Young Lives Preliminary Country Report: Vietnam

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September 2003

Young Lives

An International Study of Childhood Poverty

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Abbreviations

ADB	Asian Development Bank
AFTA	Asian Free Trade Area
CEMMA	Committee for Ethnic Minorities and Mountainous Areas
CHC	Commune Health Centre
CPFC	Committee for Population, Families and Children
CPRGS	Comprehensive Poverty Reduction and Growth Strategy (of Socialist Republic of Vietnam)
CSDS	Centre for Social Development Studies
DFID	Department for International Development, UK
GCHCC	General Clinic and Health Consulting (Ngoc Khanh, Hanoi)
GSO	General Statistics Office
GTZ	Gesellschaft für Technische Zusammenarbeit
HDI	Human Development Index
HEPR	Hunger Eradication and Poverty Reduction (nationwide programme of the Government of Vietnam)
ILSSA	Institute of Labour (MOLISA)
IMR	Infant mortality rate
MDRC	Market and Development Research Centre
MOET	Ministry of Education and Training
MoF	Ministry of Finance
MoH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
MPI	Ministry of Planning and Investment
NIN	National Institute of Nutrition
NIS	National Institute of Sociology (National Centre for Social Sciences and Humanity)
NCSSH	National Centre for Social Sciences and Humanity
NGO/INGO	non-government organisation/international non-governmental organisation
NPA	National Plan of Action for Children
PAC	Policy Advisory Committee
PCPFC	Provincial Committee for Population, Family, and Children
RTCCD	Research and Training Centre for Community Development
SC UK	Save the Children UK
SC-UK VN	Save Children UK, Vietnam Office
SDQ	The Strengths and Difficulties Questionnaire (for mental health section)
SED	Social and Environmental Department (General Statistics Office)
SOE	state owned enterprises
TAC	Technical Advisory Committee
UK	United Kingdom
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VLSS	Vietnam Living Standards Survey (conducted in 1992/3 and 1997/8)
VUSTA	Vietnam Union of Scientific and Technological Associations

Preface

The Young Lives project is a longitudinal study on child poverty being carried out in Ethiopia, India, Peru and Vietnam (website: http://www.younglives.org.uk/). The research is co-ordinated by an academic consortium involving the University of Reading, the London School of Hygiene and Tropical Medicine, London's South Bank University, the University of Sussex, the South African Medical Research Council, and Save the Children UK, which is also the dissemination and advocacy partner. The UK Government Department for International Development (DFID) is funding the first phase of the project. In each of the countries, this included the first survey of 2000 index children aged around one year and a survey of 1000 children aged around eight years, covering different geographical areas. The Young Lives project is unique in measuring child wellbeing in a holistic and consistent way across several developing countries, including economic, social, physical and demographic aspects. The first round data collection finished in 2003 and an important priority has been the early production of a preliminary report from each country, each report following a similar structure.

This preliminary report covers only a small selection of the explanatory and outcome variables. Data are mainly presented for the entire sample of an age group, in most cases separated into wealth groups or by urban/rural location. The full richness of the data is not reflected in this preliminary report, but we hope that it contains enough information to prompt academics, practitioners, policy-makers and other stakeholders to provide ideas, comments and questions to the Young Lives team.

These will feed in to further analysis plans, which will include work on the three main 'story lines' of the project: the effects on child wellbeing of (i) access to and use of services, (ii) social relations, and (iii) livelihoods. As in any longitudinal research, the most interesting and important results will come after several rounds of data collection – we hope to survey our index children approximately every three years until they are fifteen. However, an examination of this first round – like a single snap-shot, cross-sectional study – can produce notable results even at this early stage.

For further information on the Vietnam component of the Young Lives project, please contact Pham Thi Lan (phamlan@scuk.netnam.vn) or Tran Tuan (rtccd@hn.vnn.vn), or access the local website (www.younglives.org.vn).

Acknowledgements

Executive summary

Young Lives: An International Study of Childhood Poverty aims at improving our understanding of the causes and consequences of childhood poverty in the developing world, and at informing policy to reduce it. In each of four developing countries, a longitudinal survey will follow children every three years until they are 15.

In Vietnam the project is implemented by three organisations, the Research and Training Centre for Community Development (RTCCD), General Statistics Office (GSO) and Save the Children UK.

In terms of the first round of research, 2000 index children aged 6–17.9 months and 1000 children aged 7.5–8.5 years and their households were selected from 20 sentinel sites across five provinces. Survey methods included household questionnaires, anthropometry, a questionnaire and a test of mental aptitude for eight-year-old children, and a community questionnaire. Fieldwork was undertaken in late 2002.

This preliminary report on descriptive results of round one of data collection will be followed by explanatory analyses. Following are some of the highlights from the preliminary analysis of results.

1. The index children

Of these children, 52 per cent were male. The majority (80 per cent) were from rural areas. Almost all were cared for by their biological mother (99 per cent) and lived with both parents (97 per cent), while 87 per cent saw their father daily. Forty-four per cent had no siblings.

2. Caregivers of index children

Twenty-seven per cent of caregivers of index children had never attended school. Of those that had been to school, 38 per cent had experienced an incomplete primary education or had only completed primary level. The majority (86 per cent) were Kinh. One-in-five caregivers had mental ill-health (such as depression or anxiety).

3. The index children's households

Twenty-nine per cent of household heads had never attended school. Of those that had, 32 per cent had received an incomplete primary education or had completed just the primary level. In 15 per cent of cases, females were the household heads. Electricity was available in 85 per cent of the households (falling to 43 per cent for the poorest). Potable water was not available to 68 per cent of households, and 85 per cent of the poorest have homes with earth floors.

4. Nutrition of index children

Of the index children, 16 per cent were stunted (this is low by international standards) and 23 per cent were underweight (this is a high level). Six per cent were wasted (a medium level). Levels of stunted and underweight children are twice as high in rural areas than in urban areas. Stunting rates among the poorest are at 27 per cent. This falls to just one per cent among the better off, with a similar scale of difference for rates of underweight children. Rates of wasting do not differ by wealth.

5. Physical health of index children

Of the children included in this survey, four per cent had a long term illness, 17 per cent had been ill in last 24 hours, and nine per cent had suffered from a severe injury or accident.

6. Antenatal care in relation to index children

The majority of mothers (83 per cent) made at least one antenatal care visit, but only 59 per cent of the poorest did so, compared with 98 per cent of the better off. Rural women were less likely to receive care (80 per cent) compared to urban women (95 per cent). One-fifth of children were born outside of health facilities, without medical attendance, but most of these cases were among the rural poor. Forty-five per cent of the poorest delivered at home.

7. Immunisation of index children

Immunisation rates were high, with measles vaccination rates for children over a year old running at 88 percent. This was slightly lower among the poorest and in rural areas.

8. Care of the index child

 A third of the children had been cared for by non-household, non-family members (at least twice a month) and three per cent had been left alone (that is, with nobody aged over five) for at least half a day in the last six months.

9. Livelihoods

The majority (79 per cent) of households are involved in agriculture (rising to 98 per cent of the poorest). Urban households are mainly involved in wholesale/retail activities (48 per cent) and manufacturing (44 per cent). Households which have no diversification (that is they rely on only one sector) constituted 27 per cent of those surveyed, and this rises to 41 per cent for the poorest. Serious debt affected 55 per cent of rural households (and 37 per cent of urban households) and half believed they could not repay it on time. Forty-three per cent of households had suffered an event in the last three years which had decreased their wealth. The main cause of this was severe illness or injury (27 per cent). In rural areas the second most common cause was crop failure/theft and in urban area it was the arrival of an additional household member (by birth or migration). The main coping strategies employed were; to work more, to use credit and to get help from family and/or friends.

10. Social capital of the caregivers

Among the caregivers in this survey there were low overall levels of structural social capital (membership of informal and formal groups) although this was higher for the better off. The caregivers received plenty of social support and there were high levels of cognitive social capital (trust, reciprocity, sense of belonging). Levels of citizenship (participation in civil society) were low at 30 per cent.

11. Nutrition of the eight-year-olds

Among these children, 28 per cent were stunted and the same percentage were underweight. Eight percent were wasted. Among the poorest children 40 per cent were stunted. Malnutrition rates were lower among urban children.

12. Physical and mental health of eight-year-olds

Of the eight-year-olds surveyed, 14 percent had long term health problems and 11 per cent (17 per cent among the poorest, one per cent among the better off) had suffered a life threatening illness in the last three years. One-third had experienced an illness in the last two weeks (there was little difference by location and wealth) and one-fifth had probable cases of mental ill health (emotional and behavioural problems).

13. Eight-year-old's work, schooling, literacy, numeracy and cognitive development

Almost all the children (99 per cent) attended school and 14 per cent had worked for money or goods (and these children said they enjoyed it and it did not affect their schooling). Rural literacy and numeracy rates are about ten per cent lower than urban rates. Less than half of the poorest children were able to write to the level expected for their age. Cognitive development was lower among poor and rural children.

14. Eight-year-olds' perceptions of wellbeing

The majority of children (86 per cent) felt they lived in a safe area; 80 per cent thought they had good water (although in reality it was only 12 per cent – see above); 58 per cent thought their air was good but 74 per cent said the rubbish situation was bad.

1. Introduction

Young Lives is an international longitudinal study that aims to improve our understanding of the causes and consequences of childhood poverty in the developing world. At the heart of the research is a panel survey, tracking a cohort of 8,000 children and their families in four countries (Ethiopia, India, Peru and Vietnam) over a fifteen-year period. As a policy-oriented project, findings from the research will be used to help formulate policy to alleviate childhood poverty.

The objectives of this preliminary report are to: present a brief literature review of child poverty in Vietnam; review national policies which have an impact on child poverty; identify key national audiences for this study; describe the study methods, present preliminary, descriptive results, and identify provisional conclusions and policy implications.

1.1. What is known about child poverty in Vietnam from existing data?

This summary literature review is largely based on the work carried out by Neefjes (Neefjes, 2002). Vietnam is one of the few countries that have seen a significant drop in poverty over the past decade. According to international criteria established by the World Bank,[1] the total poverty rate fell from 57 per cent in 1992-1993 to 37 per cent in 1997-1998. Despite this achievement there is a growing concern about inequality. Poverty is becoming concentrated among some regions and some groups of people. Children are often said to be among the most vulnerable groups (NCSSH, 2001; ADB, 2001).

Globally, a larger proportion of children than adults live in poverty. This could be explained in many ways, for example by the fact that poor people tend to have more children, and that young families with children tend to be at the poorer end of the family life cycle. In Vietnam poverty data from national household surveys are usually not sufficiently disaggregated by age so it is difficult to explain from these data sets how poverty impacts on children's present lives (Theis, 1999a). The analysis of Vietnam Living Standards Surveys (VLSS) data from 1993 and 1998 found that 64 per cent of children (defined as under 18) compared with 55 per cent of the total population were poor (using the total poverty line) in 1993, and 45 per cent compared with 37 per cent of the total population in 1998. Further analysis by White and Masset (2002) makes adjustments for the fact that all members of a household do not consume equal amounts and the need to allow for economies of scale in larger households, but still finds that children in Vietnam are 1.5 times more likely to be poor than adults.

It has been widely acknowledged that poverty is multi-dimensional, and is not just about income. The Young Lives project defines poor children as those who are growing up without access to different types of resources that are vital for their wellbeing and for them to fulfil their potential. This includes economic, social, physical, environmental and political resources. The Young Lives conceptual framework (see Figure 1) uses a range of child wellbeing outcome measures which includes traditional, 'hard', objective measures such as nutritional status and physical health, but which also includes indicators which are innovative for Vietnam, for example, mental health, developmental stage for age, and life skills (numeracy and literacy). In addition the project has a very child-centred outcome measure – the child's own subjective perception about her/his quality of life. While more details of these innovations are provided in later chapters, this review considers areas that previous child poverty research in Vietnam has covered: livelihoods, education and health. Note that some topics on which

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1   The total poverty line is set by calculating the expenditure necessary for a household to ensure good nutritional status (2,100 calories per person per day) in the Vietnam context (the food poverty line) and adding the cost of non-food items (the total poverty line).

there is literature (eg, HIV/AIDS, disability) are not covered as the Young Lives project does not cover these topics due to design, cost or time constraints.

FIGURE 1: THE YOUNG LIVES CONCEPTUAL FRAMEWORK

MACRO-POLICY	EXTERNAL DETERMINANTS	MEDIATING DETERMINANTS	OUTCOMES
Government expenditure on education and policies on education Child labour and trade regulations	Child attributes Family attributes Physical, environmental and socio-economic assets. Social capital (household) Economic shocks Community attributes	Child care Education Work Leisure/play Security Health care Intra-family Environment Social capital (child) Migration	Nutritional status Physical health Mental health Life skills (numeracy and literacy) Development stage for age Child's perception of wellbeing

In terms of livelihoods, it is known that the phenomenon of children working to support their household economy is more prevalent amongst poor families. The families where the **In terms of livelihoods,** it is known that the phenomenon of children working to support their household economy is more prevalent amongst poor families. The families where the majority of children live are poor, and thus the pressure for children to work is significant. For example, in ethnic minority areas children have to contribute to household work and this is one of the barriers to full-time education (Theis, 1999b). While there are no official data reported about the number of child workers due to the sensitivity of the subject, a number of international non-governmental organisation (INGO) studies (for example Save the Children UK, 1999a) show that many children are working in very hazardous and difficult conditions due to a weak legal environment and inadequate law enforcement to stop child labour and protect children from exploitation. Studies by the World Bank (Edmonds and Turk, 2002) and ADB (ADB, 2001) suggest that the incidence of child labour decreased in Vietnam during the 1990s. However, the decline, according to the Asian Development Bank (ADB) report, was much sharper for children from the richest quintile. They hardly participate in the labour force and are most likely to be full-time students. Children from the poorest quintiles, on the other hand, are significantly more likely to be working while they study. In addition, it has been found that ethnic minority children are more likely to work than Kinh (the ethnic majority) children, and children of migrants tend to work harder and earlier than others (Edmonds and Turk, 2002). Though both studies come up with the same conclusion about the decline in child labour, concerns remain about the vulnerability of children given the likely growth path of Vietnam which is based on expansion of the private sector and rapid uncontrolled rural-urban migration.

Even in urban areas, children are active participants in household livelihoods. Participatory poverty studies carried out by Save the Children UK in Ho Chi Minh City, Vietnam's richest province, indicate that children in poor families contribute to household livelihoods in a variety of ways (SCUK.

1999). More recent studies reveal that even though there is a recognition that living standards for the poor have improved, the poor do not necessarily see themselves as better off for a number of reasons: livelihoods are more unstable, labour competition (from new migrants arriving in the city) is driving the price of labour down, household expenses are rising and there is growing disparity between the rich and the poor (Save the Children UK, 2002).

In terms of education, Vietnamese children and youngsters are relatively strong on school enrolment and more literate when compared to their peers in some neighbouring countries that are at the same level of economic development. In addition, there is only a small gap in levels of enrolment between boys and girls at primary and lower secondary school levels.

