
Unskilled laborer	18.7	25.5	33.5
Petty trade/service	8.7	9.7	25.1
Workers/professionals/others	2.6	13.2	11.9
Total	100.0	100.0	100.0
N	460	546	379

workers/professionals/others), especially in Thai Binh. The majority of PWD were in the agricultural sector as farmers and the low-paid sector as unskilled workers. In Thai Binh and Quang Nam – Da Nang, less than 10 percent of respondents were in petty trade and the service sector. For Dong Nai, however, the proportion was much higher, about one quarter of PWD were working in these occupations.

Table 17. Occupational structure of PWD by gender (%)

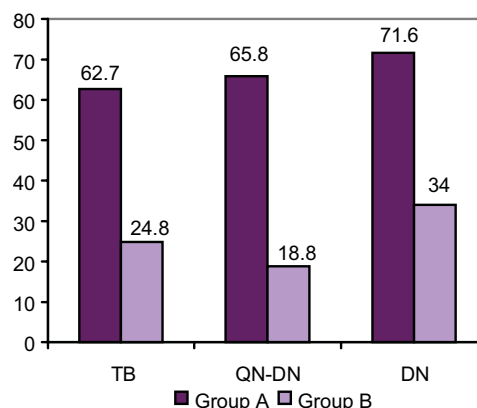
	Thai Binh		QN – DN		Dong Nai	
	Male	Female	Male	Female	Male	Female
Farmers	70.2	69.7	52.3	50.0	32.6	22.6
Unskilled laborer	19.0	18.1	28.7	17.3	33.3	33.9
Petty trade/service	8.5	9.0	4.6	22.4	23.1	29.6
Workers/professionals/others	2.3	3.2	14.4	10.2	11.1	13.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	305	155	390	156	264	115

Compared to males currently working, females in Quang Nam – Da Nang and Dong Nai were found more in petty trade and services (22 versus 5 percent and 30 versus 23 percent respectively). In Dong Nai, more males than females participated in the agricultural sector (33 versus 23 percent). Males in Quang Nam – Da Nang featured more as unskilled laborers compared to females (29 versus 17 percent) (Table 17).

Employment of PWD in Group A

For PWD in Group A, it was even harder to get a job. Chart 19 shows a comparison between this group and the group of other PWD regarding the proportion of those who were never employed. In Thai Binh, about 63 percent of PWD in the former group had never been employed, compared to about 25 percent of PWD in the latter group. The gap in other provinces was even larger, 66 versus 19 percent in Quang Nam – Da Nang, and 72 versus 34 percent in Dong Nai.

Chart 19. Percentage of PWD who had never been employed by Groups A and B



6.4 Disability situation

Multiple disabilities

As mentioned previously, in total, the survey covered 5,497 PWD aged from 1 to 70 years old living in 4,826 households in the surveyed sites, making a ratio of more than 1.1 people with disability per households. Nearly one in every three PWD in Thai Binh had more than one disability. For other provinces, the proportion was slightly less, about one in every four or five PWD. Compared to males, females having more than one disability featured more prominently in Thai Bin (32 versus 29 percent) and Dong Nai (26 versus 22 percent) (Table 18).

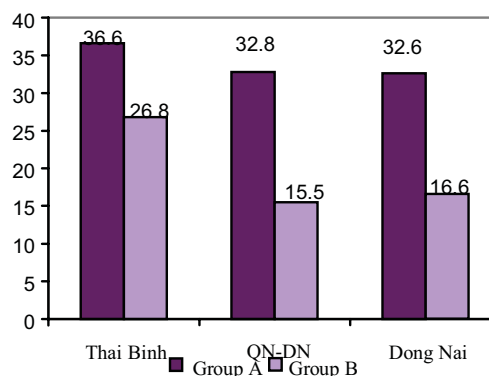
Table 18. PWD with more than one disability (%)

	Thai Binh	QN-DN	Dong Nai
Male	29.3	22.4	21.9
Female	32.2	22.9	26.1
All	30.5	22.6	23.6

Multiple disability of PWD in Group A

The situation is more severe for PWD whose disabilities were likely to be dioxin related or congenital. Compared to other type of disability, PWD in Group A are likely to suffer more than one disability. Chart 20 illustrates that the proportion of PWD having more than one disability in the southern provinces was double that of the other group of PWD. In Thai Binh, the figure was also about 10 percent higher. Having multiple disabilities means more

Chart 20. Percentage of PWD having multiple disabilities by Groups A and B



difficulties and vulnerabilities in various areas of life, and this is what PWD in Group A are currently suffering, as shown in the other sections of this report.

Type of disability

In our survey, for convenience of comparison, we adopted the classification used by the Vietnamese ministries. Table 19 presents the distribution of PWD by types of disability and province. As we can see, in all provinces, around a half of the respondents reported motor/moving disability. Hearing disability accounted for about 10 to 15 percent of PWD. People having a speaking disability comprised around 16 percent of the provincial samples.

Table 19. Types of disability (%)

	Thai Binh	QN - DN	Dong Nai
Motor	44.6	51.9	46.8
Hearing	15.5	9.8	9.6
Speaking	15.6	15.3	16.2
Vision	17.2	13.9	10.7
Learning	20.5	17.8	20.3
Mental	26.7	17.1	21.0
Others	4.4	5.8	7.7
N	1822	1806	1869

From 11 to 17 percent had vision disability. About one in every 5 PWD experienced learning disability. Mental illness was also serious, as the percentage of PWD suffering from it ranged from 17 to 27 percent, depending on the locality (highest in Thai Binh province).

Compared to males, in all the provinces females with motor disability accounted for a lower proportion. In contrast, the ratio of females with mental illness was significantly higher than that of males in Thai Binh (31 versus 24 percent) and Quang Nam – Da Nang (22 versus 14 percent). There were also higher proportions of females with learning disability compared to males in all the provinces (see Table 20).

Table 20. Types of disability by gender (%)

	Thai Binh		QN – DN		Dong Nai	
	Male	Female	Male	Female	Male	Female
Motor	49.2	37.8	55.4	46.2	49.5	42.9
Hearing	15.7	15.1	9.7	9.9	8.9	10.5
Speaking	14.2	17.7	15.2	15.4	15.4	17.4
Vision	16.8	17.8	14.9	12.4	10.2	11.4
Learning	18.0	24.1	16.6	19.7	17.9	23.7
Mental	23.6	31.3	14.0	22.2	21.3	20.6
Others	4.6	4.1	4.8	7.3	6.4	9.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	1087	735	1111	695	1091	778

Type of disabilities for Group A

Not only are PWD in this group likely to have more than one disability, the types of disability they have are also more serious and, in many cases, cannot be improved through rehabilitation. For example, the proportion of Group A’s PWD suffering from learning (cognitive/intellectual) disability was triple that of PWD with other types of disability in Thai Binh, nearly fourth times higher in Quang Nam – Da Nang, and fifth times higher in Dong Nai (Table 21). The PWD in Group A were also more likely to suffer from hearing and speaking disability. During fieldwork, we encountered various cases of AO-suspected

disabled people, who are hearing-speaking impaired due to brain suffering caused by cerebral palsy.

Table 21. Types of disability by Groups A and B (%)

	Thai Binh		Quang Nam – Da Nang		Dong Nai	
	Group A	Group B	Group A	Group B	Group A	Group B
Hearing	17.5	14.2	13.9	6.9	14.1	6.0
Speaking	22.0	11.3	29.2	5.5	27.2	6.9
Learning	33.2	11.6	31.1	8.4	34.3	7.8
N	732	1045	750	1026	857	961

Age getting disability

The majority of PWD in the studied provinces acquired their disability before the age of 40. Congenital disability was particularly widespread among the samples, accounting for around half the PWD in all three provinces. Early disability thus reduced or even prevented PWD’s education attainment and labor force participation. The data shows that before the age of 20, 67 percent of the sample in Thai Binh, 66 percent in Quang Nam – Da Nang, and 75 percent in Dong Nai were already disabled. By the time they reached 40 years of age, the figures were about 90 percent of the respondents in all the studied provinces. For the community and society in general therefore, a considerable proportion of the labor force was losing labor capacity. The consequences for the family was that many became dependents even before they could make an economic contribution (Table 22).

Table 22. Age getting disability (%)

	Thai Binh	QN - DN	Dong Nai
Congenital	48.0	46.0	50.1
1-19	19.0	20.2	24.7
20-39	23.6	24.3	16.5
40+	8.6	8.8	8.3
Not know	0.9	0.7	0.3
Total	100.0	100.0	100.0
N	1822	1806	1869

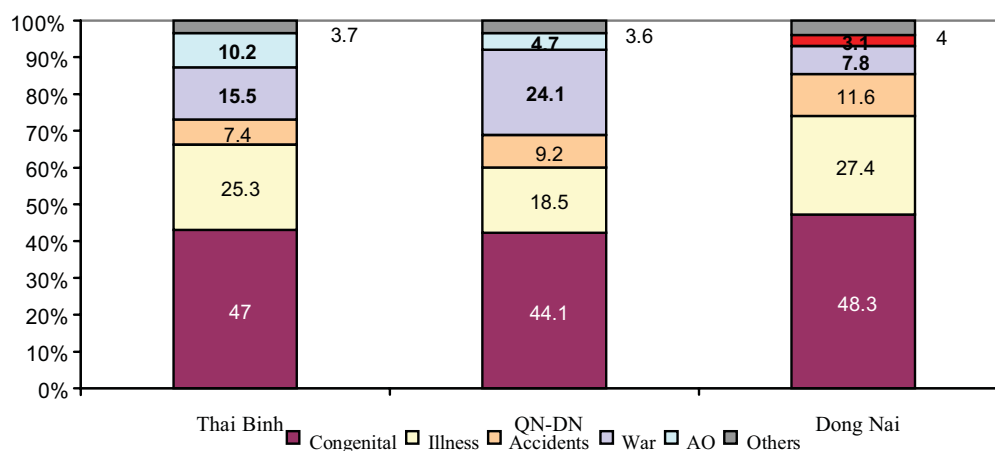
Cause of disability

As previously stated, congenital diseases caused disability for close to half of the samples across the studied provinces. Three other main causes of disability included illness, war (including disability suffered by participating in combat or disability of civilians), and dioxin exposure. In the case of war-related disability, Quang Nam – Da Nang registered the highest number: nearly one in every five PWD. These provinces are well known to have suffered most during the Vietnam War. For Thai Binh, the proportion was close to one in every seven PWD (Chart 21). Thai Binh was the province where many men joined

I was assigned to Quang Tri in about 1966, then to Asau and Aluoi, where fighting was very intense. This area was right on the strategic route for the troops to approach Da Nang. I served in Quang Trung transportation brigade..... In the entire zone, trees had no leaves. They [US airplanes] sprayed herbicides, once in every fifteen or twenty days. Each C130 [planes] sprayed an area of four or five hundred meters on each side [left and right wings]. When they came, we got into our shelter, covering ourselves with clothes or blanket imbued with water as we did not have anti-poison gas masks..... We were exposed to many kinds of toxic chemicals. (Male, Thai Binh)

the army and became involved in battles in the South. Soldiers from Thai Binh were considered to be tough fighters with many injuries incurred, according to one explanation from a local war veteran. Memories of wartime and the U.S. spraying of herbicide remain vivid among ex-soldiers.

Chart 21. Disability cause (%)



The consequence of the war on disability prevalence is more obvious if we look at the differentials between males and females. War-related disability was found in 31 percent of males respondents in Quang Nam – Da Nang and 22 percent in Thai Binh. In Dong Nai, it was 10 percent. Figures for females were 5, 13 and 4 percent in Thai Binh, Quang Nam – Da Nang, and Dong Nai respectively (Table 23).

Table 23. Causes disability by gender (%)

	Thai Bin		QN – DN		Dong Nai	
	Male	Female	Male	Female	Male	Female
Congenital diseases	41.2	55.6	39.4	51.7	43.4	55.1
Illness	21.9	30.3	15.8	23.0	25.8	29.6
Accidents	9.1	5.0	10.8	6.6	15.2	6.5
War	22.3	5.4	30.9	13.4	10.4	4.1
Dioxin	11.2	8.6	4.1	5.8	2.6	3.9
Others	3.4	4.1	3.3	4.2	3.9	4.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	1087	735	1111	695	1091	778

Agent Orange, or dioxin, is considered to cause severe conditions for the offspring of people who were exposed to it. The fact that considerable volumes of AO had been sprayed over the territory of the southern provinces by the US Air Force during the Vietnam War and some forms of disability found in the children of Vietnamese soldiers and civilians who had been in sprayed areas were identified by the government as evidence of dioxin-induced disability. While the debate about whether AO is the direct cause of disability of a high number of Vietnamese people continues, subjectively 10 percent of the sample in Thai Binh, 5 percent in Quang Nam – Da Nang, and 3 percent in Dong Nai were thought to be caused by it. If we

include people whose congenital diseases were likely to be AO related, then the proportion of AO-affected disability would certainly be higher.

Degree of disability

Because our sampling frame was drawn from the official lists of PWD provided by the local authorities (at provincial and commune/ward levels), the majority of PWD selected in the survey were those whose disabilities were visible and serious. This was also reflected in the subjective ranking of PWD themselves when being asked to scale their disability.

Thus, in Thai Binh 95 percent of PWD self-classified as having a heavy or medium disability. The proportion for Quang Nam – Da Nang and Dong Nai provinces was similarly high, 95 and 88 percent, respectively. Only a minority of PWD in these provinces considered their disability as “light” (not serious) (Table 24).

The concentration of PWD with heavy/medium disability was roughly the same for both males and females, with slightly higher proportions of females in these categories compared to their male counterparts (Table 25).

Compared to other PWD, the proportion of Group A PWD who considered their disability as ‘heavy’ was even higher, as shown in Chart 22.

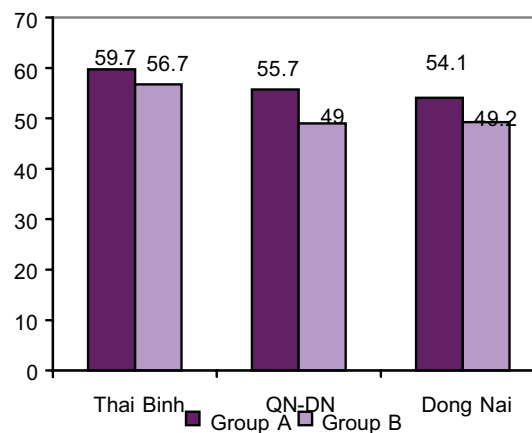
Table 24. Degree of disability (%)

	Thai Binh	QN - DN	Dong Nai
Heavy	58.5	52.0	51.3
Medium	36.0	42.9	36.6
Light	5.5	5.1	12.1
Total	100.0	100.0	100.0
N	1822	1806	1869

Table 25. Degree of disability by gender (%)

	Thai Binh		QN – DN		Dong Nai	
	Male	Female	Male	Female	Male	Female
Heavy	57.2	60.4	50.9	54.0	50.7	52.2
Medium	36.3	35.5	43.5	41.9	36.7	36.5
Light	6.4	4.1	5.7	4.2	12.7	11.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	1087	735	1111	695	1091	778

Chart 22. Heavy disability by Groups A and B (%)



7 DIFFICULTIES FOR PEOPLE WITH DISABILITY

It is predictable that PWD often face more difficulties than other people, but little is known about the quantitative measures and patterns of main difficulty of PWD in Vietnam. This section presents some assessments on difficulties that the surveyed PWD had in various aspects of life, including their daily activities, education, employment, healthcare, marriage and having children, and social participation. These are the key areas where supports for PWD should focus to make a difference in their life.

For each type of difficulty, not only levels of difficulty but also methods to overcome those difficulties (i.e. their ‘coping strategy’) are examined. In order to provide evidence for intervention to support PWD, their opinions of what actions and programs should be made are also analyzed.

7.1 Difficulties in the performance of daily activities

Level of difficulty

Having a disability can create difficulties in one’s daily activities. In this survey, the respondents were asked to describe levels of difficulty in performing some basic daily activities, including: eating and/or drinking; hearing and/or speaking; seeing; moving/walking; communication; and personal hygiene. Levels of difficulty in the analysis include: no difficulty (a person can do it by himself/herself without the need of someone’s support or the use of instrumental aids); some difficulty (self-performance with some difficulties but without someone’s support or the use of aids); substantial difficulty (cannot perform without support or the use of aids or both).

The survey data shows that the majority of PWD interviewed in the survey had some or substantial difficulties in performing basic daily activities described above: 95 percent in Thai Binh; 90 percent in Quang Nam – Da Nang; and about 76 percent in Dong Nai. Essentially there was no major difference between males and females regarding the performance of daily activities (Table 25).

Table 26. Percentage of PWD having difficulties in daily activities

	Thai Binh	QN-DN	Dong Nai
Sex			
Male	95.6	89.6	73.7
Female	94.6	90.4	79.6
Cause of disability			
Group A	94.6	91.0	78.9
Group B	95.9	89.2	73.7
Total	95.2	89.9	76.1

People with AO-suspected and/or congenital disability (Group A) were more likely to have difficulties in daily activities than other PWD (Group B), especially in Dong Nai. However, the difference was not considerable.

Table 26 lists in detail three levels of difficulties that the two groups of PWD in each province had in performing basic daily activities. Although variations existed among activities (from 22 percent to 76 percent in Group A; and from 25 percent to 73 percent in the other-cause group), in general the figures show that there were high percentages of the

respondents, especially among people with AO-suspected and/or congenital disability, facing considerable difficulties in performing daily activities.

Table 27. Degree of difficulties of PWD in performing daily activities (%)

	PWD of Group A			PWD of Group B		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Eating/Drinking						
No difficulty at all	57.6	65.4	50.0	59.8	75.5	60.0
Some difficulty	21.4	15.4	20.4	24.7	15.6	22.6
Substantial difficulty	21.0	19.2	29.6	15.5	8.9	17.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Hearing/Speaking						
No difficulty at all	42.0	43.4	34.0	57.6	76.4	63.1
Some difficulty	27.3	22.9	23.8	23.9	13.3	19.4
Substantial difficulty	30.7	33.7	42.2	18.5	10.3	17.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Seeing						
No difficulty at all	72.6	77.2	77.9	68.1	76.7	75.0
Some difficulty	17.9	14.4	11.7	19.9	15.0	15.0
Substantial difficulty	9.5	8.4	10.4	12.0	8.3	10.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Walking						
No difficulty at all	46.0	50.6	46.9	36.9	31.1	27.0
Some difficulty	32.2	27.2	21.4	35.1	37.6	32.2
Substantial difficulty	21.8	22.2	31.7	28.0	31.3	40.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Communication						
No difficulty at all	29.7	28.1	23.6	49.4	64.4	54.2
Some difficulty	20.1	23.8	19.9	18.5	15.9	19.0
Substantial difficulty	50.2	48.1	56.5	32.1	19.7	26.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Personal hygiene						
No difficulty at all	34.6	49.9	33.6	34.8	53.2	39.5
Some difficulty	23.7	18.7	18.9	33.0	29.1	28.0
Substantial difficulty	41.7	31.4	47.5	32.2	17.7	32.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	693	680	682	998	919	707

For people with AO-suspected and/or congenital disability, substantial difficulties were most frequent in communication (around a half), personal hygiene (31% to 48%), and in hearing or/and speaking (31% to 42%). These performances are often strongly affected by mental disorder, a common syndrome of the AO-suspected PWD.

For the other-reason group (Group B), substantial difficulties are also found to be most frequent in communication (20% to 32%), personal hygiene (18% to 33%), and in hearing or/and speaking (10% to 19%), but not as common as in Group A. Among all

“She cannot sit by herself. Her arms and legs are so feeble, like there are no bones. I think her brain is damaged. She cannot speak, just make some sounds. When she was 8 months, we found that her vagina has no hole”
(Male, suspected AO-affected, father of a disabled child, Thai Binh City)

performances presented in Table 27, walking was the only activity in which the other-reason PWD in all three provinces suffered from substantial difficulty more frequently than PWD in Group A. In addition, the figures for the other-reason group tend to depend more closely on provinces. For example, there were 41 percent of the other-reason PWD in Dong Nai but only 28 percent in Thai Binh having a substantial difficulty in walking. This can be explained by the fact that the composition of types of disability among the other-reason group varies significantly over the three provinces.

Coping measures

In order to overcome difficulties in daily activities, the three most important coping measures adopted by PWD are: relying on assistance from others; trying to adapt; and seeking instrumental aids (Table 28). The majority of PWD had to rely on assistance and support from family members, relatives, neighbors, or friends. The proportion of people with AO-suspected and/or congenital disability depending on such supports was highest in Thai Binh (81%), then Quang Nam – Da Nang (74%) and Dong Nai (71%), while the figures for the other-reason PWD were lower, although still quite high, falling within a similar range for the three provinces (76%, 64% and 61%).

Table 28. Major coping measures toward difficulties in daily activities (%)

	PWD in Group A			PWD in Group B		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Did nothing	10.4	12.7	14.9	7.0	11.3	15.0
Asked others' help	80.7	74.1	71.2	76.3	63.5	60.8
Sought instrumental aids	13.6	16.2	13.0	21.1	19.4	17.8
Tried to adapt	40.5	34.8	22.8	54.6	47.8	37.2
N	693	679	677	998	918	707

Many PWD also struggle themselves to adapt to their difficulties in daily activities. These efforts, including self-control, self-management, and self-learning methods from different information sources, including experiences of other PWD, have been applied by 23 to 41 percent of the people with AO-suspected and/or congenital disability, and by 37 to 55 percent of other-cause PWD. The prevalence and use of this coping measure is significantly higher in the other-cause group than in Group A, reflecting the more difficult situation of people with AO-suspected and/or congenital disability, who are more dependent on others' help.

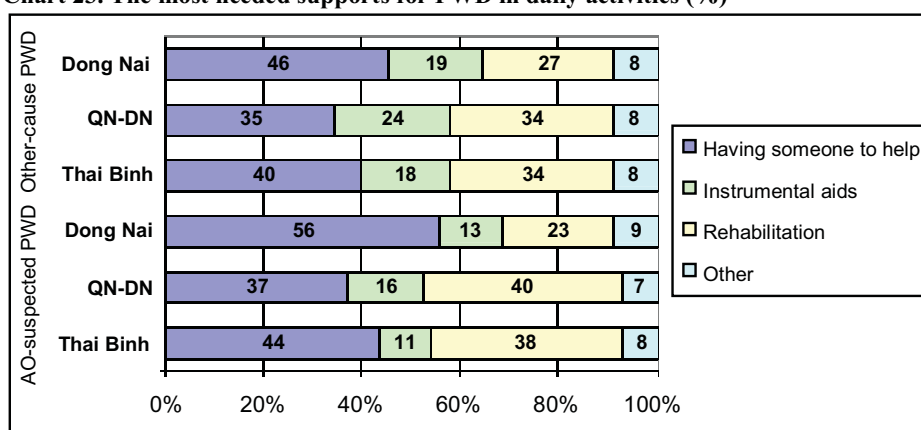
Seeking and using instrumental aids is a more active coping tactic of PWD in dealing with their daily-activity difficulties, but has been applied by only 13 to 16 percent of PWD in Group A, and about 18 to 21 percent in Group B. Perhaps the reason for this is that, for many PWD, especially those in Group A, instrumental aids are often too expensive and/or quite hard to obtain and to utilize.

Most needed supports

Three main priorities in support identified by the respondents included: (i) having someone to help in their daily activities; (ii) receiving rehabilitation services; and (iii) provision of instrumental aids for them to use in their daily activities.

Chart 23 shows the proportion of the most-needed supports according to the opinions of the respondents themselves. In general, having someone to help and rehabilitation were preferred by PWD in Group A more than by PWD of Group B, but vice versa for instrumental aids. Since daily activities are multiple, immediate, and very personal, having someone who can provide instant support was most valued by 37 to 56 percent of PWD in Group A, and by 35 to 46 percent of PWD in Group B. In fact, the majority of respondents were helped by family members in their daily activities. For those who had no such crucial support from family, community assistance should be considered as an alternative. On the other hand, rehabilitation support is often expected to be provided by the government, both central and local, community organizations, NGOs and donors' support programs. Although there have been rehabilitation programs designed for PWD on a national scale, access to these programs is not available to all PWD due to financial shortages and problematic social equity issues.

Chart 23. The most needed supports for PWD in daily activities (%)



Having someone to help and rehabilitation are followed by instrumental aids, which were more frequently ranked to be the most needed support for PWD in Group B in Da Nang (24%) than in Thai Binh (18%) and Dong Nai (19%). The same order was found in Group A, but with significantly lower percentages than those in Group B. Less than 10 percent of the PWD considered other kinds of most-needed supports and this proportion did not vary much across the three provinces or the two cause groups.

