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The Socio-Economic Impacts of COVID-19 on Children and Families in Viet Nam

Ha Noi, Ho Chi Minh City, Da Nang, and Bac Giang province in focus

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Acronyms

ANC	Ante-natal Care
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COVID-19	Coronavirus disease (SARS-CoV-2)
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CWD	Children with Disabilities
FGD	Focus Group Discussion
GBV/DV	Gender-based violence/Domestic violence
GDP	Gross Domestic Product
GSO	General Statistics Office
Ha Noi CDC	Ha Noi Centre for Disease Control and Prevention
HH	Household
IYCF	Infant and Young Child Feeding
KI	Key Informant
KII	Key Informant Interview
MCH	Maternal and Child Health
MCHN	Maternal and Child Health and Nutrition
MICS	Multiple Indicator Cluster Survey
MODA	Multiple Overlapping Deprivation Analysis
NDVP	National Deployment and Vaccination Plan
NPI	Non-pharmaceutical Interventions
PNC	Post-natal Care

PPE	Personal Protective Equipment
PPP	Purchasing Power Parity
PWD	Person with Disabilities
SA	Social Assistance
SA/SP	Social Assistance/Social Protection
SDGCW	Sustainable Development Goal Indicators on Children and Women
SDGs	Sustainable Development Goals
SP	Social Protection
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USD	United States Dollar
VND	Vietnamese Dong
WASH	Water, Sanitation and Hygiene
WBMS	World Bank Monitoring Surveys
WHO	World Health Organization

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1. Introduction: Objectives of the Study

Entering the third year of the pandemic, children and families in Viet Nam have experienced multitudes of challenges in the face of ongoing and new global socio-economic, political, and environmental volatility. Understanding the extent to which families with children in Viet Nam are protected from, and resilient in the face of, large-scale crises such as the COVID-19 pandemic is critical to provide updated evidence to inform social spending which promotes and protects investments in sustainable human capital development. Therefore, a follow-up study on the socio-economic impacts of covid 19 on children and families in Viet Nam was commissioned by UNICEF Viet Nam in partnership with Social Policy Research Institute.

This study aims to assess the socio-economic impacts of the COVID-19 pandemic on children and families in select cities and provinces between 2021 and 2022, namely the capital Ha Noi, the southern economic hub of Ho Chi Minh City, the central city of Da Nang and north-eastern Bac Giang province. The study builds upon the first rapid assessment of the socio-economic impacts of COVID-19 on children and families in the country.[1] As a follow-up study, a crucial element of this research involved taking a multidimensional approach to understanding the extent to which the situation of children and families has evolved between the two major periods in 2020 and 2021, which witnessed strict containment measures including lockdowns, school closures, and social distancing.

COVID-19's arrival in Viet Nam during January 2020 led to a swift and comprehensive pharmaceutical and Non-pharmaceutical Interventions (NPI) response by the government in the form of extensive screening and testing, rigorous contact tracing, and the mandating of masks, disinfection and social distancing. A third wave began at the end of January 2021 followed by a fourth wave in April 2021.[2] As of June 2022, more than 10 million cases of COVID-19 have been reported in Viet Nam, leading to more than 40,000 deaths.[3] In response to the onset of the fourth wave, strict containment measures were enforced in select cities and provinces in Viet Nam from May 2021 and enduring selectively until present day. Understanding the true impact of COVID-19 on households remains a challenge, not least due to the outbreak in April 2021 which limited evidence on the socio-economic situation of children and families being published. This outbreak was the largest for Viet Nam since the first case emerged in 2020 with a greater number of cases in a month than in the whole of the previous year combined. The Delta and Omicron variants led to a quickly evolving context that soon undermined the relevance of surveys, such as the World Bank's monitoring surveys of 2020 and early 2021, in contributing to an explanation of the current situation.[4]

The rapid review of literature suggests a exponentially higher number of COVID-19 cases since April 2021 – in combination with an overburdened health care system, delayed vaccination roll out, and NPIs which have been of stricter nature and longer duration – have resulted in deeper, multidimensional impacts on children and their families, compared to 2020. The evolution of this picture, and of previously underlying assumptions, frame the context of this research.