Regional disparities

Not all Vietnamese children have achieved the same levels, and not all have benefited from improvements over the past decade. Enrolment rates (both at primary and secondary school) are very low in the poorer and very rural north, Central Highlands and the Mekong River Delta, but relatively high in the richer and more urbanised Red River Delta and South East *(see Figures 2 and 3).*

FIGURE 2: NET PRIMARY SCHOOL ENROLMENT BY REGION, 2000
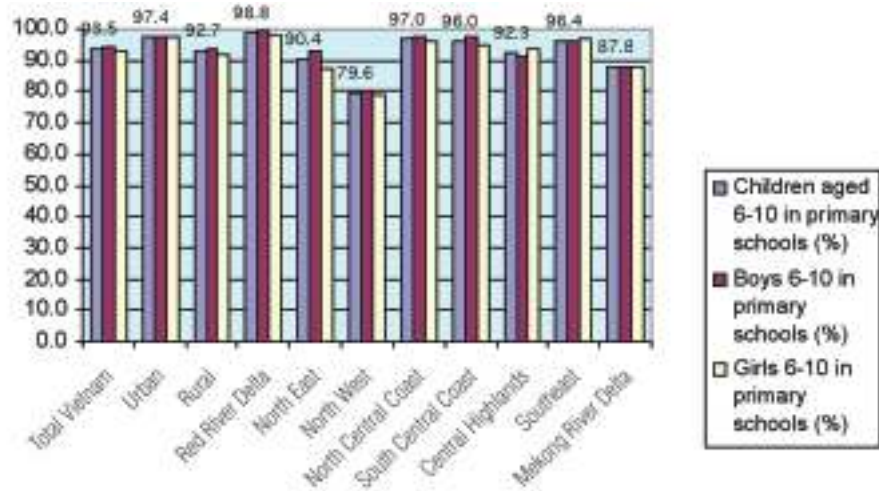
Source: GSO & CPCC (2000)

FIGURE 3: NET LOWER SECONDARY SCHOOL ENROLMENT BY REGION, 2000
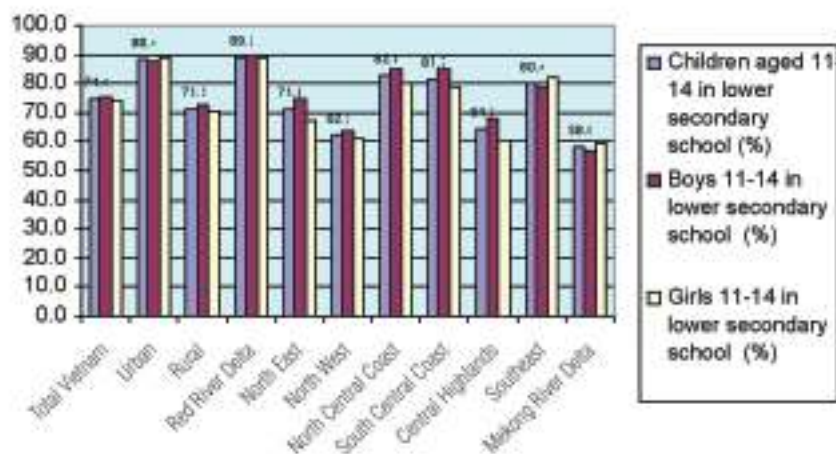
Source: GSO & CPCC (2000)

In addition to school enrolment, other problems are: low completion rates, shorter school cycle compared with regional competitors and low quality of teaching.

Regional variations are also observed for kindergarten enrolment, which is only about 30 per cent in the north, Mekong River Delta region and the Central Highlands, while the figure is double that for the Red River Delta and South East (GSO and CPCC, 2000). Low pre-school enrolment rates in mountainous areas affect students' ability to learn sufficient Vietnamese in order to keep up with the demands of the full primary school curriculum.

In terms of learning outcomes, a recent study of Grade 5 pupil achievement through tests of maths and reading comprehension (World Bank and ADB, 2002), found there is no observed disparity across sexes, but the difference across regions is significant. The Red River Delta region scores very well, while learning performance of the Mekong Delta region is more than two times lower. This raises a question of whether the quality of teaching and learning of these groups of pupils is good enough to ensure high leaning outcomes.

Ethnic disparities

The enrolment figures for ethnic minorities are much lower than those of the majority Kinh group. For example, the net primary school enrolment rate of the Kinh is 93.4 per cent while that of Hmong is 41 per cent (Baulch et al, 2001). Besides the above mentioned problems there are other specific factors that can prohibit poor ethnic minority children from going to school, such as language barriers, culture, remoteness, cost of providing infrastructure and low population density.

Income/expenditure disparities

An ADB study (2001) shows that, by expenditure quintile, there is not a substantial difference in primary school enrolment among different groups. The gross enrolment rate for primary education was almost 100% in 1997–98, which suggests universal education. There was a small drop in gross

enrolment rate[2] for the fifth quintile that could be explained by the fact that children from this group generally complete their primary education with less repetition. The gap has however increased between the poor and non poor in secondary school *(see Table 1)*.

TABLE 1: GROSS ENROLMENT RATE, CHILDREN AGED 11 TO 14 (%)

EXPENDITURE QUINTILE	VLSS 1992-93	VLSS 1997-98
1	24.3	47.3
2	31.9	70.5
3	51.0	84.8
4	56.3	90.5
5	83.7	90.5
Total	**49.2**	**78.4**

Source: ADB, 2001, p.19.

In terms of child health and nutrition, Vietnam has achieved a high rate of immunisation coverage across the country (about 95 per cent on average). Coverage is generally equal among children from different quintiles. In terms of full immunisation, the poor, however, are still substantially behind the non-poor quintiles. For example, 60 per cent of children from the lowest quintile were fully immunised in 1997-98, while coverage of the children from the highest quintile was more than 80 per cent. Infant mortality rate (IMR), which is a commonly used indicator for health status, is also improving. For example, between 1992 and 1998 there was a remarkable reduction in IMR from 36 to 27 per thousand live births (see Table 2). The gap between IMR among poor and non-poor households has widened and is more severe in poorer provinces.

TABLE 2: INFANT MORTALITY RATES FOR POOR AND NON-POOR HOUSEHOLDS IN THE SURVEYS 1992/3-1997/8

ECONOMIC STATUS	VLSS 1992-93	VLSS 1997-98
Non poor	34.4	24.5
Poor	39.4	33.6
Total	**35.8**	**26.9**

Source: ADB, 2001, p.23

In addition, there are differences in IMR by region. Existing data (for example ADB, 2001; NCSSH, 2001) shows that, on average, infants in the remote mountainous and coastal areas have a significantly lower survival rate (eg, 65 per thousand live births in Central Highlands compared with 17 in the south-east of the country; (NCSSH, 2001). By wealth quintile, much of the decline in infant mortality is attributable to the improved health status of the non-poor. Infant mortality for the better off 40 per cent of the population is reasonably low at just over 20 per thousand live births, but for the poorer 60 per cent it is more than double that. However, the relatively small differences in infant mortality between the poorest 20 per cent and the second and third quintile suggests that getting out of poverty

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2   Gross enrolment rate = total enrolments in level X / children eligible to attend level X

Net enrollment rate = total enrollments in level X of children eligible to attend level X / children of age eligible to attend level X.

does not immediately result in a great reduction of vulnerability of children.

Vietnam outperforms with regard to both infant mortality and under-five mortality, compared to the average for East Asia and the Pacific region (UNICEF, 2001) *(see Figure 4).*

FIGURE 4: INFANT AND CHILD MORTALITY RATES FOR SELECTED ASIAN COUNTRIES
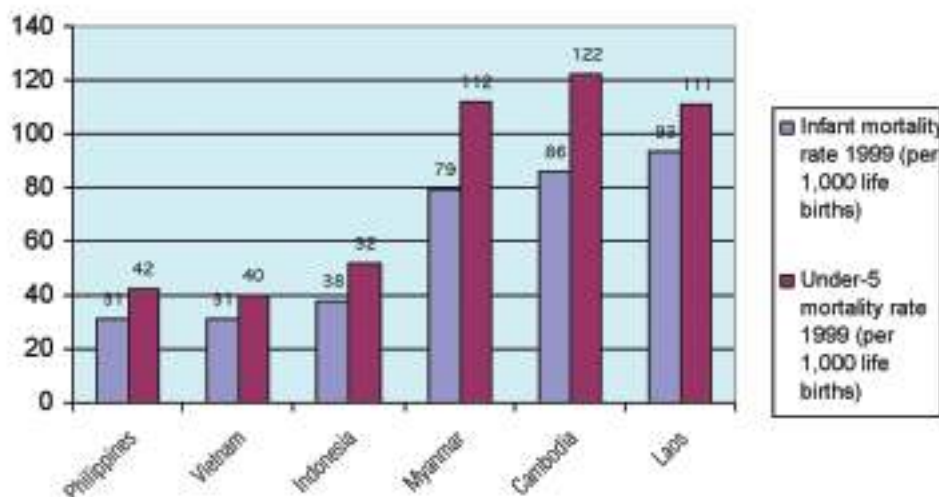
Source: UNICEF (2001)

Malnutrition, which is normally defined as underweight (weight-for-age) and stunting (height-for-age) of children under five years, is also a good proxy for child health. While malnutrition has declined considerably (National Institute of Nutrition 2002; Koch and Linh, 2002; Neefjes, 2002), it is still very prevalent despite Vietnam's status as the world's third biggest rice exporter. By poverty quintile, the rate of malnutrition (based on underweight) in the bottom quintile is now twice as high as the top quintile. By region, malnutrition varies from 28 per cent in the South East to 58 per cent in the Central Highlands. It is more prevalent (45 per cent) in rural than in urban areas (24 per cent). In comparison with other low-income developing countries, though Vietnam has a relatively high human development index, the malnutrition rate as it currently stands is really unexpected (Koch and Linh, 2002). Research (Koch and Linh, 2000; Neefjes, 2001) suggests that inadequate household livelihoods (household income and food security), caretaker behaviour and education (breastfeeding and weaning practices, balanced diets, etc) and inadequate household water supply and sanitation appear to be underlying reasons for high malnutrition rates.

Antenatal care plays an important role in ensuring the survival and wellbeing of the child. An analysis conducted by ADB based on surveys from 1992-98 shows that although there has been an increase in the use of antenatal care services, the intensity of use is different (ADB, 2001). For example, the number of women in the top two expenditure quintiles who receive antenatal care is nearly double that of the lowest quintile. From an inequitable base to start with, antenatal care is becoming even more inequitable in terms of both quality and quantity.

1.2. Policy related to child poverty

Over the past two decades, the government of Vietnam has made efforts towards sustaining economic growth, reducing poverty, and building up Vietnam as an industrialised country. Beginning in the 1980s, macroeconomic reform was initiated with an aim to integrate Vietnam into the world economy. Social sector reforms have also been undertaken. Besides these two key areas, there have been targeted programmes such as the Hunger Eradication and Poverty Reduction Programme (HEPR), that aims to reach the most disadvantaged groups of people. The most recent ten-year socio-economic strategy and five-year plan, particularly the Comprehensive Poverty Reduction and Growth Strategy (CPRGS), shows a strong commitment of the government to combat poverty, tackle inequality and build up an industrial nation with a socialist market-oriented economy. The CPRGS includes the Vietnamese Development Goals which are more ambitious than the International Development Targets. For a number of population groups that need the special attention of the government, such as children, there has also been a specific policy framework. A recent child-focused policy is the National Plan of Action for Children (NPA) 2001-10.

Private sector reform aims to promote domestic and foreign private sector investment and expansion, that will help create employment opportunities. The number of private enterprises increased from 6,808 in 1993 to 26,021 in 1998 (Webster, 1999). In the year 2001 there were about 8,800 new enterprises registered (Mid-year Consultative Group Meeting 2002). The Enterprise Law of 2000 has encouraged development of the informal sector where a great number of children work (Save the Children UK, 1999b). There is a lack of regulations for monitoring investors' operations including labour recruitment and treatment of workers. Even when employers are found recruiting children and badly treating children, law enforcement is too weak to stop child labour or protect children from exploitation. There is also concern about widening disparity as investment tends to be focused in areas with already high levels of income such as the South East (World Bank, 1999).

The public sector, particularly state owned enterprises (SOEs), is being reformed with the aim of reducing debt and wastage, and enhancing competitiveness. Almost all small SOEs were liquidated soon after the reform. Social discontent was generally avoided as a result of the government's successful severance pay and early retirement schemes. A more recent study (Hoa, 2001), however, finds that formal sector re-employment is difficult, and is easier for men than women. This raises the issue of cessation of social benefits among families with redundant workers. As the restructuring of SOEs could lead to about 25,000 job losses between 2002 and 2005 (World Bank and ADB, 2002), lessons need to be learned in order to minimise social impact on households in general and on children in particular.

To enable *world economic integration* Vietnam has signed the US Bilateral Trade Agreement and has been preparing for entry to Asia Free Trade Area and access to the World Trade Organisation. Though there are only a few studies that show the social impact of globalisation on families and children it is becoming obvious that Vietnam's integration into the world economy has brought more opportunities for people, and has made a significant contribution to economic growth . On the other hand, the exposure to world market price fluctuations has marginalised many poor people and their children. A joint study undertaken by Oxfam GB and Oxfam Hong Kong shows that when coffee planters lost crops as a result of the reduction in the international price, the first coping strategy was to withdraw children from school because of the unaffordability of school costs (Oxfam GB and Oxfam Hong Kong, 2001).

Among macroeconomic reforms, *public expenditure reform* is likely to have a great impact on children. Several studies (World Bank and ADB, 2002; Save the Children Sweden, 1999) show that public expenditure for social services has increased in recent years. For instance, total government expenditure for the health sector increased from three per cent in 1992 to seven per cent in 1998, and for the education sector from 11 per cent in 1992 to 17 per cent in 1998 (Government of Vietnam and Donor Working Group, 2000). The pattern of spending, however, is questionable as most spending (about 80 per cent) is for recurrent expenditure such as salaries. Another concern is the decentralisation of budgetary decision-making. Local administrative units have often "resorted to an ad hoc array of fees and contributions in non-transparent and sometimes regressive ways" (Government of Vietnam and Donor Working Group, 2000, p.85).

In terms of *social sector reform,* the most obvious impact on children is from cost recovery policies. High user fees have been a major obstacle for poor children to receive adequate health treatment. More than three million people in Vietnam fell back into poverty as a result of high medical costs (quoted in ADB, 2001). While primary education is free, household survey analysis and Participatory Poverty Assessments reveal that financial contributions remain the difficulty many families face when sending their children to schools. Families pay for textbooks and learning materials, for school building and maintenance costs, and for other costs such as transportation and uniforms. These payments and contributions place proportionately heavier burdens on poor families (World Bank and ADB, 2002).

The *Hunger Eradication and Poverty Reduction programme* (HEPR) of 1998 is a co-ordination programme between many sector ministries and services at central, provincial and district level. These services include free health cards for poor families and exemption from education related costs, but the lion's share under this programme is for subsidised credit. While this type of policy is supposed to be supportive to the poor, not all poor people benefit from it as targeting is inadequate (ADB, 2000). The question remains as to what extent the programme has actually reached the poorest. While the programme is biased towards credit activities, less than 50 per cent of their credit is received by about 40 per cent of the poor (ADB, 2000). Instead it went to wealthy people who were most able to repay the loan or to relatives of credit officers (SCUK, 1999). In addition, as the HEPR is a national programme, only those people who are poor and who have a legal registration status are eligible to access the programme, thereby excluding poor migrant families and their children (Save the Children UK, 2002) .

To bridge the gap between ethnic minorities and the majority group the '*135 programme*' targets more than 2,000 poorest mountainous communes and provides each commune with financial support of 400 million Vietnamese dongs (equivalent to approximately $25,000) per year that is supposed to be used to improve the infrastructure of the commune. One criticism of the programme is that its budget is equally distributed to all communes. This seems unfair as costs of building infrastructure are often greater in more remote and higher communes. In addition, while the programme aims to decentralise financial responsibilities to local governments, their implementation capacity is in question.