7.2 Difficulties in education

Types of difficulty

In the above section, we have provided data showing the poor educational attainment of PWD. Clearly, disability is a key obstacle to education for the respondents. This sub-section examines in detail various difficulties that PWD, aged between 6 and 30, had to face at schools and in education more generally.

Table 29 shows that, overall, more than 80 percent of the respondent cohorts in Thai Binh and Quang Nam – Da Nang, and close to 70 percent of the cohort in Dong Nai had difficulties in schooling. In Thai Binh and Quang Nam – Da Nang, the proportions were similar for males and females. In Dong Nai, however, females with disabilities were more likely to have difficulties in schooling than the male group and the difference was considerable (75% versus 61%). This corresponds with the figures presented earlier, where the proportion of learning disability was notably higher among female PWD in Dong Nai.

Table 29. PWD having difficulties in schooling (%)

	Thai Binh	QN-DN	Dong Nai
Sex			
Male	86.1	82.5	60.9
Female	85.7	84.0	75.0
Cause of disability			
PWD of Group A	90.9	89.6	70.7
PWD of Group B	72.4	68.1	61.2
All	85.9	83.1	66.8

Regarding the causes of disability, the proportion of people with AO-suspected and/or congenital disability having difficulties in school is clearly higher than those in the other-cause group in every surveyed province. The results supplement solid evidence pointing to the educational disadvantages of PWD, especially people with AO-suspected and/or congenital disability.

Table 30. Difficulties of PWD in school by Groups A and B (%)

	Group A			Group B			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Travel	34.9	26.7	29.8	32.4	46.8	43.3	34.0	31.3	34.2
Communication with teachers/mates	43.6	44.0	33.1	38.0	25.8	17.3	42.5	39.9	27.2
Learning	63.1	61.8	59.7	66.2	59.7	49.0	64.2	61.2	56.7
Participation in school activities/sport	39.8	34.2	14.4	31.0	33.9	18.3	37.7	34.4	16.4
Inappropriate school infrastructure	12.0	11.6	7.2	18.3	9.7	13.5	13.5	11.0	9.4
Teachers lack skills to teach PWD	6.6	12.9	5.0	4.2	4.8	3.8	6.3	11.0	4.4
Classmates ridicule, tease, disregard	24.5	15.1	12.2	16.9	14.5	10.6	23.0	14.8	11.7
Teachers' discrimination	2.9	1.8	1.7	7.0	0.0	1.0	3.8	1.4	1.3
Family's discouragement	1.7	0.4	3.9	2.8	1.6	1.0	1.9	0.7	2.7
N	241	225	181	71	62	104	318	291	298

The question is which kinds of educational difficulty did they have? Table 30 shows that the major difficulties were those relating to learning, communication, travel (to/from school), participation in school activities, schools' inappropriate infrastructure (PWD-unfriendly), and

explicit stigma and discrimination from other classmates. Only 11 percent or less PWD reported having problems in teachers' skills, teachers' discrimination, or family's discouragement. In general, these difficulties were more frequent in Thai Binh than in the other two provinces.

Travel between home and school was indeed difficult, sometimes prohibiting, for students who suffered from motor disability or vision disability (e.g. blind). For other PWD, it could also be hard, as their disability may seriously affect their health, making traveling long distances or on rough topography (or both) difficult. As many PWD in our samples resided in the countryside, including mountainous and remote areas, traveling difficulties were therefore substantial. Thus, about one in every three PWD in the provincial samples reported to the researchers about traveling difficulty.

At school, students with disability faced certain difficulties in communication with teachers and/or classmates. In Thai Binh, Quang Nam – Da Nang and Dong Nai, those who had this difficulty comprised respectively 43, 40 and 27 percent of PWD aged 6-30. Communication difficulties can indeed be a direct consequence of disability, for example of hearing, speaking, or mental disability. It can also be the result of negative attitudes towards students with disability from other classmates, or even from a minority of teachers.

As we can see from Table 30, among PWD aged from 6 to 30, 23 percent of them in Thai Binh, nearly 15 percent in Quang Nam – Da Nang, and 12 percent in Dong Nai reported being the target of classmates' discrimination, such as teasing and making fun of their disability. Common practices included giving students with disability negative nicknames, isolating them, or disregarding them. Occasionally students with disability were abused or even beaten up. In general, teachers did not have discriminatory attitudes. However, this did happen to minorities of students, 4 percent in Thai Binh, and less than 1 percent in the other provinces. If some communication difficulties are also considered to be the result of stigma and discrimination, then the situation in schools is even more alarming. Stigma and discrimination towards PWD will be described in more detail in Section 8 of the report.

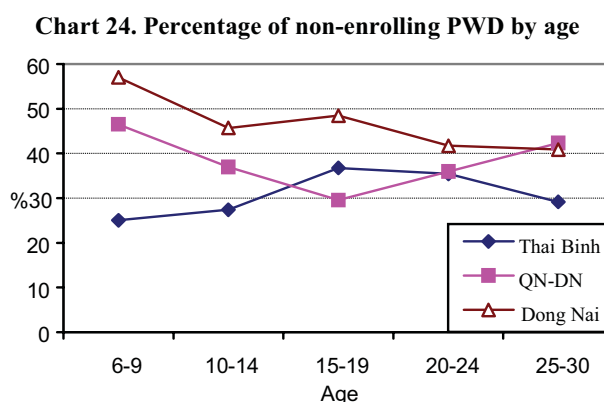
Partly because of their disability and partly because of these negative attitudes from other students, more than a third of the students with disability in Thai Binh and Quang Nam – Da Nang found difficulties in participating fully in school activities, including sports. The proportion for Dong Nai was much lower, about 16 percent.

More than 60 percent of PWD in Thai Binh and Quang Nam – Da Nang had difficulties in learning because of their disability status. In Dong Nai, the proportion was also high, about 57 percent. Besides, there was a lack of skilled teachers to teach students with disability. As integrated education is applied nationwide, students with disability are taking the same classes with other students. Nevertheless, teachers in most schools do not receive sufficient training to undertake classes with the participation of students with disability. In Quang Nam – Da Nang, about one tenth of PWD reported having difficulties in learning due to teachers' lack of skills in teaching integrated classes. This schooling difficulty was less frequent in Thai Binh (6%) and Dong Nai (4%).

Infrastructure in almost all schools is often constructed in a way that is inconvenient for PWD. For example, there is no access for people with motor disability. Nearly 14 percent of the respondents in Thai Binh, 11 percent in Quang Nam – Da Nang and 9 percent in Dong Nai considered school conditions to be an obstacle to their learning.

Finally, lower perceptions and negative attitudes of parents on the necessity of education created difficulties for some PWD in the samples. Perhaps for these families, it was economic difficulties that made them less supportive of the education of their children. However, the percentages of PWD facing this difficulty were fairly small (less than 2% in Thai Binh, 1% in Quang Nam – Da Nang, and 3% in Dong Nai).

Regarding cause of disability, the people with AO-suspected and/or congenital disability in Quang Nam – Da Nang and Dong Nai were less likely than the other-cause group to have difficulties in traveling to school. One of the reasons can be easily seen in the composition of disability types, in which the proportion of moving disability was higher in the other-cause group. On the other hand, the PWD in this group were indeed more disadvantaged in education as they had a higher probability of facing difficulties in many other aspects of schooling, especially in communication with teachers/mates, friends’ discrimination, learning (in Dong Nai), and teachers’ skills. Both males and females in the samples shared all these above difficulties with no large differentials between the two groups.



Certainly because of these difficulties, there were considerably high proportions of PWD, who never enrolled (Chart 24). The increase in this proportion from 25 percent in the ages 6-9 to 38 percent in the ages 15-19 in Thai Binh indicates that the chance for young PWD to go to primary school has improved in the last decade. In Quang Nam – Da Nang and Dong Nai, the highest percentages of non-enrolling PWD at the age group 6-9 suggest that the enrolling rate in primary school may have declined. At the ages 25-30, there were still more than 40 percent of PWD in Quang Nam – Da Nang and nearly 30 percent of PWD in Thai Binh had never attended any school.

Table 31. Drop-out schooling status (%)

For those PWD who did enroll, there were alarming drop-out rates (at least for one semester) found across the studied provinces. It was close to 60 percent in Thai Binh, 46 percent in Quang Nam – Da Nang and 54 percent in Dong Nai (Table 31).

	Thai Binh	QN-DN	Dong Nai
Drop-out rate			
Male	56.5	45.6	55.8
Female	61.7	47.2	51.6
All	58.6	46.3	54.0
Education level of drop-outs			
Primary	50.7	43.8	56.0
Lower secondary	35.5	40.1	31.5
Upper secondary	12.4	13.6	15.6
Vocation/college	1.4	2.5	0.8

Drop-out mainly took place when PWD were in primary and lower secondary levels (nearly 90 percent across the studied provinces). This means that the majority of PWD could not attain sufficient education for their later maturity stage as adults and laborers. Partly because of that, PWD later faced multiple difficulties in getting and sustaining paid employment as well as various difficulties in life and social participation, as discussed in other sections of this report.

The figures in Table 32 reveal that disability was the major reason for PWD aged 6-30 years to leave schools or not enroll (89% in Thai Binh, 88% in Quang Nam –Da Nang and 83% in Dong Nai). Compared to males, the rates of disability-related reasons of drop-out or non-enrollment in females were slightly higher across the three provinces. Regarding the cause of disability, people with AO-suspected and/or congenital disability were evidently more vulnerable in schooling as the corresponding percentages for this PWD group were significantly higher than those in the other-cause groups.

Table 32: Disability-related cause of drop-out or non-enrollement (%)

	Thai Binh	QN – DN	Dong Nai
Drop-out or never-enrolled because of disability			
Male	88.9	85.3	80.3
Female	89.5	91.0	86.3
AO-suspected group	91.0	90.4	87.5
Other-cause group	83.5	78.1	69.9
All PWD aged 6-30 years	89.2	87.8	83.0
Disability-related cause of drop-out/never enrolled			
Travel	34.1	38.8	39.1
Communication with teachers/mates	62.4	56.9	48.6
Learning	79.5	77.2	68.2
Participation in school activities/sport	31.8	29.2	13.1
Inappropriate school infrastructure	19.4	15.7	13.5
Teachers lack skills to teach PWD	9.5	12.3	2.7
Friends ridicule, tease, disregard	11.3	6.8	6.3
Teachers' discrimination	2.3	0.9	0.8
Family's discouragement	4.9	3.4	4.3
N	346	325	512

Table 32 also details the disability-related causes of drop-out or non-enrollment of PWD aged 6-30 years in the three sampled provinces. High on the list are disability-related difficulties in: traveling between home and school; communication with teachers and classmates; learning; participation in school activities, including sport; inappropriate school infrastructure; and discriminatory attitudes from friends. Indeed, teacher's capacity to teach PWD, teachers' discrimination, and family's discouragement were also obstacles for PWD in schooling, although much fewer students were affected. The most serious causes of drop-out or non-enrollment were poor learning of the students with disability (nearly 80% in Thai Binh and Quang Nam – Da Nang, and close to 70% in Dong Nai) and their poor communication with teachers and classmates (about 30% in Thai Binh and Quang Nam – Da Nang).

Realizing their substantial difficulties in schooling, not many PWD wanted to enroll or go back to school. Among those PWD aged 6 to 30 who did not enroll at the time of the survey, only about one quarter in Thai Binh and Dong Nai and one third in Quang Nam – Da Nang expressed this desire.

Coping measures

As can be seen in Table 33, about one fourth to close to one third of respondents aged between 6 and 30 were passive, essentially doing nothing to cope with the difficulties they had at school (26% in Thai Binh, 24% in Quang Nam – Da Nang, and 29% in Dong Nai). Compared to those in the other-cause group, the proportion of people with AO-suspected and/or congenital disability being passive were lower in Thai Binh and Quang Nam – Da Nang but higher in Dong Nai.

The rest of respondents however, tried various ways to overcome the situation. Thus, around a half of respondents in the studied provinces sought help from other people, mostly their relatives and friends (56% in Thai Binh, 50% in Quang Nam – Da Nang, and 42% in Dong Nai). Instrumental aids of various kinds were also used by some PWD to support their travel and learning at school (15% in Thai Binh and Dong Nai, and 20% in Quang Nam – Da Nang). One in every two PWD we met in Thai Binh and Quang Nam – Da Nang adapted themselves to the disability situation, learnt from other PWD on how to improve the situation, searched for useful information, or found schools that were most suitable for them. The proportion in Dong Nai was one in every

Table 33. Coping measures toward difficulties in education by Groups A and B (%)

	Thai Binh	QN - DN	Dong Nai
Group A			
Did nothing	23.7	23.1	30.4
Asked others' help	58.1	51.1	43.1
Sought instrumental aids	15.8	20.0	11.6
Tried to adapt	49.3	44.4	26.0
Group B			
Did nothing	32.4	29.0	26.0
Asked others' help	52.1	48.4	42.3
Sought instrumental aids	12.7	22.6	21.2
Tried to adapt	33.8	41.9	34.6
Both groups			
Did nothing	26.4	24.4	29.2
Asked others' help	56.3	50.2	41.9
Sought instrumental aids	14.8	20.3	14.8
Tried to adapt	45.3	43.7	29.8
N	318	291	298

Table 34. Supports most needed in schooling (%)

	Group A			Group B			Total		
	Thai Binh	QN- DN	Dong Nai	Thai Binh	QN- DN	Dong Nai	Thai Binh	QN- DN	Dong Nai
Help in traveling	24.1	14.2	26.0	22.5	35.5	32.7	23.3	19.2	28.9
Teachers' skills	24.5	33.8	30.4	19.7	24.2	22.1	23.3	31.6	26.8
Waiving/reducing fees	17.8	21.8	22.1	22.5	14.5	22.1	18.6	19.9	22.1
Appropriate school infrastructure	11.2	14.2	8.3	11.3	11.3	9.6	11.6	13.4	8.7
No stigma and discrimination at school	7.9	8.0	6.6	14.1	6.5	7.7	9.7	7.6	7.4
Others	0.8	1.8	1.1	0.0	3.2	0.0	0.6	2.1	0.7
N	241	225	181	71	62	104	318	291	298

three. Indeed, some PWD adopted several measures in their ‘coping strategy’ towards difficulties faced at school.

Most needed supports

Table 34 lists the most needed supports for PWD to overcome difficulties in schooling, according to the opinions of the respondents. About one in every four PWD in Thai Binh and Dong Nai, and almost one in every five PWD in Quang Nam –Da Nang would like to have some support with traveling between home and school.

The proportion of respondents wanting teachers to have special skills to teach students with disability in integrated classes were similar in Thai Binh and Dong Nai, but much larger in Quang Nam – Da Nang (32%). When classified by cause of disability, these proportions were higher in the group of people with AO-suspected and/or congenital disability, especially in Quang Nam – Da Nang (34%).

Close to one in every five respondents was concerned about the reduction or waiving of tuition and other school fees as a way to facilitate their education. As mentioned previously, most of the households with PWD faced serious economic hardship, and (comparatively) high education costs significantly discouraged parents to send their children to school. However, this proportion appears to be lower in Group A in Thai Binh and in the other-cause group in Quang Nam – Da Nang.

Between 9 and 13 percent of PWD thought that more PWD-friendly school infrastructures would be necessary for their learning. Similarly, close to 10 percent of the respondents believed that stigma and discrimination against students with disability should be eliminated, or at least be reduced to a minimum. Perhaps due to regional cultural characteristics, this percentage was remarkably higher in the other-cause group in Thai Binh (14%).

For the schools, there are also many difficulties:

“Teaching disabled students requires more time while teachers are under great pressure to complete the curriculum in a timely manner. Plus, there is no financial incentive for teachers teaching classes with disabled students. To provide quality teaching, we should have separate classes (10 students and 2 teachers) so that sufficient support could be provided to disabled students”

(Local government education official, Dong Nai).

7.3 Difficulties in accessing healthcare service

Health seeking behaviors of the PWD

Table 35. Health seeking behaviors of PWD (%)

	Group A			Group B			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Did nothing	0.5	0.4	0.1	1.4	0.5	0.8	1.0	0.5	0.5
Self-treatment	27.8	16.8	26.5	32.2	18.8	27.6	30.4	18.0	27.1
Invited medical personnel	11.1	1.6	2.2	15.7	3.6	2.7	13.8	2.8	2.5
Went to healthcare center	84.1	83.6	73.1	75.5	79.8	71.2	79.0	81.4	72.1
Worshipping	1.2	0.3	0.0	1.5	0.3	0.3	1.4	0.3	0.2
Other	0.3	0.5	0.6	0.9	1.1	0.9	0.6	0.9	0.7
N	729	730	810	1036	999	926	1765	1729	1736

Certainly PWD often need healthcare services more than people without disabilities. However, for various reasons, this does not mean PWD were able to receive appropriate healthcare every time they needed it. Table 35 depicts the patterns of health care seeking behavior of the respondents, in which a person can have several options rather than one. We can see that a high proportion of sick respondents sought services at health care centers and/or hospitals (nearly 80% in Thai Binh and Quang Nam – Da Nang, and more than 70% in Dong Nai). Some, particularly in Thai Binh (14%), sought services by inviting medical doctors or nurses to their home. Relatively high proportions of respondents across all the studied provinces did not go to health care establishments. Instead, they relied on self-treatment, such as buying/making medication and/or adopting some traditional or self-invented treatment methods. A very few practiced worshipping or did nothing for their sickness.

Compared with the other-cause groups, the group of people with AO-suspected and/or congenital disability were more likely to visit healthcare facilities but less likely to practice the other two major kinds of health seeking behaviors (invited medical personnel, and self-treatment). However, the differences were not substantial.

Types of difficulty

About half of the respondents said they faced difficulties in accessing healthcare facilities. This proportion varied from 42 percent in Quang Nam – Da Nang to 51 percent in Dong Nai and 59 percent in Thai Binh (Table 36).

Table 36. Difficulties in accessing healthcare services (%)

	Group A			Group B			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
No difficulty	45.8	58.6	51.4	37.9	57.2	47.1	41.0	57.7	49.2
No appropriate service	10.4	8.9	4.4	9.7	5.7	3.9	10.2	7.0	4.2
High fees, costs	26.1	16.3	31.0	27.6	16.1	30.6	27.1	16.2	30.4
Difficult for PWD to access	2.3	2.2	1.6	5.4	4.2	3.8	4.0	3.4	2.7
Bureaucracy	13.2	6.2	7.2	16.0	6.8	10.9	14.9	6.5	9.1
Stigma and discrimination	6.9	1.8	2.2	6.9	1.2	2.5	6.9	1.5	2.3
Long distance from home	6.6	5.9	5.6	10.1	7.2	8.1	8.5	6.7	6.7
No suitable transportation means for PWD	14.5	10.0	6.3	20.9	11.4	8.5	18.3	10.8	7.5
N	729	730	810	1036	999	926	1809	1759	1783

Among the difficulties they faced, the most common was the cost of medicines and services which they thought were too high comparative to their purchasing power (16% in Quang Nam – Da Nang, 27% in Thai Binh and 30% in Dong Nai). These proportions were quite similar between the two groups of disability cause, suggesting that high fees and costs could exist as an objective obstacle to PWD. The lack of appropriate services for their specific needs at healthcare establishments was mentioned by about 10 percent of respondents in Thai Binh, 7 percent of in Quang Nam – Da Nang, and 4 percent in Dong Nai. Bureaucracy, complicated, annoying and time-consuming procedures to get examinations and treatment were other constraints (15% in Thai Binh, 7% in Quang Nam – Da Nang, and 9% in Dong Nai). Long distances from home to healthcare establishments and the lack of suitable transportation for PWD were also important constraints, as the proportion of PWD reporting these difficulties were respectively 7 to 9 percent and 8 to 18 percent. Some PWD (about 4% in Thai Binh and Quang Nam – Da Nang and about 3% in Dong Nai) mentioned specific access difficulties for PWD themselves, such as location, stairs, doors, facilities, etc. Finally, stigma and discrimination at healthcare establishment was mentioned as a problem for about 2 percent of the PWD in Quang Nam – Da Nang and Dong Nai, but nearly 7 percent of PWD in Thai Binh.

Coping measures

Difficulties in accessing healthcare facilities in fact discouraged a considerable number of PWD. As shown in Table 37, from 4 to 9 percent of respondents stopped visiting healthcare centers because of these difficulties. Being a convenient but often inefficient alternative, self-treatment at home was undertaken instead by 42 percent of the respondents in Thai Binh, 27 percent in Quang Nam – Da Nang, and 33

Table 37. Coping measures toward difficulties in healthcare (%)

	Thai Binh	QN - DN	Dong Nai
Stop going to healthcare center	9.4	4.2	7.7
Self-treatment at home	41.9	27.4	32.5
Seek help from others	55.3	49.2	47.9
Obtain assistance means	16.6	16.3	14.3
Find suitable healthcare services	28.9	21.1	13.0
Try to adapt	16.9	15.5	13.6
N	1068	744	907

percent in Dong Nai. Around half the respondents sought help from other people they knew. Many PWD attempted to find other healthcare services, which were more appropriate and friendly towards them. In fact, this proportion of PWD varied across the three provinces, 29 percent in Thai Binh, 21 percent in Quang Nam – Da Nang and 13 percent in Dong Nai. Being less active, many other PWD tried to adapt or accept these difficulties (17% in Thai Binh, 16% in Quang Nam – Da Nang, and 14% in Dong Nai).

Most needed supports

Table 38 lists the opinions of respondents on supports that were most needed to address their difficulties in accessing health care service. Given their low economic status, clearly many PWD expected that the government would waive, or at least reduce, the present relatively high fees for services at healthcare centers and hospitals. Close to 36 percent of respondents in Thai Binh, nearly 40 percent in Quang Nam – Da Nang, and up to 60 percent in Dong Nai expressed this need. Also high was the proportion of respondents, particularly in Thai Binh and Quang Nam – Da Nang (about 30%), who wanted the government to introduce policies and programs designed to specifically support PWD in healthcare. Less bureaucracy in procedures of health checks and treatment was also mentioned (8% to 11%). Finally, a minority (less than 4%) of respondents considered reducing stigma and discrimination against PWD was important so that they could receive equity in service provision.

Table 38. Support most needed in healthcare

	Thai Binh	QN - DN	Dong Nai
Waiving/reducing fees	35.7	39.0	60.6
Policy/program for PWD	30.6	28.0	14.1
PWD-friendly infrastructure	14.1	17.9	11.9
Less bureaucracy	10.9	6.7	8.2
No stigma/discriminations	3.6	1.2	2.3
N	1067	743	907

The Ordinance on Disabled Persons stressed the importance of meeting the healthcare needs of PWD. Over the past decade, great efforts have been made by the government and society to support PWD with better and equitable health care services. One important support was the provision to the poor in general and PWD (who are generally poor) with health insurance cards, and cards for health checks and treatment. Indeed people themselves can purchase social insurance or sometimes body insurance schemes. In the survey, we wanted to know the extent to which PWD in the sample could get access to more affordable health care services through the possession of these insurance schemes.

In Thai Binh and Quang Nam – Da Nang, more than 50 percent of the respondents had health insurance cards and more than 20 percent had health check and treatment cards (Table 39). For Dong Nai, however, the proportions were notably lower, respectively 33 and 12 percent. As a result, about 36 percent of respondents in Thai Binh, 28 percent in Quang Nam – Da Nang, and even up to 60 percent of respondents in Dong Nai had none of these insurances. Obviously, those PWD have more difficulties in accessing healthcare service, since they must pay for every service they have when visiting healthcare facilities.

For those who had a valid insurance card, we can see that these schemes were useful, as most of them used insurance cards when visiting healthcare establishments (Table 40). In Thai Binh, 45 percent of respondents having insurance used it often, 35 percent used insurance

cards sometimes, only 15 percent rarely used those cards, and 5 percent never used them. The figures were similar in Quang Nam –Da Nang. In Dong Nai, however, the frequency of card use was remarkably lower. About 28 percent of respondents used cards often, 19 percent rarely used and 14 percent never used cards.

Clearly, the issuing of different insurance schemes has benefited PWD, as they found them useful and used them consistently for health checks and treatment. This finding thus confirms the importance of the current insurance schemes and recommends more efforts to be carried out in this direction to support PWD in accessing healthcare services.