1 United Nations Children's Fund 2020e.

2 World Bank and Australian Aid 2021.

3 World Health Organization 2022.

4 Ibid.

1.Research questions

Focusing on the target study sites of **Ha Noi, Bac Giang, Da Nang, and Ho Chi Minh City,** the research questions and sub-questions guiding this study and the design of the methodology were:

A. *'**What is the socio-economic impact** of COVID-19 in Viet Nam; and how have children and their families, particularly the most vulnerable groups in selected cities and provinces in Viet Nam been impacted by COVID-19 and **what were their coping strategies**?'*

   a. ***What was the situation of children and their families** while stronger social distancing measures are applied?*

   b. ***How were children and their families coping** (including what kind of support and level of support they get from the government and other sources, and the society/families/social capital etc.) **while social distancing measures are re-applied**?*

   c. ***What were the current government policies** in place in response to COVID-19, **especially in relation to social assistance and what were strengths and remaining gaps of these policies?***

B. *'**What are the specific strategic and practical recommendations** for mitigating the socio-economic impacts of COVID-19 on children and their families in the short, medium, and long term?'*

   a. ***Given the analysis of current government policies** in place in response to COVID-19, **what are the recommendations for the future**?*

   b. ***What are the support programmes – both humanitarian and long-term - that should be implemented** to safeguard the well-being of children to mitigate the impacts of COVID-19 on UNICEF's interventions for women and children in Viet Nam?*

The research questions were framed around the fulfilment rights of the child specified in the Convention on the Rights of the Child, to determine the extent to which children and families experienced deprivation, vulnerability, and/or inaccessibility or unaffordability of key services aimed at fulfilling these rights. The following thematic areas were analyzed in-depth by this study, with further details in Annex I, section I.I:

- Poverty and economic impacts
- Maternal and child health and nutrition
- Mental health
- Education and learning
- Child protection
- Water, Sanitation and Hygiene (WASH)
- Parental care, duties, and decision-making
- Social protection and social assistance
- Gender differences in family decision-making, duties, and responsibilities

Background and context

2.1. COVID-19 situation and response in Viet Nam

Viet Nam took early action to contain the outbreak in the early months of the pandemic in 2020. Even before Viet Nam's first case was confirmed (January 23), swift containment and preventive measures – including social distancing policies, contract tracing, and border closures – were imposed and a National Steering Committee for Disease Prevention and Control was formed in response to confirmation of the first cases.[5] By the end of March 2020, the prime minister declared Viet Nam to be in a national health crisis, prompting social distancing and the use of Personal Protective Equipment (PPE) as well as suspension of non-essential activities until at least May 2021.[6] Thereafter, measures such as lockdowns have only been further implemented locally. To keep the public informed, the government also adopted a strategy of clear communication and transparent policy-making. Provinces worked closely, response taskforces were created at 31 central hospitals and all provincial hospitals, and multiple communication initiatives were launched. At the onset of the pandemic, 22 hospital hotlines were opened[7], information channels were established[8], and a song was created to teach children about the necessity of hand washing and other hygienic precautions.[9] This communication strategy was effective in containing the spread of the virus in the early stages of the pandemic.

As the first wave of infections slowed by the end of April 2020, the government started to implement a social protection strategy. The first government package amounted to VND 62,000 billion. This support allowed a one-time expansion of existing allowances.[10] Other measures worked indirectly such as deferred tax payments, reduced communication-related fees for health- and education-related data, lower water and electricity bills, amongst others.[11] Resolution 43/2022/QH15, approved in January 2022, proposed a plan to promote the socio-economic recovery and development with a support package of VND347,000 billion. This resolution included a set of fiscal and monetary policies to support key sectors and valuable import goods such as medicine, vaccines and medical supplies for COVID-19 prevention.[12]

Labour force. Viet Nam's pandemic-related social protection coping strategy was primarily centred on supporting a work force greatly affected by the pandemic. From April to June 2020, employees with work affected by the