2. Methods

2.1. Overall design

The Young Lives study is designed as a panel study that will follow 2,000 index children in each country from age 6–17.9 months (hereafter called one-year-olds) until they are 15 years old. A birth cohort model (following children from birth) was rejected due to the difficult logistics of identifying births when a large proportion are home-based, and the high attrition rates in the first six months when most infant mortality occurs. These two factors made a birth cohort prohibitively expensive. Index children were selected from 20 sentinel sites that were defined specifically in each country. The concept of a sentinel site comes from health surveillance studies and is a form of purposeful sampling, where the site (or cluster, in sampling language) is deemed to represent a certain type of population or area, and is expected to show early signs of the impact of trends affecting those particular people or areas. For example, monitoring a typical slum in Ho Chi Minh City might detect events and trends which will have an impact on most slums in that city. The caregiver and, when the child is old enough, both the caregiver and the child will be interviewed every three years. The height and weight of each child will also be measured and community level questionnaires will be completed for each sentinel site at every data collection round.

In addition to the one-year-old household questionnaire, anthropometric measurements and community questionnaires, one thousand 7.5–8.5-year-old children (hereafter called the eight-year-olds) and their caregivers were interviewed in the first round of data collection to provide a comparative group for when the Young Lives index children reach eight, and to provide more timely results on a neglected age group. These children will not be followed up. A number of thematic, largely qualitative projects which will investigate issues that emerge from the first round of data analysis, will be conducted in 2004 onwards. Information at the macro policy level will be referred to in seeking explanations for children's development status.

The Young Lives first round study in Vietnam started in September 2001 when the project was approved by the Vietnam Union of Science and Technology Associations (VUSTA) (VUSTA, 2001). Besides the three key partners (GSO, Save the Children UK, RTCCD) in the Young Lives research, who kept in regular communication with the UK-based academic consortium to design the research in phase one, there was participation from Technical Advisory Committee (TAC) and Policy Advisory Committee (PAC) members who represent 29 government institutions, international donors, and local NGOs in different stages of the survey design (see acknowledgements for details).

2.2. Questionnaires

2.2.1. Household questionnaire

TABLE 3: QUESTIONNAIRE TOPICS IN THE ONE-YEAR-OLD HOUSEHOLD QUESTIONNAIRE AND THE EIGHT-YEAR-OLD HOUSEHOLD QUESTIONNAIRE

- locating information (for tracking in future rounds)
- household composition
- child health (chronic and acute)
- caregiver characteristics
- livelihoods
- economic changes (shocks) and coping strategies
- socio-economic status (assets)
- social capital
- anthropometry of child.

Plus:
One-year-old specific:
- pregnancy, delivery, breastfeeding, vaccination
- child care
- caregiver psychosocial wellbeing.

Eight-year-old specific:
- child mental health
- child's schooling
- child labour
- child leisure.

Full copies of the core questionnaires can be found at www.younglives.org. While Annex 1 presents all the variables of the survey, Table 3 shows the general topics covered in the core (common to all four countries) household questionnaires. For the purpose of tracking, information about close family members from both the maternal and paternal family was recorded. Table 4 presents the added country specific variables for the one-year-old household survey and the eight-year-old household survey.

TABLE 4: COUNTRY SPECIFIC TOPICS FOR THE ONE-YEAR-OLD HOUSEHOLD QUESTIONNAIRE AND THE EIGHT-YEAR-OLD HOUSEHOLD QUESTIONNAIRE

One-year-old's household:
- household cigarette use level
- household tobacco pipe use level
- use of community kindergarten service
- age of child at first use of community kindergarten service
- currently using community kindergarten services
- specific forms of support that household received regularly during the last 12 months
- any support that household gave to people outside of the household during the last 12 months
- total value (in VND) that household gave to support others during the last 12 months
- self-evaluation of level of change of household living standard during the last three years
- self-evaluation of main factors contributing to increased household living standard during the last three years

- use of heater
- use of electronic fan
- self-evaluation of household economic level
- having official certificate of household poverty status
- address details of (1) key person in family; (2) close person from paternal family; (3) close person from maternal family.

8 year old's household:
- public or private school
- does child attend boarding school
- extra classes during the last year
- subjects in these extra classes
- people who advise child to attend these extra classes
- number of hours/week for each group of subjects
- expenses for child's schooling during last year
- amount for the child's extra subjects.

In the core questionnaire, eight-year-olds were interviewed about aspirations, perceptions of quality of life, social relations, study, work, health, numeracy and literacy. In Vietnam, eight-year-old children were also asked about: thinking about equal treatment between boys and girls; taking a siesta yesterday; time they went to bed last night; and time they woke up this morning. The core questions about quality of life covered issues that emerged from the World Bank's international 'Voices of the Poor' study (Narayan, 2000): having enough food, feeling respected, feeling safe, having a good environment (water, air, rubbish). The Raven's Coloured Progressive Matrices were used with 200 eight-year-olds to assess cognitive development for age.

2.2.2. Community questionnaire

There are five sections in the community questionnaire: natural environment, social situation, infrastructure and services access, economy, and health and education. The additional country specific variables focused on availability of health services, primary and secondary education, poverty status as defined by the national poverty eradication programme, and the toll of wars on the community, as it is hypothesised that there are long-term war consequences related to child poverty. Respondents were key informants within the community.

2.2.3. Policy monitoring

As the Young Lives study focuses on child development, policy at meso- and macro-levels must be considered in explaining evidence from community-based surveys. The policies that are assumed to have the most direct impact on child development are: health care, education, poverty reduction, social safety net, social security/insurance and public expenditure. Information on these policies is collected every six months, using a policy matrix framework, with support from members of the Policy Advisory Committee from eight government institutions: Ministry of Health (MoH), Ministry of Labour, Invalids and Social Affairs (MOLISA), Institute of Education Research (MOET), National Programme on Poverty Alleviation, and National Committee for Ethnic and Mountainous Affairs. This will ultimately be used in analysing changes observed in the longitudinal analysis of Young Lives.

2.2.4. Questionnaire translation

The translation of the questionnaire was an iterative process: translate > review > test in office > revise > back translation > compare with the core questionnaire (English) or country specific module (Vietnamese) > field test > revise > put in the training course > revise > field test second time (during the training course) > revise and back translation.

The translation team consisted of one Australian who can read Vietnamese, one Vietnamese American doctor and four researchers whose English ability meets the standard required for enrolment in Masters and PhD study programmes in Australia and the USA. In addition, all questionnaires were circulated among TAC and PAC members before the training was organised. The 'Child Mental Health' section's back translation was approved by Dr Goodman of the UK Institute of Psychiatry who developed the instrument. The respective Provincial Committee for Childcare and Protection then translated the questionnaires to local dialects in each province.

2.3. Sampling

In order to have a sample of two thousand index children and 1000 eight-year-old children from 20 sentinel sites, a five-step process that followed a partly-random/partly-purposive approach to fit the Young Lives objectives was conducted in Vietnam. In Vietnam, a sentinel site is defined as a commune. A commune has a local government, primary school, commune health centre, post office and a market. Its average population is approximately 7000 persons (+/- 4000). The steps were: (1) selecting five regions out of a total of nine; (2) selecting one province out of all provinces in each region chosen; (3) selecting four sentinel sites in each province with over-sampling of poor communes; (4) screening and listing eligible children; (5) selecting a sample of 100 index children and 50 eight-year-olds in each sentinel site using simple random sampling.

In the event that a commune selected as a sentinel site had insufficient numbers of one-year-old children at the time of the survey, a neighbouring commune with similar socio-economic conditions was additionally selected in order to reach the quota of index children. Therefore, with 20 sentinel sites, Vietnam had a total of 31 communes involved in the study sample.

2.3.1. Selecting regions and provinces

Criteria for selecting regions were that the sample should: (1) consist of regions in the North, Central, and South; (2) consist of urban, rural, and mountainous areas; (3) be over-poor; (4) reflect some unique factors of the country, such as natural disaster and war consequences.

Administratively, Vietnam has 10,321 communes, 600 districts and 61 provinces and cities. In terms of socio-economic development, Vietnam stratifies the whole country into eight socio-economic regions: North-West, North-East, Red River Delta, North Central Coast, South Central Coast, South-East, Central Highlands, and Mekong River Delta. We categorised all major urban centres (Hanoi, Ho Chi Minh City, Da Nang, Hai Phong, and Ba Ria-Vung Tau) as a new region – the Cities region. Five regions were selected out of these nine regions and a typical province from each chosen region was selected through a process of iterative consultation between the Principal Investigator (PI), National Coordinator (NC), and all TAC/PAC members using various methods such as individual interview, group meetings, and individual sampling exercises. Five provinces from the five regions were selected: Lao Cai (North-East region), Hung Yen (Red River Delta), Da Nang (Cities), Phu Yen (South Central Coast), and Ben Tre (Mekong River Delta). The research site map is presented in Figure 5. The main characteristics of each province that led to its selection are summarised in Tables 5 and 6.

FIGURE 5: STUDY SITES IN VIETNAM YOUNG LIVES PROJECT

TABLE 5: MAIN CHARACTERISTICS OF PROVINCES SELECTED

Hung Yen
- typical rural; representative of the Red River Delta region
- populous; high population density
- main source of income: rice farming
- good infrastructure
- near big cities (between Hanoi and Hai Phong)
- will be influenced by urbanisation
- absolute number of poor people is high, although percentage of population living under poverty line is not high.

Lao Cai
- typical province for the North-East and North-West
- high percentage of minority ethnic groups
- mountainous
- underdeveloped infrastructure; far from big cities
- border with China, subjected to commercial and trading activities
- highest poverty rate.

Da Nang
- ranking in the middle of the five-city group
- rapid urbanisation
- attractive to rural people in central provinces for migration, including child labour and drug problems.
- public transportation is poor
- high potential for environmental pollution
- high level of education
- receiving big investment from international sources and government
- poverty rate is low.

Phu Yen
- typical province for central coast of Vietnam
- suffering severe natural disasters
- severely damaged by wars
- mix of coastal, midland and highland
- poor infrastructure
- main sources of income from agriculture and seafood
- very high percentage of population is living under poverty line
- high child migration rate to cities.

Ben Tre
- typical province for Mekong River Delta
- severely damaged by flooding
- difficult transportation within and between communes
- high percentage of landless families in rural area
- low educational level
- providing agricultural raw materials to industrial zones
- high percentage of population living under poverty line.

2.3.2. Selecting sentinel sites

The selection of four sentinel sites in each province was principally carried out by each provincial government. In each province, a workshop to introduce the research was organised with the participation of VUSTA, RTCCD, GSO, Save the Children UK, and TAC/PAC representatives from MOLISA, National Committee for Protection and Child Care, Institute of Sociology, Institute of Educational research. A 'Provincial Commitment of Participation' in the research was reached at the end of the workshop. A provincial working group (consisting of representatives from the People's Committee; the Committee for Child Care and Protection; the Health Department; and the Statistics Centre) ranked all communes in the province by poverty level: poor, average, better off and rich. Criteria used in ranking included: (1) development of infrastructure; (2) percentage of the poor in the commune according to MOLISA; (3) child malnutrition status. Selection of four sentinel sites followed, using an over-poor sampling strategy: two communes from the poor group, one from the average, and one from the above average group (combined better off and rich). In selecting communes from each group, other criteria were considered: (1) whether the commune represents common provincial/regional features; (2) whether there was commitment from the local government for the research; (3) feasibility conditions for the research logistics; (4) population size. If a selected commune had a population of under 6000 persons,[3] a similar commune in the same poverty level group was additionally selected to assure that 100 index children were able to be found in that sentinel site. Among the 31 communes selected, 15 communes were from the poor group (48%), nine communes were from the average (29%), and the remainder (seven communes, 23%) were from the above average. Box 1 presents a brief profile of the 31 communes with information obtained from the Young Lives community survey.

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3 Average annual growth rate for Vietnam 1989-99 = 1.7% (the 1999 Census of Vietnam at a glance, GSO, Thong Ke publishing house, 2000, page 11); to have 100 index child, a commune should have a population size of: (100 x 100)/1.7 = 5883 persons.

TABLE 6: SOCIO-ECONOMIC INDICATORS OF THE FIVE PROVINCES SELECTED FOR THE VIETNAM YOUNG LIVES STUDY

Province	Human development index rank*	Total population (1999)	Migration (1994-99)	Population under poverty line according to Vietnamese standard (%)	GDP per capita (US$)	Infant mortality rate (% - 1999)	Underweight children under age 5 (% 1998)	Population without access to safe water (% 1999)	Population without access to sanitation (% 1999)	Percentage of ethnic minority population (%)
Lao Cai	55	594,632	-415	22	144	5.36	46	54	43	67
Hung Yen	14	1,068,704	-14,886	13	209	2.59	40	6	3	0.1
Da Nang	4	684,131	24,692	12	409	1.9	38	5	15	1
Phu Yen	49	786,969	-3,659	9	202	4.30	41	10	12	10
Ben Tre	27	1,296,914	-34,816	22	258	4.08	34	80	3	0.4

Ranking out of 61 provinces and cities with descending order (1=the best)

Source: NCSSH, 2001.

BOX 1: BRIEF PROFILE OF THE 31 COMMUNES

A shop selling basic provisions is available in 29 out of 31 communes (94 per cent). The two communes without shops are in mountainous and remote areas. Twenty-five (81per cent) of the communes have a cement or tar road to the centre of the commune. All communes have a commune health centre. There are only three communes where access to a hospital is really difficult. The communes in question are mountainous and remote. Thirty communes have a pre-school. All have an elementary school and 97 per cent of communes have junior high schools.

Source: Young Lives community survey

Table 7 presents results of ranking communes in each province and number of communes selected in each group of communes.

TABLE 7: COMMUNE POVERTY RANKING BY PROVINCE AND SELECTION OF SENTINEL SITES

Province	Total communes* (total of communes selected for Young Lives study)	COMMUNE POVERTY LEVEL RANKING		
		Poor Subtotal (number of Young Lives communes)	Average Subtotal (number of Young Lives communes)	Above average Subtotal (number of Young Lives communes)
Hung Yen	160 (6)	33 (3)	87 (2)	40 (1)
Phu Yen	101 (6)	10 (4)	64 (1)	27 (1)
Lao Cai	180 (7)	138 (4)	17 (2)	25 (1)
Ben Tre	160 (8)	41 (4)	75 (2)	44 (2)
Da Nang	47 (4)	0	29 (2)	18 (2)
TOTAL	648 (31)	222 (15)	272 (9)	154 (7)

Data for the year 2001 reported by the Provincial Committee for Population, Family, and Children (PCPFC) of each province

2.3.3. Selecting eligible children within sentinel sites

A door-to-door screening survey, for all children born between 1 January 1993 and 31 December 1994 and between 1 January 2000 and 31 December 2001, was conducted in each commune from April to June 2002. A list of eligible children was formed, noting date of birth. This broad range of two years was covered because it was not clear when exactly data collection would begin. Simple random sampling was then applied to select 100 children who were 6–17.9 months old and 50 children who were 7.5–8.5 years old at the time of fieldwork. Non-response rate (refusals by caregivers) was less than two per cent (36 out of 3000) and replacement sampling was used.

2.4. Fieldwork

2.4.1. Training

Sixty-one members selected by GSO from its Social and Environment Department, and from provincial Departments of Statistics, together with ten members from RTCCD, went through a two-week training course conducted by a team of ten persons including the Young Lives local principal investigator, RTCCD health and nutrition researchers, Save the Children UK consultants on conducting child interviews, and GSO household survey experts. One of the UK-based academic

group participated in the first three days of training. The training included ten days of discussion of the questionnaires in class and child interview techniques. Twenty-four women with children in the relevant age groups were invited to the training sessions and interviewed. In addition, two days of fieldwork allowed each participant to conduct at least two household interviews and two child interviews as well as testing the survey organisation as a whole. The last two days of training were used to test the trainees. Three tests were applied to all participants. Results, together with remarks from trainers and fieldwork exercises, were used to select the 34 best participants. All these 34 participated in the formal survey in the first two sentinel sites. After the first week of fieldwork, 30 interviewers were selected, of which 28 formally participated in the surveys and two members were for the purpose of replacement in the event of illness or any unforeseen events. Only one interviewer was male.