Table 39. Possession of healthcare cards (%)

	Thai Binh	QN-DN	Dong Nai
Health insurance	50.1	63.3	33.1
Health check & treatment	20.2	26.8	12.4
Social/body insurance	5.7	3.4	3.6
None	36.4	28.2	59.7
N	1822	1806	1869

Table 40. Frequency of card use (%)

	Thai Binh	QN-DN	Dong Nai
Often	44.8	39.6	28.1
Sometimes	34.9	46.4	39.4
Rarely	15.1	9.0	18.9
Never	5.2	5.1	13.6
Total	100.0	100.0	100.0
N	1098	1259	708

7.4 Difficulties in employment

Types of difficulty

As discussed previously, the low rate of labor force participation of PWD suggests that they are currently facing many difficulties in accessing the labor market as well as difficulties in the workplace.

Table 41. Difficulties of the PWD employment (%)

	Thai Binh	QN-DN	Dong Nai
Had difficulty in present job due to disability			
Group A	87.8	81.3	56.6
Group B	88.6	83.3	61.9
All	88.3	83.2	60.4
N	460	546	379
Gave up or lost job because of disability			
Group A	86.7	77.8	79.5
Group B	85.1	74.0	79.9
All	85.7	74.4	80.3
N	554	453	401
Never worked because of disability			
Group A	90.6	83.5	86.7
Group B	92.5	82.4	76.8
All	91.6	83.0	82.0
N	629	522	713

Table 41 presents three indicators related to employment of PWD aged from 15, including the proportion having difficulties in their current job, the proportion losing jobs due to their disability, and the proportion being unable to find employment because of their disability.

As we can see in all the three provinces, there were high percentages of PWD currently working but had difficulties caused by their disability, although regional differences should also be noted. For example, while 88 and 83 percent of the respondents who were presently working in Thai Binh and Quang Nam – Da Nang had difficulties in their work because of disability, the proportion for Dong Nai was much less, 60 percent. Of the PWD who used to work in these provinces, the proportion of those giving up or losing their job because of disability was also quite high, 86 percent, 74 percent, and 80 percent respectively in Thai Binh, Quang Nam –Da Nang and Dong Nai. For those PWD who had never had a job, disability was the cause for more than 92 percent in Thai Binh and more than 80 percent in Quang Nam – Da Nang and Dong Nai.

Table 42 provides detailed information on why disability had caused PWD to give up/lose jobs. As shown, the most frequent reason was low effectiveness in work performance, which led to firing or giving up jobs for nearly 60 percent of respondents in Thai Binh and Quang Nam – Da Nang, and about 45 percent of their counterparts in Dong Nai. The proportions were much higher in the group of people with AO-suspected and/or congenital disability, especially in Thai Binh and Dong Nai, indicating that low effectiveness in work performance could be one of the most vulnerable aspects for this group of PWD.

Among those PWD who gave up/lost their jobs, 36 percent in Thai Binh, 46 percent in Quang Nam – Da Nang, and 43 percent in Dong Nai blamed difficulties in traveling to work to be the main reason. The proportion of PWD being unable to do their previous job was also quite high, respectively 43, 28 and 31 percent in these three provinces. For these two reasons, the figures in the other-cause group were higher than in the group of people with AO-suspected and/or congenital disability.

Table 42. Disability-related causes of giving up or lost jobs (%)

	Group A			Group B			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Low effectiveness in work	73.5	65.0	62.1	53.3	56.8	41.6	57.1	57.9	44.6
Difficulty in traveling	30.2	40.9	37.9	38.9	48.3	45.3	36.2	46.0	43.2
Unable to do previous job	23.3	12.4	15.8	47.0	30.2	33.1	42.6	27.6	31.2
Unsuitable job	14.8	13.1	9.5	14.2	10.5	16.8	14.4	11.0	14.9
Inferior complex	11.6	9.5	2.1	4.7	4.2	2.3	6.0	5.1	2.2
Stigma/discrimination	3.2	2.9	4.2	1.1	1.4	1.8	1.5	1.6	2.2
N	189	137	95	664	636	435	881	791	551

In addition, many PWD found their previous job unsuitable to their labor capacity. The proportion of respondents giving up their jobs for this reason were about 15 percent in Thai Binh and Dong Nai, and 11 percent in Quang Nam – Da Nang. Some PWD gave up their job

because of inferiority-complex feelings (6% in Thai Binh, 5% in Quang Nam – Da Nang, and 2% in Dong Nai). The proportions were significantly larger among the people with AO-suspected and/or congenital disability in Thai Binh and Quang Nam – Da Nang, but not clearly related with the figures on stigma/discrimination, which were only 2 percent in Dong Nai and lower in the other studied provinces. These figures, however, should be much higher if we consider some other causes, such as inability to find suitable jobs or go back to previous job, poor job performance, since there were certain degrees of stigma and discrimination by employers related to these causes. As explained by respondents themselves, forms of stigma and discrimination were fairly complex. The most common forms included:

- Disregard/disrespectful attitudes towards PWD at workplace from co-workers, colleagues, managers and employers;
- PWD were assigned to only certain work that was perceived as being “suitable” for them (often this work was low-paid and low status);
- PWD could not get job promotions on equal terms with others, even if they were doing the same work with the same quality;
- It was harder for PWD to get long-term contracts from employers, thus exposing them to the insecurity of being fired from work;
- PWD were less likely to receive vocational/on-the-job training to improve their production capacity;
- For those who sold food or other products or provided services, it was not easy to have customers due to common stigma attitudes from the community and society towards themselves and their products and services.

The case study presented in the box below illustrates not only the difficulties that workers with disabilities have in small enterprises, but also those of employers who have sympathy towards the employment needs of PWD.

Son’s company hired 72 workers, of them 4 were disabled. His decision to hire disabled persons came from his sympathy with employment needs of PWD. He also considers it with pride as he can contribute to society. However, the PWD at his company received much lower salary compared to other co-workers. The average salary here is 1,000,000-1,100,000 dong per month for key workers; for assistant workers, it is 700,000-800,000; for disabled workers, it is from 350,000 – 400,000 dong. The reason provided by the employers is that because the working capacity of the PWD is very low; a product takes them from two weeks to a month to complete. For a key worker, they finished in 2-3 days”. In fact, he does not want to hire more disabled workers, since they should have undergone vocational training and in order to do so his company must pay. Training for PWD is also difficult, due to their often lower educational level, so it takes a longer time compared to training “normal” apprentices. He knows only the name of the Ordinance over the radio. No one from local authorities ever talk about the Ordinance to him. Department of Labor from province, Labor Office at community, local authorities praised him at every annual meeting, giving him certificate of merit, but no further support was ever provided. In fact, he knows nothing about policies regarding support for businesses recruiting PWD. (Employer, Wood and Carpentry Company in Quang Nam).

The survey also collected information on the disability-related causes of unemployment (i.e. never worked). As shown in Table 43, poor health conditions explained unemployment for most PWD, from 80 to 87 percent. Of other reasons, difficulty in travel from home to work due to disability caused unemployment of one in every five PWD in Thai Binh and Quang Nam – Da Nang and one in every four in Dong Nai. From 18 to 25 percent of those PWD who had never been employed because they could not find a job that was suitable with their health conditions. 26 percent of Quang Nam – Da Nang, unemployed PWD in Thai Binh, 23 percent of them in Quang Nam –Da Nang, and 15.4 percent in Dong Nai could not have employment because of employers’ refusal.

Family discouragement was also a reason, although one that was not common. In any event, however, nearly 7 percent of the respondents in Thai Binh, 5 percent in both Quang Nam –Da Nang and Dong Nai were discouraged from seeking employment by other family members who thought there was no use, or no way, for the PWD to work. Finally, self-stigma (inferiority complex) made the PWD believe that they should not or could not work. The last three causes give us a rough idea of the prevalence of stigma and discrimination, including self-stigmatization, against the employment of PWD in the samples. Indeed, stigma and discrimination in employment of PWD appeared to be more prevalent in Thai Binh and Quang Nam – Da Nang than in Dong Nai.

Table 43. Disability-related causes of unemployment (%)

	Thai Binh	QN-DN	Dong Nai
Difficulty in traveling	20.0	22.4	24.4
Poor health	86.6	82.7	79.3
Can’t find suitable job	18.6	24.7	17.9
Employer’s refusal	26.2	22.6	15.4
Family’s discouragement	6.6	4.8	5.0
Self-stigma	5.2	4.2	3.4
N	576	433	585

Coping measures

To overcome difficulties in finding and keeping employment, the majority of PWD either sought help from others (friends, relatives) or actively tried to prove their labor market worth. Among those PWD facing employment difficulties, the former solution was adopted by 65 percent in Thai Binh, 54 percent in Quang Nam – Da Nang, and 38 percent in Dong Nai. For the later solution, the figures were similar in all three provinces, around 27-28 percent (Table 44).

The proportion of PWD seeking assistance as a means to overcome their employment difficulties were also considerable, 17 percent in Thai Binh, and around 20 percent in Quang Nam – Da Nang and Dong Nai. However, as available assistance means have never been very effective for the people with AO-suspected and/or congenital disability, the proportions relying on this solution in this group were much lower than in the other-cause PWD group.

Table 44. Coping measures toward difficulties in employment (%)

	AO-suspected			Other causes			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Seek helps from others	66.4	53.2	39.1	64.0	55.7	38.5	64.8	54.1	38.4
Seek assistance means	10.2	18.3	15.6	20.8	20.8	24.2	17.2	19.8	21.4
Share experience within similar PWD	11.7	5.5	4.7	11.7	6.0	2.5	11.8	5.7	3.1
Try to prove one's worth	21.9	33.9	25.0	30.7	26.2	27.3	28.1	27.9	27.1
Move to suitable job	9.5	4.6	9.4	9.1	7.4	13.0	9.1	6.6	12.2
Did nothing	16.8	22.0	28.1	12.9	17.0	19.9	14.0	19.3	21.8
N	137	109	64	264	336	161	406	455	229

Another coping measure was to find a more suitable job for their situation, but this solution seemed to be not easy as only a small proportion of PWD facing employment difficulties were able to apply (less than 10% in Thai Binh, 7% in Quang Nam – Da Nang, and 12% in Dong Nai). A relatively high proportion of respondents simply gave up by doing nothing to deal with their employment difficulties. It varied from 14 percent in Thai Binh to 19 percent in Quang Nam – Da Nang and 22 percent in Dong Nai. In every studied province, this proportion was higher in the group of people with AO-suspected and/or congenital disability than in the other-cause group.

Most needed supports

There was a high expectation from PWD on government supports for their employment (Table 45). Around 30 percent of respondents in all the studied provinces believed that policies and/or programs aimed specifically at supporting PWD on employment and work matters would be most important. However, this figure for people with AO-suspected and/or congenital disability in Dong Nai was less than 20 percent.

Many PWD also realized the need to have their work capacity improved, given their present relatively low levels of education and vocation. Thus, one in every four PWD in Thai Binh and Quang Nam – Da Nang expressed a need to receive vocational training to learn/upgrade their work skills. In Dong Nai, the ratio was one in every three respondents. Interestingly in all three provinces, the proportions of PWD that regarded vocational training as the most-needed support in their employment were considerable higher in the group of people with AO-suspected and/or congenital disability than in the other-cause group.

Table 45. Supports most needed in employment (%)

	Group A			Group B			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Vocational training	32.4	37.4	45.8	20.8	18.5	27.1	24.5	23.6	32.0
Job introduction	24.5	21.6	20.4	21.0	17.6	18.5	22.3	18.8	18.6
Related policy/program	31.9	25.8	19.7	30.9	31.5	30.4	31.0	30.3	27.0
No stigma/discrimination	2.8	7.9	6.3	4.1	6.0	6.6	3.7	6.6	7.3
N	216	190	142	414	466	362	645	670	522

Job introduction to PWD was considered very important by about one fifth of respondents, with minor variations across the studied provinces but slightly higher percentages in the group of the people with AO-suspected and/or congenital disability. Finally, a few stressed the importance of eliminating or reducing disability-related stigma and discrimination in the workplace as an important need for PWD themselves.

7.5 Difficulties in marriage and having children

Type of difficulty

As mentioned earlier, being a PWD means having difficulties in getting married. As shown in Table 46, the majority of 15-or-older PWD said they were unmarried (i.e. single, separated or divorced) because of their disability (82% in Thai Binh, 69% in Quang Nam –Da Nang, and 65% in Dong Nai).

Table 46. PWD being unmarried because of disability (%)

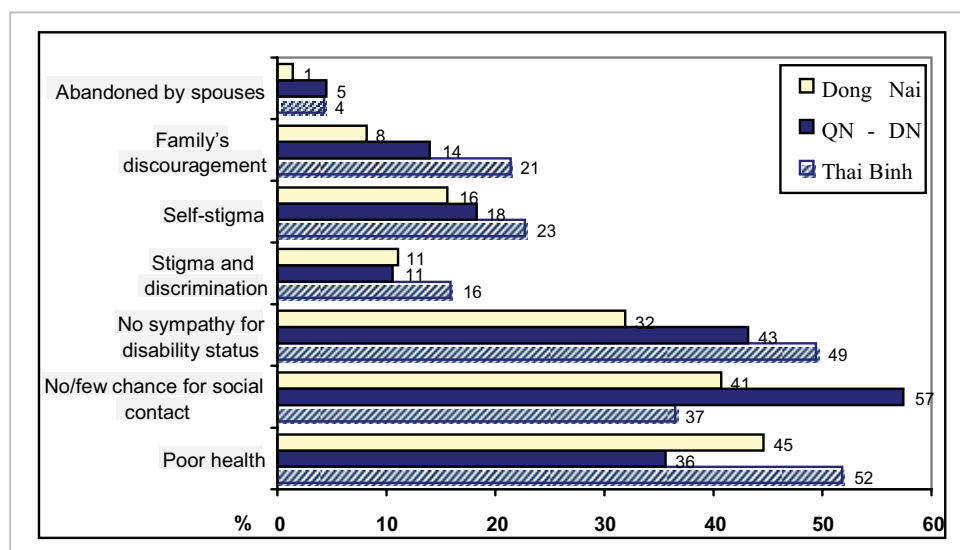
	Thai Binh	QN - DN	Dong Nai
Sex			
Male	75.6	65.0	61.4
Female	85.4	71.7	69.2
Age			
15-29	67.6	52.1	55.1
30-49	94.6	87.1	76.6
50+	86.5	66.4	76.7
All	81.6	68.5	65.1
N	778	710	896

When classified by gender of PWD, the data shows that disability caused more difficulties for females than males in getting married. In Thai Binh, for example, 76 percent of males and 85 percent of females aged 15 or older and unmarried blamed their disability for their marital status. A similar situation was found in other provinces: 65 versus 72 percent in Quang Nam – Da Nang, and 61 versus 69 percent in Dong Nai.

Certainly marriage status depends strongly on the age of the PWD. The results show that the percentages of PWD being unmarried due to their disability were much higher among the ages 30 or older. For instance, the figures for the age group 30-49 in Thai Binh, Quang Nam – Da Nang and Dong Nai were respectively 95, 87 and 77 percent. However, it does mean young PWD can still find a spouse, but many of them were too young to consider getting married.

Chart 25 describes specific disability-related difficulties causing PWD to be unmarried, according to their own opinion. For these PWD, poor health caused by disability was one of the key difficulties that they faced in getting and sustaining marriage. This was the problem of one in every two PWD having difficulties relating to marriage in Thai Binh and Dong Nai. In Quang Nam – Da Nang, one in every three PWD shared this difficulty.

Chart 25. Disability-related causes of being unmarried



Stigma and discrimination was clearly a barrier to the marriage prospects of PWD. Although only 11 to 16 percent of respondents directly mentioned this problem, we might expect that the scope of this situation was much wider. In fact, among those PWD who were unmarried due to disability, around 40 percent in Thai Binh and Dong Nai, and 57 percent in Quang Nam – Da Nang reported that no or limited chances for social contact was the main reason. Other stigma-related difficulties, namely no sympathy for disability status (32 to about 50 percent), family’s discouragement (8.2 to 21.4 percent), and spouse’s abandonment (1.4 to about 5 percent), were also listed. In combination, the figures clearly indicate that stigma and discrimination from family and community have been an important reason causing difficulties in marriage of PWD. It is a fact that many people, including PWD themselves, perceive marriage with PWD is impossible or at best an unlucky or ironical commitment. In general, these difficulties were most frequent in Thai Binh, except for the responses

‘abandoned by spouse’ and ‘no or few change for social contact’.

Table 47. Percentage of unmarried PWD intent to get married (%)

	Thai Binh	QN - DN	Dong Nai
Sex			
Male	27.0	14.8	14.5
Female	6.8	8.7	4.8
Age			
15-29	26.2	16.6	12.5
30-49	9.5	10.4	8.7
50+	1.7	4.1	1.5
All	14.0	11.5	9.6
N	635	486	583

Realizing their difficulties, the proportion of unmarried PWD intending to get married was quite small, 14 percent in Thai Binh and around 10 percent in Quang Nam – Da Nang and Dong Nai (Table 47). This figure was significantly lower in females and the large difference between the two sexes was in Thai

Binh (27% for males versus 7% for females).

Perhaps along with their marital opportunities, the intention to get married declined very quickly from younger to older groups of unmarried PWD. At the age 50 or older, only about four percent of unmarried PWD in Quang Nam – Da Nang and less than two percent of unmarried PWD in Thai Binh and Dong Nai still expressed this desire.

Table 48. Disability-related difficulties in marriage of current-married PWD (%)

	Thai Binh	QN - DN	Dong Nai
No disability-related difficulties	45.0	72.3	85.1
Hard to have children	5.0	2.0	2.7
Borne congenital-defect children	10.4	2.1	1.0
Hard to take care children	30.3	13.7	5.5
Hard to ensure family's life	38.3	18.1	7.6
No sympathy/encouragement from spouse	5.1	0.2	1.0
Unsatisfied sexual life	7.7	1.2	0.8
N	865	811	596

Table 48 reveals that for currently-married PWD, disability also generated substantial difficulties in maintaining their happiness (15% in Dong Nai, 28% in Quang Nam – Da Nang, and 55% in Thai Binh). The majority of them had problems in taking care of children and/or ensuring the living conditions of their family. Particularly among currently-married PWD in Thai Binh, 38 percent realized that it was difficult to ensure the living conditions for their family, 30 percent felt it was hard to take care of their children, 10 percent had borne congenital-defect child/children, eight percent were unsatisfied with their sexual life, and the five percent for both lack of sympathy and encouragement from spouse, and difficulties in having children. In Quang Nam – Da Nang and Dong Nai, the corresponding figures were considerable lower but in a similar order.

As difficulties in bearing children is a sensitive issue to reveal in interview, the proportion of married PWD reporting difficulties in bearing children was not very high (19% in Thai Binh, 10% in Quang Nam – Da Nang and Dong Nai). More particularly, the main difficulties in childbearing were difficult delivery, infertility, and miscarriage/stillbirth (Table 49).

However, figures in Table 50 may reflect more closely the situation. Among PWD who had a child, the proportions having congenital defect child/children were 21, 9 and 13 percent respectively in Thai Binh, Quang Nam – Da Nang and Dong Nai. It can be predicted that the figures were larger in males and in the group of people with AO-suspected and/or congenital disability. The proportions having children that had died were relatively high, about ten percent in all three studied provinces.

Table 49. Difficulties in bearing children (%)

	Thai Binh	QN - DN	Dong Nai
Stigma/discrimination	1.4	0.1	.5
Infertile	6.3	1.3	1.8
Difficult delivery	6.2	6.8	7.1
Miscarriage, stillbirth	3.9	1.2	0.5
Hard to access services	2.4	0.6	0.8
No difficulties	81.5	90.0	89.8
N	845	821	609

Table 50. Congenital-defect children and deceased children (%)

	Having congenital-defect children			Having deceased children		
	Thai Binh	QN - DN	Dong Nai	Thai Binh	QN - DN	Dong Nai
Sex						
Male	22.2	9.3	14.6	12.4	10.0	10.7
Female	16.7	9.5	10.4	8.8	11.5	7.0
Cause of disability						
Group A	31.2	14.3	19.2	13.2	5.6	4.8
Group B	15.6	8.2	11.9	10.8	11.5	10.5
All	20.9	9.4	13.2	11.6	10.4	9.5
N	871	865	592	871	865	592

Coping measures

From one fifth to nearly one third of PWD did nothing to change the situation regarding marriage (Chart 26). However, as their need for marriage and children are culturally important, about a half to nearly 70 percent of PWD sought marriage (successfully or unsuccessfully) through the assistance of others, such as family and friends. Other coping measures were “finding suitable assistance means” and “share experience with other PWD” that were applied by around 10 percent of PWD who faced this kind of difficulty. Few PWD, however, sought solutions in marriage with other PWD.

Most needed support

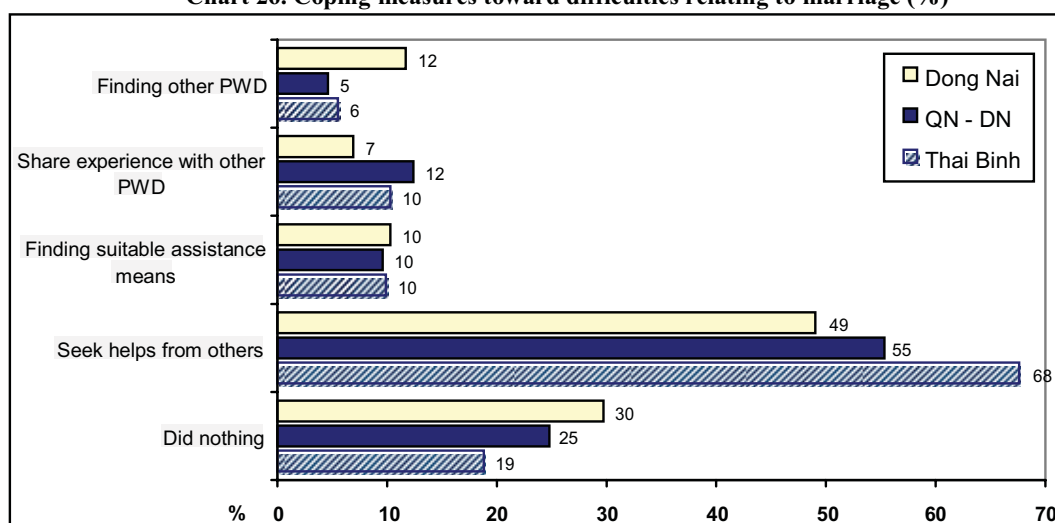
Regarding marriage, from one tenth to one fifth of the respondents in the studied provinces wanted counseling services for PWD (Table 51). From a half to over 60 percent of respondents hoped for sympathy and encouragement from family and community. About 7 to 12 percent expect that they can participate in meeting clubs. Nevertheless, many PWD (about 17%) did not know what help might be made available for them to overcome their difficulties in marriage.

Regarding childbearing, many PWD thought that the most-needed support should be with medical treatment (30% to 44%) and counseling for PWD (20% in Thai Binh and more than 30% in Quang Nam – Da Nang and Dong Nai). Supportive policies and sympathy from family and community were also considered to be the most-needed supports in childbearing, but by a lower percentage of PWD (13% to 16%).

Table 51. Most needed supports toward difficulties in marriage (%)

	Thai Binh	QN - DN	Dong Nai
In marriage			
Marriage counseling for PWD	11.9	19.6	20.0
Sympathy from family/community	62.5	49.5	55.9
Meeting club for PWD	7.4	12.1	6.9
Do not know	16.8	17.8	16.6
N	565	281	145
In childbearing			
Childbearing counseling for PWD	19.5	31.9	31.3
Medical treatment	44.2	30.2	35.7
Supporting policies	16.2	12.9	12.5
Sympathy from family/community	16.2	13.8	14.3
N	154	116	112

Chart 26. Coping measures toward difficulties relating to marriage (%)



7.6 Difficulties in social participation and access to information

Difficulty in participating in social organizations

Only PWD aged 15 years or older are included in the analysis presented in this section. In general, the participation of PWD in local formal organizations was poor in the studied provinces and the situation increased from the North to the South of the country. Indeed, the proportion of PWD who did not participate in any of six formal organizations were remarkably high, from 63 percent in Thai Binh to 70 percent in Quang Nam – Da Nang and

87 percent in Dong Nai (Table 52). These percentages were even higher in the group of people with AO-suspected and/or congenital disability.

Of the six formal organizations, PWD were most likely to be members of the Peasant Association, then members of Veteran Association (mostly men) and Women's Union (women only). Very few PWD were members of the other four formal organizations (5% or less).