5 Thu Vien Phap Luat 2020.

6 AMRO 2022; Quang Minh 2020.

7 Báo Điện tử Chính phủ 2020.

8 Bích 2020.

9 Nguyen 2020.

10 Duc Binh 2020.

11 AMRO 2022.

12 Manh Tran 2022.

pandemic were entitled to VND1-1.8 million or VND1 million per month depending on eligibility. Furthermore, enterprises in financial difficulties that still paid at least 50 per cent of employees' salaries despite lockdowns, were entitled to preferential loans.[13] Similar policies were implemented in 2021 for six months.[14] Additionally, employees who were members of unemployment funds received a one-off payment from the Unemployment Insurance Fund (UIF) based on their premium payment period, and employers contributing to the UIF were exempted of contributions for a period of one year.[15] Finally, business households whose activities were suspended for at least 15 consecutive days between May and December 2021 could benefit from a one-time transfer of VND3 million per household.[16] With those resolutions on supporting employees and employers affected by the virus, more than 24 million people should have received around USD970 million by October 2021.[17]

Education. Schools were selectively closed from February 2020, until full closure from April 2020 until May 2020.[18] Schools were gradually re-opened with local exceptions and closures of certain schooling levels only.[19] In 2021, schools were selectively closed nationwide. As of February 2022, after the Lunar New Year Holiday, children from Grade 7 up to college were allowed back to school.[20] From 18 April 2022 onwards, all schools across all levels were expected to reopen.[21] In the context of remote and online learning, a new programme on "Protection of and support for children to interact in a healthy and creative manner in the cyber environment in the 2021-2025 period"was established to combat increased incidences of online child abuse.[22] Further, new legislation was passed in April 2022, whereby the government would lend up to VND10 million to students in difficult living situations for the purchase of computers to pursue online learning and reduce the digital divide underlying educational inequities.[23] Additionally, non-public early childhood and primary schools closed for at least one month were eligible for a loan of up to VND200 million.[24]

Vulnerable households. Due to limited access to formal financing, the pandemic was a challenge for households in poor or near-poor situations. Accordingly, it was observed through a survey that households and small businesses were more likely to rely on informal coping strategies, such as self-insurance and lending from their community, during the pandemic.[25] In 2020, the Government of Viet Nam approved its first support package, which allowed each member of a poor or near-poor household to apply for a one-time allowance of VND250,000.[26] In 2021, another support package of a minimum of VND40 million was announced per household that have also suffered from losses of home due to external circumstances. Under the same decree, (20/2021/

13 Luat Viet Nam 2020.

14 Luat Viet Nam 2021c.

15 Luat Viet Nam 2021d.

16 Luat Viet Nam 2021e.

17 VOV 2021.

18 UNESCO and UNICEF 2021b.

19 AMRO 2022; UNESCO and UNICEF 2021b.

20 Báo Điện tử Chính phủ 2022.

21 Ministry of Health and World Health Organization 2022.

22 Luat Viet Nam 2021b.

23 Luat Viet Nam 2022b.

24 Luat Viet Nam 2022a.

25 World Bank 2021.

26 Duc Binh 2020.

ND-CP) vulnerable households were eligible for funeral support of VND7.2 million[27] and the social assistance level for people with disabilities was increased by almost 30 per cent.[28] Moreover, the Viet Nam Bank for Social Policies announced that 1.3 million poor or near-poor households had access to loans for a total of USD12 million.[29] Finally, Decree 75/ND-CP[30] and Resolution 42/NQ-CP announced support packages to be delivered to people with meritorious military services.[31]

Along with the nationally-issued policies, local organizations as well as city authorities provided support. According to the Minister of Labour, Invalids and Social Affairs, State support was delivered alongside local support packages through a combination of official and community-led, humanitarian efforts in the context of an evolving pandemic situation.[32]

While social assistance policies were issued to provide cash and in-kind support to some of the most vulnerable groups, existing research suggested that implementation fell short and many families with children became poor during the first waves of the pandemic, while cash assistance was deemed the most necessary and desired form of short-term assistance.[33] Reasons for this largely revolved around structural challenges in ensuring that these benefits were adequate, inclusive, and accessible by all who needed them. Among these challenges, access to social protection and assistance in 2020 was limited by: 1) cash assistance package design and eligibility criteria not being child-sensitive, considering the full scope of children's needs and additional needed expenses in the pandemic context, 2) administrative bottlenecks, narrowly defined eligibility criteria, exacerbated by limited local-level budgets, which excluded some of the most vulnerable groups, 3) benefit amounts being too low to offset the additional costs and economic losses incurred in the pandemic context, 4) delayed delivery of cash assistance during the social distancing period and 5) ineligibility for cash assistance by some of the most vulnerable groups, such as children of sex workers, street children, and children living in social protection centres.[34] The main social protection and assistance packages rolled out in Viet Nam to date are summarized in Table 1.