After participating in the 15 days of household survey training, 12 RTCCD resource persons attended one additional day of training with the purpose of re-training in anthropometry. Trainers came from RTCCD's Health and Nutrition Unit, and had all had substantial experience in conducting community nutrition surveys over the last three years, including an 18 month longitudinal study on child nutrition with interval repeated measurement of weight and height of 240 children under 36 months in Phu Tho (Dibley and Tuan, 2001; Marsh et al, 2002; Tuan et al, 2002a; Tuan et al, 2002b). All of these 12 resource persons then were trained for two days on conducting the Raven's test. Trainers were from the University of Hanoi's Departments of Sociology and Psychology.

2.4.2. Field data collection

Field data collection was conducted by two teams: (1) GSO survey team which conducted the household surveys and community surveys; (2) RTCCD survey team which conducted Raven's Test and anthropometric measurements. They all worked together in the first four sentinel sites in Hung Yen province, which is 60 km from Hanoi, under the supervision and technical guidance of the principal investigator, RTCCD and GSO resource persons. After finishing the first four sentinel sites in three weeks in July 2002, a debriefing workshop was organised by RTCCD, GSO, and Save the Children UK. Given experience in the first province, a strategy of launching the next 16 sentinel sites within the remaining four provinces was designed, in which all GSO and RTCCD field workers were organised into two teams who worked simultaneously for two months (September–November 2002).

2.4.3. Supervision and quality control

The whole survey process was under the technical management and supervision of RTCCD with daily technical support from the UK-based academic consortium to RTCCD using email and teleconference. RTCCD communicated with local governments to finalise all procedures for fieldwork. For the household survey and community survey, RTCCD signed a contract with GSO's Social and Environment Department and GSO organised internal supervision of its fieldwork activities. In addition, RTCCD took the role of providing independent supervision to GSO survey teams through daily work together with GSO's teams. For RTCCD's work on anthropometric measurement, a national nutrition expert provided technical supervision. For the Raven's Test, a lecturer from the Hanoi University, Department of Sociology took the role of supervisor. In addition, Save the Children UK performed a co-ordinating role as well as acting as independent observer of the surveys, conducting an observation field trip to Lao Cai province.

Before launching the survey in each province, RTCCD conducted all administrative preparation for the survey in collaboration with the Provincial Committee for Child Care and Protection (now called Provincial Committee for Population, Family and Children). A list of identified children by sentinel site, commune, and hamlet, together with the questionnaires, was prepared and released by RTCCD to GSO two weeks before fieldwork commenced in each province. The questionnaires were differentiated by the colour of the cover and were printed separately for each province. Two days before the launching of the survey in each province, a mixed team of RTCCD-GSO fieldwork organisers conducted a preparation fieldtrip and a schedule of surveys for each sentinel site was designed, with participation from local government, including a logistics plan. For interviews with ethnic minority groups, GSO selected local interpreters who had previous experience working with GSO in the Living Standards Surveys. GSO resource persons conducted training for interpreters.

In each survey team, RTCCD assigned two RTCCD staff who were responsible for quality control of household surveys. Questionnaires completed by GSO interviewers were checked by a GSO supervisor and team leader, and then were checked again by a RTCCD quality control person. Successfully completed questionnaires then were packed by commune and sent to GSO Hanoi. In Hanoi, GSO rechecked the questionnaires to confirm completeness, then grouped them by province and sent them to RTCCD's Information Technology Unit.

2.4.4. Data entry

RTCCD signed a second contract with Central Data Processing Centre (at GSO) to conduct data entry and cleaning. The data entry programs written by the University of Reading (UK) Statistical Services Centre were sent to RTCCD. The Information Technology Unit of RTCCD then conducted all adaptation into Vietnamese, including guidelines. Three RTCCD information officers conducted daily supervision of data entry at GSO and were responsible for any adjustments to the data entry programs and correcting data.

2.5. Data analysis

Data was stored in Microsoft Access databases (Access 2000) and was transferred to SPSS Version 11.0 for analysis. Before analysis, data was checked for inconsistencies by using the Double Data Entry program developed by Boster Sibande. Anthropometric indicators were computed using the EpiNut module of EpiInfo 2000, which uses the World Health Organisation (WHO) International Growth Reference as a growth standard.

For purposes of preliminary data analysis, this report presents descriptive information on the whole sample and provides breakdown by location (urban, rural) and wealth category. The wealth index draws on work undertaken by the World Bank and Macro International used to develop the wealth index cited in the UNICEF Multiple Indicator Cluster Surveys. It has been designed to include sufficient variables that vary substantially across the sample according to wealth. Type of cooking fuel performs well as an indicator of wealth in Demographic and Health Surveys (DHS surveys) and can be used to discriminate between households in areas without electricity that therefore do not have televisions and refrigerators. The index is constructed from:

- the number of rooms per household member as a continuous variable

- a set of dummy consumer durable variables, each equal to one if a household member owns a radio, refrigerator, bicycle, television, motorbike, motor vehicle, mobile phone, land phone, or some additional consumer durable indicators specific to the country context such as electronic fan and heater

- a set of three dummy variables equal to one if the house has electricity, brick or plastered wall, or a sturdy roof (such as corrugated iron, tiles or concrete)

- a dummy variable equal to one if the dwelling floor is made of a finished material (such as cement, tile or a laminated material)

- a dummy variable equal to one if the household's source of drinking water is piped into the dwelling or the yard

- a dummy variable equal to one if the household has a flush toilet or pit latrine (not shared with others in the community)

- a dummy variable equal to one if the household uses electricity, gas or kerosene for cooking.

The wealth index is a simple average of the following three components:

- housing quality, which is the simple average of rooms per person, floor, roof and wall

- consumer durables, being the scaled sum of the consumer durable dummies

- services, being the simple average of drinking water, electricity, toilet and fuel, all of which are 0–1 variables.

The wealth index is thus a score between 0 and 1. In this report, four groups are used: <0.25 the 'poorest', 0.25–<0.5 'very poor', 0.5–<0.75 'less poor', >=0.75 'better off'. An initial analysis which used only three groups had huge lumping in two of the groups and was therefore deemed less useful.

Young Lives did not measure household income or consumption. Income poverty data, which are measured at the household level, are not a child-specific poverty measure (Harper, Harpham, and White 2001). Poverty is commonly recognised as multi-dimensional. Adequacy of livelihoods that include income, assets, food availability, etc, is only one of five major dimensions to be considered in this study.[4] Recent research suggests that the asset-consumption relationship is quite close (Wagstaff et al, 1991; Filmer and Pritchett, 1998; Montgomery *et al,* 1997). In addition, using income or expenditure for measuring poverty increases costs for fieldwork in comparison with using the wealth index. Certain household asset variables may reflect household wealth better in some countries than in others, or may reflect differing degrees of wealth in different countries. Country-specific asset indices with a country-specific choice of assets variable are, therefore, used.

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4   The major dimensions of poverty to be measured in the Young Lives study are: (1) adequacy of livelihoods; (2) social indicators (health and education); (3) other child welfare indicators (including work, leisure, play), indicators of quality of child's environment (housing, infrastructure, access to clean water, sanitation); (4) quality of social life (contact time with carer, feeling of closeness to family/friends, extent to which they can rely on others for help); (5) dignity/autonomy, including mental health, participation.

2.6. Ethics

In each phase of the study – including the selection of sentinel sites and eligible children, and conducting interviews – written consent forms for all aspects of the research were sent to participants and local government at different levels (i.e. provincial, district, and communal). For illiterate people, verbal consent was gained by village health workers who delivered a consent form some days before the survey, and by interviewers prior to the interviews. Besides getting research ethics approval from London South Bank University UK, London School of Hygiene and Tropical Medicine UK, and Reading University UK, in Vietnam ethical approval for the Young Lives project was granted by VUSTA.

3. Results – one-year-old survey

3.1. General characteristics of the index child, their caregiver, and their household

Boxes 2–4 show the characteristics of the caregivers, their households and the index children.

BOX 2: GENERAL CHARACTERISTICS OF THE CAREGIVERS (N=2000)

- Four per cent aged 15–49, 64 per cent aged 20–29, 32 per cent aged 30 and over
- only nine males
- 51 have no partner, 17 have partner outside of the household
- 27 per cent never schooled, 38 per cent completed primary, 22 per cent completed secondary, 13 per cent completed higher level
- 80 per cent literate
- 83 per cent no religion, ten per cent Buddhist
- 86 per cent Kinh, six per cent Hmong, eight per cent other ethnic group
- 71 per cent live in household of two to five people, 28 per cent live in household of six to ten people.

BOX 3: GENERAL CHARACTERISTICS OF THE HOUSEHOLDS OF THE CAREGIVERS (N=2000)

- 85 per cent male headed households (87 per cent of poorest households, 83 per cent of better off households)
- Household size; 71 per cent have two to four people, 28 per cent have six to ten people
- 35 per cent have more males than females, 42 per cent have more females than males, 23 per cent have equal number of each sex
- 32 per cent of heads of household did not complete primary school
- 90 per cent of households have no history of any child death.

BOX 4: GENERAL CHARACTERISTICS OF THE ONE-YEAR-OLDS (N=2000)

- 52 per cent male, 48 per cent female (no significant difference between wealth groups)
- 20 per cent urban, 80 per cent rural
- 22 per cent poorest, 38 per cent very poor, 31 per cent less poor, 10 per cent better off
- 99 per cent cared for by biological mother
- 97 per cent live with both parents
- 99 per cent see their mother daily
- 87 per cent see their father daily (four cases where father is dead)
- 44 per cent are an only child

3.2. Nutrition status

TABLE 8: NUTRITION STATUS OF ONE-YEAR-OLDS BY LOCATION AND WEALTH INDEX

	Total (N=1994*)	%	Urban % (N=400)	Rural % (N=1594)	Poorest % (N=443)	Very poor % (N=751)	Less poor % (N=609)	Better off % (N=191)
Stunting *(Z score Height for Age < -2)*	314	16 [12-21]**	6 [2-15]	18 [14-24]	27 [17-30]	16 [13-20]	11 [9–14]	1 [0.5–2]
Wasting *(Z score Weight for Height < -2)*	112	6	5	6	5	6	6	4
Underweight *(Z score Weight for Age < -2)*	452	23 [19-27]	12 [7-20]	25 [22-29]	32 [25-39]	25 [22-28]	19 [15-23]	5 [2-11]

* 6 missing cases; ** 95% Confidence Interval

Nutritional status is one of the two 'outcome variables' that are measured for the Young Lives one-year-olds, the other is physical health. Although in other studies, the two indicators are sometimes related, we will see that in Young Lives, the respective indicators have very different patterns when examined by location and wealth. Table 8 presents three key indicators of nutritional status by location and wealth.

The World Health Organization categorise 16 per cent as a 'low' level of stunting, six per cent as a 'medium' level of wasting and a prevalence of 23 per cent underweight is regarded as 'high'. Table 8 shows that the distribution of malnutrition is significantly different by location and socio-economic status. Stunting and underweight was twice as high in rural areas compared with urban. The prevalence of malnourished children increased steadily as the wealth index decreased. Differences between boys and girls are not significant in any nutrition indexes (WAZ 25 per cent for boys; [95%CI: 21–30], and 20 per cent for girls [95%CI:16–25]).

The Young Lives data have high face validity when compared against the 2002 National Institute of Nutrition (NIN) and GSO National Nutrition Survey which found the following rates for 5–12-month-old children and 13–24 month old children respectively: stunting 19 per cent, 36 per cent (Young Lives 16 per cent); wasting six per cent, 11 per cent (Young Lives six per cent); underweight 15 per cent, 33 per cent (Young Lives 23 per cent) (NIN-GSO 2003).

3.3. Physical health

TABLE 9: PHYSICAL HEALTH OF ONE-YEAR-OLDS BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Health compared to others								
Same	940	47	46	47	48	45	47	55
Better	522	26	28	26	22	26	28	30
Worse	538	27	26	27	31	30	25	15
Perceive of long term health problem	85	4	6	4	4	4	4	6
Occurrence of life threatening illness	264	13	9	14	18	14	12	3
(Sought treatment for it)	(233)	(88)	(44)	(87)	(89)	(85)	(93)	(83)
Occurrence of severe injury/accident	171	9	8	9	9	9	7	6
Illness in last 24 hours	334	17	17	17	16	19	16	12

Table 9 shows various chronic and health conditions of the index child. Twenty-seven per cent of caregivers evaluated their children as having worse health status than others. However, only four per cent of them reported their children as having long-term health problems. Seventeen per cent of children were reported to have had an illness during the last 24 hours, and this prevalence was similar across socio-economic groups as well as in rural and urban areas. Severe injuries/accidents was reported for nine per cent of the children. This did not differ by location or wealth.

Mothers' perceptions of the comparative health of the index child does not vary much across groups – presumably became the reference category that mothers use corresponds to the groups used here – i.e. a very poor rural mother compares her child with those of other very poor rural mothers. Future within group analysis might prove interesting. Overall, physical morbidity differs very little by location or wealth – unlike nutrition. Reasons for this difference in the two indicators will be explored in future analysis.

3.4. Antenatal care and immunisation

TABLE 10: ANTENATAL CARE, PLACE OF BIRTH, ASSISTANCE AT DELIVERY AND BIRTH WEIGHT RELATING TO ONE-YEAR-OLDS, BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Any antenatal care	1640	83	95	80	59	84	94	98
Received tetanus injection	1309	81	81	80	73	80	85	80
Delivered at								
Home	378	19	2	23	45	19	6	1
Hospital	999	50	73	44	28	44	62	89
Health centre	564	28	24	29	26	33	30	11
Medically trained person attended delivery	1577	79	92	76	51	82	90	97
Low birth weight baby	171	9	6	11	14	11	8	4

Conditions before and at birth can affect the development of children so Young Lives measures these factors. More than 80 per cent of mothers received antenatal care and a tetanus injection during pregnancy. However, the proportion receiving any antenatal care is a little lower in the rural group than in the urban (80 per cent versus 95 per cent) and significantly lower in poorest group compared to the better off group (53 per cent versus 98 per cent).

One-fifth of children were born outside of health facilities without help from medical professionals, but most of these cases are from the households of poor socio-economic level. While less than two per cent of children in urban areas were delivered at home, the rate is 23 per cent for rural children. Forty-five per cent of children in the lowest wealth index household group were born without assistance from health professionals, while this figure is one per cent in the better off group. Prevalence of low birth weight was nine per cent. Of the caregivers, 263 could not provide an answer about their baby's weight (missing cases).

TABLE 11- VACCINATION STATUS OF CHILDREN OVER ONE-YEAR-OLD BY LOCATION AND WEALTH INDEX

	Total (N=899)	%	Urban % (N=206)	Rural % (N= 693)	Poorest % (N=180)	Very poor % (N= 341)	Less poor % (N=292)	Better off % (N=86)
BCG only	65	7	4	8	11	7	7	0
Measles only	50	6	1	7	5	7	6	0
Both BCG and measles	741	82	94	79	76	80	84	100
Neither BCG nor measles	43	5	2	6	8	5	3	0

The coverage of both measles and BCG vaccines was high (for both urban and rural children) and was not significantly different by location (94 per cent for urban and 79 per cent for rural children) or socio-economic levels.