Table 52. Membership of six local formal organizations (%)

	Thai Binh	QN - DN	Dong Nai
Member of:			
Local authority	0.6	3.0	1.3
Fatherland Front	2.4	2.0	1.2
Women's Union	8.6	7.3	3.4
Veteran Association	12.1	7.2	2.5
Peasant Association	18.3	11.8	3.2
Youth Union	5.1	4.3	2.7
Not belong to any:			
Group A	77.4	81.7	94.4
Group B	55.9	64.1	81.9
All	63.1	70.2	86.5
N	1643	1521	1492

Disability was considered by PWD themselves as the major cause of poor participation, especially among females. The results reveal that females were more likely than males to be impeded by their disability in participating in these formal local organizations. Among male PWD who were not in any local organizations at the time of the survey, the proportion of non-participants because of disability was 86 percent in Thai Binh, 72 percent in Quang Nam – Da Nang and 57 percent in Dong Nai.

The corresponding figures for females were unanimously higher in the three provinces, respectively 92, 82 and 63 percent (Table 53). A comparison between the two cause of disability groups found similar differences, which evidently indicates that the people with AO-suspected and/or congenital disability were more vulnerable than the other-cause group in participating in these organizations.

The next table illustrates the main disability-related causes of non-participation. It can be seen that

difficulties in communication were the most frequent obstacle for PWD in participating in local formal organizations. Among those PWD who were not

Table 53. Proportions of non-participation caused by disability (%)

	Thai Binh	QN - DN	Dong Nai
Sex			
Male	85.6	72.2	56.8
Female	91.8	82.2	62.9
Cause of disability			
Group A	91.4	82.3	67.9
Group B	86.0	72.4	54.0
All	88.3	76.1	59.3
N	1631	1500	1453

members of any local formal organization, 69 percent in Thai Binh, 51 percent in Quang Nam – Da Nang and 59 percent in

Dong Nai reported that communication difficulty was one of the main reasons impeding them from participating.

Table 54. Disability-related causes of not participating in local formal organizations (%)

	Group A			Group B			Total		
	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai	Thai Binh	QN-DN	Dong Nai
Not to be invited	39.9	37.0	25.2	39.9	32.8	27.5	41.6	38.4	29.2
Travel difficulty	33.9	36.1	36.2	46.8	54.1	56.6	37.4	43.0	45.2
Communication difficulty	74.5	65.7	72.8	57.6	35.5	40.0	68.8	50.9	54.9
Inferiority complex	24.3	20.7	13.6	21.2	10.5	16.1	20.1	14.2	14.1
N	416	338	345	571	512	422	1020	869	786

However, this was not confined to those having hearing and speaking disability alone but to other PWD as well, because of their relative social isolation caused by stigma and discrimination. Hence, the data also reveals that around 40 percent of PWD in Thai Binh and Quang Nam – Da Nang were not invited to be members of the local formal organizations. The figure for Dong Nai was less, about 30 percent. Related to this general context of stigma and discrimination was a high percentage of the respondents who did not participate because of their inferiority complex, i.e. feelings regarding their incapacity in any form of social participation. Finally, as with other areas already discussed, travel difficulty remained a strong barrier for PWD preventing them from participating, as reported by 37, 43, and 45 percent of the respondents in Thai Binh, Quang Nam – Da Nang and Dong Nai respectively.

Table 55. Participation in local informal organizations (%)

	Membership of a local informal organization			Non-participation in informal organizations because of disability		
	Thai Binh	QN - DN	Dong Nai	Thai Binh	QN - DN	Dong Nai
Sex						
Male	34.2	19.2	9.9	83.5	65.4	58.0
Female	14.5	14.4	7.5	86.9	77.0	59.7
Cause of disability						
Group A	15.9	11.5	5.2	86.5	77.7	68.5
Group B	32.7	20.5	11.3	83.7	65.3	53.1
All	26.3	17.4	8.9	85.1	69.9	58.7
N	1643	1521	1492	1199	1243	1339

Concerning causes of disability, the figures reveal that communication difficulties were more likely to obstruct people with AO-suspected and/or congenital disability than the other-cause group in participating in local formal organizations. On the other hand, travel difficulties resulted in non-participation for the other-cause group more often than for the group of people with AO-suspected and/or congenital disability. In general though, the figures correspond with the distribution of disabled functions (motor and hearing/speaking) in these two groups.

As indicated in Table 55, only a small proportion of PWD were members of at least one of the existing informal organizations (self-organized) in the community, and this extended to include associations of PWD, groups of elders, schoolfellows, ex-soldiers, saving-credit circles, hobbies etc. While the proportion in Thai Binh was about one quarter, it was less than one fifth in Quang Nam – Da Nang and less than one tenth in Dong Nai. The figures were much lower for females as well as people with AO-suspected and/or congenital disability in all the studied provinces. Like the situation with participation in formal organizations, disability explained much of the non-participation of PWD in local informal organizations, particularly for females and the group of people with AO-suspected and/or congenital disability.

Similar disability-related causes of non-participation in local informal organizations are listed in Table 56. Clearly many PWD were not invited to participate as organization members because the organization itself saw no need to have “incapable” members. Travel difficulty, communication difficulties and the self-imposed inferiority complex of PWD themselves, all were direct and indirect consequences of a generalized process of social isolation, and this explained most of their non-participation.

Table 56. Disability-related cause of not participating in local informal organizations (%)

	Thai Binh	QN - DN	Dong Nai
Not to be invited	39.7	34.2	26.1
Travel difficulty	40.4	46.4	47.1
Communication difficulty	65.3	47.8	55.2
Inferior complex	22.1	14.6	15.0
N	1020	869	786

For those PWD who were non-members, only 17 percent in Thai Binh, 33 percent in Quang Nam – Da Nang, and 19 percent in Dong Nai wanted to participate in formal or informal organizations. For those PWD who were members of a formal or informal organization at the time of the survey, the proportion reporting that they faced difficulties in participating were notably large: 58 percent in Thai Binh, 45 percent in Quang Nam – Da Nang and 24 percent in Dong Nai.

Table 57 shows that, for those few PWD who were participating in local informal organizations, poor health caused by disability posed considerable difficulties to over 70 percent of them. Three other types of difficulties that are more or less related to their level of social inclusion include communication difficulties, stigma and discrimination from other organization members, and their own self-stigmatization (inferiority complex).

Table 57. Disability-related difficulties in participating in organizations (%)

	Thai Binh	QN - DN	Dong Nai
Poor health	73.3	77.4	75.7
Communication difficulties	22.1	27.4	16.2
Stigma and discrimination	3.5	0.8	0.0
Inferior complex	19.0	9.7	8.1
Family’s discouragement	3.5	0.8	0.0
Community’s discouragement	0.8	3.2	2.7
N	258	124	37

Being PWD, many members also had difficulties in participating in the various activities of their organizations. The proportions were 58 percent in Thai Binh, 45 percent in Quang Nam – Da Nang, and 24 percent in Dong Nai. Disability was indeed a chief reason for difficulties, as identified in 73 percent of cases in Thai Binh, 77 percent in Quang Nam – Da Nang, and 76 percent in Dong Nai. Communication difficulty is mentioned as the second most

important reason, with 22.1 percent in Thai Binh, 27.4 percent in Quang Nam – Da Nang, and 16.2 percent in Dong Nai. However, perhaps of equal importance are the various forms of stigma and discrimination from organizations, family, community, as well as the self-stigmatization of PWD themselves.

7.7 Difficulty in participation in cultural and sporting activities

Table 58. Non-participation in cultural or sporting activities because of disability (%)

	Thai Binh	QN - DN	Dong Nai
Sex			
Male	82.7	75.7	68.8
Female	92.3	85.6	72.5
Cause of disability			
Group A	87.6	85.3	76.8
Group B	85.8	75.7	64.7
All	86.6	79.7	70.3
N	1458	1149	1304

Table 59. Proportion of PWD not participating any cultural or sporting activity in the last 12 months (%)

Age group	Thai Binh	QN – DN	Dong Nai
6-29	76.1	61.4	69.3
30-49	86.7	71.6	74.4
50+	81.3	65.6	76.9
All	81.6	66.1	72.7
N	1786	1737	1793

Table 60. Disability-related causes of not participating in cultural and sporting activities (%)

	Group A			Group B			Total		
	Thai Binh	QN- DN	Dong Nai	Thai Binh	QN- DN	Dong Nai	Thai Binh	QN- DN	Dong Nai
Not to be invited	34.8	23.0	16.7	26.0	19.8	20.4	29.5	21.1	18.1
Travel difficulty	41.9	36.6	46.3	57.0	61.2	65.1	50.0	50.2	55.1
Communication difficulty	68.6	69.4	70.7	48.5	35.0	42.3	57.3	49.7	56.8
Inferiority complex	24.1	19.9	14.0	17.4	10.7	15.4	19.7	14.4	14.5
Stigma/discrimination	10.5	3.7	5.9	4.4	1.6	1.8	7.0	2.6	3.8
Other	7.6	6.8	3.8	7.0	11.1	2.9	7.0	9.1	3.4
N	503	382	443	726	515	447	1263	916	917

As indicated in Tables 58 and 59, at least two thirds of PWD did not participate in any cultural or sporting activity (playing or watching sports, entertainment, going to theatres, cinemas, or churches, or going on a tour, etc.) in the 12 months leading up to the survey. In particular, the proportions were 82 percent in Thai Binh, 66 percent in Quang Nam – Da Nang and 73 percent in Dong Nai. Among them, 87 percent Thai Binh, 80 percent in Quang Nam – Da Nang and 70 percent in Dong Nai explained that they did not participate because of their disability. As with most other activities, the proportions were higher among females and for the people with AO-suspected and/or congenital disability.

Travel difficulty and communication difficulty were the most frequent disability-related causes and was offered as an explanation by around half of PWD (Table 60). The next most frequently offered reason was not to be invited and feelings relating to an inferiority complex. Stigma and discrimination was also offered by 7 percent of the cases in Thai Binh and less than 4 percent in the other two provinces. In comparison with the other-cause group, the

group of people with AO-suspected and/or congenital disability reported a higher proportion of communication difficulty but a lower proportion claimed travel difficulty.

Concern expressed by PWD appears reasonable as the few PWD who did join in cultural and sporting activities actually faced difficulties in their participation (56% in Thai Binh, 53% in QN-DN and 34% in Dong Nai). In this case, the main reasons given were poor health condition, communication difficulty and self-stigma.

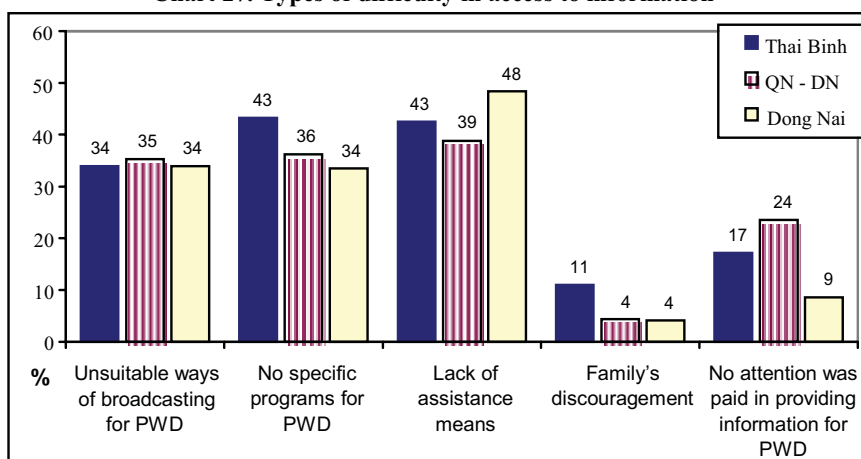
Table 61. Proportions of PDW had difficulties in accessing information (%)

	Thai Binh	QN – DN	Dong Nai
Sex			
Male	57.3	40.3	42.2
Female	70.9	52.9	49.6
Cause of disability			
Group A	68.9	57.7	61.5
Group B	58.9	37.9	36.0
All	62.8	45.0	45.2
N	1643	1521	1492

Difficulty in accessing information

Certainly information is very important for PWD in overcoming their hard situation. However, access to various sources of information is also a common difficulty for nearly half of PWD in Quang Nam – Da Nang and Dong Nai and more than 60 percent of PWD in Thai Binh (Table 61). Similar to the situations with many other difficulties discussed earlier, the proportions of PWD facing problems in accessing information were significantly higher among females and for the people with AO-suspected and/or congenital disability. The findings provide more evidence emphasizing the scale of disadvantage of these groups.

Chart 27. Types of difficulty in access to information



The distribution of main difficulty for PWD in accessing information is presented in Chart 27. In general, the most frequently cited difficulty was a lack of assistance with the means to participate (such as equipment, or special books for the blind) and no specific communication programs for PWDI (24% to 43%), followed by unsuitable forms of broadcasting for PWD (34% to 35%) and no attention paid to providing information for PWD (9% to 24%). Family discouragement was also reported, but only by less than 11 percent of PWD who faced difficulties accessing information.

Coping measures

The results in Table 62 show that less than 22 percent of PWD did nothing to deal with their difficulties in participating in social organizations, while the corresponding percentages regarding difficulties accessing information were remarkably high, about half of those who faced this problem. On the other hand, many other PWD were not so passive. Among those PWD who faced difficulties in participating in social organizations, nearly two thirds in Thai Binh, and about a half in both Quang Nam – Da Nang and Dong Nai sought help from relatives/friends, while the corresponding figures regarding difficulties accessing

information were much lower (35% in Thai Binh, 36% in Quang Nam – Da Nang, 39% in Dong Nai). Perhaps the reason was that many PWD did not realize the importance of information, or suspected that their relatives/friends' were capable of obtaining better access to information than them.

The next notable coping measures were more activity in overcoming difficulties in

Table 62. Coping measures toward difficulties in social participation and accessing information (%)

	Thai Binh	QN-DN	Dong Nai
In participating in organizations			
Did nothing	19.4	11.3	21.6
Sought help from others	64.7	54.8	45.9
Sought assistance means	22.5	25.0	10.8
More active in participating	27.1	31.5	29.7
Struggling to participate	3.9	11.3	10.8
N	258	124	37
In accessing information			
Did nothing	54.3	49.2	49.3
Sought help from others	34.7	35.5	39.0
Sought assistance means	12.4	12.3	13.2
Diversified information sources	3.9	3.4	3.6
Shared experience with other PWD	6.2	5.7	2.7
Tried to adapt	15.6	16.8	11.1
N	1031	685	675

Table 63. Most-needed support for participating in social organizations and accessing information (%)

	Thai Binh	QN-DN	Dong Nai
In participating in organizations			
Wider accessibility for PWD	43.8	46.0	32.4
Policies protecting PWD's rights	19.4	29.0	40.5
Sympathy of organization members	26.7	17.7	24.3
N	258	124	37
In participating in cultural/sport			
Wider accessibility for PWD	24.3	28.3	26.5
Assistance means	19.8	19.8	22.0
Sympathy for PWD	22.7	16.6	20.2
Policies protecting PWD's rights	19.5	23.4	22.4
N	1786	1736	1793
In accessing information			
Suitable information for PWD	32.7	39.7	35.7
Assistance means/equipment	29.4	27.0	36.1
More information for PWD	8.0	10.7	11.1
N	1031	685	675

participating in social organizations, trying to adapt to difficulties in accessing information, and finding assistance with the means for both kinds of difficulty. The percentages of PWD applying these measures varied from 10 to 32 percent, depending on province and types of difficulty.

Most needed support

Regarding measures which were most needed by PWD to improve their participation in local formal and informal organizations, from 32 to 46 percent of the respondents wanted wider accessibility to these organizations for their full participation, for example through easing the conditions of participation (Table 63).

About 19 percent in Thai Binh, 29 percent in Quang Nam – Da Nang and 41 percent in Dong Nai suggested policies designed specifically to protect the “rights” of PWD. From 18 to 27 percent of respondents facing this difficulty thought that sympathy and understanding from organization members towards their needs and desire to participate was the most important single factor.

Regarding difficulties accessing information, from about one quarter to more than one third of PWD having this difficulty believed that the provision of suitable information as well as assistance means/equipment for PWD would be helpful for them in diminishing this disadvantage. In general, the results suggest that disability has definitely been the primary reason for the low participation of PWD in social organizations, cultural and sporting activities and in accessing information, but a corresponding increase in awareness, more understanding behaviors and support from both the local community and society in general could be significant factors having a positive effect on this currently disappointing situation.

7.8 Multivariate analysis

A multivariate analysis of the various difficulties of PWD is presented in Table 64 and Table 65 (from Model 10A to Model 17). Among them, only Model 10B is an OLS regression, while all the others are logistic regressions. Note that all below assessments of effects of any variable are made with the condition that the models are controlled by other independent variables.

Model 10A exposes that the probability of facing *difficulty in performance of daily activities* for PWD in Quang Nam-Da Nang would be lower than in Thai Binh, but higher than in Dong Nai. The impact of the indicator “at least two PWD in household” is negative and it may be related to strong adaptation efforts by households having more than one person with a disability. The coefficient is positive for “farm household”, but negative for “income”, “male”, and “age group 50-59”.

The dependent variable of Model 10B is level of *difficulty in performance of daily activities*, generated by summing scores of difficulties (ranging from 1 for “no difficulty” to 6 for “cannot do at all”) in six major activities. The model indicates that the impact of *household size* turns to significantly positive; the effects of age and education are clearer than in the Model 10A; and PWD living in Buddhist households had lower levels of difficulties in

performance of daily activities than those in other households. In addition, the results provide solid evidence showing that PWD of Group A had to face much heavier difficulty in their daily activities than PWD of Group B (once they have the same characteristics defined by other independent variables). There is also a similar situation for female PWD in comparison with male PWD.

Model 11 estimates the possibility of having disability-related difficulty in education for PWD aged 6-30 years. In general, this difficulty was more likely to occur to PWD in Thai Binh, female PWD, those Group A, younger than 20, and in households with low education. The dependent variable of Model 12 is the probability of facing difficulty for PWD in accessing healthcare services. Similarly, PWD in Thai Binh and Dong Nai, living in households with low education (less than primary) and PWD in Group A had more probability of having this difficulty.

Table 64. Regression models of difficulties for PWD

Independent variables	Model 10A	Model 10B	Model 11	Model 12
<i>Province</i>				
QN-DN (ref.)	0.000	0.000	0.000	0.000
Thai Binh	0.737 ***	2.620 ***	0.487 *	0.634 ***
Dong Nai	-0.966 ***	-0.082	-0.397	0.276 **
<i>Urban (ref.=rural)</i>	-0.026	0.503	0.101	-0.010
<i>Household size</i>	0.004	0.155 **	0.064	0.024
<i>At least two PWD in hh</i>	-0.478 ***	-1.545 ***	-0.281	-0.158 *
<i>Farm household</i>	0.292 **	0.180	0.265	-0.102
<i>Highest education in hh</i>				
< primary	0.000	0.000	0.000	0.000
< low secondary	-0.097	-0.503	-0.776 *	-0.367 ***
< high secondary	0.052	-0.860 *	-0.367	-0.532 ***
Secondary	-0.276	-1.189 **	-0.673 *	-0.549 ***
Higher	-0.195	-0.725	-0.374	-0.701 ***
<i>Log of income per capita</i>	-0.119 *	-0.182	-0.006	-0.051
<i>Male (Ref.=female)</i>	-0.182 *	-0.739 ***	-0.434 **	-0.012
<i>Age of respondent</i>				
< 10 (ref.)	0.000	0.000	n/a	0.000
10 – 19	-0.364	-3.240 ***	0.0 (ref.)	-0.017
20 – 29	-0.248	-3.510 ***	-0.350 *	-0.076
30 – 39	-0.214	-4.054 ***	-1.087 **	0.100
40 – 49	-0.185	-3.987 ***	n/a	-0.050
50 – 59	-0.454 *	-4.510 ***	n/a	-0.108
60+	-0.051	-3.645 ***	n/a	-0.103
<i>Main religion of household</i>				
None (ref.)	0.000	0.000	0.000	0.000
Buddhism	-0.068	-0.897 **	0.041	-0.158
Catholic & others	0.062	0.491	-0.129	0.104
<i>Cause group 1 (ref.=no)</i>	0.179	1.618 ***	0.846 ***	-0.253 ***
<i>Constant</i>	3.515 ***	15.584 ***	2.017 *	0.689
N	5497	5497	1927	5351
Log likelihood	-1930.81	-18508.26	-700.862	-3626.49

The dependent variables of the logistic regressions in Table 65 are probabilities of PWD having disability-related difficulties in *employment* (Model 13), *marriage and having children* (Model 14), *participating in communal activities* (Model 15), *accessing information* (Model 16), and in *participating in cultural/sporting activities* (Model 17). The results show that the possibility of facing all these difficulties in QN-DN were much lower than in Thai Binh, but higher than in Dong Nai. However the coefficients are insignificant for Dong Nai for the cases of *marriage and having children* and *accessing information*.

Table 65. Regression models of difficulties for PWD

Independent variables	Model 13	Model 14	Model 15	Model 16	Model 17
<i>Province</i>					
QN-DN (ref.)	0.000	0.000	0.000	0.000	0.000
Thai Binh	0.646 ***	1.149 ***	0.804 ***	0.997 ***	0.872 ***
Dong Nai	-0.248 *	-0.153	-0.331 **	-0.067	-0.354 ***
<i>Urban (ref.=rural)</i>					
Urban (ref.=rural)	0.172	0.461 ***	0.397 ***	-0.018	0.312 ***
<i>Household size</i>					
Household size	0.055 *	0.004	-0.002	0.054 **	0.014
<i>At least two PWD in household</i>					
At least two PWD in household	-0.330 ***	0.022	-0.291 ***	-0.182 *	-0.362 ***
<i>Farm household</i>					
Farm household	0.239 *	-0.089	-0.011	-0.044	-0.131
<i>Highest education in household</i>					
< primary	0.000	0.000	0.000	0.000	0.000
< low secondary	-0.238	-0.479 ***	-0.329 *	-0.737 ***	-0.278 *
< high secondary	-0.314 *	-0.483 ***	-0.521 ***	-0.941 ***	-0.461 ***
Secondary	-0.698 ***	-0.597 ***	-0.642 ***	-1.109 ***	-0.572 ***
Higher	-0.855 ***	-0.544 **	-0.521 ***	-1.104 ***	-0.436 **
<i>Log of income per capita</i>					
Log of income per capita	-0.354 ***	-0.200 ***	-0.292 ***	-0.204 ***	-0.233 ***
<i>Male (Ref.=female)</i>					
Male (Ref.=female)	-0.195 *	-0.559 ***	-0.321 ***	-0.436 ***	-0.444 ***
<i>Age of respondent</i>					
< 20 (ref.)	0.000	0.000	0.000	0.000	0.000
20 – 29	-0.977 ***	-0.071	-0.044	0.112	0.108
30 – 39	0.113	1.148 ***	0.359 **	0.231	0.220
40 – 49	0.380 *	1.365 ***	0.396 **	0.260 *	0.015
50 – 59	0.505 ***	1.059 ***	0.256 *	0.131	0.079
60+	0.277 *	0.581 ***	0.094	0.181	-0.065
<i>Main religion of household</i>					
None (ref.)	0.000	0.000	0.000	0.000	0.000
Buddhism	-0.138	0.059	0.016	0.078	-0.054
Catholic & others	0.332 *	0.212 *	0.116	0.060	0.005
<i>Cause group 1 (ref.=no)</i>					
Cause group 1 (ref.=no)	0.407 ***	0.694 ***	0.542 ***	0.732 ***	0.330 ***
<i>Constant</i>					
Constant	4.300 ***	1.132 **	3.350 ***	2.020 ***	3.214 ***
N	4657	4657	4657	4465	4657
Log likelihood	-2007.24	-2788.21	-2644.21	-2806.53	-2614.83

The coefficients for “urban area” are significantly positive in Models 14, 15 and 17, indicating some disadvantages for urban PWD in the corresponding issues. Concerning household characteristics, an increase in household size could lead to a higher risk of facing disability-related difficulties in employment and accessing information. PWD living in households with other PWD were more likely to have most of these difficulties, except for difficulty in *marriage and having children*. In this case, perhaps the main reason was that

there are married couples of PWD in many of these households. It is quite consistent in all models that PWD in households with higher income or higher education levels had lower possibilities of facing corresponding difficulties. Similarly, male PWD and PWD of Group B correspond with higher probabilities of having difficulties.

On the other hand, the coefficients for age and religion are relatively different within these models. This seems reasonable as higher risks are for the age group 20-29 in Model 13, for older groups (30-39 and older) in Model 14, for the middle age group in Model 15 and Model 16, but no significant differences within age groups are found in Model 17. Note that the data reflect not only the actual situation of difficulties, but also the issues being of most concern to PWD and their families. Compared with those in Buddhist or non-religious households, PWD living in households with Catholic or other religions were more likely to realize their difficulties in employment and in marriage and having children. However, religion did not show a significant impact in the other three models.