27 Luat Viet Nam 2021a.

28 Yen Hai Le 2021.

29 VOV 2021.

30 Viet Nam Social Security 2022.

31 Luat Viet Nam 2020.

32 Viet Nam Social Security 2022.

33 United Nations Children's Fund 2020c; FAO et al. 2020.

34 UN COVID-19 Economic Impact Assessment Working Group 2020; FAO et al. 2020; United Nations Children's Fund 2020c.

Table 1. Government responses to the COVID-19 pandemic relevant to social protection and assistance

No.	Issuer	Legislation	Title of legislation	Active since	Active until	Relevant groups	Coverage
1	Government	Resolution 42/NQ-CP	Measures to support people affected by the COVID-19 epidemic	Apr-20	Jun-20	Employees and employers, poor and near-poor households, social protection beneficiaries and people with meritorious services	National
2	Government	Decree 105/2020/ND-CP	Prescribing early childhood education development policies.	Sept-20	No end date	Pre-school children	National
3	Prime Minister	Decision 17/2021/QD-TTg	Providing levels of vocational training support for workers covered by unemployment insurance	May-21	No end date, Up to three months	Employees	National
4	Prime Minister	Decision 830/QD-TTg	Program on support for children in the cyber environment 2021-2025	Jun-21	No end date	Children	National
5	Government	Decree 20/2021/ND-CP	Social assistance policies for social protection beneficiaries	Jul-21	One-off support	Social protection beneficiaries, employees and employers, poor and near-poor households and people with disabilities and with meritorious services	National
6	Government	Resolution 68/NQ-CP	Policies to support COVID-19-hit employees and employers	Jul-21	Dec-21	Employers and employees	National
7	Prime Minister	Decision 28/2021/QD-TTg	Implement support policy for employees, employers affected by COVID-19 from Unemployment Insurance Fund	Oct-21	One-off support Until Sep/2022	Employee Employer	National
8	Government	Resolution 126/NQ-CP	Amending Resolution 68/NQ-CP on policies to support employees, employers facing difficulties due to COVID-19	Oct-21	One-off support	Business households	National
9	Prime Minister	Decision 2239/QD-TTg	Approval of the Vocational Education Development Strategy in the 2021-2030 period with the vision towards 2045	Dec-21	No end date	Junior and high school graduates	National
10	MOLISA	Circular 37/2021/TT-BLDTBXH	Adjustment of pension, social insurance allowance and monthly allowance, the time to enjoy pension for cases without original dossiers	Mar-22	No end date	Pensioners and public workers	National
11	Prime Minister	Decision 09/2022/QD-TTg	Credit applicable to pupils and students with difficult circumstances for purchase of computers and equipment in service of their online learning	Apr-22	No end date	Students	National
12	Prime Minister	Decision 11/2022/QD-TTg	Credit applicable to non-public early childhood and primary schools affected by the COVID-19 pandemic	Apr-22	No end date	Non-public early childhood and primary schools	National

3. Methodology

3.1. General approach and conceptual framework

The methodology for this assignment employed a **mixed-methods approach** with quantitative and qualitative analysis. The thematic areas described in Section 1.1 were used as the analytical framework, providing **a multidimensional approach** to assess the socio-economic impacts of COVID-19 on children and their families in the capital **Ha Noi**, the southern economic hub of **Ho Chi Minh City**, the central city of **Da Nang** and north-eastern **Bac Giang province**. The methodology builds on that of the first rapid assessment of the social and economic impacts of COVID-19 on children and families in Viet Nam, carried out in 2020.[35] This latest research encompassed three main components: **1) desk review, 2) quantitative research using secondary data analysis and 3) qualitative research with key groups of interest.** The general approach underlying these three components followed the: (i) equity-based and human-rights approach, (ii) life cycle approach, (iii) gender-sensitive approach, and (iv) participatory/inclusive approach, outlined in Annex I, section I.II.

The conceptual framework underlying the analysis of COVID-19 impacts on children and families is summarized in Figure 1. COVID-19, in combination with government-enacted Non-pharmaceutical Interventions (NPI) – including school closures, social distancing and lockdown policies – increased the risk of short- and long-term adverse effects on children and families across all domains of life.