The expected relationship of antenatal care, assisted delivery and birth weight coverage by wealth has differences large enough to expect some impact on child survival. Although it should be noted that most infant (under one) mortality will have happened in the age group purposely not covered by the Young Lives project (under six months) it may still be possible to detect impact of pregnancy and birth on older children. This analysis will be possible after the next round of data collection (when the index child is around four years old).

3.5. Caregiver mental health

TABLE 12: CAREGIVER'S MENTAL ILL HEALTH BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Mental ill-health	401	20	22	20	22	23	18	13

Caregiver's mental health was measured by the World Health Organization (1994) recommended 'Self-reporting questionnaire – 20 items' (SRQ20). This consists of 20 yes/no questions and measures depression and anxiety. It has been validated in Vietnam for the Young Lives study by comparing it to in-depth psychiatric interviews with 66 respondents. The validity and the reliability are good (Tuan, Harpham, and Huong, 2003) and a cut off point of eight or more 'yes' answers is defined as a case of mental ill-health.

Table 12 shows that caregiver mental ill health was found in 20 per cent of the respondents, and there are no great differences by location or wealth. This prevalence is normal for poor women in developing countries. This is the first time mental health has been measured in a community-based survey in Vietnam. In other countries maternal mental health is positively associated with child wellbeing. The Young Lives study will be able to investigate whether this is true in Vietnam and to identify the determinants of maternal mental health in order to suggest interventions.

3.6. Child care

TABLE 13: CHILD CARE BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Cared for by individuals not in the household	667	33	28	35	29	35	35	31
Been left alone (with nobody aged over 5) for at least half a day in the last 6 months	54	3	3	3	3	2	4	2

About one-third of children were cared for by individuals not in the household and this rate did not vary significantly between urban and rural children. Three per cent of children had been left alone for at least half a day in the last six months.

3.7. Housing

On average, 85 per cent of households use electricity, ranging from 81 per cent in rural areas to 100 per cent in urban areas. However, only 43 per cent of the poorest socio-economic households use electricity compared with 100 per cent in the better off group. Forty-one per cent of households use unhygienic sources of drinking water, and approximately 85 per cent of children in the poorest group live in households with an earth floor. There is a startlingly large percentage of households using unprotected water sources. This may have a great impact on child survival and morbidity which will be possible to analyse after the next round of data collection (when the child will be four to five years old).

TABLE 14: HOUSING CHARACTERISTICS BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Electricity	1689	85	100	81	43	92	100	100
Source of drinking water								
Piped into dwelling/yard/plot	200	10	48	.5	.2	.3	9	76
Tube-well in dwelling	455	23	35	20	2	20	43	18
Public standpipe/tube-well	7	.4	1	.1		.1	.8	.5
Unprotected well/spring/pond/river/stream	809	41	12	48	54	51	30	2
Other	529	27	4	32	44	30	17	3
Toilet facility								
Flush toilet/septic tank	440	22	84	7	.2	2	39	98
Pit latrine (household's)	539	27	3	33	5	33	44	2
Pit latrine (communal)	7	.4	2	.1		.7	.3	0
None	709	36	12	41	71	42	13	0
Other	305	15		19	24	23	5	0
Floor material								
Earth	606	30	.5	38	85	29	1	0
Wood	9	.5	.5	.4	1	.4	.2	0
Stone/brick	199	10	2.8	12	5	18	7	.5
Cement/tile	1099	55	96	45	5	45	90	100
Laminated material	1	.1	0	.1	0	.1	0	0
Other	86	4.3	.5	5.3	4	7.2	2	0
Roofing material								
Straw/thatch	100	4	0	6.3	20	2	0	0
Earth/mud	1	.1	.3	0	0	.1	0	0
Wood/planks	1	.1	0	.1	0	.1	0	0
Galvanised iron	482	24	60	15	9	20	32	52
Concrete/cement	161	8	17	6	0	3	14	30
Tiles/slates	493	40	22	44	8	54	52	17
Other	462	23	1	29	64	22	2	0
Wall material								
Brick/concrete	1171	59	95	50	3	51	96	100
Adobe/mud	18	.9	0	1	.9	2	.2	0
Wood/branches	511	26	4	31	31	58	31	0
Galvanised iron	8	.4	.3	.4	.4	.7	.7	0
Matting	6	.3	0	.4	.4	.2	.7	0
Other	286	14	1	18	18	38	14	0

3.8. Livelihoods, diversification, debts, shocks and coping strategies

TABLE 15: HOUSEHOLD'S MAIN TYPE OF ECONOMIC ACTIVITIES BY LOCATION AND WEALTH INDEX

	Total % (N=4062)	%	Urban % (N=827)	Rural % (N=3235)	Poorest % (N=804)	Very poor % (N=1523)	Less poor % (N=1321)	Better off % (N=414)
Sector*								
Agriculture, hunting, forestry and fishing	1579	79	19	94	98	93	70	10
Mining and quarrying	38	2	.5	2	2	2	2	
Manufacturing	602	30	44	27	16	28	39	42
Electricity, gas and water	6	.3	1	.1	8	12	.5	2
Construction	268	13	23	11			19	14
Wholesale and retail trade	626	31	48	27	18	29	39	49
Transport, storage and communications	235	12	28	8	4	9	15	27
Finance, insurance, real estate and business services	160	8	19	5	2	4	10	33
Community, social and personal services	536	27	24	28	33	25	21	39
Household has no activities	12	.6	1	.4		.4	1	.5

(*) Households may be involved in none, one or more than one sector

TABLE 16: DIVERSIFICATION OF ECONOMIC ACTIVITY BY LOCATION AND WEALTH INDEX

	Total % (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Activities in only one sector	543	27	25	28	41	26	20	22
Activities in more than one sector	1457	73	75	72	59	74	80	78

It is increasingly recognised that diversification of economic activity can protect poor households against shocks. Young Lives thus measures diversification as an aspect of livelihoods.

The main employment sector is agriculture (79 per cent); 98 per cent of the poorest are in agriculture. In urban areas, households are mainly involved in wholesale/retail (48 per cent) and manufacturing (44 per cent). Twenty-seven per cent of households are involved in only one sector. No difference was observed in non-diversity between urban and rural (25 per cent for urban and 28 per cent for rural). Households with higher levels of wealth index have more diversification of economic activities (78 per cent for the better off, 59 per cent for the poorest).

TABLE 17: HOUSEHOLD DEBT AND ABILITY TO REPAY BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Serious debt	1022	51	37	55	61	56	45	27
Can repay on time	859	43	29	46	49	47	40	25

The proportion of households in rural areas having serious debt was 55 per cent – higher than that in urban areas (37 per cent). However, perception of ability to repay was similar across the three poorer groups (around 45 per cent) but interestingly, only 25 per cent of the better off group who had a serious debt, felt they would be able to repay on time – presumably they have particularly large debts – perhaps that is why they are better off! (they are getting into debt to gain assets).

TABLE 18: ECONOMIC SHOCKS DURING LAST THREE YEARS BY LOCATION AND WEALTH INDEX

	Total N=2000	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
No event	1138	57	67	54	52	50	63	77
Only one event	540	27	24	28	30	30	23	20
More than one event	322	16	9	18	18	20	14	3

Economic shocks and associated coping strategies can greatly influence the wealth of households. Forty-three per cent of households mentioned events that decreased their economic welfare during the last three years (i.e. shocks). Households in rural areas had slightly more shocks than urban households did at 46 per cent and 33 per cent respectively. The poorest socio-economic groups had more shocks than the better off (48 per cent and 23 per cent respectively).

The total shocks mentioned by 862 households are 1256 *(see Table 19)*. The leading shock was severe illness or injury, accounting for 23 per cent (292 out of 1262) of all types of shocks, and mentioned by 27 per cent of households (234 out of 862), with no difference by location or wealth. The second shock was having crops fail or stolen for rural (19 per cent) and birth/new household member for urban (24 per cent). The 'face validity' of these economic change data appears good in that they do not vary much across categories when one would not expect them to, but do where one would expect them to vary. For example, job loss is worse for the better off because they had jobs in the first instance.

TABLE 19: DISTRIBUTION OF TOTAL 1262 SHOCKS AMONG 862 HOUSEHOLDS WITH SHOCKS BY TYPE OF SHOCK, LOCATION, AND WEALTH INDEX

	Total % N=862	%	Urban % (N= 133)	Rural % (N= 729)	Poorest % (N= 216)	Very poor % (N=374)	Less poor % (N=229)	Better off % (N= 43)
Natural disaster (n=183)	94	11		13	7	17	7	2
Decrease in food availability (n=2)	2	0		0	0	0	0	0
Death/reduction in household members (n=38)	26	3	6	2	4	3	2	2
Job loss (n=100)	81	9	16	8	6	9	12	19
Severe illness or injury (n=292)	234	27	29	27	29	27	25	30
Victim of crime (n=3)	2	0	1	0	0	0	0	0
Divorce/separation (n=11)	4	1	1	0	0	0	1	0
Birth/new household member (n=158)	97	11	24	9	9	10	13	21
Paying for child's education (n=8)	1	0	1	0	0	0	0	0
Moved/migrated/ fled (n=20)	14	2	3	1	2	1	2	5
Livestock died or were stolen (n=90)	41	5	1	5	8	4	3	2
Crops failed or were stolen (n=204)	139	16	1	19	24	17	11	0
Other (n=153)	127	15	19	14	9	12	24	19

Table 20 shows coping strategies used by households in response to the worst shock. About half of the households (53 per cent) used only one coping strategy although they were asked to name a maximum of three strategies used, and this is similar in all groups. There were also eight per cent of households who said they had no coping strategy for shocks, with no statistical difference by location or wealth.

TABLE 20: NUMBER OF COPING STRATEGIES USED TO RESPOND TO ECONOMIC SHOCKS BY LOCATION AND WEALTH INDEX

	Total % N=.862	%	Urban % (N=133)	Rural % (N=729)	Poorest % (N=216)	Very poor % (N=374)	Less poor % (N=229)	Better off % (N=43)
None	66	8	5	8	10	7	6	7
1. strategy	454	53	55	52	54	54	49	51
2. strategies	300	35	35	35	34	33	38	33
3. strategies	42	5	6	5	2	5	6	9

Tables 21 and 22 allow examination of household responses by type of shocks. For 66 households with no coping strategy, crop failure appears as the most common shock, but of course, is not seen in the urban or the better-off groups. However, attention should be given to severe illness shocks: about 11 per cent of households (7 out of 66) did nothing when they suffered from severe illness, and this happened in all groups of rural households with wealth index <0.75.

For 454 households using only one coping strategy, severe illness is most often seen as the shock (28 per cent; 128 out of 454) in rural (27 per cent), urban (33 per cent), as well as all wealth groups *(see Table 22)*. The next (for urban) is birth or having a new household member (29 per cent), and for rural it is crop failure (23 per cent). A similar trend is seen in 300 household with two, and 42 households with three coping strategies.

TABLE 21: DISTRIBUTION OF 66 HOUSEHOLDS HAVING NO COPING STRATEGY FOR THEIR WORST ECONOMIC SHOCKS BY TYPE OF SHOCK, LOCATION AND WEALTH INDEX*

	Total % N=.66	%	Urban % (N=6)	Rural % (N=60)	Poorest % (N=22)	Very poor % (N=27)	Less poor % (N=14)	Better off % (N=3)
Natural disaster	7	11		12	9	19		
Livestock died or were stolen	7	11		12	18	4	7	33
Crops failed or were stolen	15	23		25	27	19	29	
Death/reduction in household members	3	5	17	3	9		7	
Job loss	7	11	17	10	9	15	7	
Severe illness or injury	7	11		12	9	15	7	
Victim of crime	1	2		2		4		
Birth/new household member	5	8	17	7	9	7		33
Moved/migrated/ fled	1	2		2	5			
Other	13	20	50	17	5	19	43	33

 Caregiver/household leader was asked to name up to three coping strategies that household used for their worst shock during the last three years.

TABLE 22: DISTRIBUTION OF 454 HOUSEHOLDS WHO HAVE ONLY ONE COPING STRATEGY FOR THEIR WORST ECONOMIC SHOCKS BY TYPE OF SHOCK

	Total % N=.454	%	Urban % (N=73)	Rural % (N=381)	Poorest % (N=117)	Very poor % (N=202)	Less poor % (N=113)	Better off % (N=22)
Natural disaster	39	9		10	7	11	7	5
Decrease in food availability	2	0		1	1		1	
Livestock died or were stolen	22	5	1	6	9	4	2	
Crops failed or were stolen	88	19	1	23	26	22	12	
Death/reduction in household members	13	3	4	3	3	4		5
Job loss	45	10	19	8	6	8	14	27
Severe illness or injury	128	28	33	27	29	27	28	36
Divorce/separation	2	0		1	1		1	
Birth/new household member	51	11	29	8	6	10	16	23
Paying for child's education	1	0	1				1	
Moved/migrated/ fled	7	2	3	1	3	1	2	
Other	56	12	8	13	10	12	17	5

Tables 23, 24 and 25 allow examination of what type of responses are most common and what shock prompted a particular coping strategy. Working more (33 per cent; 388 out of 1180); use of credit (29 per cent; 340 out of 1180); and receiving help from relatives/friends (12 per cent; 137 out of 1180) were the most common coping strategies used. One-third (33 pre cent; 113 out of 340) of credit use was for severe illness/injury, and also one-third (33 per cent; 45 out of 137) of help from relatives/friends was for severe illnesses/injury (see Table 24). Receiving support from the Government or charity organisations was very low at three per cent (see Table 25) and mostly (75 per cent; 30 out of 40) for natural disaster (see Tables 23 and 24). Insurance paid happened for only two cases out of 1180 responses (see Table 23). Very little support was received from outsiders when crops failed.

It is rare to have such detailed quantitative information on shocks and coping strategies in Vietnam and further analysis will relate these data to child wellbeing.