Mother of a disabled child



A grandmother was feeding her disabled niece



A twin whose disabilities were believed to be AO affected



A likely dioxin affected man



A disabled couple



A self-made vehicle of a disabled person



A disabled man was drying rice sheet to produce noodle



Keep working.....



Helping family with housework



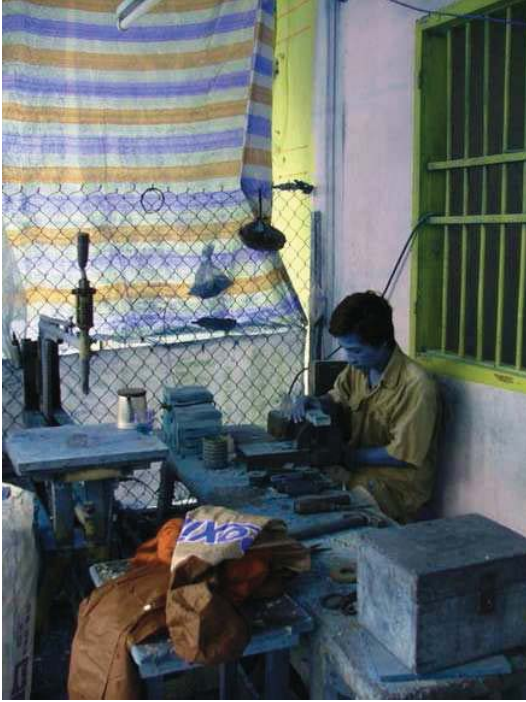
A multi-disabled person was working



A disabled man opens a game on-line shop



And his shop



Producing....



Reading Braille



And writing.....



A blind child wanted to see the sun



Help is often needed



Social participation is a need and a right of PWD

8 DISABILITY-RELATED STIGMA AND DISCRIMINATION

When we designed the survey, one of our key interests was on the perceptions and attitudes displayed towards PWD from the community. One hypothesis we formed was that a key obstacle to full societal support, protection of PWD's rights, as well as enabling the conditions for full human development of PWD is attitudinal, as communities of non-disabled people often view PWD as "abnormal". Our prior conceptualization of disability as "social product" brought us to the study of stigma and discrimination against PWD.

The standard point of reference for defining stigma is Ervin Goffman's classic study (1963) which describes three types of stigma: (1) "abominations of the body", or stigma related to physical deformities; (2) stigma related to "blemishes of individual character" such as people who are considered to be weak-willed, to have unnatural passions, or to be dishonest; and (3) "tribal stigma", or stigma related to race, nation or religion, or membership of a despised social group. Later work by Parker and Aggleton (2003) develops a framework that views stigma as a social process that produces and reproduces relations of power and control. They also examine how stigma is used to turn difference into inequality, allowing some groups to devalue others based on the attribution of "differences" (Ogden & Nyblade, 2005).

According to Goffman's definition, disability can cause type 1 stigma against PWD. However, some disabilities can result in type 2 stigma as well. As mentioned previously, the traditional view of disability as punishment for sins committed by one's ancestors has a significant influence here. Thus, disability is associated with shame and pity. Stigma is probably strongest against people with mental disabilities, which, under the influence of Buddhism and Animism, are believed to represent possession by evil spirits (Hunt, 2002). In our study, there were many cases in which families took every measure possible to keep members with disabilities out of the public eye, due to the fear of stigma.

In the following sub-sections, we will examine various views of the people of the community towards PWD in the surveyed provinces. What we found strongly confirms our hypothesis that PWD face widespread stigma from communities that ultimately leads to various forms of discrimination against their full participation in economic and social life in the mainstream of society.

8.1 General perceptions, attitudes and practices towards PWD

"Pity" is a common attitude towards PWD from non-disabled people in the communities studied. The word 'disability' immediately conveys a negative pre-conception of what the PWD cannot do, not what they can do. This perception was found invariably across all the samples (Table 66).

Another negative view towards PWD is that they tend to overly rely on others' support (mostly their family members). Implicitly it conveys a message that PWD do not even want to try but put on the shoulders of others the "responsibility" of supporting them. PWD

therefore becomes shorthand for lazy people and those who are a burden for others. This view was commonly found in Thai Binh and Dong Nai where one in three community people expressed it. Clearly, PWD were often considered not only unproductive, but also passive. This common expressed view creates a barrier to employment for PWD, as we have highlighted several times in this report.

Regardless of types and level of severity of disability, overall, from 40 to 60 percent of people interviewed thought that PWD could not live a “normal” life like people without disability, as they were “disabled”.

A considerable number of respondents even thought that encountering PWD brings “bad luck” and risks to themselves. In Thai Binh, close to one in 5 respondents interviewed expressed such a view. While in the other provinces the ratio was less, it still remained relatively high: nearly one in every 10 respondents. As “bad luck”, PWD easily become victims of many discriminatory attitudes and behaviors. The most common maltreatment that PWD faced was verbal insult. In Thai Binh, insulting PWD was often witnessed by up to more than half of the respondents (54%). In Quang Nam-Da Nang, the figure was nearly one in every seven (15%) while in Dong Nai it was nearly one fifth (18%).

Another common practice is avoidance: people try to avoid PWD before an important departure (to do business, tourism, to take exams, to see friends etc.). Shop or restaurant owners may refuse to sell goods or food to PWD if they are the first customers, believing the sale will be small that date. More than one fifth of the respondents in Thai Binh reported witnessing this practice. For Quang Nam – Da Nang and Dong Nai, the figure was just about 5 percent. PWD can also be refused to see a newborn as people are afraid that they will bring bad luck to the baby. Also, people will not welcome PWD to visit their home on the first day of Tet (the Vietnamese Lunar New Year).

Not only PWD themselves, but sometimes also their families are stigmatized. Especially for families with members suffering from mental health problems, or were dioxin-infected, the stigmatization and discrimination were particularly severe. Seventeen percent of respondents

Table 66. General perception towards PWD from community (%)

	Thai Binh	QN - DN	Dong Nai
PWD are pitiful	98.7	99.4	98.4
Overly rely on others	31.0	18.6	32.3
Cannot have ‘normal’ life	59.4	58.5	40.0
Bring bad luck to others	17.3	9.4	9.6
N	1085	1078	1079

Table 67. Stigmatized and discriminated PWD (%)

	Thai Binh	QN - DN	Dong Nai
Children	19.7	32.8	25.9
Motor	45.6	31.2	29.7
Speaking/Hearing	28.4	25.5	26.3
Vision	23.2	15.8	9.9
Mental	67.7	45.7	47.4
AO-affected	10.8	9.7	9.2
N	1568	1633	1625

Table 68. General perception on cause of disability (%)

	Thai Binh	QN - DN	Dong Nai
Because of fate	64.9	55.8	56.1
Because past “wrong doing”	20.5	14.6	16.1
Bearing all sins/risks of family	64.0	20.4	49.0
N	1085	1078	1079

from households in Thai Binh knew cases in the community where PWD were held up for ridicule (7% in Quang Nam – Da Nang and Dong Nai) and 12 percent knew families where PWD became the target of ill-will and rumors (about 5% in Quang Nam – Da Nang and Dong Nai).

The respondents even witnessed PWD being beaten up by either family members or someone in the community. In Thai Binh, 11 percent of respondents reported often witnessing this practice. For Quang Nam-Da Nang and Dong Nai, it was 3 and 5 percent respectively. Other forms of severe maltreatment included: locking PWD in houses so that they could not go out, accusations of making their family “look bad” by neighbors; left without care; or they could even be provided with no food. In Thai Binh, 23 percent of respondents often witnessed the practice of one or some of these forms of misconduct. For Quang Nam – Da Nang, the figure was much less, 4 percent. For Dong Nai, it was 5 percent. There were even about 5 percent of the respondents in the Thai Binh sample that knew of cases where PWD, mostly female, were raped or sexually abused by villagers or someone else. Sometimes, they were even sexually abused by family members. Newspapers already carry reports of girls and women with disability, including those who were dumb or had mental problems, suffering from rape or sexual abuse from strangers and acquaintances. In the other provinces, the percentage was lower, 1 percent in Quang Nam – Da Nang, and 2 percent in Dong Nai.

Victims of the above stigma and discrimination also included children. From one fifth to one third of the respondents witnessed children fall victim to these discriminatory practices. People with mental disability were most maltreated, as reported by 46 to nearly 70 percent of the respondents. For people with other types of disability, including dioxin-caused disability, the proportion of respondents who witnessed maltreatment was also high (Table 67).

Superstition about the cause of disability was found to be widespread. For example, from 56 to 65 percent of the community respondents thought that disability was a matter of “fate” – something that PWD could not avoid. Many respondents (from 15 to 21%) even thought that PWD were those who were paying the “price” for “bad things” they or their family members had done in their “previous life”. As explained previously, this perception was rooted in the concept of reincarnation in Buddhism. Even more common than this is the view that PWD are those who are destined to bear all the sins and/or risks that other family members may have. People find this notion appealing: someone should sacrifice for the well-being of the whole family, and this is quite “natural” (Table 68).

“They rumored that my grandfather sold the bell [of the Buddhist temple] to the French, thus we are disabled because of that”
(Male respondent, Thai Binh City)

“Before I always thought that this [having disabled children] was because my grandparents did wrong things so I had to bear the consequences. I did not say about it, just thought, and kept that thought for myself. Now I know that this was because of dioxin so I am now a war victim. So I no longer blame my grandparents and feel more comfortable”
(Female respondent, mother of disabled children, Dong Nai)

Even in their own family, PWD were no better treated, as many non-disabled members shared similarly negative views of other disabled members (see Table 69). In fact, as the figures show, more respondents from families with PWD had these views compared to people from families with no PWD. As a result, discriminatory practices could be observed at family level as well. Local people at these sites often observed maltreatment of PWD from their own family. For example, in Thai Binh 16 percent of respondents in the communities knew families in which PWD were disregarded or held in less respect. Nearly 40 percent knew families where PWD were considered a “burden” to other family members, or parents of children with PWD where they blamed “fate” for giving them those children (41%). One in every five respondents interviewed knew families in their community where other members considered PWD as useless, or “good-for-nothing”. About 14 percent observed family members insulting and cursing their own family members suffering from disability. There was even 7 percent of the respondents that knew cases where PWD were left uncared for by other family members, and 3 percent witnessed PWD being beaten by their family. The situation, however, was less serious in the other provinces under study.

My major problem is psychological. People here (in the commune) all leave me, away from me. I want to join them but they despise me
(Female respondent, Thai Binh)

Table 69. Stigma and discrimination of PWD in family (%)

	Thai Binh	QN-DN	Dong Nai
PWD are pitiful	98.8	99.5	98.0
Overly rely on others	37.1	20.9	35.0
Cannot have ‘normal’ life	65.9	60.9	42.2
View as burden	39.9	10.9	10.9
View as useless	20.7	4.5	6.2
Disregard	15.6	4.4	5.4
Leave uncared	7.1	1.4	2.7
Insult/curse	14.2	1.8	3.3
Parents blame ‘fate’	41.3	14.0	11.4
Beat up	2.9	0.2	1.3
N	1085	1078	1079

Table 70. Self stigma of PWD (%)

	Thai Binh	QN-DN	Dong Nai
Same as other people	21.5	39.6	20.6
Passive	26.4	17.8	25.8
Pessimistic	49.5	28.9	32.4
Anti-social	40.3	17.7	28.2
Avoid social activities	24.1	17.0	27.2
N	1085	1077	1068

Being stigmatized and discriminated against in a wide range of contexts and under various forms, obviously PWD can tend to hold pessimistic views and attitudes towards life. Self-stigma was thus observed by half of the respondents in Thai Binh. The figure in Quang Nam – Da Nang was one in every five respondents. In Dong Nai, it was one in every three. As a result, we found that PWD were passive in almost all activities, be it economic or social, as noted by around a quarter of the respondents in Thai Binh and Dong Nai and nearly one fifth in Quang Nam – Da Nang. They were considered to be anti-social by 40 percent of the respondents in Thai Binh, 18 percent in Quang Nam – Da Nang, and 28 percent in Dong Nai. This partly explains the low participation of PWD in social activities in communities, as noted by the respondents at the studied sites (24% in Thai Binh, 17% in Quang Nam – Da Nang, and 27% in Dong Nai). Overall, only 22 percent of respondents in Thai Binh saw no

difference between PWD and other people. The figures for Quang Nam- Da Nang and Dong Nai were 40 percent and 21 percent respectively. In other words, nearly 80 percent of the

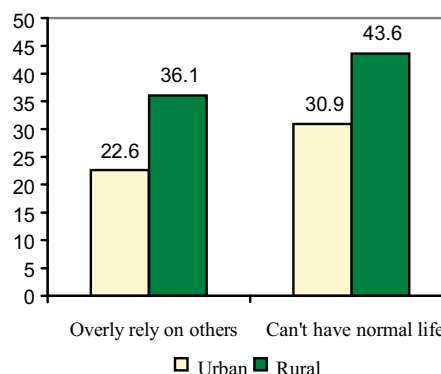
respondents in Thai Binh and Dong Nai, and 60 percent in Quang Nam – Da Nang considered PWD “different” (Table 70).

Urban-rural differences

Perceptions towards PWD varied between urban and rural areas. The major contrast was found in Dong Nai, where there was a larger negativity in the perception of respondents living in rural communes, compared to their counterparts in urban communities. As depicted in Chart 28, 36 percent of the rural respondents in Dong Nai considered PWD as those who overly rely on others’ support. The figure dropped to 23 percent for the urban respondents. Similarly, 44 percent of rural respondents believed PWD could not have a “normal” life. In urban areas, the figure was 31 percent.

For the other two provinces under study, negative perceptions towards PWD were found to be relatively the same between urban and rural areas. The common-sense thinking that urban life often means more tolerance in attitudes towards ‘differences’ among social groups cannot be applied broadly without a consideration of the specific local socioeconomic and cultural context. Thus, while in Dong Nai less people in urban areas have negative views towards PWD, in Thai Binh, the percentage of people thinking that ‘PWD overly rely on others’ were essentially the same (30%) for both urban and rural respondents. For the former group, 62 percent thought ‘PWD cannot have a normal life’ compared to 59 percent of the latter group. In Quang Nam – Da Nang, even more urban respondents (21%) viewed PWD as ‘overly rely on others’ compared to rural respondents (16%). For the notion that ‘PWD cannot have a normal life’, the figure was similar, 59 and 58 percent respectively.

Chart 28. Perception towards PWD in Dong Nai by rural/urban area (%)



Urban and rural difference is also reflected in the perception of respondents on disability causes. Proportionately, less respondents living in urban areas believed that disability is an

Table 71. Perception of disability causes by urban/ rural area (%)

	Thai Binh		QN - DN		Dong Nai	
	U	R	U	R	U	R
Because of fate	61.0	65.3	55.9	55.6	50.2	58.4
Because past “wrong doing”	20.0	20.5	14.6	14.5	12.0	17.7
Bearing all sins/risks of family	56.0	64.8	18.6	22.4	42.2	51.7

unavoidable consequence of fate, compared to those residing in rural areas. In Thai Binh, the gap was 61 versus 65 percent. In Dong Nai, it was 50 versus 58 percent. Also in Dong Nai, the proportion of urban respondents believing that disability results from the wrong conduct of one’s ancestors was 12 percent, compared to 18 percent of the rural respondents. Finally,

the belief that PWD are those who bear all the sins and risks of other family members was shared by a lower proportion of urban respondents in all the studied provinces (Table 71).

Differences between males and females

Perceptions towards PWD by males and females also showed some differences. For example, we find that regarding cause of disability, the superstitious belief that PWD are those who are destined to bear all sins and risks of the whole family was shared a greater proportion of female respondents. This is particularly true in Thai Binh and Dong Nai, where the difference between males' and females' perception is largest (Chart 29).

Similarly, proportionately more females thought that disability is a matter of fate, which is pre-defined by supernatural forces, to which PWD have to accept. Again, the difference between males and females was most noticeable in Thai Binh and Dong Nai (Chart 30). Also in these two provinces, more females thought that PWD could not have a "normal" life like non-disabled people. In Thai Binh, the gap was 57 percent for males and 63 percent for females. In Dong Nai, it was 36 percent versus 43 percent respectively.

Difference across age groups

Another dimension of perception differences is age. As mentioned earlier, some common negative perceptions towards PWD are rooted in religious and cultural perspectives on disability. We would therefore expect to see differentials between generations in their views of PWD. In our analysis, we focus on three major age cohorts, those aged below 40, from 40 to 49, and 50 and above. As we can see from Chart 31,

Chart 29. View that PWD bear sins/risks for family by sex (%)

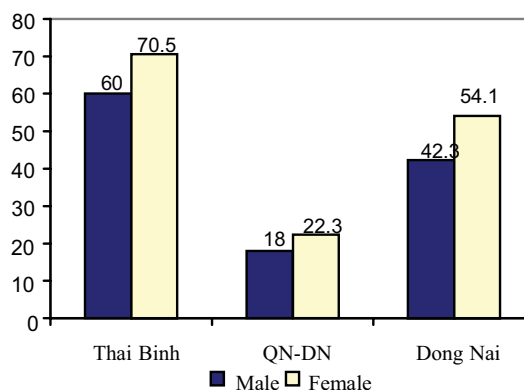


Chart 30. Disability is caused by fate, by sex (%)

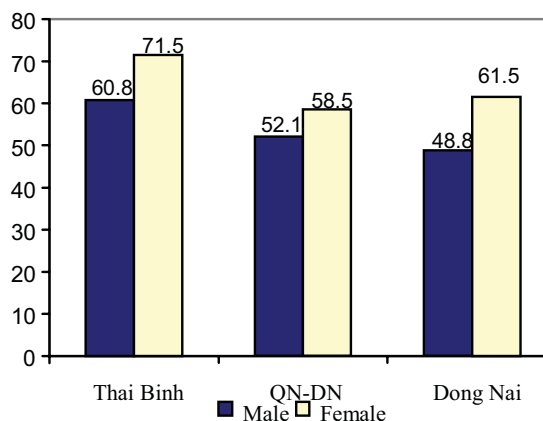
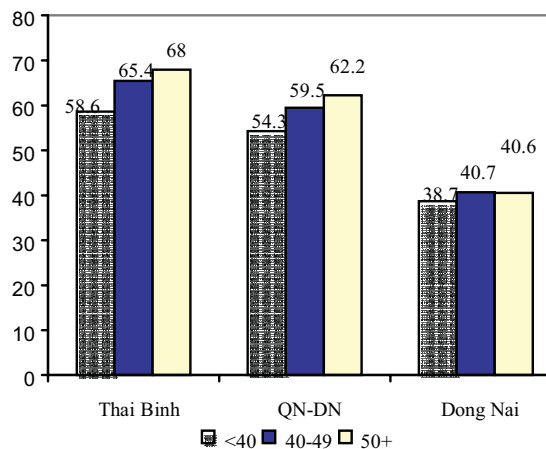


Chart 31. View that PWD cannot have normal life, by age (%)

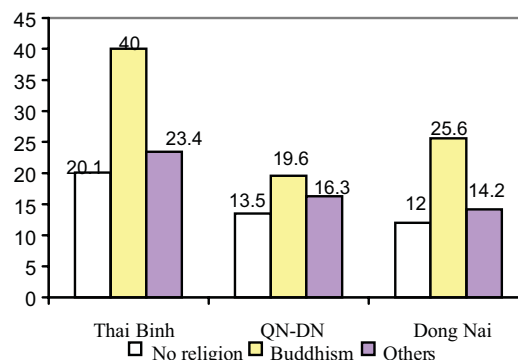


while differences between those cohorts were not clear for Dong Nai, in the two provinces of Thai Binh and Quang Nam – Da Nang, there was an increase in the proportion of respondents of higher age cohorts regarding the view that PWD cannot have a normal life.

Impact of religion

Among religions, Buddhism followers tend to think more that disability is the result of cyclical lives in which punishments of sins of the past generations are passed down to their offspring. In Thai Binh, 40 percent of Buddhism followers had this belief, compared to 20 percent of the non-religious respondents and 23 percent of the followers of other religions. Similar findings were also found in Quang Nam – Da Nang, and in Dong Nai (Chart 32).

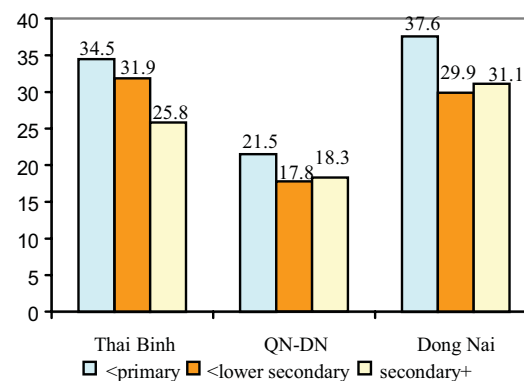
Chart 32. View that disability is caused by ancestors' "wrong doing" (%)



Impact of education

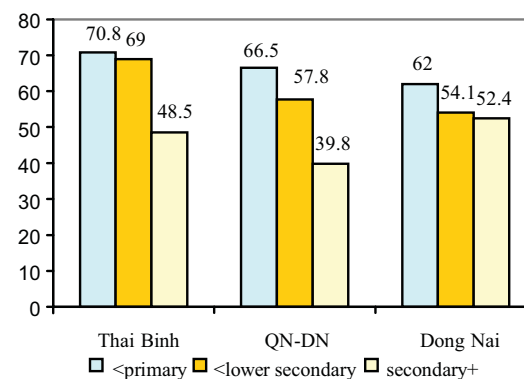
People with higher education are more likely to have less negative views of PWD. Referring to the same notions above, i.e., PWDs are ‘overly rely on others’ and ‘cannot have a normal life’, we see a lesser proportion of respondents with higher education attainment who agreed with these notions. This trend was found across the studied provinces.

Chart 33. View that PWD overly rely on others, by education (%)



For example, regarding the notion that PWD tend to overly rely on others, as illustrated in Chart 33, more respondents of lower education attainments agreed with it. The same finding was found from the respondents of different education levels regarding the notion that PWD cannot have a normal life. Likewise the belief that PWD are those who bear risks and sins of all other members in the family; disability is caused by fate; or disability resulted from past “wrong doing” of ancestors, were all held by a greater percentage of people with low education attainments. For instance, in Dong Nai, while 71 percent of the

Chart 34. View that disability caused by fate, by education



respondents whose education was below the primary level perceived that disability is caused by fate, for those with upper secondary education the figure dropped to 49 percent. Similar figures for Quang Nam-Da Nang were 67 versus 40 percent, respectively. For Thai Binh, it was 62 versus 52 percent (Chart 34). Similarly, 32 percent of respondents in Thai Binh with lower primary level education believed disability resulted from past “wrong doing” or sins of one’s ancestor. For those with upper secondary education, the proportion believing the same was cut by more than half (13%). In Quang Nam – Da Nang, the figure for the former groups was 22 percent. For the latter, it was just 7 percent (Chart 35). Similar findings were found regarding the perception that meeting PWD would bring “bad luck” or risks for oneself (Chart 36);

Chart 35. View that disability caused by ancestors' "wrong doing" by education

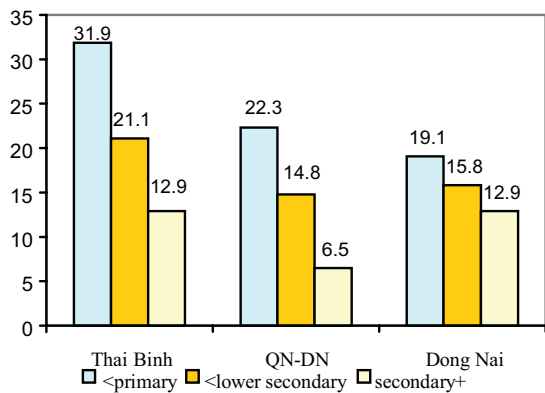
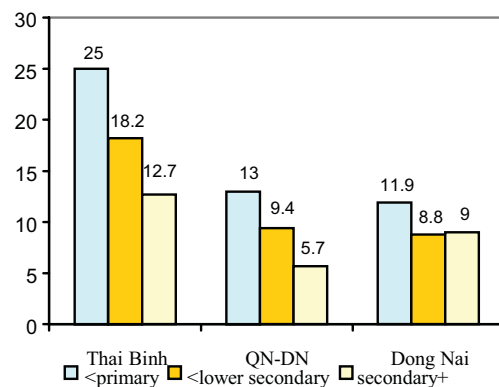


Chart 36. View that PWD bring bad luck to others by education



PWD are those who bear sins and risks for family (Chart 37); and PWD cannot have a “normal life” (Chart 38).

Chart 37. View that PWD bear sins/risks for family, by education

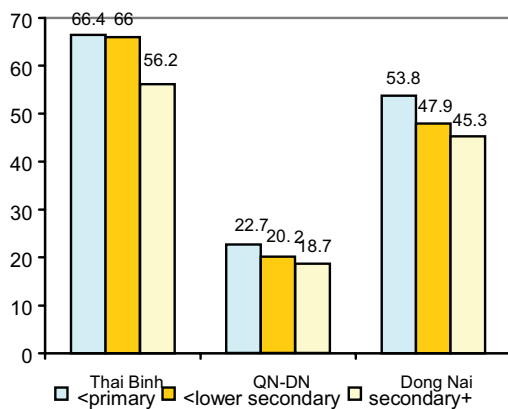
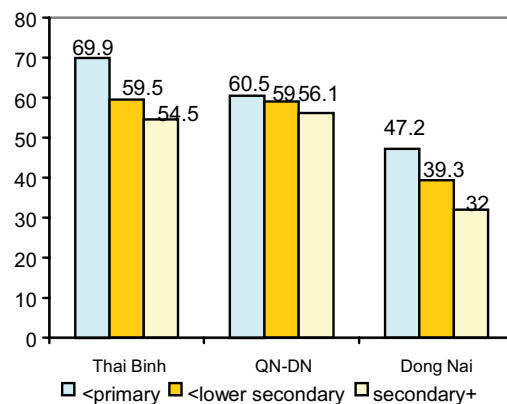


Chart 38. View that PWD cannot have normal life, by education



Obviously education is an important area that will help reduce the negative perceptions of society towards PWD, and this should be taken into consideration in any intervention programs designed to support PWD.

Impact of information

Another important factor that helps in reducing the negative perceptions of society towards PWD is information on disability from newspapers, television and other media. The survey data shows clearly that the more people get information about various disability issues, the less negative is their view on disability and PWD, as their understanding of what disability means gradually improves. Obviously, there have been many articles and broadcast programs on disability in which the government highlighted the strong agency of PWD, their contribution to the socioeconomic and cultural development of communities and the country, as well as the need for the further integration of PWD into all areas of life.

Chart 39 presents the percentage of respondents thinking that disability is brought about by destiny, or fate. In all the three provinces, people who rarely read, watch, or hear of disability issues tend to think more superstitiously, compared to those who routinely received this information. A gap also existed between the two groups regarding the belief that PWD are paying the “price” for their ancestors’ “sins” (Chart 40).

Chart 39. View that disability caused by fate, by frequency of receiving information

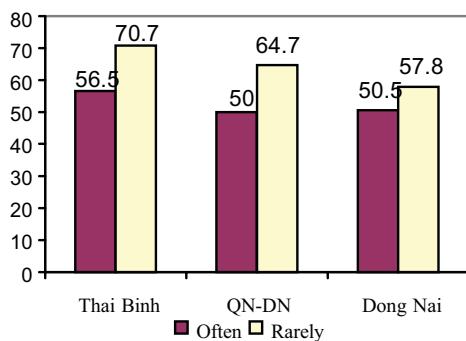
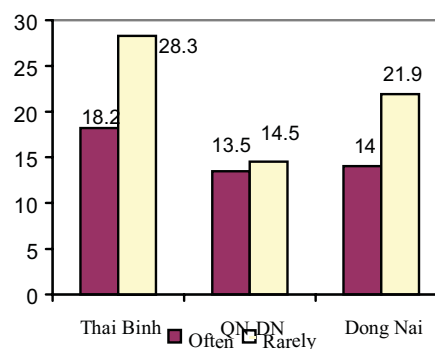


Chart 40. View that PWD are paying "price" for ancestors' sins, by frequency of receiving information



8.2 Disability and education

In addition to an analysis of the general perceptions of the community towards disability and PWD, in the survey, we asked questions on people’s perceptions in four critical areas: education, employment, marriage, and social participation. As reported elsewhere, despite the government’s efforts to boost PWD’s participation in those areas, little achievement has been made. One of the major obstacles, in our view, is the poor perception of society, including PWD themselves, on the importance of participation for PWD. As shown in this section, the perceptions of the surveyed respondents on the need for PWD to participate in the above four areas are quite poor.

Table 72. Opinions about children who should not attend school by type of disability (%)

	Thai Binh	QN - DN	Dong Nai
Motor	4.7	2.9	6.7
Hearing/speaking	10.2	4.7	8.3
Vision	15.8	6.6	10.7
Mental	64.9	61.7	58.5
AO-affected	28.8	33.1	36.7
N	1085	1078	1079

proportions of respondents (from around 60% to 65%) thought they should not attend. Similar opinions were given by a high proportion of respondents (from 30% to 37%) regarding the schooling of children suffering from dioxin infection (Table 72).

Table 73. Reasons why CWD should not attend school (%)

	Thai Binh	QN - DN	Dong Nai
Impossible to learn	92.5	86.2	89.3
Harm other's learning	50.4	38.6	33.1
N	724	682	653

attended classes, would affect the learning of other children (Table 73). Clearly, there is a sense of protecting the non-disabled at the expense of CWD. Even for people who thought children with disability should attend school, 67 percent of respondents in Thai Binh, 51 percent in Quang Nam – Da Nang, and 57 percent in Dong Nai thought it was better to put those children in “special classes” or schools rather than mix them together with other “normal children” as practiced in integrated education, which is carried out by the government.

As discussed in Section 7, this negative attitude towards the education of PWD has been brought into schools, where many students with disabilities are stigmatized and face discrimination against them. For example, in a commune in Thai Binh that we surveyed, many children themselves stated that they do not want to study in integrated classes because of fear of stigma and discrimination. A student respondent in a class consisting of all CWD told the interviewer that she did not want to study in other “normal” classes as she would have no friends there. Already students at other classes taunted her and other classmates as being of a “slow development class”. Even if they want to associate with these students, they are often avoided. Her class had no picnic so far (students in other classes had) and she, as well as other friends, were not asked to join the school’s song and dance performance.

8.3 Disability and employment

PWD’s need for employment has been highlighted in various studies and reports and is stressed in the Ordinance on Disabled Persons. Disability often means a loss of livelihood for PWD themselves and their family, especially when the majority of them are classified as

Starting first with education, opinions on the schooling needs of children with disability (CWD) varied by types of disability. For children with motor disability, the majority of respondents thought they should attend school. However, for hearing/speaking and vision disabilities, more considered that children with these disabilities should not attend school, especially in Thai Binh (10% and 16% for each type of disability, respectively). Particularly for children suffering from mental disability, high

For these four types of disability, the general opinion of respondents (87% to 93%) was that it was impossible for them to study at school as these disabilities severely limit, even prohibit, children’s learning ability. From one third to a half of respondents thought that children with disability, if they

being poor or less well-off. However, employment is not only economically important for PWD, it has a significant social meaning as well. Employment means self-worth and social acceptance and respect for PWD.

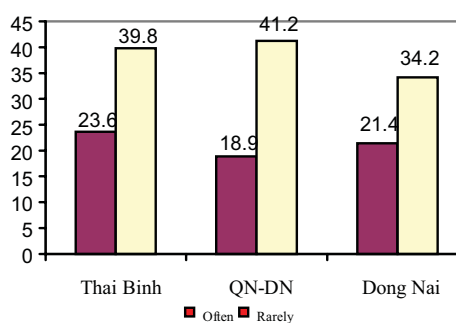
“Having a job is a dream of all disabled persons. Anyone wants to be the same as the others, having desire to work, to live, to support oneself without being dependent. I think this the dream of everybody, not only of disabled persons”
(Female respondent, unemployed, Da Nang)

Table 74. Opinions about important support society should provide to PWD (%)

	Thai Binh	QN - DN	Dong Nai
Employment	41.5	45.0	41.5
Rehabilitation	14.7	17.5	20.1
Subsidy for family	29.6	26.7	28.4
Put in institution	14.2	10.7	10.0
Total	100.0	100.0	100.0
N	1085	1078	1079

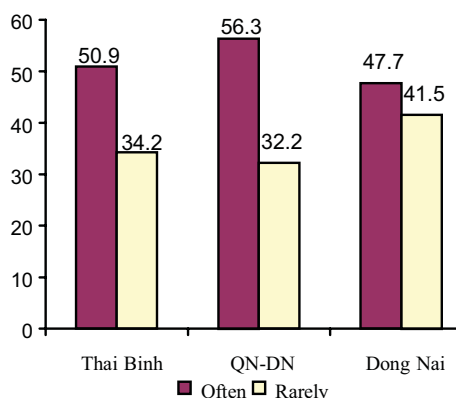
Nonetheless, the perception of society towards this important need remains thus far insufficient. In our interviews, we asked two specific questions to capture in relative terms the perception of the community towards support for PWD. The first question was what society should do to support PWD, and the second question was what business or enterprise should do to support PWD. Table 74 lists respondents’ views on what they think societal support to PWD should be directed towards.

Chart 41. View that most important support should be subsidy to family to give better care to PWD, by frequency of receiving information (%)



Across the three provinces where the survey was undertaken, about 40 percent or slightly more agreed that employment is the most important need. In other words, about 60 percent of respondents did not see why PWD should get employment as a matter of urgency. For the majority of respondents, PWD should be inactive and receive family, community, and government support. Thus, about 30 percent of them think that the government and community should provide financial and material assistance for PWD’s families so that they can take care of them better. From 15 to 20 percent emphasized the need for PWD rehabilitation. And from 10 to 14 percent thought that the best thing

Chart 42. View that employment is an important need for PWD, by frequency of receiving information (%)



for PWD and their families is to send them to institutions. Given their view that PWD cannot live a “normal life” and are “passive”, PWD would be better off in institutions to receive better care from professionals and reduce the burden they create for their family.

The ignorance of the employment needs of PWD is also reflected in respondents’ opinions regarding what business should do to support PWD. The data shows that just around a half of respondents (54% in Thai Binh, 48% in Quang Nam – Da Nang, and 52% in Dong Nai) thought about employment. The other half thought businesses should simply provide them with some welfare such as part of the surplus or benefits they made as a fund to support PWD in financial terms rather than with an opportunity for employment. The reason, as mentioned above, was that for many, disability means incapability to work, or working at low efficiency at best.

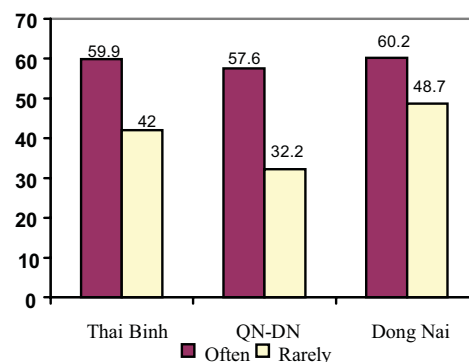
“People should understand disabled persons, that they have their own capacity, so they can work..... In my family, my parents understand that, so it’s fine. But for society, people should understand more about disability so that they can sympathize with our needs. (Female respondent, unemployed, Thai Binh)

For these respondents, the employment needs of PWD were obviously neglected. Interviews with PWD, however, showed a different view of PWD themselves about their own capability.

Clearly, it is important to change the perceptions of society towards the capacity of PWD. There must be work in some form that the PWD can perform as they are not a homogenous group of incapable people. The question is how to change that perception.

Again, the importance of disability information and an awareness of the employment needs of PWD is highlighted in the data. Comparing the opinions of the two groups of respondents regarding the frequency of receiving disability information shows a substantially higher proportion of the group often receiving information in favor of employment rather than pure welfare provision. For example, in Thai Binh and Quang Nam – Da Nang, while for the respondents who rarely accessed disability information, 40 percent of them prefer subsidy rather than employment for PWD, for those who often received information, the proportion dropped by a half. For Dong Nai, the gap was between 34 percent for the former group and 21 percent for the later group (Chart 41). In contrast, the proportion of those viewing employment as an urgent need for PWD of the latter groups increased to about 50 percent, while for the former groups, the proportions were much less (Chart 42). Finally, around 60 percent of the respondents in the often-receiving-information group were of the opinion that business should provide jobs to PWD rather than simple welfare contributions. For respondents who

Chart 43. View that businesses should provide employment to PWD rather than simple welfare contribution (%)



rarely received information, the proportions sharing similar views were be as low as 32 percent (Chart 43)

Clearly, with more understanding of disability, this group is much more aware of employment as a real and urgent need for PWD. In fact, at the studied communes, some respondents themselves knew PWD of working age who had been rejected by employers as being unqualified for work. In Thai Binh, 14 percent of the respondents knew of such cases. For Quang Nam- Da Nang, it was 10 percent. For Dong Nai, it was 8 percent. Employed PWD could be a target of labor abuse and exploitation in many ways, for example PWD could receive work that other workers refused to do and at the same time be paid a lower wage. Employers could also dismiss them quite easily. At the workplace, PWD were also stigmatized by other co-workers, who often see PWD as “troubles” that reduce production efficiency of the enterprise. Thus, according to an employer that we interviewed, PWD often want to work together as there will be more understanding and sympathy among people in the same situation. If PWD work with other non-disabled workers, there can be conflict. Since PWD can be easily hurt, if they are teased by other co-workers, they can quit the job immediately.

“I think there should always be jobs that are suitable for people with disability, whatever type of disability it is. The problem is that they always think immediately that we cannot work, no matter what kind of work. If they take our need seriously, they can easily find jobs that we can do. (Male respondent, unemployed, Da Nang)

“Most people pity disabled persons while we should not be pitied. We do study hard, thriving, being dependent, working like ‘normal’ people. There is only a difference that some works we could not do. So people just pity us without noticing our strengths. So I hope people will really understand us. We do not need pity. Now I think we should assert ourselves first, should promote our ability first and not receive people’s pity” (Female respondent, unemployed, Dong Nai)

8.4 Disability and marriage and childbearing

Marriage for PWD is a sensitive issue. One rather common opinion was that disability, if serious, would create considerable difficulties for PWD to maintain a “normal life”, including a married life. Disability means impossibility, or great difficulties, in performing basic daily activities, work, childbearing, or social participation. If married, a person with disability cannot fully support his or her family. He or she is likely to be a burden for his or her spouse and other family members, including their own children. Therefore, they should consider giving up marriage for the sake of the “others”. There was even a perception, found in 17 percent of respondents in Thai Binh, 16 percent in Quang Nam-Da Nang and 25 percent in Dong Nai,

Table 75. Opinions that males should not marry by type of disability (%)

	Thai Binh	QN - DN	Dong Nai
Motor	18.7	12.7	22.4
Hearing/speaking	13.2	11.4	21.6
Vision	20.7	17.7	25.1
Mental	77.7	83.1	80.4
AO-affected	63.8	70.5	69.4

Table 76. Opinions that females should not marry by type of disability (%)

	Thai Binh	QN - DN	Dong Nai
Motor	30.5	14.7	24.3
Hearing/speaking	19.6	12.6	23.5
Vision	34.1	19.2	27.5
Mental	81.1	83.3	82.0
AO-affected	69.5	72.8	71.4

that PWD should only get married with other PWD. This reflects a clear discriminatory view of PWD as “they” versus “us”. In this conception, PWD are considered as a potential threat to the welfare of other “normal” people, and should be avoided in marriage.

Table 75 and 76 present in detail the opinions of respondents regarding marriage and PWD. As we can see, opinions on whether PWD should marry varied by types of disability, with the highest proportion of respondents objecting to the marriage of people with mental health problems or those affected by dioxin. As expressed by one respondent whose son was probably affected by dioxin, the community’s fear of inter-generational effects on birth of AO was the reason preventing him finding a marriage partner in the commune.

“People here said that those affected by poisonous chemical will have birth defects from generation to generation. I asked three, four families to have a wife for my son, but they all refused. They did not tell it straight to me, just said that their daughters and my son are not fit, but I know the real reason..... They are afraid that my son cannot produce good children”
(Mother of a disabled man, Thai Binh)

Other types of disability were considered less serious an obstacle to marriage. Nevertheless, up to one third of the respondents disagreed that people with these disabilities can have a satisfactory married life. For PWD themselves, many accept the situation, perceiving it as fate, something that they must just bear. Others considered that they would only find marriage opportunities with other PWD.

There was a clear double standard regarding the marriage of males and females with disability. Of the same type of disability, we found a more “tolerant” view of respondents towards males’ marriage. For example, for people with motor disability, while few respondents thought they should not marry, the proportions were higher regarding the marriage of females with disability, compared to marriages of males with disability (15 to 30 percent versus 13 to 22 percent). This double standard was most visible in the studied communes of Thai Binh, compared to the rest of the studied provinces.

Table 77. Opinions that females should not give birth by type of disability (%)

	Thai Binh	QN - DN	Dong Nai
Motor	45.8	24.1	34.7
Hearing/speaking	28.8	21.2	30.4
Vision	45.5	29.5	36.9
Mental	88.9	86.8	84.7
AO-affected	89.7	85.3	80.7
N	1085	1078	1079

Round pot should be covered by round lid; distorting pot should be covered by distorting lid. But so far I have nobody.
(Disabled man, Dong Nai)

While opinions objecting to the marriage of females with disability were quite common, even more objected to females with disability giving birth to children. Indeed, mental disability and disability due to dioxin were considered most negatively by the respondents, as close to 90 percent objected to people with these disabilities giving birth (Table 77). Again, the fear is linked to the effect of AO on birth. For AO-suspected PWD, the fear of the effect is constant.

I am in constant fear since my wife pregnancy. I heard that the effect is over generations. My boss told me that I should have family planning..... I could not keep it, so now I am worried days and nights. (Male respondent, Quang Nam)

In the end, reasons making the respondents object to PWD having children, like those about marriage, were more about “protecting” the welfare of the “others”, rather than that of PWD themselves. The most common reason was that if giving birth, the PWD would not be able to raise and take care of their children:

from 70 to 77 percent of respondents shared this opinion; 54 to 73 percent even feared that children born by to PWD could be genetically disabled, without any clear understanding of how disability could be transferred across generations. From around one third to a half of the respondents thought that women with disability should not have children because either children would become a burden for the PWD, or a burden for their family or society, or both (Table 78). The desire fro PWD to have children, which is culturally important and legally provided for, is often not considered.

Table 78. Reasons why females with disability should not give birth (%)

	Thai Binh	QN - DN	Dong Nai
Cannot take care of children	77.1	77.1	69.7
More burden for themselves	46.4	36.0	40.0
More burden for family and society	47.0	31.4	33.2
Children may be genetically disabled	73.0	59.4	54.3
N	1036	979	945

My major difficulty in life is psychological. I often think of my situation and feel extremely sad. I am a married woman but have no perfect child. I am a human as others, but they have perfect children, while I do not. (Female respondent with disabled children, Da Nang)

8.5 Disability and social participation

The need, and necessity, for social participation by PWD was also poorly understood and respected. Two groups of PWD, those having mental disability and those being affected by dioxin, continued to be severely stigmatized and discriminated against: from 54 to 63 percent of respondents thought people with mental health problems should not participate in any social activities, because they did not have sufficient mentality to meaningfully contribute to these activities. The need for PWD themselves to participate are totally ignored, or disregarded. For people with dioxin-caused disability, the proportion of respondents objecting to their participation was also high, from 30 to 34 percent. As in the areas of education, marriage, and childbearing, PWD were considered to be “abnormal”, and should be treated differently in all areas of life.

Table 79. Opinions that PWD who should not participate in social activities at community (%)

	Thai Binh	QN - DN	Dong Nai
Motor	10.2	5.5	9.0
Hearing/speaking	18.0	8.9	11.4
Vision	19.1	12.6	13.9
Mental	62.4	54.2	57.8
AO-affected	29.6	30.4	33.8
N	1085	1078	1079

For other types of disability, while a lower percentage of respondents objected to their participation, essentially from nearly one in every ten to one in very five respondents did not think people with hearing; speaking and vision disability should participate in social

activities. For motor disability, the percentage of respondents with objections was from 5 to 10 percent (Table 79).

In practice, it is common to see PWD disregarded or marginalized in any decision-making process of the community. For example in Thai Binh, 11.5 percent of the respondents reported this form of discrimination. Social participation is a clear need for PWD, as pointed out by *Khuat Thu Hong et al* (2001). At the studied communes, barriers to social participation of PWD remain strong.

Previously, disabled persons were hesitant to contact with the [non-disabled] others.... Now everybody [disabled persons] is happy. They all participate in our club [for disabled people]. (Focus Group Discussion, Thai Binh)

Many disabled children cannot go to our neighborhood activities, such as singing and dancing, by themselves. So they have to ask sisters or friends to carry them on their back. They like our activities very much and I feel very happy that they now can participate in community. (Focus Group Discussion, Dong Nai)

The Ordinance on Disabled Persons has emphasized the need to have the participation of PWD in all social activities. However, awareness of the Ordinance is poor, even among local government officials, as mentioned earlier. In communes where such awareness is relatively high, we observed higher levels of social participation by PWD. For PWD themselves, participation is meaningful for their self-esteem and happiness.

One important measure to enhance the participation of PWD is to have them selected as members of local authority (People’s Committee) and mass organizations. Their presence in this governance structure is not only symbolically necessary, but also involves them in the decision-making process at the grassroots level. Nevertheless, as discussed above, at the studied communes we observed extremely low percentages of PWD in such local organizations. The barrier for their accessibility to local governance is indeed attitudinal.

I am lucky to be a member of the Blind Association, so I can participate in meetings of the Women’s Union. If not, no one will invite me. People just think I am a disabled person but they do not realize that I have my memories. I heard them saying ‘Tomorrow we should meet [at the Women’s Union meeting]’. I asked ‘Where will the meeting be held?’. They replied ‘How come you think you can join us?’. I felt so self-pity to receive such a response. (Female respondent, Da Nang)

8.6 Perception of the PWD of their rights

In the survey, we asked questions if the PWD themselves think they have equal rights with the non-disabled persons on a number of important areas, namely rights to work; rights to education; rights to marriage; rights to child bearing; and rights to social participation. Data collected show that there were PWD who did not even

Table 80. Percentage of PWD who do not know if they have equal rights as non-PWD (%)

	Thai Binh	QN - DN	Dong Nai
Rights to work	4.6	1.9	6.9
Rights to education	5.2	2.1	5.9
Rights to marriage	11.7	4.2	8.6
Rights to childbearing	11.4	4.4	8.0
Rights to social participation	11.9	4.9	10.5
N	691	73	525

know if such rights exist, or if they can claim those rights. The situation is worse in Thai Binh, where 11 or 12 percent of the PWD did not know if they have equal rights in marriage, child bearing, and social participation (see Table 80).

Comparison between males and females further show a much higher percentage of female PWD who did not know if they have equal rights with the non-disabled persons in these areas. For example, while less than 3 percent of male PWD in Thai Binh did not know they have rights to work and rights to education, for female PWD, the percentage was about 10 percent. There were about 17 percent of female PWD did not know if they have rights to marriage, childbearing, and social participation, compared to less than 10 percent of male PWD (Table 81).

Table 81. Percentage of PWD who do not know if they have equal rights as non-PWD by gender

	Thai Binh		QN-DN		Dong Nai	
	Male	Female	Male	Female	Male	Female
Rights to work	2.4	9.1	1.8	2.3	5.0	9.9
Rights to education	2.8	10.0	1.8	2.7	4.0	8.9
Rights to marriage	8.9	17.3	3.5	5.4	6.8	11.4
Rights to childbearing	8.7	16.9	3.7	5.8	6.2	10.9
Rights to social participation	9.2	17.3	3.9	6.9	8.4	13.9
N	460	231	510	260	322	202

One direct cause of this serious lack of knowledge on rights was due to the complete absence of awareness of the Ordinance on Disabled Persons which in fact affirms those rights. It is a disturbing fact that among the sample of PWD covered by the survey, 60 to 77 percent did not even hear about it from any information source. From 13 to 23 percent knew of the Ordinance in name only. From 8 to 16 percent knew little of the contents of the Ordinance. In combination, nearly all of them do not have any knowledge at all about the Ordinance (Table 82).