TABLE 23: DISTRIBUTION OF 1180* RESPONSES TO ECONOMIC SHOCKS THAT HAPPENED IN 862 HOUSEHOLDS, BY TYPE OF SHOCK (EVENT)

WORST EVENT	Sell things/sell assets	Use Savings	Use credit	Eat less	Buy less	Work more/start work	Take children out of school	Send children to work	Fled/moved away from problem	Migrated to work/find work	Received help from relatives/friends	Received help from government/NGO	Insurance paid	Other	Total N=1180
Natural disaster		8	40	1	2	29				1	24	30		3	138
Decrease in food availability			1											1	2
Livestock died or were stolen		1	11	4	3	21			1		3			5	49
Crops failed or were stolen	3	5	43	6	5	82	1	1			7			10	163
Death/reduction in household members		2	10	1	1	10					8	1			33
Job loss	2	11	32	5	9	36				2	4	1	1	4	107
Severe illness or injury	10	21	113	11	13	94	1		1	2	45	6	1	24	342
Victim of crime						1					1	1			3
Divorce/separation			2			1				1	2				6
Birth/new household member	3	8	25	8	11	55		1			17	1		9	138
Paying for child's education			1												1
Moved/migrated/fled		2	4	2	1	6				1	4				20
Other	1	14	58	5	12	53				1	22			12	178
Total	19	72	340	43	57	388	2	2	2	8	137	40	2	68	1180

*Total responses told by 862 households = (66 x 0 + 454 x 1 + 300 x 2 + 42 x 3)

TABLE 24: DISTRIBUTION OF 1180 RESPONSES TO ECONOMIC SHOCKS THAT HAPPENED IN 862 HOUSEHOLDS, BY TYPE OF SHOCK (COLUMN %)

WORST EVENT	Sell things/ Sell assets	Use savings	Use credit	Eat less	Buy less	Work more/ start work	Take children out of school	Send children to work	Fled/ moved away from problem	Migrated to work/ find work	Received help from relatives/ friends	Received help from govern-ment /NGO	Insura-nce Paid	Other	Total
Natural disaster		11	12	2	4	7				13	18	75		4	12
Decrease in food availability			0											1	0
Livestock died or were stolen		1	3	9	5	5				13	2			7	4
Crops failed or were stolen	16	7	13	14	9	21		50			5	3		15	14
Death/reduction in household members		3	3		2	3		50			6	3		3	3
Job loss	11	15	9	12	16	9				25	3	3	50	6	9
Severe illness or injury	53	29	33	26	23	24	50		50	25	33	15	50	35	29
Victim of crime				2		0									0
Divorce/separation			1			0				13	1			1	1
Birth/ new household member	16	11	7	19	19	14	50				12	3		13	12
Paying for child's education			0												0
Moved/Migrated/fled		3	1	5	2	2			50	13	3				2
Other	5	19	17	12	21	14				13	16			18	15
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

TABLE 25: DISTRIBUTION OF 1180 RESPONSES TO ECONOMIC SHOCKS THAT HAPPENED IN 862 HOUSEHOLDS, BY TYPE OF SHOCK (ROW %)

WORST EVENT	Sell things/ Sell assets	Use savings	Use credit	Eat less	Buy less	Work more/ start work	Take children out of school	Send children to work	Fled/ moved away from problem	Migrated to work/ find work	Received help from relatives/ friends	Received help from govern-ment/ NGO	Insura-nce paid	Other	Total
Natural disaster		6	29	1	1	21				1	17	22		2	100
Decrease in food availability			50											50	100
Livestock died or were stolen		2	22	8	6	43				2	6			10	100
Crops failed or were stolen	2	3	26	4	3	50				1	4	1		6	100
Death/reduction in household members		6	30	3	3	30		3			24	3			100
Job loss	2	10	30	5	8	34				2	4	1		4	100
Severe illness or injury	3	6	33	3	4	27		0		1	13	2	1	7	100
Victim of crime				33		33				0	33			7	100
Divorce/separation			33							17	17	33			100
Birth/new household member	2	6	18	6	8	40			1	1	12	1		7	100
Paying for child's education			100												100
Moved/migrated/ fled	1	8	20	10	5	30			5	1	20	12		7	100
Other		8	33	3	7	30			1	1	12	3		6	100
Total %	2	6	29	4	5	33	<.01	0	<.01	1	12	3	<.01	6	100

3.9. Social capital

TABLE 26: DIMENSIONS OF SOCIAL CAPITAL OF CAREGIVER BY LOCATION AND WEALTH INDEX

	Total (N=2000)	%	Urban % (N=400)	Rural % (N=1600)	Poorest % (N=446)	Very poor % (N=753)	Less poor % (N=610)	Better off % (N=191)
Absolute structural social capital (ASSC)								
No ASSC	1481	74	72	75	85	73	70	63
Medium ASSC	478	24	26	23	15	25	26	34
High ASSC	41	2	2	2		2	4	3
Relative structural social capital (RSSC)								
No RSSC	1487	74	72	75	86	74	70	63
Medium RSSC	456	23	26	22	13	23	26	34
High RSSC	57	3	2	3	1	3	4	3
Social support (SS)								
No SS	70	3	1	4	5	3	3	1
Medium SS	1681	84	78	86	87	86	83	74
High SS	249	13	21	10	8	11	13	26
Cognitive social capital (CSC)								
No CSC	6	.3	1	.2		.4	.3	1
Medium CSC	179	9	11	9	10	10	9	6
High CSC	1815	91	88	91	90	90	91	93
Citizenship (CIT)								
No CIT	1394	70	62	72	71	70	71	63
Some CIT	606	30	38	28	29	30	29	37

Structural social capital can be objectively measured as an individual's involvement in networks (for example, the number of community groups an individual belongs to). It is a measure of what people do, as opposed to cognitive social capital, which is a measure of what people think. It is measured here by the caregiver's activity in informal and formal groups in her community. It is measured in an absolute sense (simple number of groups) and in a relative sense (number of groups participated in as compared to actual number of groups/organisations present in community). Cognitive social capital is how people feel (subjectively) about trust, reciprocity and sense of belonging in their community. Overall 74 per cent of caregivers were not active members of any community group (absolute structure social capital = 0) but the better off did have more structural social capital. However, almost all of the caregivers have received social support in the last year (97 per cent), and 91 per cent of the caregivers trusted in community people as well as feeling that they were really a part of their community (high cognitive social capital). However, it is not common for them to work together to address a problem or common issue (no citizenship = 70 per cent). This is similar between rural and urban areas, as well as across socio-economic groups.

The fact that structural social capital is positively correlated with wealth may mean that the increasingly common development hypothesis that the poor may make use of social capital assets in the absence of other assets of a livelihoods framework (human, physical, financial and natural capitals) may not prove to be correct. To the authors' knowledge, this is the first time that a systematic measure (covering both structural and cognitive social capital) of this topic has been undertaken in Vietnam. Future analysis will examine social capital at an aggregated, community level and will be able to determine whether children in communities with high levels of social connections (regardless of their own household's level of social capital) fare particularly well.

4. Results – eight-year-old survey

4.1. Nutrition status

TABLE 27: NUTRITION STATUS OF EIGHT-YEAR-OLDS BY LOCATION AND WEALTH INDEX

	Total (N=1000)	%	Urban % (N=200)	Rural % (N=800)	Poorest % (N=185)	Very poor % (N=378)	Less poor % (N=346)	Better off % (N=91)
Stunting (Z score Height for Age < -2)	276	28 [21-35]	18 [9 –31]	30 [23-39]	40 [22-61]	30 [24-36]	23 [19-28]	10 [5 –17]
Wasting (Z score Weight for Height < -2)	78	8	8	8	5	9	8	10
Underweight (Z score Weight for Age < -2)	283	28 [24-33]	18 [9-32]	31 [27-35]	33 [26-41]	31 [27-37]	27 [23-31]	11 [5-21]

FIGURE 6: DISTRIBUTION OF POOR NUTRITION STATUS (<-2SD) OF EIGHT-YEAR-OLDS BY LOCATION
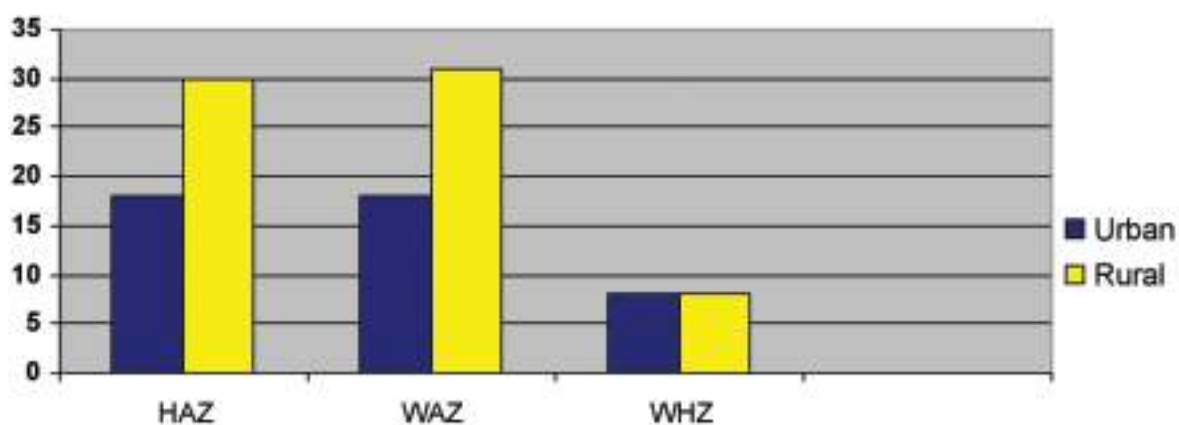
The prevalence of underweight and stunted children were both high at 28 per cent. Rural children were more malnourished than urban children with 31 per cent underweight and 30 per cent stunted in rural areas, compared to 18 per cent in urban areas. However, there is still overlap in their 95%CI. This is probably because the sample size for urban is not enough to detect a significant difference on child malnutrition between urban and rural. Children with poor socio-economic conditions have significantly higher prevalence of malnutrition than the better off. Boys have higher prevalence of stunting than girls, but not a statistically significant difference (33 per cent for boys [95%CI: 25–41]

compared with 23 per cent for girls [95%CI:16–31]. However, for underweight, boys are statistically significantly higher (34 per cent, 95%CI: 29–40) than girls (23 per cent; 95%CI: 18–28).

The very high level (40 per cent) of stunting among the poorest children confirms that improvements in child nutrition have been least pronounced among the poor as indicated in the World Bank/ADB Vietnam Development Report 2003 (World Bank &ADB 2002, p59). The gap between the rich and poor in terms of changing child nutrition is due to increased inequality between the poor and better off in commune-level influences on child malnutrition (Wagstaff et al, cited in World Bank & ADB 2002) "The lack of comparable commune-level data over time makes it difficult to identify precisely what these [influences] are" (World Bank/ADB 2003, p.59). The Young Lives project will fill this knowledge gap in future longitudinal analysis.

4.2. Physical health

Approximately 30 per cent of caregivers perceived their children's health status as worse than other children. Long-term health problems were reported at 14 per cent. A quarter of children had had severe toothache in the last year, and 33 per cent had illness in the last two weeks. This pattern is similar by location and socio-economic conditions.

TABLE 28: PHYSICAL HEALTH OF EIGHT-YEAR-OLDS BY LOCATION AND WEALTH INDEX

	Total (N=1000)	%	Urban % (N=200)	Rural % (N=800)	Poorest % (N=185)	Very poor % (N=378)	Less poor % (N=346)	Better off % (N=91)
Health compared to others								
Same	483	48	40	50	48	47	49	52
Better	221	22	24	22	20	21	23	25
Worse	296	30	37	28	32	32	28	23
Long-term health problem	139	14	17	13	15	15	11	15
Occurrence of life threatening illness in last 3 years	106	11	6	12	17	13	7	1
(Sought treatment for it)	(99)	(93)	(100)	(93)	(91)	(92)	(100)	(100)
Occurrence of severe toothache in last year	255	26	24	26	29	27	24	19
Illness in last 2 weeks	327	33	33	33	38	33	31	25

4.3. Child's schooling

Almost all children attended school (99 per cent). Among the listed activities that children do for fun, playing with friends is the top option (63 per cent). The next is watching television (18 per cent). No difference by location or socio-economic status was found regarding these features. Children found it easier to talk about things they like about school than about what they do not like. Teachers or pupils beating the child were the most common thing expressed by children as what they do not like about school. This is similar by location and socio-economic status. What made children like school was

'having teachers and friends' (42 per cent) and 'learning' (25 per cent). Compared to rural children, urban children are more interested in going to school because of 'having teachers and friends' (39 per cent versus 56 per cent). Interest in learning is similar between rural and urban children, as well as by level of socio-economic status.

4.4. Child's work

TABLE 29: MAIN CHARACTERISTICS OF CHILD WORK

		N	%
Has child ever worked for money or goods?	*Yes*	144	14
	Not yet	856	86
Group total		**1000**	**100**
Main reason for working (N=144)	*Supplement HH income*	72	50
	Generate own income	7	5
	Gain experience	2	1
	They like to work	20	14
	Keep them out of trouble	10	7
	Other	33	23
Group total		**144**	**100.0**
Has child been seriously hurt while working?*	*Yes*	6	.7
	No	994	99
Group total		**1000**	**100**

Fourteen per cent of children have ever worked for payment, although the incidence of child work is more common among rural children (17 per cent) than among urban (six per cent). There is no difference between the poor and the better off. Urban children are said (by caregivers) to work because they like to do so (36 per cent) or other reasons (36 per cent) rather than to supplement household income (27 per cent). Meanwhile, 52 per cent of rural children worked to supplement household income, 12 per cent because they like to, and 22 per cent for other reasons. Differences in reasons for work by socio-economic level are not found. Almost all children reported (themselves) to like working (96 per cent) and it seems that working is not impacting on their schooling as only five per cent of those who had ever worked said they had to consequently miss school.

4. 5. Child's mental health

Child mental health was measured by the SDQ which consists of 25 items and has been validated in several developing countries. The caregiver is asked questions about the child's emotional symptoms, behaviour problems, hyperactivity, interaction with peers and general social interaction. A system of scoring allows children to be classified as 'normal', 'borderline' and 'abnormal'. An abnormal score can be used to identify likely 'cases' with mental disorders. Typically 10 per cent of a community sample scores in the abnormal category, with a further 10 per cent in the borderline category. It will be noted that results from this study are much higher than this. However, caution should be exerted when

interpreting these results as the SDQ has not yet been validated in Vietnam. However, results do suggest that child mental ill-health is potentially a problem in Vietnam. The prevalence of children with abnormal results was 20 per cent. This figure is a little higher in urban (26 per cent) than in rural areas (19 per cent). There was little variation by socio-economic level.

TABLE 30: CHILD'S MENTAL HEALTH BY LOCATION AND WEALTH INDEX

	Total (N=998*)	%	Urban % (N=200)	Rural % (N=798)	Poorest % (N=185)	Very poor % (N=378)	Less poor % (N=344)	Better off % (N=91)
Normal	616	62	52	64	65	62	59	63
Borderline	180	18	23	17	18	18	18	19
Abnormal	202	20	26	19	17	20	23	19

* 2 missing cases

After fieldwork, this section was mentioned by interviewers as the most difficult among all sections of the four surveys (one-year-old household survey, eight-year-old household survey, eight-year-old child survey, and community survey). Some interviewers admitted that they changed the wording in order to elicit an answer from interviewees (Coulson, 2002). However, this is not linked to a problem in translation from English into Vietnamese. The translation of this section received highest attention from the people involved and was back translated by an experienced consultant and the author of the tool verified the back-translation. Practice during training sessions did not show any problems in translation, but did identify difficulties in asking about socio-psychological health in general. Interviewers were not patient enough to wait for interviewees' responses, and because this section is asked at the end of the interview, this could explain changing the wording of this section by interviewers.

4.6. Child's perception of wellbeing

TABLE 31: CHILD'S PERCEPTION OF WELLBEING BY LOCATION AND WEALTH INDEX

	Total (N=997*)	%	Urban % (N=200)	Rural % (N=797)	Poorest % (N=182)	Very poor % (N=378)	Less poor % (N=346)	Better off % (N=91)
Is the water people drink around here (N=997)								
Good	794	80	76	81	87	78	77	85
Bad	16	1	1	2	1	2	2	
Average	187	19	23	18	12	20	21	15
Is the air people breath around here (N=995)								
Good	579	58	64	57	54	57	61	64
Bad	70	7	10	6	13	6	5	7
Average	346	35	27	37	33	37	34	30
Is the amount of rubbish on the street (N=994)								
Good	105	11	12	10	9	13	9	10
Bad	734	74	73	74	79	71	75	70
Average	155	16	16	16	12	16	16	20
Is the area you live in safe for children (N=997)	858	86	85	86	88	86	86	80

* 3 missing cases

A child-centred outcome measure of Young Lives is the child's own perception of their quality of life. Some of the indicators that make up this outcome are considered here. Almost all children perceived the water in their area as good even though in reality it is only 12 per cent (see section on 'housing'). Seventy-four per cent of children reported that the amount of rubbish in their surrounding area was bad, but less than two per cent regarded the quality of drinking water as bad. Approximately 86 per cent of children thought their area was safe for children. This is similar between rural and urban groups, as well as across the socio-economic levels.