Table 82. Knowledge of Ordinance on Disabled Persons (%)

	Thai Binh	QN - DN	Dong Nai
Never hear of the Ordinance	60.1	67.7	77.2
Know the name only	23.3	13.3	13.0
Know very little of the content	15.3	15.5	8.6
Know the content well	1.3	3.5	1.3
Total	100.0	100.0	100.0
N	691	73	525

To be honest, we know about the Ordinance only through the radio or television. No legal document was sent to the community..... I believe that in general the Ordinance reaches only the sub-district, not to the residential clusters so we do not know its contents. (Focus Group Discussion, Quang Nam)

Not only the Ordinance but other information on PWD in printed materials (newspapers, magazines, books, reports, etc.), radio and television programs were also rarely received by the people. This is indeed more serious in the rural areas due mainly to accessibility difficulties. In Thai Binh, for example, while 17 percent of the respondents living in the urban areas never (or rarely) read or heard information on PWD, the proportion among rural respondents was 27 percent. Similar gaps were also

found in other provinces covered in the survey (Chart 44).

Chart 44. Never/rarely receiving information of PWD by area (%)

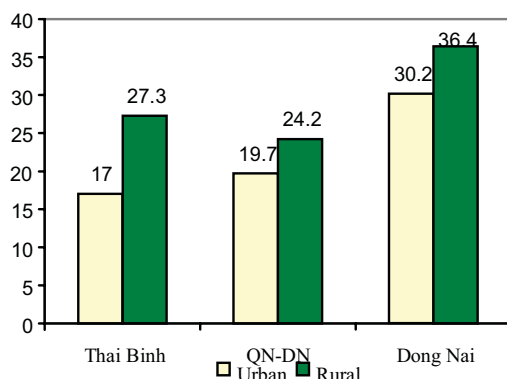
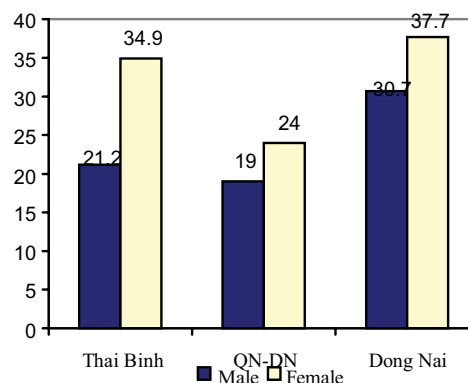


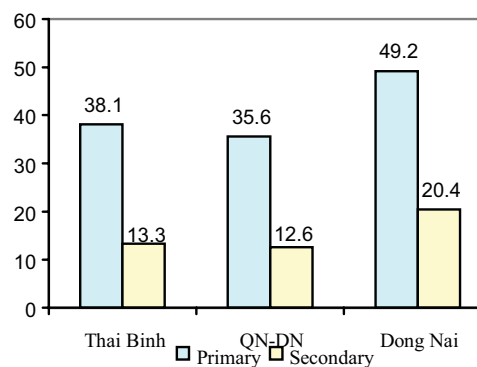
Chart 45. Never/rarely receiving information on PWD by sex (%)



It is found that there are higher proportions of female respondents who never/rarely access information about PWD. Chart 45 illustrates these gaps clearly. For instance, 35 percent of female respondents in Thai Binh never/rarely access this information. The figure for male respondents was 21 percent.

Education, too, is another factor influencing information access. The survey data suggests a large difference between groups of respondents with different levels of educational attainment. As shown in Chart 46, while from one third to a half of respondents whose education was at primary level or lower never/rarely access information on PWD, for those achieving secondary education level, the proportion was much lower.

Chart 46. Never/rarely receiving information on PWD by education (%)



Previously both leaders and people viewed disabled persons with pity but without respect. With the issuance of the Ordinance and especially when there are campaigns encouraging disabled people to participate then local leaders and local people have a visible change.... We no longer see disabled people as before [being pitiful]. Now if we can make disabled people to be sympathized and if we wholeheartedly support them then they can develop their human capacity. (Focus Group Discussion, Da Nang).

The lack of knowledge on government policies, especially the Ordinance as well as other information regarding disability and PWD requires immediate actions from the state and civil society to solve. In communities where the Ordinance was introduced and implemented seriously, the situation of the PWD was considerably

improved.

Otherwise, without clear awareness on policies, PWD will continue to suffer inequality in all areas of life.

I would say that the implementation of government policies regarding disability is very poor because these policies have not been introduced widely. Many disabled persons persons doing business without knowing policies on tax reduction [for the PWD]. Tax collectors themselves know these policies but they keep collecting taxes from those businesses. If someone [PWD] knows the policies, then tax collectors will not collect. But if someone does not know, then tax collectors will ask them to pay. Or the instruction that business should employ 2 to 3percent workers who are disabled; it is not implemented at all, except at some places where employers are themselves sympathize with the PWD. Not because of the policies.
(Local government official, Da Nang)

Three major measures were suggested by PWD themselves in order to promote their rights: awareness raising of the public through the media and educational campaigns; strong supervision on policy implementation from the government at all levels; and, particularly in the south, the actions of PWD themselves to fight for their rights. It should be noted that more than one tenth of the respondents did not even know what measures are needed to promote their rights (Table 83).

Table 83. Measures needed to promote PWD's rights (%)

	Thai Binh	QN - DN	Dong Nai
Awareness raising	55.3	50.8	37.1
Authority/community supervision	20.4	15.8	18.1
PWD's participation in supervision	3.9	3.8	9.5
PWD fight for their rights	7.1	17.9	25.0
Do not know	13.3	11.7	10.3
Total	100.0	100.0	100.0
N	691	773	525

To end this sub-section, we present in the box below a case study of a family with members whose disabilities were probably caused by dioxin. The conclusion that can be drawn from this case is that PWD, particularly those affected by dioxin, face multiple forms of stigma and discrimination that severely affect all aspects of their life. Thus, immediate policy measures and interventions should be made to redress their situation through a deep and nationwide realization of their rights.

Nguyen Thi Huong, 28 years old, was a daughter of a man who was exposed to the Agent Orange during his military service in the Vietnam War. Her husband was the eldest son of a farmer family in Hung Yen province in the Red River delta in the North. In the Vietnamese traditional culture, eldest son and his wife are strongly expected by the entire husband's (extended) family to have a son to continue the family line. Out of frustration when Thu's sons, one after the other, were "highly abnormal" with obviously no capacity for reproduction, other family members, particularly her mother-in-law, put all their anger upon her. She was thus constantly cursed as though she had intentionally brought "such monstrous features" into the family to harm its line and reputation. Living in a small rural community, rumors about her sons quickly spread everywhere. She and her husband immediately became a target of villagers' gossip even when she was still in the rural clinic's bed after labor. The rumors became so intense that she and her husband had to move South to escape the disturbing surroundings. Their belief was that, as there are many more people affected by AO in the South, they would face less stigma and receive sympathy from the others in the new place. However, since the community where they resettled consisted of mainly Northern migrants, the situation was not much improved. Thu thus spent most of time in the house, did not want/dare to go out, and felt extremely sad.

When her two sons reached school age, she sent them to the local school where they became the clear object for discriminatory practices of not only schoolmates but also from teachers as well. Other students often approached them to tease and to ridicule. When they went to school toilet, other students followed to see how they looked without a penis. This affected their nerves and all Thu could do was to tell her sons go to toilet only when all the other students were in class. Some teachers did the same to the sons. Teachers even pulled down their pants to see and to comment curiously.

At present, the sons refused to go to school as they feel extremely ashamed. Thu was considering taking them to hospital for surgery (to make a fake penis from their own flesh). She even hopes that with penis, her children would be able to get married and to have children when they grow up. Indeed, the most urgent need was for her children to go back to school without being ridiculed. However, she told the interviewer that her economic situation did not allow her to pay for the surgery, and she did not know when she could save enough money for this purpose.

In the community, her sons were isolated as other families did not let their children to associate with them. Her sons thus hide themselves in the house most of time and have no chance for socialization and integration into the community social life.

Things have not stopped there. Just after a short time, her husband abandoned her and the two "abnormal sons" to return to his parent's home. They persuaded him to leave her and get married to a new wife who could have "normal sons". He never wrote her and provided his son with no support of any sort. Nor the cursing and insulting stopped at Thu alone. Since Thu's in-laws lived just nearby her own parent's house, they blamed them too for having "such a daughter".

(Female, Bien Hoa City, Dong Nai)

8.7 Multivariable analysis

The logistic regression models in Table 84 are helpful in assessing the effects of each socioeconomic variable on perceptions and attitudes toward PWD when it is controlled by other independent variables. The dependent variables of Model 1A, Model 2A and Model 3A are attitudes (1=agree, 0=disagree) of non-disability household sample toward three statements on the PWD. Model 1B, Model 2B and Model 3B are the corresponding regression models for the household-with-disability sample. For continuous independent variables, sign of a coefficient simply reflects the direction of its effect on the dependent variables, while for categorical variables, the categories with positive/negative coefficients indicate their positive/negative effects on the dependent variables in comparison with corresponding reference categories.

Regarding the first statement “PWD cannot have normal life”, the results show that for households without disability (Model 1A), the respondents in Dong Nai, urban area, being male, young, having higher education, were less likely to agree than the corresponding groups, respectively those in Quang Nam-Da Nang and Thai Binh, rural area, females, older, and low education. However, the variances of other variables in the model (occupation, disability status, income, religion) do not show statistically significant effects.

The results are similar for households with PWD (Model 1B), except that the effects of sex of respondents and urban-rural areas are no longer significant, while the difference between Thai Binh and Quang Nam-Da Nang become significant at the 0.05 level. In this model, it can be predicted that the respondents with disability were less likely to agree with this “discriminatory” statement than their non-disability household members.

Regarding respondents’ opinion about the second statement “PWD should marry only other PWD”, the first notable difference to the two previous models is that in comparison with those in Quang Nam-Da Nang, respondents in Dong Nai were more likely to agree with the statement. In addition, while income has negative impact in Model 2A, urban-rural area, age and disability status are not found to have significant effects. For households with PWD (Model 2B), working respondents were more likely to agree with the statement than those who did not work. Especially, information played an important role as the coefficient of this variable is statistically significant at the 0.001 level in both Model 2A and Model 2B. Those people who often or sometime received information about PWD had higher possibility to agree with the statement than the counterparts. Perhaps the reason was that, receiving more information, people became more realistic about the actual situation of marriage opportunity for PWD.

Model 3A and Model 3B present the effects of independent variables on attitudes toward the statement “families should concentrate their spending/investment for children without disability”. The results indicate that respondents in Dong Nai were much more likely to agree with the statement than in Thai Binh and Quang Nam-Da Nang, even when the models were controlled by other independent variables. The coefficient for urban area is negative in both models, but statistically significant only in Model 3B (households with disability). Remarkably, the coefficient for the age group 60+ is negative in Model 3A but positive in

Model 3B, suggesting that old age people in households with disability could be a source of discrimination, especially if they were household heads.

Table 84. Regression models of attitudes towards PWD

Independent Variable	Model 1A	Model 1B	Model 2A	Model 2B	Model 3A	Model 3B
<i>Province</i>						
QN-DN (ref.)	0.000	0.000	0.000	0.000	0.000	0.000
Thai Binh	0.033	0.195 *	0.302 *	-0.021	0.427 *	0.153
Dong Nai	-0.867 ***	-0.719 ***	0.642 ***	0.470 ***	1.138 ***	0.899 ***
<i>Urban</i> (ref.=rural)	-0.204 *	0.037	0.162	-0.025	-0.281	-0.390 **
<i>Male</i> (ref.=female)	-0.201 **	-0.013	-0.223 *	-0.040	0.056	-0.039
<i>Age of respondent</i>						
< 30 (ref.)	0.000	0.000	0.000	0.000	0.000	0.000
30 – 39	0.164	0.115	0.073	-0.011	-0.242	-0.111
40 – 49	0.206	0.154	0.189	0.168	-0.246	0.174
50 – 59	0.270	0.304 **	0.117	-0.036	-0.114	-0.018
60+	0.459 *	0.459 ***	0.123	0.134	-0.637 *	0.431 *
<i>Education</i>						
< primary	0.000	0.000	0.000	0.000	0.000	0.000
< low secondary	-0.015	-0.172 *	-0.090	-0.311 **	-0.265	0.075
< High secondary	-0.313 **	-0.134	-0.409 **	-0.439 ***	-0.520 **	-0.241
Secondary	-0.320 *	-0.224	-0.690 ***	-0.752 ***	-1.018 ***	-0.384 *
Higher	-0.658 **	-0.439 *	-0.298	-0.872 **	-0.512	-1.218 **
<i>Occupation</i>						
Not working	0.000	0.000	0.000	0.000	0.000	0.000
Farm	-0.101	0.043	0.124	0.218 *	0.180	0.119
Non-farm	0.130	0.045	0.016	0.257 *	0.055	0.184
<i>Disabled</i> (ref.= no)	n/a	-0.288 ***	n/a	-0.012	n/a	0.008
<i>Received information about PWD</i> (ref.= no)						
<i>Log of income per capita</i>	0.071	0.024	-0.141 *	-0.057	0.030	0.034
<i>Main religion of hh</i>						
None (ref.)	0.000	0.000	0.000	0.000	0.000	0.000
Buddhism	-0.107	-0.112	0.244	-0.087	0.212	0.065
Catholic & others	-0.047	-0.143	0.159	-0.032	-0.106	-0.262
<i>Household size</i>	0.024	-0.010	0.029	-0.004	0.001	0.034
<i>Constant</i>	-0.186	0.365	-0.809	-1.342 **	-2.524 ***	-2.747 ***
N	3143	4668	3003	4419	3109	4570
Log likelihood	-2101.82	-3084.35	-1480.2	-2012.95	-1034.88	-1633.58

Independent variables in Model 4 and Model 5 are attitudes of households without disability toward other two statements about PWD: “disability was caused by *wrong doing* in previous incarnation or of forefathers” and “PWD often bring bad luck to other people”. Likewise the results from previous bi-variable analysis, both statements were much more assented in Thais

Binh than in Quang Nam-Da Nang and Dong Nai. The coefficient of *receiving information about PWD* is negative in both models but not significantly different to zero in Model 5. Sex of respondents and level of income appears to have no significant effects. Especially, opinions toward those two statements of Buddhist households closely reflects the ideology of this religion. Indeed, they strongly agree with the first statement but disagree with the second one.

The next two models (6A and 6B) estimate the effects of independent variables on the preference of support for PWD. In particular, the dependent variable is the answer to the question: whether employers should employ PWD or offer other supports? The results reveal that for households without disability (Model 6A), living in Dong Nai, living in rural area, receiving information about PWD, higher income per capita had significantly positive effects on their preference for employment for PWD. For households with disability (Model 6B), negative effects were from those living in Thai Binh and old age, while positive effects were high level of education, being male, receiving information, high income, and catholic households.

The impacts of independent variables on households have support for PWD are shown in Model 7A and Model 7B. Households in Quang Nam – Da Nang were much more likely than those in Thai Binh and Dong Nai to have support for PWD. Furthermore, level of education, income per capita, and receiving information about PWD were strong positive factors of providing supports. The coefficient of household size is also significantly positive in both models, suggesting that people living in large families may have a stronger spirit of charity. Nevertheless, it could be simply result from the accumulated probability of offering support to all individuals in each household. A surprising result is that for the non-disability sample, religion was a negative factor in providing support for PWD. A possible explanation is that, many religious households may prefer contributing support through religious organizations (e.g. church, pagoda) without awareness of their specific target groups.

Models 8A and 8B in Table 86 presents results from logistic regression of probability to receive information about PWD (often or sometime) for non-disability and disability sample. As indicated by both models, when other independent variables were fixed, respondents in Thai Binh and Dong Nai were undoubtedly less likely than those in Quang Nam-Da Nang to receive information about PWD. Males, middle ages (from about 30 to 59), education level, and income were important positive factors in receiving information. The coefficient for working respondents is negative in the non-disability sample, while working status seems to have no clear effects in the disability sample. The coefficients for Buddhist and other religions are negative in both models, but only the coefficient of Catholic and other religions in the disability sample is statistically significant. These findings could be useful in improving communication programs supporting PWD.

The logistic regression method was also applied to model the understanding of respondents about the definition of Agent Orange (Models 9A and 9B). The dependent variable takes value 0 or 1 for every incorrect or correct answer. The first point to note is that the coefficients for Thai Binh and Dong Nai are positive, though the threat of Agent-Orange contamination to environment in Quang Nam-Da Nang is apparently more serious than in Thai Binh. For the non-disability sample, urban area had negative effect in the presence of

other independent variables. It is not surprising that being male, education level, and income were significantly positive factors of correct awareness of Agent Orange. Compared with young respondents (under 30), older groups appeared to have positive effects. However for the non-disability sample (Model 9A), only the coefficient of the age group 40-49 is statistically significant. That means middle-aged and older respondents in households with disability had much better knowledge of Agent Orange than young people, while the situation was not so clear in households without disability. In addition, the results indicate positive impact of Buddhist religion, though this phenomenon may need further information to explain.

Table 85. Regression models of attitudes and supports towards PWD

Independent variables	Model 4	Model 5	Model 6A	Model 6B	Model 7A	Model 7B
<i>Province</i>						
QN-DN (ref.)	0.000	0.000	0.000	0.000	0.000	0.000
Thai Binh	0.511 ***	0.795 ***	0.106	-0.247 **	-1.170 ***	-0.484 ***
Dong Nai	-0.139	0.132	0.219 *	-0.128	-1.510 ***	-1.176 ***
Urban (ref.=rural)	-0.197	0.133	-0.235 *	-0.123	0.078	-0.260 *
Male (ref.=female)	-0.125	-0.022	0.086	0.181 **	-0.289 *	-0.051
<i>Age of respondent</i>						
< 30 (ref.)	0.000	0.000	0.000	0.000	0.000	0.000
30 – 39	-0.001	0.297	0.125	0.047	0.044	-0.031
40 – 49	0.170	0.333 *	-0.032	-0.024	0.152	0.098
50 – 59	0.294	0.164	-0.101	-0.089	0.159	0.133
60+	0.222	-0.107	0.043	-0.327 *	0.269	-0.089
<i>Education of responde t</i>						
Less than primary	0.000	0.000	0.000	0.000	0.000	0.000
< low secondary	-0.223	-0.320 *	0.067	0.114	0.315 *	0.099
< High secondary	-0.371 **	-0.450 **	0.223	0.329 ***	0.817 ***	0.572 ***
Secondary	-0.723 ***	-0.762 ***	0.140	0.427 ***	0.868 ***	0.473 **
Higher	-1.490 ***	-0.915 **	0.348	0.517 **	0.765	1.084 **
<i>Occupation</i>						
Not working	0.000	0.000	0.000	0.000	0.000	0.000
Farm	0.089	-0.341 *	-0.100	0.035	0.420 *	0.190
Non-farm	0.174	-0.109	-0.046	0.028	0.262	0.067
Disabled (ref.= no)	n/a	n/a	n/a	0.037	n/a	-0.129
Received information about PWD (ref.= no)	-0.393 ***	-0.136	0.514 ***	0.253 ***	0.923 ***	0.989 ***
Log of income per capita	0.093	0.043	0.156 **	0.155 ***	0.642 ***	0.718 ***
<i>Main religion of household</i>						
None (ref.)	0.000	0.000	0.000	0.000	0.000	0.000
Buddhism	0.678 ***	-0.442 *	-0.180	0.161	-0.366 *	0.052
Catholic & others	0.074	-0.306	-0.030	0.420 ***	-0.448 **	-0.138
Household size	0.049	-0.058	0.024	0.020	0.074 *	0.122 ***
Constant	-2.251 ***	-1.897 **	-1.862 ***	-1.965 ***	-3.889 ***	-5.358 ***
N	3071	3183	3174	4708	3213	4735
Log likelihood	-1391.7	-1144.9	-2150.9	-3144.3	-1071.9	-2303.1

Table 86. Regression models of receiving information about PWD and knowledge of Agent Orange

Independent variables	Model 8A	Model 8B	Model 9A	Model 9B
<i>Province</i>				
QN-DN (ref.)	0.000	0.000	0.000	0.000
Thai Binh	-0.494 ***	-0.423 ***	0.199	0.423 ***
Dong Nai	-0.616 ***	-0.536 ***	0.711 ***	0.701 ***
<i>Urban</i> (ref.=rural)	0.033	-0.107	-0.311 **	-0.006
<i>Male</i> (Ref.=female)	0.296 ***	0.377 ***	0.632 ***	0.481 ***
<i>Age of respondent</i>				
< 30 (ref.)	0.000	0.000	0.000	0.000
30 – 39	0.385 ***	0.062	0.146	0.340 **
40 – 49	0.492 ***	0.363 ***	0.326 **	0.749 ***
50 – 59	0.671 ***	0.327 **	0.311	0.820 ***
60+	0.106	0.275 *	0.359	0.741 ***
<i>Education of respondent</i>				
Less than primary	0.000	0.000	0.000	0.000
< low secondary	0.511 ***	0.576 ***	0.509 ***	0.417 ***
< High secondary	0.805 ***	0.888 ***	0.465 **	0.500 ***
Secondary	1.175 ***	1.221 ***	0.954 ***	0.695 ***
Higher	1.493 ***	1.304 ***	1.026 ***	1.335 ***
<i>Occupation</i>				
Not working	0.000	0.000	0.000	0.000
Farm	-0.226	-0.045	-0.098	-0.153
Non-farm	-0.304 *	0.016	0.037	0.078
<i>Disabled</i> (ref.= no)	n/a	0.020	n/a	0.055
<i>Log of income per capita</i>	0.386 ***	0.298 ***	0.255 ***	0.166 **
<i>Main religion of household</i>				
None (ref.)	0.000	0.000	0.000	0.000
Buddhism	-0.197	-0.146	0.408 **	0.278 *
Catholic & others	-0.198	-0.439 ***	-0.166	-0.017
<i>Household size</i>	0.042	0.055 **	0.058 *	0.052 *
<i>Constant</i>	-2.884 ***	-2.658 ***	-4.846 ***	-4.584 ***
N	3234	4783	3234	4783
Log likelihood	-1762.53	-2978.57	-1680.3	-2189.36

9 SUPPORTS TOWARD PWD

Care and support for PWD has been considered to be a tradition in Vietnamese society. It is also a priority issue in the Government's social policy framework. Since its inception in 1945, the government of Vietnam has issued various policies and legal documents that have created a favorable legal framework for resource mobilization and implementation of assistance activities for PWD.

9.1 Legal provisions

The first important legal document is the Constitution of Vietnam in 1946 and its amendments (in 1980 and 1992) confirming the undeniable equal rights of disabled people. The Constitution also forms the fundamental base for the construction of more specific and direct policies to support PWD in many aspects of life. Examples of these policies include the Labor Code (1994), the Decree 81CP (1995), the Laws of Protection and Care for Children (1996).

Most notably, on July 30th 1998, the Standing Committee of the National Assembly promulgated the Ordinance for Disabled Persons that stipulates clearly roles and responsibilities of government bodies, society and families towards PWD and affirms their rights in key areas of life, including health, education, employment and social participation. The Ordinance also defines the date of April 18th to be the Day of Care and Protection of People with Disability.

Social assistance

One year later on July 10th 1999, the Government issued the Resolution No 55/ND-CP that provides guidelines for the implementation of some Articles of the Ordinance. It stipulates norms of regular minimum subsidization to a person with disability who does not have any source of income; and who does not have family; or who has family but with economically insufficient income to receive an amount of 45,000 VND per person per month from commune's or ward's authorities; or to receive an amount of 100,000 VND per person per month at a social support center established by the government. A severely mental disabled person living at a fostering center established by the government receives an amount of 115,000 VND per month.

Health care

The Resolution also confirms the rights of PWD to receive guidance, advice, and services, including rehabilitation, at health care establishments. The Article 8 stipulates in detail that a person with disability who is defined to have artificial limbs or orthopaedic devices can buy those devices according to the government stipulated (reduced) price or can be provided free of charge if being recommended by his/her commune's or ward's People Committee. For severely disabled people who do not have any source of income; and who do not have anyone to rely on; and who are classified by local government to be poor can have health care costs

exempted. When a severely disabled person who is under subsidization scheme dies, burial services are undertaken by the local People's Committee or by the fostering center.

Education

Before 1995, education for children with disability used to be under the responsibility of MOLISA. On April 17th 1995, the Government has approved the Decree 26/CP on transferring this responsibility to the Ministry of Education and Training (MOET). On October 11th 1995, MOET has issued the Circular 20/GD-DT guiding and assigning the responsibilities for different institutions under MOET to plan of development of education for disabled children into a sub-branch of the national education system.

Chapter III of the Ordinance defines the support and the creation of favorable conditions and other regulations applied to students with disability, including considerations for exemption or reduction of school fees and other school contributions; and receiving social subsidies and scholarships. Education for CWD is provided either in integrated education in general schools or in specialized schools. Teachers teaching in specialized schools are granted special allowances.

More specifically, the Resolution No 55/ND-CP stipulates in the Article 11 that students with disability who have no one to rely on; and who are recommended by the commune/ward People's Committee to be fostered in support centers are exempted of school fees during the time of staying there and receive a social subsidy with an amount of 100,000VND per person per month; and they are provided with books, notebooks, learning tools according to the Regulations of MOET. Teachers of specialized schools/classes for general education or vocational training should receive special allowances. Private organizations which open schools, or charity classes teaching general education or vocational training to PWD should receive convenient conditions for getting working license by local authorities. The Education Law promulgated on December 11th 1998 encourages organizations and individuals to open schools/classes for people with disability in order to help them to have rehabilitation, education, vocational training, and social integration.

The Law of Protection and Care for Children and the Law of Universalization of Primary Education also address the education for disabled children.

In 1997 the Prime Minister has approved the Resolution 121 Ttg on the scholarship for disabled students in public universities and vocational schools: a disabled student should receive 120,000VND a month.

Vocational training and employment

The Article 13 of the Labor Code issued in 1994 confirms that the Government, enterprises and the entire society have responsibilities to provide jobs and to ensure that all people who are capable of work to have opportunities for employment. The Chapter XI, item III defines specific regulations for laborers with disability. Article 125 of this Item confirms that the Government will protect the rights to work of PWD and encourage job creation for them.

Every year, the Government spends a certain budget to assist people with disability to rehabilitate, improve working capacity, and to attend vocational training. The Government has a policy to give them loans with low interest rates for job creation. Production or vocational training establishments accepting PWD to work will get support or tax exemptions or reductions, and will be given loans with low interest rates. Establishments which do not accept people with disability have to pay an amount to the Employment Fund in order to assist people with disability.

According to the Article 126, working time for disabled laborers is 7 hours per day and 42 hours per week. Article 127 defines regulations and working conditions for disabled laborers. According to Article 128, laborers who are invalid, disabled veterans should receive a special subsidy besides the above stated benefits.

The Resolution No 81/CP of the Government issued on November 23rd 1995 defines that PWD studying at a government vocational training center should receive an exemption of 50 percent of tuition fee if they lost from 31-40 percent of their working capacity; 100 percent of tuition fee if they lost 41 percent or more of their working capacity. During their period of training, if they do not have a salary, allowances, or scholarship, they should receive a social subsidy of 100,000VND per person per month. This Resolution provides a series of regulations on subsidy to PWD in the duration of their vocational training and duration of looking for jobs.

The Circulation No 23/TCT of the Ministry of Finance (MOF) about tax exemption to production units having PWD defines regulations of tax exemption to businesses meeting stipulated requirements including sale tax, income tax, housing tax, and tax on use agricultural land.

The Ordinance defines the Chapter IV regulations on employment and vocational training for PWD. The Government and economic organizations should have responsibilities to create favorable conditions for people with disability to choose suitable occupation, vocational training, and employment. Vocational training centers and production units having PWD should receive loans, subsidized teaching devices, and production equipments as well as tax exemption from the government.

The Resolution No 55/ ND-CP of the Government clearly stipulates that PWD who are in needs of professional orientation, consultation, vocational training, and employment should receive help from employment service centers with reduction/or exemption of service fee. In the case PWD are themselves employed, they should receive priority to borrow loans with special interest rates according to laws. Article 10 defines that schools or vocational training facilities should give exemption or reduction of tuition fee and other contributions, or provide scholarships and social allowances to students with disability studying at vocational facilities or undergoing update vocational training at public schools.

Article 21 of the Ordinance and Article 13 of the Resolution No 55/CP define that administrative organizations which have demand for recruitment of new staff or for labor contracts should inform in public about their demand and should not refuse people with

disability if they show sufficient working ability. Criteria for selection should be applied to both non-disabled and disabled people with the exception of specific cases.

Participation in cultural activities and sport; and to use of public facilities

The Chapter IV of the Ordinance defines favorable conditions for PWD to participate in cultural activities, sports and to utilize public facilities. Articles 24 and 25 stipulate that the Government and society should create favorable conditions for PWD to develop their potentials and ability in literature and arts, sports, sciences and technologies; their creativity in works, performances, competitions at home country and abroad; and to participate in other cultural and sport activities. Article 26 defines that the construction of houses, public facilities, transportation and communication means should consider utilization needs of PWD. In addition, on November 17th 2002, the Ministry of Construction issued the Vietnam Construction Standards: TCXD-VN 264/2002 “Houses and construction – Fundamental principles on construction to assure PWD accessibility and Use”; TCXD-VN 265/2002 “Roads and pavements - Fundamental principles on construction to assure PWD accessibility and Use”; and TCXD-VN 266/2002 “Residential houses - Fundamental principles on construction to assure PWD accessibility and Use”.

Article 11 of the Ordinance on Sport approved by the Standing Committee of the National Assembly on September 25th 2000 stipulates that the Government and the society should create favorable conditions to help PWD to participate in sports and physical activities; to provide means and convenient conditions for training and competitions of games which are specifically for PWD. Article 36 defines that sport and physical facilities should have responsibilities to help and support PWD to participate in sport and physical activities.

International agreements

Vietnam is one among many nations which actively supported and participated in international activities and treaties for disabled people. In 1982, in response to the International Year of Disability promoted by the United Nations, the Government of Vietnam has established the National Committee for the International Decade of Disabled People. In 1993, Vietnam signed the Joint Declaration on the Rights to Equal and Full Participation of Disabled People of the Asian –Pacific Region.

9.2 Institutional structure of support

State

The Chapter V of the Ordinance defines the government management of the protection and care for PWD. MOLISA is assigned to be the chief ministry responsible for the overall management of activities relating to protection and social assistance for people with disability. Other line ministries and ministerial level organizations have responsibilities to coordinate with MOLISA in their programs of PWD support. The People’s Committees at all levels have responsibilities to manage the implementation of protection and care for PWD residing living in their localities.

The Chapter III of the Resolution No 55/ND-CP also stipulates that MOLISA implements the government management of protection and care for people with disability in the whole country. Ministry of Health takes responsibility in providing health care for disable people including rehabilitation, orthopaedic, and primary health care for disability prevention. MOET takes responsibilities to train teachers, to develop curricula, and textbooks for teaching students/pupils with disability.

According to Article 26 of the Ordinance, the Ministry of Construction, the Ministry of Transportation and other related ministries should develop construction standards used in constructions of public facilities, hospitals, schools, offices and transportation means that meet utilization demands of PWD. The Ministry of Construction defines prioritized regulations for PWD in using public transportation; reduction/exemption of transportation fees; and exemption of fees for transportation of wheelchairs and trolleys serving PWD.

The Ministry of Culture-Information and the mass media are responsible for propaganda, to widely introduce measures of disability prevention, policies, and regulations of the government to people with disability, to promote assistance to people with disability in the community; to develop and broadcast education programs about people with disability; to create favorable conditions for disabled people to participate in appropriate cultural activities. Other ministries and branches take responsibilities to implement the protection and care for people with disability according to their defined functions, responsibilities and authorizations.

The People's Committee at different levels is responsible to implement the government management of protection and care for disable people living in localities; to identify the number and structure of disability population in the localities; to implement policies, and to promote disability prevention and assist disabled people.

In February 2001, the Coordination Committee of Assistant Activities for People with Disability was established with members who are representatives from MOLISA, MOET, Ministry of Construction, Ministry of Transportation, MOH, Ministry of Culture and Information, Committee of Sports and the Association of Blind People in Vietnam.

Mass organizations

Besides government organizations, mass organizations such as the Women's Union, the Veteran Association and other organizations of people with disabilities such as the Association of Blind People, the Red Cross, etc. are also actively involved in assistance activities for disabled people.

During recent years, many social organizations supporting people with disability have been established and are very active. Examples include the Association of Social Protection of Disabled Children and Orphans (1993), the Vietnam Association of Supporting Disabled Children (1994), etc. The movements of disabled people supporting each other, especially in Ho Chi Minh City, have been set up and proved to be effective. This reflects the shift from the tendency of passively receiving support from the state to the active tendency of self-help and mutual support of PWD themselves.

9.3 Policy implementation

Regarding the implementation situation of these above policies, as of 2002, 111,185 people with serious disabilities (30.6 percent of the total) received social assistance in their communities or social protection centers. The number of PWDs receiving social protection in 2002 was double that in 1998 when the Ordinance on PWDs was promulgated. Of the 327 social protection centers in existence in 2003, there were 21 centers established and funded by the Government. There were nearly 610,000 PWD who were wounded soldiers and those that benefit from Decree No. 28/CP of 29/4/1995. There were about 29,000 people that participated in the resistance and about 40,000 children that were affected by toxic chemicals received monthly social assistance allowance.

As of June 2001, the community-based orthopaedic rehabilitation network has been extended to 41 provinces. Training was provided to 74 percent of families having PWD. 44 percent of PWD were integrated into their communities, and 56 percent of children went to school and integrated into their communities.

From 1998-2002, about 12.5 percent of people with serious disabilities, that is 2.9 percent of the 5.1 million PWD, underwent orthopaedic rehabilitation operations.

In 2003, there were 70 special schools for 6,000 children with disabilities and 50,000 children with disabilities were going to integration classes. There were about 16,000 vision impaired people studying Braille. There were about 400 businesses for PWD with a total number of 15,000 employees.

According to an assessment of the Government, these above policies have created a favorable legal environment for PWD and their organizations' access to basic social services and economic activities. There has been a rapid increase in the number of PWD receiving social assistance, orthopaedic rehabilitation, free health care and medical treatment, vocational training and found jobs. The issue of assistance to PWD has been broadened, it now includes the promotion of PWD participation in all aspects of social life. There are more associations for PWD and international cooperation in the interests of PWD has been expanded. Overall, a nation-wide movement to care for PWD has been promoted.

From the government's point of view, according to the assessment, weaknesses identified are as follows:

- There is not yet a harmonization among the related legal instruments and policies;
- A number of implementation guidelines are still vague and they were not provided in time for prompt implementation of the related legal instruments and policies;
- Regarding resources, the Government budget for PWD has increased but remains limited;
- Advocacy work has not been done regularly and needs more substance, especially at the grassroots level;

- Just a limited number of children with disabilities can go to school. Current models of special education or integration education for them need to be made more effective and there need to be more teachers trained to educate children with disabilities;
- Capacity in health care, medical treatment and orthopaedic rehabilitation remain limited;
- Management and use of resources, including monitoring work, need to be improved to enhance coordination, effectiveness and transparency;
- There needs to be stronger and more effective policies and measures to prevent injuries;
- Most public facilities do not have features convenient for PWD access and use.

9.4 Support for PWD at the surveyed communities

Indeed, the major assistance and care for most disabled people in Vietnam comes from their families and communities. In the survey, we attempted to document the support that the community gave to PWD in the studied areas. We also wanted to understand perception of the community towards the support needs of PWD, as it will significantly define directions of actual support towards more efficiency.

It is encouraging to see that, as proved by the data, the majority of families in the studied areas supported PWD at least occasionally. However, care should be taken in concluding about the readiness, or willingness, of the community to support PWD. It should be noted that support for PWD is a policy matter which has been translated into actual programs. Increasingly the government insists

Table 87. Family support for PWD (%)

	Thai Binh	QN - DN	Dong Nai
Often	12.4	17.0	12.1
Sometimes	74.5	77.6	64.1
Never	13.2	5.4	23.7
Total	100.0	100.0	100.0
N	1085	1078	1079

on societal responsibility towards various social issues, including support for the poor and the disabled. A specific term for this new approach is “socialization”, which essentially means societal contributions both in terms of material and labor inputs. At the community level, local people were asked, sometimes with administrative enforcement measures, to contribute money to various social programs, either national or local. Thus, the high percentage of families supporting PWD should be considered less in terms of their readiness and willingness. As a matter of fact, in our interviews, many respondents said that they were “forced” to support PWD.

Still, from 5 to about 24 percent of families at the studied provinces never support PWD. The percentage varied across provinces, with the highest in Dong Nai and the lowest in Quang Nam – Da Nang (Table 87).

Table 88. Forms of support (%)

	Thai Binh	QN - DN	Dong Nai
Money	93.1	91.0	84.3
Food or/and clothes	17.4	24.2	41.6
Moral	46.2	40.4	30.0
N	1085	1078	1079

Table 88 lists three major forms of support that the families in the studied provinces gave to PWD, namely money, food and/or clothes, and moral support. Again we see that the support is charitable in nature. Few families

reported support such as information provision, employment introduction or provision, support in work, or calling for overall community support for the PWD.

Support is mainly psychological and sentimental.... Occasionally we received some sugar and milk. (Female respondent, Thai Binh)

Obviously, an important factor contributing to the willingness and actual support of households towards PWD is economic, i.e. households with higher income should have more capacity to provide support. Data from the survey show that there were much higher proportions of households with higher income often supporting PWD, compared to households of the lower income brackets. For example, in Thai Binh, while the proportion of households with income per capita higher than 5.5 million dong often supported PWD was 18 percent, the figure for households with income per capita lower than 3 million dong was just 6 percent. In Quang Nam – Da Nang, these figures were 23 versus 12 percent. For Dong Nai, it was 17 against 5 percent. These gaps in support are illustrated in Chart 47.

Chart 47. Household often supported PWD by income group (%)

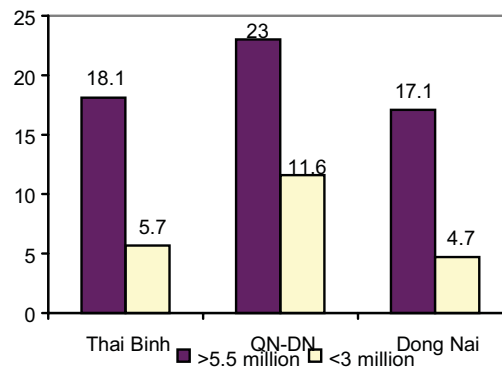
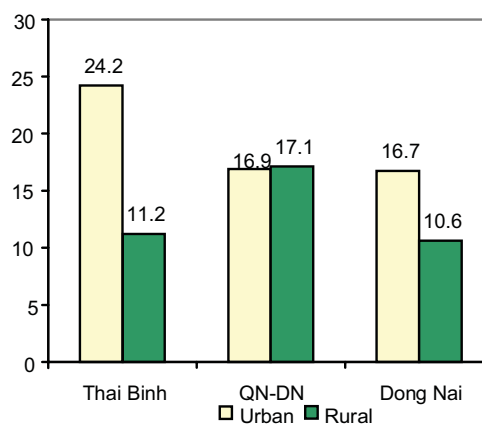
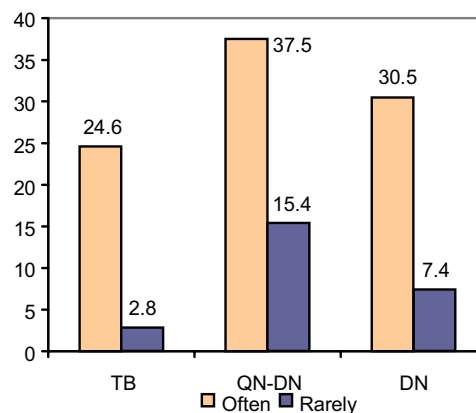


Chart 48. Household often supported PWD by area (%)



Support for PWD also varied between urban and rural areas. Clearly, urban households are often in a better economic situation to provide support. Except for the case of Quang Nam – Da Nang, for the other two provinces of Thai Binh and Dong Nai, we can see a clear gap between urban and rural households that often supported PWD (Chart 48).

Chart 49. Households often supported PWD by frequency of information receiving (%)



Frequency of receiving information on PWD also plays an important role. Comparison between households that often and those that rarely received information show a large gap, as the percentage of households of the former groups that often supported PWD was much higher than that of households of the latter group. In Thai Binh, the gap was between 25 percent of the former group of households and merely 3 percent of the latter group. In Quang

Nam – Da Nang, it was 38 versus 15 percent. For Dong Nai, the gap was between 31 and 7 percent (Chart 49).

Beside support that came from other families in the communities, in the survey, we also collected information about actual government

studied communities. Figures in Table 89 show clearly that most of the support was on tax reduction, tuition reduction or waving, social / health insurance, free medical treatment, rehabilitation, wheelchair.

respondents in various areas of human development and social participation, for example in employment provision, vocational training, recreational and cultural activities, and participation in local organizations. Clearly, these above supports, while helpful, did not fully meet the needs of PWD. These supports, as we can see, were more towards social assistance, rather than capacity building and social participation. As expressed by a local government official in Thai Binh, such supports, although needed, are not sustainable. It can also be counter productive, making PWD more dependent.

Table 90 listed what PWD themselves wanted to see developed in their community. As we can see, many respondents wanted to have support relating to employment and vocational training, reflecting not only the need to improve family income, which is often low among family with PWD, but also their desire to have their rights to work achieved. Employment therefore should be seen as an urgent social need for PWD.

Needless to say, many respondents were really concerned about having social and health insurance as well as free medical treatment, as current support did not meet demand. Finally, some considered having more institutions where care is provided to PWD as an important need.

Table 89. Observed supports at community (%)

	Thai Binh	QN-DN	Dong Nai
Social Assistance			
Social/health insurance	52.4	63.8	27.1
Free medical treatment	39.7	58.2	26.2
Rehabilitation	9.0	15.5	10.0
Wheelchair	9.6	17.0	11.6
Capacity building			
Employment	6.7	9.6	7.9
Vocational training	6.1	8.9	6.7
Organization participation	5.0	8.4	1.5
N	1568	1633	1625

Table 90. Further supports needed (%)

	Thai Binh	QN-DN	Dong Nai
Employment	36.4	28.2	35.0
Vocational training	21.5	12.9	14.0
Social/health insurance	33.1	28.8	33.0
Free medical treatment	36.5	24.8	42.0
Rehabilitation	27.7	26.3	26.3
N	1568	1633	1625

Government's and societal support should be comprehensive, and should not be charity-oriented, i.e. we should give them the fishing-rod, not the fish. Charity-like support make them over reliance. (Local government official, Thai Binh)

The disabled persons should know clearly that they can not simply ask the government and society to care about them. They must assert themselves first so that they can take advantage of support given to them. Government and societal support should be considered as a catalyst only. We cannot totally depend on the government. (Local government official, Thai Binh).

Ironically, other important needs regarding social participation were not seriously considered by community and PWD themselves. This however does not reflect reality, as those needs are strong. Rather, it shows how needs were socially constructed: people do not see the benefits of social participation for PWD, including PWD themselves.

PART 3. CONCLUDING REMARKS

We come now to some key concluding remarks of the report. These remarks are supported by empirical data collected from the survey of 8,068 households randomly selected from all the households in 49 rural communes and urban wards of the four selected provinces, and from 5,497 PWD who are the members of these households. Among these PWD, one important group included the people who were reported to be affected by Agent Orange (AO).

Remark 1: PWD, particularly those affected by the AO, is a particularly disadvantaged population regarding their demographic and socioeconomic characteristics.

A sample of 8,068 households was randomly selected from all the households in 49 rural communes and urban wards of the four studied provinces. Of those households, 4,826 had members who were PWD (5,497 individuals in total). The rest were households without PWD, to be selected as the control group in analysis. Preliminary findings evidenced the following difficulties that the PWD have:

Demography of disadvantages: Key demographic characteristics of the households with PWD show disadvantages compared to those households with no members with disabilities. Households with PWD tend to have either a shortage of labor (thus having low production capacity) or too many dependents to support (economic burden). More of the households with PWD are headed by females (lower social status). Educational attainments of household members are generally very low, with many members having education below the primary level (low labor quality). Many of the household heads are PWD themselves with poor health.

Poor assets: Households with PWD are more likely to live in inadequate houses with very poor conditions for health. Their houses tend to be in geographically disadvantaged locations with difficulties in accessing economic opportunities and basic social services.

Low income and expenditure: Those households with PWD can sustain only minimum income for survival. Household expenditure is consequently very low, hence affecting the well-being of all household members.

Unemployment: Few PWD aged 15 and above are employed; Most PWD either never work or used to work but were unemployed at the time of the survey. Disability is the major cause of their unemployment.

Remark 2: Because of their disability-caused disadvantaged status, PWD are facing multiple and critical vulnerabilities in all spheres of life

Disability is the major causes of PWD difficulties in performing daily activities, in education, employment, access to health care services, marriage and child bearing, and social participation, including cultural and sporting activities. To cope with these difficulties, PWD mostly rely on the support of their families as the major source of assistance. These difficulties are however worsened by the negative attitudes towards their disability from the community where they live (see more in Remark 3).

Remark 3: Perception of society on disability is negative, viewing them as being “abnormal”. Largely because of it, there are evidences of widespread stigma and discrimination (S&D) in various forms against PWD in different settings (family, community, schools, hospital, workplace, and local organizations). The very poor awareness of the society on the rights of PWD and government policies on disability has worsened the situation.

Negative perception of community: Almost all the community populations consider PWD as being “pitied”, and there are high percentages of them view PWD as being over-reliant on others; cannot live “normal life” like the other people, thus it is good to send all PWD to institutions for “better care”; PWD deserve their fate because they are paying the “price” for bad conduct in their “previous lives”; and it is “bad luck” if encountering PWD.

Discrimination in family: A high number of the respondents know PWD who are discriminated against by their own family members: disregarded; considered to be a lifelong burden; “useless being”; consistently insulted; left without care; even abandoned; provided with no food; locked/chained in house; forced to beg. Many of families with PWD blamed “fate” for having member(s) with disability.

Discrimination in community: Various forms of discrimination against PWD are found in their own community. Many respondents reported knowing PWD in the community who are: disregarded; insulted; ignored in community activities; refused to marry; beaten up; refused to be served in restaurant/shops; and sexually abused;

Poor awareness of policies and rights of PWD: A considerable proportion of the surveyed people had never heard of the Ordinance on Disabled Persons; or had heard of the Ordinance but know nothing of the content.

Remark 4: Stigma and discrimination is the direct cause of the marginalization of PWD and their exclusion from community socioeconomic, political and cultural activities. Stigma and discrimination have also caused a high level of unemployment and low education among PWD. It has also prevented many PWD from pursuing married life and having children which are very important culturally.

Discrimination at work place: Forms of discrimination include: job refusal; disrespect at work; assigning to “appropriate jobs” (low paid; low status); refusing to be promoted; having only short-term contract; few/no opportunity to receive training; labor exploitation; etc.

Discrimination in education: The general perception of the community of the education needs of PWD is very poor: Many think that PWD of various disabilities should not go to school as they will not be able to learn or will affect the learning of other “normal” students. Partly as a result of these attitudes, most PWD never go to school. For those who did attend school, or could not finished primary education level. Most of students with disability have difficulties at school because of their disability, including difficulties in travel, learning, communication with teachers and classmates, participation on school activities, disability-unfriendly school

infrastructure; teachers' lack of skills to teach PWD, discriminatory behaviors of classmates and teachers.

Discrimination regarding marriage and having children: A rather common view of the surveyed people is that PWD should not get married because: PWD cannot have a “normal life”; unable to support themselves and their family; will be burden for their family. Similarly, many of the community think that women with disability should not be having children because: they will not be able to raise their children; more burden for themselves and their family; their children can be disabled “genetically”. Partly as the result of these attitudes, about a half the PWD aged 15 and above have never been married.

Discrimination regarding social participation of the PWD: Community people tend to think that PWD should not participate in social activities. As a result of these attitudes, most PWD do not participate in any local organizations (formal and informal) and in cultural and sporting activities in their community.

Self-stigmatization of PWD: Societal attitudes towards PWD in fact constructed PWD as being “disabled” (disability is a social product). There are quite few PWD think of themselves as being “normal”. Most PWD consider themselves as being inferior, having an inferiority complex, difficult to integrate into community life, thus avoiding social participation.

Remark 5: Since the rights of PWD are poorly realized and mainstreamed into current socio-economic agenda, support for PWD is limited to the provision of a safety net. It has also limited efforts of the government to mobilize community resources to support PWD. There is therefore a large gap between PWD's real needs and the actual support they receive.

Charity driven rather than human development support from government and community: Observations of the respondents show most supports come through provision of health and social insurance or hunger relief rather than employment, vocational training, and social participation. Supports are therefore sporadic and unsustainable in nature.

Remark 6: Compared to other groups of PWD, those affected by dioxin are found in the survey to be in more critical conditions of disability and therefore face much more difficulties in almost all areas of work and life.

Remark 7: A new approach in social policies for PWD is urgently needed with a shift in focus towards human development (human capacity building) and the provision of an enabling environment for their active and sustainable integration into life as equal members of the community.

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