4.7. Child's social capital

Young Lives experimented with some measures of child social capital (social relations and connectedness with community). Some indicators are considered here. Playing daily with friends was reported by 91 per cent of children. It seems that rural children and poor children spend more time daily playing with friends than urban and better off children (93 per cent in rural versus 89 per cent in urban, and 95 per cent in poor wealth index groups compared to 92 per cent in better off groups). When they had a problem, 94 per cent of children reported they could find people to help them, but this figure is lower in the poor children (83 per cent) compared with the better off children (96 per cent).

4.8. Literacy and numeracy

TABLE 32: LITERACY AND NUMERACY OF EIGHT-YEAR-OLDS BY LOCATION AND WEALTH INDEX

	Total	%	Urban %	Rural %	Poorest %	Very poor %	Less poor %	Better off %
Reading* (N=994)								
Cannot read anything	43	4	0	5	20	2	0	0
Can read letters only	34	3	3	4	12	2	1	0
Can read words only	45	5	3	5	6	6	3	0
Can read sentence	872	88	95	86	62	90	96	100
Writing (N=993)								
*Could not write sentence***	82	8	3	10	33	5	2	0
Wrote without difficulty or errors	741	75	85	72	49	75	81	98
Wrote with difficulty or errors	170	17	12	19	18	20	17	2
Numeracy (N=771)* **								
Multiply correct	663	86	92	84	75	84	88	99
Multiply incorrect	107	14	8	16	24	16	12	1*

*Sentence = It's hot in summer ** Sentence = I like dogs *** 2 x 4 = ?*

The life skills of numeracy and literacy are outcome measures in the Young Lives conceptual framework. This section has the highest rate of missing cases, ranging from six cases for reading, seven cases for writing, up to 229 cases (23 per cent) for the numeracy section. Unfortunately, most of the missing cases for the numeracy section come from ethnic minority children (reportedly due to shyness).

Eighty-eight per cent of children who conducted the reading test could read the sentence, 75 per cent could write without errors or difficulties, and 86 per cent could answer the numeracy test correctly. However, there is significant variation by location and socio-economic level. Rural children performed poorer than urban children in all rates of success in reading, writing, and numeracy tests (95 per cent, 85 per cent and 92 per cent in reading, writing, and numeracy for urban children compared with 86 per cent, 72 per cent and 84 per cent for rural children respectively).

Variations are even more obvious across the wealth index group. The fact that under half of the 'poorest' children were able to write to the level expected for their age matches with a recent study that emphasises that although enrolment rates are high, the quality of primary education needs attention, particularly in poor areas (World Bank & ADB, 2002). While the World Bank study referred to children around 11 years old, the present study identifies a large group of eight-year-old children who might be on a trajectory to emerge from primary school without adequate numeracy and, particularly, literacy skills.

4.9. Child development

TABLE 33: RAVEN'S TEST RESULTS BY LOCATION AND WEALTH INDEX

	Total (N=197*)	%	Urban % (N=40)	Rural % (N=157)	Poorest % (N=29)	Very poor % (N=76)	Less poor % (N=69)	Better off % (N=23)
Set A								
Average (5-8)	117	59	45	63	79	70	49	30
High (9-12)	80	41	55	37	21	30	51	70
Set B								
Low (0-4)	103	52	40	55	62	59	51	22
Average (5-8)	83	42	45	41	38	38	45	52
High (9-12)	11	6	15	3		3	4	26
Set AB								
Low (0-4)	55	28	25	29	28	37	23	13
Average (5-8)	117	59	45	63	69	55	65	44
High (9-12)	25	13	30	8	3	8	12	44

* 3 missing cases

In addition to literacy and numeracy, children's cognitive development can be affected by schooling (as well as home conditions) and this is another outcome measure in the Young Lives conceptual framework. The Raven's test assesses children's cognitive development.

There were only three missing cases out of 200 children randomly selected for administering the Ravens Test. For set A, no children got scores at low level (0–4 score), while 59 per cent of children got average (5–8 score), and 41 per cent got high score. Urban and non-poor children seem to have higher scores than the rural and poor children. For set AB, 28 per cent of children got low, 59 per cent got average, and 13 per cent got high scores. All of the children who got high scores come from urban areas and from the better off groups. For set B, approximately six per cent of children got high scores, most of them coming from urban and high socio-economic levels. Forty-two per cent of children got average, and 52 per cent got low scores. Location and socio-economic levels do not explain the variation of set B scores among children.

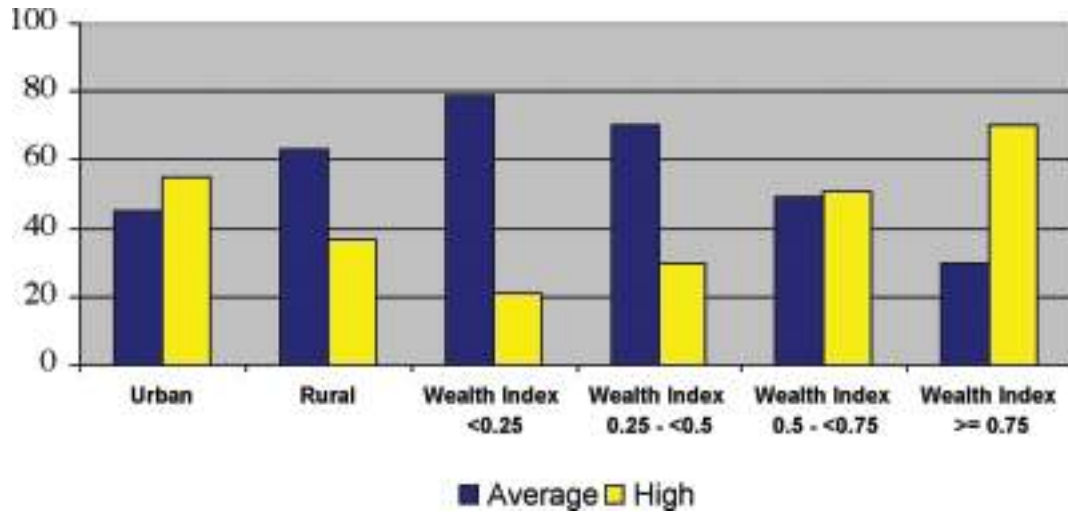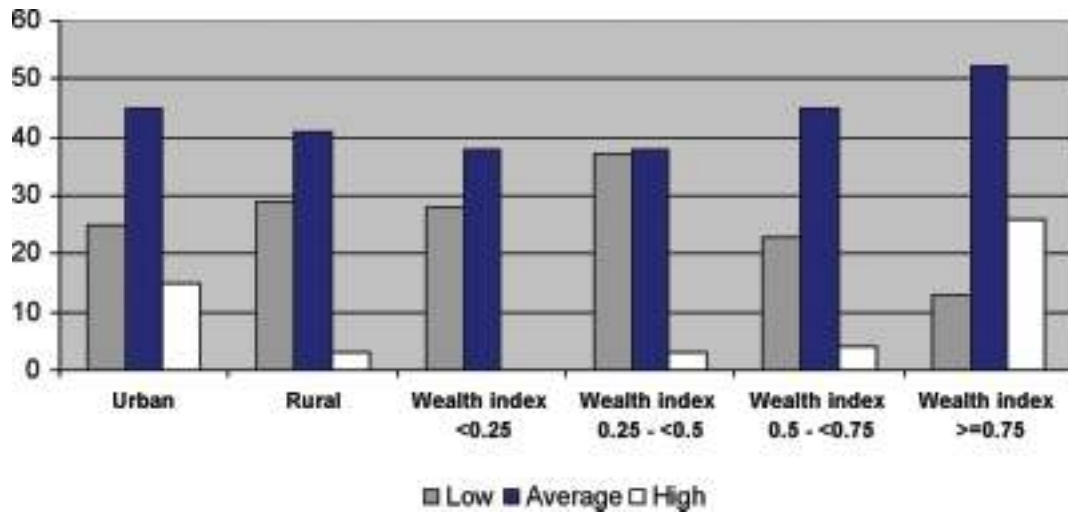## FIGURE 7: RAVEN'S TEST RESULTS BY LOCATION AND WEALTH INDEX

(Set A)

FIGURE 8: RAVEN'S TEST RESULTS BY LOCATION AND WEALTH INDEX

(Set B)

5. Provisional conclusions and policy implications

This report only provides descriptive, partial results. There is no analysis of explanatory factors or determinants. There is no disaggregation by province. All this will follow. However, even now, it is possible to tentatively identify some messages and implications from this baseline study.

5.1. Control of child malnutrition in poor, rural areas

This study provides further evidence to confirm that child malnutrition is a public health concern in Vietnam. Prevalence of acute malnutrition (WAZ<-2SD) is at a high level, and chronic malnutrition (HAZ <-2SD) is at moderate level. However, the focus for controlling child malnutrition should be on the rural areas, where malnutrition was twice as high compared with that in urban areas. In rural areas, children from poor households had approximately twice as high a prevalence of acute malnutrition and almost three times prevalence of chronic malnutrition compared with children from better off households. Children in rural poor households therefore should be the targeted group for the national programme on control of child malnutrition. Further analysis of child malnutrition in relation to morbidity, caregiver characteristics, household characteristics (sanitation, access to safe water, etc) and by sentinel site will be undertaken to understand malnutrition problems in the study areas.

5.2. Poorer children have no higher morbidity

Approximately 17 per cent of children were ill in the last 24 hours. That is a high rate of morbidity. Difference in morbidity between locations or socio-economic levels was not found.

5.3. Children in poor areas received daily care from parents

Most children received daily care from their biological parents; in fact, children from poorer socio-economic conditions see their parents daily at a higher rate than children from the better off group. The model of the child caregiver being the grandmother is rare, not only in urban areas (1.5 per cent) but also in rural areas (0.7 per cent).

5.4. Female caregiver as targeted group for health and development education

This study showed that almost all caregivers are women (99.5 per cent). There are still approximately 28 per cent of them who did not go to school. Further analysis on child health and development by caregivers with lower and upper primary education levels is needed. Specific child health and development education programmes can then be designed that are suitable for caregivers with lower levels of education.

5.5. Poor, rural women lack health assistance in delivery

There were approximately nine per cent of women in urban areas who lacked assistance from a

medically trained person at delivery. However, for poor, rural women, this figure increased to 55 per cent. Research on barriers for such women accessing medical assistance in delivery is needed.

5.6. Severe illness or injury is the main reason for decrease in household socio-economic status

The prevalence of households experiencing events that decreased household economic situation during the last three years was high, ranging from 33 per cent in urban areas to 46 per cent in rural areas; the poorer socio-economic level had the higher prevalence (48 per cent compared to 23 per cent). Among 13 types of shocks listed, severe illness or injury was reported most (27 per cent). Crops failed/stolen and natural disaster are significantly lower at 16 per cent and 11 per cent. Further investigation is needed to identify the economic costs of severe illness or injury with the expectation that control of the economic costs of severe illness will significantly contribute to reducing poverty.

5.7. The poor are enjoying social support and a fairly high level of cognitive social capital but have low structural social capital

Although the proportion of the poor not being an active member of any community group was significantly higher than the better off group (88 per cent compared to 68 per cent), the poor still enjoyed fairly good social support from their community. The proportion of households receiving social support in the last year was 94 per cent in the poor compared with 97 per cent in the better off. In addition, almost all of the caregivers trusted in community people and felt that they were really a part of their community with no differences between wealth group in this regard. Is structural social capital more important than cognitive social capital for the wellbeing of children? If so, then the poor might lose out. Future rounds of Young Lives will explore this.

5.8. Mental health should be a public health concern

Caregiver depression was found in 20 per cent of the respondents. No difference was seen between rural and urban areas or across the socio-economic groups. This prevalence is high and real as the validation and reliability tests on the instrument have shown. Poor mental health of a caregiver can have significant effects on child development and wellbeing. This is an under-explored area in Vietnam and we need to identify the determinants of mental ill health in this population in order to suggest appropriate interventions.

5.9. Literacy and numeracy among poor eight-year-olds needs strengthening

Although primary school enrolment is high, schools in rural, poor areas are failing to provide good services for their pupils. Literacy and numeracy levels need strengthening by improving the quality of primary school teaching.

5.10. The need to diversify income generating activities

Forty-one per cent of the poorest households relied on one sector economic activity only. Income generation programmes and provision of credit need to stimulate diversification among the poor.

5.11. The need to educate children about environment and health

Although 68 per cent of households were using unhygienic sources of water (ie, lacked potable water), nearly all eight-year-olds (who come from similar households) perceived their water as 'good'. There is an urgent need to give practical, appropriate education to children about environmental contamination and how it can affect their health.

5.12. Government and non-government institutions need to support the poor in times of crisis

In the face of economic shocks, very few households received help from an 'official' institution (40 actions out of 1180). Flexible, rapid-reaction programmes are needed to improve institutional responses instead of relying on people to get help from friends and family.

5.13. Basic services are lacking for some groups

With only 43 per cent of the poorest group having access to electricity and 68 per cent of the total sample lacking potable water, the expansion of basic services to the poor remains a priority.

Annex 1: Main study variables in the core questionnaire by specific components

A: ONE-YEAR-OLD SPECIFIC

1. Demographic characteristics

- Age
- Sex
- Ethnic group
- Religion
- Birth order

2. Anthropometry

- Birth weight
- Weight measurement at survey time
    Weight for Age
    Weight for Height
    Height for Age

3. Child health

- Perceived general health
- Illness since yesterday up to now
- Ever serious illness or trauma that might die
    Types of illness/trauma
    Hospitalisation
- Ever burn that left a scar
- Ever broken bone
- Ever severe fall
    Effect of severe fall
- Chronic diseases/disabilities
- Types of disease/disability
- Vaccination
    Tuberculosis
    Measles

B: EIGHT-YEAR-OLD SPECIFIC

1. Demographic characteristics of the child

- Age
- Sex
- Ethnic group
- Religion
- Birth order

2. Anthropometry

- Birth weight
- Weight measurement at survey time
    Weight for Age
    Weight for Height
    Height for Age

3. Child health

- Perceived general health
- Illness last 2 weeks
- Types of illness
- Health problem affects ability to make friends or play
    Types of problem
- Health problem affects ability to attend school or work
    Types of problem
- Chronic diseases
    Types of disease
- Serious illness/trauma might die last 3 years
    Types of illness/trauma
    Hospitalisation
- Toothache so could not eat

4. Child mental health

- 25 questions about child mental health

5. Child school

- Ever attend school
    Age of enrolment
    Years of schooling
    Highest grade
- Currently attending school
- Main reasons not attending school
- Type of school
- Activities for fun last 6 months

B: EIGHT-YEAR-OLD SPECIFIC (CONTINUED)

- Attend boarding school
- Taking extra classes last year
    Subjects
    Person advise
    Hours for extra classes
- Estimated amount for child schooling
- Amount for schooling and extra classes

6. Child work
- Working during last 12 months
    Type of activities
    Employment
    Work place
    Number of working days per month
    Number of working day per week
- Undertake formal/informal activities for cash/ kind
- Age when start working
- Time for working
- Keep/save money from earning
- Main reasons for working
- Involved in house chores last 7 days
    Working hours per day
    Receive cash/goods
- Serious illness/injuries while working
    Types of illness/injuries

7. Child's perception about life
- Job that child wants to do when growing up
    Reason like the job
- Thing that makes child happy
- Thing that makes child unhappy
- Like about living
- Unlike about living
- Thinking about water
    Main reason dirty water
- Thinking about air
    Main reason not clean air
- Thinking about rubbish
    Describe dirt
    Amount of rubbish
- Thinking about treating in the commune
- Thinking about safe place

    Main reasons not safe place
- Enough food
- Treating equality between boys and girls

8. Child's social relations
- Frequency playing with friends
- Person who help child when having problem
    Relationship with child

9. Child's perceived health
- Health problems limits ability to make friends or plays
    Types of problem
- Health problems stop study or work
    Types of problem
- Other health problems
    Types of problem

10. Child's literacy and numeracy
- Reading ability
- Writing ability
- Multiplication ability
- Watching clock/watch

11. Child's study and work
- Go to school last year
- Worst things in school
- Satisfaction about school
- Earning money for self and family
    Types of job
    Like/dislike each job
    Main reasons dislike this job
- Miss lessons due to work
- Activities at home yesterday
    Time for study
    Time for reading/listening stories
    Time for watching TV/video/film
    Time for participating in house work
    Time for playing with friends
- Taking a nap yesterday
- Time go to bed last night
- Time wake up

C: CHILD'S PARENTS

Mother

1. Background information
- Place of living
- Time living in the commune
- Ethnic group
- Religion
- Literacy
- Reading newspaper/magazine
- Fluency in Kinh language
- Education

2. Marital status
- Ever married
- Currently married
- Living with current partner
- Head of household or not

3. Pregnancy
- Any prenatal check-up
- Month of pregnancy for the first prenatal check-up
- Times of prenatal check-up
- Intention to be pregnant

4. Delivery
- Difficulty with labour
- Place of birth
- Undergoing an operation
- Aware of the operation
- Person who was the delivery attendant
- Birth premature
- Perceive birth weight
- Total number of births
  Number of boys
  Number of girls
  Number of children still living
  Number of children die before 5 years old

5. Child care
- Frequency meet child
- Sending child to childcare facility since born
- Months old when enrolment

- Sending child to childcare facility last 6 months
- Relationship between caregiver and child
- Months taking care child
- Payment for child care
- Leaving child alone every week last 6 months

6. Breastfeeding
- Ever breastfed child
- Duration of breastfeeding
- Vaccination against tetanus

7. Maternal depression
- Perceived health status
- SRQ20 questions about mother's mental health

8. Livelihood and time allocation
- Three most important activities
- Description of activities
- To be hired to do this job
- Working months last 12 months
- Working days per week
- Activities contributed most to household economy
- Remittance last 12 months
- Receive cash or in kind for self-caregiver
- Relationship between the sender and the child
- Times receive money/goods last 12 months
- Forms of support
- Support for child or household
- Donation/offering last 12 months
- Relationship between receiver and child
- Times of sending money/goods
- Forms of support
- Total monetary value of support
- Any large debt
- Lending sources
- Able to repay debt

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Fathers/partners

1. Background information
- Place of living
- Frequency meet child

D: CAREGIVERS

1. Background information
- Place of living
- Time living in the commune
- Ethnic group
- Religion
- Literacy
- Reading newspaper/magazine
- Fluency in Kinh language
- Education

2. Marital status
- Ever married
- Currently married
- Living with current partner
- Identify head of household

3. Child care
- Frequency meet child
- Sending child to childcare facility since born
- Months old when enrolment
- Sending child to childcare facility last 6 months
- Relationship between caregiver and child
- Months taking care child
- Payment for child care
- Leaving child alone every week last 6 months

4. Maternal depression
- 20 questions about caregiver's feeling

2. Livelihood and time allocation
- Three most important activities
- Description of activities
- To be hired to do this job
- Working months last 12 months
- Working days per week

5. Livelihood and time allocation
- Three most important activities
- *Description of activities*
  To be hired to do this job
  Working months last 12 months
  Working days per week
- Activities contributed most to household economy
- Remittance last 12 months
  Receive money or in kind for self-caregiver
  Relationship between the sender and the child
  Times receive money/goods last 12 months
  Forms of support
  Support for child or household
- Donation/offering last 12 months
- *Relationship between receiver and child*
  Times of sending money/goods
  Forms of support
  Total monetary value of support
- Any large debt
- Lending sources
- Able to repay debt

6. Social capital
- Active member of community groups
- Receiving any spiritual/physical support
- Trust/feel to be a part of community
- Working with others to solve common problems

E: HOUSEHOLD CHARACTERISTICS

1. Household composition and demographics

- Name
- Sex
- Age
- Relationship with the index child
- Current schooling
- Education level completed or still studying
- Chronic diseases/injuries
- Support index child with cash/kinds last 6 months
- Cigarette and tobacco pipe smoking
  Numbers of cigarettes per day
  Numbers of tobacco pipe per day

2. Livelihood and time allocation

- Three most important activities
  Description of activities
  To be hired to do this job
  Number of working months last 12 months
  Number of -working days per week

3. Economic situation of household

- Self-wealth ranking
- Durable goods owned
  List of 12 specific durable goods owned
  House characteristics
  Owning of dwelling
  Number of rooms
  Electricity supply
  Wall material
  Roof material
  Material of dwelling floor
  Source of drinking water
  Toilet facility
  Fuel use
  Heater

4. Land investment and livestock

- Owning/renting of other lands
  Plot size of land used
  Land owned/rented
  Purposes of land use
- Use irrigation last 12 months
  Total square metres of land use irrigation
- Use chemical and fertiliser last 12 months
  Amount of used chemical and fertiliser
- Sharing agricultural machinery last 12 months
- Exchanging labour with others last 12 months
- Livestock last 12 months
  Types of livestock
  Number of livestock owned currently
  Number of livestock bought last 12 months
  Number of livestock sold last 12 months

5. Poor status of household

- Poor certificate received from MOLISA

6. Shocks happened in last 3 years

- Having events declined household economy
- Specify major events
- Events affects household economy most
- Coping strategy with economic shocks
- Change of household economy compared to 3 years ago
- Events improve household economy better than 3 years ago

F: COMMUNITY

1.   Natural environment

- Total land area
- Population
- Numbers of households
- Activities used land most
- Whether or not belonging to a city or town
  Name of city/town
  Numbers of resident
- Changing population last 3 years
- District/provincial town nearest the commune
- Distance from centre of commune to district town
- Ecological classification for commune
- Natural disasters occurred since last 2 years
  Types of disaster
  Percentage of population affected
  Receiving supports
  Types of support

2.   Social characteristics

- Main languages spoken by people in commune
  Kinds of language
  % of population using each language
- Main ethnic groups in commune
  % of population for each ethnic group
- Main religious groups in commune
  % of population for each religious group
- Three biggest kin groups in the commune
- Identity status of the commune
- Commune representative at DPCs and PPCs and up
  Forms of selection
  Living in the commune or not
- Acting organisations/social groups in commune
- Person in charge of commune culture
  Visiting commune or not last year
  Living in the commune or not
  Visiting commune or not last year
  Forms of selection
- Security status of commune
- No. of households received social welfare

Events happened around a year
  Type of events

Month events happen

4.   Infrastructure and services

- Services accessible to people
  Types of service
  Service improvement status during last 2 years
  Distance from commune centre to the service
  Travel time commune centre to the service
- Type of toilet used commonly in commune
- Loudspeaker system available at hamlet level
- Name of TV channels received at commune
- Main source of drinking water
- How rubbish is treated
- Levels of factors affect the commune
- Trade affairs accessible anywhere or not
- Main places people purchase goods, foods
- Markets
  Kinds of market available
  Selling vegetables/goods produced at market
  Distance from commune centre to the markets
  Travel time from commune centre to markets
- Styles of house
- Main roads
  Road accessibility by month in a year
  Types of road can be accessed by car
  Distance to the nearest car-road
  Types of road
- Kinds of public transportation used most
- Distance to the nearest public transport service
- Daily schedule of public transport service
- Any service contracts used >= 5% of population
  Type of contract
  Number of villagers work for each contract
  Type of products workout from the contract
- Health and development programmes
  Types of programme
  Main objectives of the programme

F: COMMUNITY (CONTINUED)

Commune health service
- Commune health centre (CHC) types of building
- Distance to the nearest health clinic
- Travel time from commune centre to CHC
- No. of CHC staff
- Total no. of health professionals in commune
- Medical equipment available in CHC
- Types of services provided by CHC
- Cost of each service provided
- Number of patient consultations at CHC during the first 6 months of 2002
- Types of medicines stored at CHC
- Health programmes launched by CHC
- Any medical exemption scheme applied at CHC
- Number of private clinics
- Type of private clinic by services provided
- Cost of each service provided by private providers
- Number of western medicine pot

Education
- Name/types of school available in commune
- Distance to the nearest school
- Travel time to the nearest school
- Tuition fees by level of education
- Illiterate eradication programme for adults
- last 2 years
- Drop-out rate for primary school student
- Drop-out rate for secondary school student
- Main reasons of drop-out
- % of students passed high school entrance examination
- % of students passed university entrance examination
- Kinds of educational encouragement/awards

5. Community economy
- Average day-wage for an unskilled personworking for Commune People's Committee
- Average day-wage for a primary school teacher

- Average day-wage for a PHC nurse
- Average daily Labour wage in agricultural work
    By gender (male, female)
    By age (adult, children)
    By types of work
- Average income per capita/month
- Main jobs for livelihood
- Types of job attracted by most of people
- % households classified very poor by MOLISA
- % of households classified poor by MOLISA
- Any owner has >= 20% commune agricultural land
- Credit
    Source of money for lending
    Kinds of finance resource
    Kinds of borrower
    Average annual interest rate
    Maximum amount of each loan
    Loan term
    Distance to finance resources
- Main ways to get agricultural land use right
- Three main crops planted
- Main ways to consume the crops product
- % or population use fertilisers for crops
- % population use pesticides and herbicides for crops
- Price
- Any crop subsidised by Government or NGOs
    List of the main items
    Price for each item
- Any farms used >=5% of population in last 12
- Months
    Name of farm
    Main crops planted
- Any factory used >= 5% of population in last 12
- Months
    Name of factory
    Numbers of employees
    Industrial products
    Labour wage per day by gender and age

References

ADB (2000) Vietnam, *Macroeconomic Policies and Poverty,* Asian Development Bank, Vietnam, Hanoi

ADB (2001) *Human Capital of the Poor in Vietnam,* Asian Development Bank, Hanoi

Baulch, B et al (2001) *Ethnic Minority Development in Vietnam: A socio-economic perspective,* World Bank, Hanoi

Coulson, J (2002) *Young Lives Vietnam - Fieldwork debriefing report,* Save the Children UK, London

Dibley, M J and Tuan, T (2001) *Evaluation report – Save the Children Japan: Integrated child nutrition project Thanh Hoa province,* Research and Training Centre for Community Development (RTCCD), Hanoi.

Edmonds, E and Turk, C (2002), *Child Labour in Transition in Vietnam,* The World Bank, Development Research Group, Macroeconomics and Growth, Policy Research Working Paper 2774

Filmer, D and Pritchett, L (1998) *Estimating Wealth Effects without Expenditure Data-or Tears: An Application to Educational Enrolments in States of India,* World Bank, Washington, URL: <www.worldbank.org/research/projects/edattain/wealthtears-paper.pdf>

Government of Vietnam and Donor Working Group (2000) *Pubic Expenditure Review,* World Bank Vietnam, Hanoi

GSO and CPCC (2000) *Analysis of Results of the Multiple Indicator Cluster Survey II (MICSII),* Government Statistics Office and Committee for Protection and Child Care, Hanoi

Harper, C, Harpham, T, and White, H (2001) *Children of the Millennium Project (CMP): Conceptual framework,* Save the Children UK, South Bank University, and IDS

Hoa, NT (2001) *Globalisation and the Impact of Restructuring in the Textiles Sector on Households in Vietnam,* DFID Hanoi, unpublished manuscript

Koch, S and Linh, NB (2002) *Child Malnutrition: Analysis from VLSS 1993-1998,* Government Statistics Office, Hanoi

Marsh, DR, Pachon, H, Schroeder, DG, Ha, TT, Dearden, K, Lang, TT, Hien, ND, Tuan, DA, Thach, TD, and Claussenius, DR (2002), 'Design of a prospective, randomised evaluation of an integrated nutrition programme in rural Vietnam', *Food and Nutrition Bulletin,* vol. 23, no. 4 (supplement), pp.36–47

Montgomery, MR, Burke, K and Paredes, E (1997) *Measuring Living Standards with DHS Data,* Mimeo, Research Division, The Population Council, New York

NCSSH (2001) *Human Development Report Vietnam 2001.* National Centre for Social Sciences and Humanity, Hanoi

Narayan, D (2000) *Voices of the Poor: Can Anyone Hear Us?,* Oxford University Press, Oxford

Neefjes, K (2002) *Child Poverty in Vietnam,* Save the Children UK, Hanoi office

NIN-GSO (2003) Vietnam: Nutrition Status 2002, *(Tinh Hinh Dinh Duong Vietnam 2002),* Nha Xuat Ban Y Hoc, Hanoi.

NIN (2002) *National Nutrition Survey 2000 (summary of results),* National Institute of Nutrition, Ministry of Health, Hanoi

Oxfam GB and Oxfam Hong Kong (2001) *Rice for the Poor and Trade Liberalisation in Vietnam,* Oxfam GB and Oxfam Hong Kong, Hanoi

Save the Children UK (1999a) *Child Labour in HCMC,* Save the Children UK, Vietnam programme

Save the Children UK (1999b) *From Housework to Gold Mining,* Save the Children UK, Vietnam programme

Save the Children UK (2002) *CPRGS Consultation in HCMC,* Save the Children UK Vietnam programme

Save the Children Sweden (1999) *Budget for Disabled children in Vietnam,* Save the Children Sweden, Vietnam office, Hanoi

Theis, J (1999a) *Children and Poverty in Vietnam: Disaggregating living standards survey data by age,* Save the Children UK, Vietnam programme, Hanoi

Theis, J (1999b), *Ethnic Minority Education: Problem analysis and programme strategy,* Save the Children UK, Vietnam programme, Hanoi

Tuan, T, Harpham, T, and Huong, NT (2003), 'Validity and reliability of the self-reporting questionnaire (SRQ20) in Vietnam', *British Journal of Psychiatry,* (in press)

Tuan, T, Marsh, DR, Ha, TT, Schroeder, DG, Thach, TD, Dung, VTM, and Huong, NT (2002a), 'Weighing Vietnamese children: How accurate are child weights adjusted for estimates of clothing weight?', *Food and Nutrition Bulletin,* vol. 23, no. 4 (supplement), pp.48–52

Tuan, T, Thach, TD, Huong, NT, Hau, NM, and Hart, M (2002b), *Sustainability of the Integrated Child Nutrition Project, Thanh Hoa Province: Evaluation report,* RTCCD, Hanoi

UNICEF (2001) *The State of the World's Children 2002,* UNICEF, New York

VUSTA (2001), Re: *Decision on implementing the child poverty research (Young Lives) in Vietnam,* Lien Hiep Cac Hoi Khoa Hoc va Ky Thuat Viet Nam.

Wagstaff, A, Paci, P and van Doorslaer, E (1991) *On the Measurement of Inequalities in Health* Social Science and Medicine, 1991. 33:p.544-447

Webster,L (1999) *Vietnam: Which way to prosperity,* Mekong Development Project Facility, Hanoi

White, H and Masset, E (2002) *Child Poverty in Vietnam: Using adult equivalence scales to estimate income-poverty for different age groups,* first published 2002, Young Lives–Save the Children UK.

World Bank and ADB (2002), *Vietnam, Delivering on its Promise,* World Bank and Asian Development Bank, Hanoi

World Bank (1999) *Vietnam: Attacking poverty* World Bank, Hanoi