UNICEF's 2021 projections on child poverty suggested that, due to the pandemic, an additional 140 million children in developing countries were estimated to be living in monetarily poor households, and 150 million additional children will be living in multidimensional poverty.[36] At least one-in-three children in the world, and 20 per cent of children in East Asia and the Pacific, were unable to access remote learning during pandemic-induced school closures. An additional six-seven million children may face acute malnutrition as a result of poverty, losing out on school meals, and food insecurity.[37] Evidence from recent studies on the impacts of the pandemic and from previous crises, suggests that the impact on children's exposure to harm, worsening mental health, and disrupted access to life-saving health treatments and vaccines will yield adverse short- and long-term outcomes.[38] These negative outcomes risk the erosion of human capital and thus the capacity for countries to recover from the COVID-19 crisis and build resilience going forward.

35 United Nations Children's Fund 2020e.

36 United Nations Children's Fund n.d.

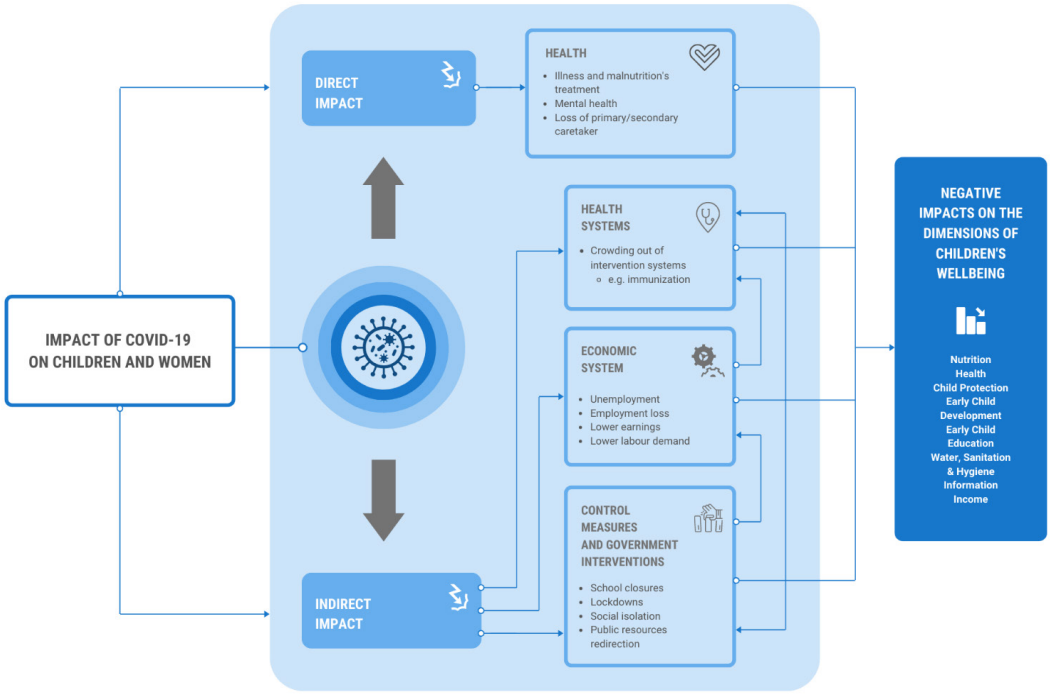
37 Ibid.

38 United Nations Children's Fund 2020a; ibid.; United Nations Children's Fund 2021a; United Nations Children's Fund 2021b; UNDP 2021; Ge et al. 2021.

3.2. Desk review

The desk review analyzed relevant literature and studies on the social and economic impacts of the COVID-19 pandemic on children and families between 2020 and 2021 in Viet Nam, to inform the methodology and contextualize the findings of the quantitative and qualitative analyses. Importantly, the desk review informed evidence-based recommendations for policy and programming, presented in Section 5.

Figure 1. Conceptual Framework on Impact of COVID-19 on Children



***Source**: Author*

3.3. Quantitative research

The quantitative analysis used two major data sources to conduct the analysis: the World Bank Monitoring Surveys (WBMSs) 2020-2021 and Viet Nam SDG Survey on Children and Women (SDGCW) 2020-21. At the time of the study, the WBMSs included five rounds of nationally representative surveys with data collected at household level on matters of behaviours, access to services such as health and education, employment, access to safety nets, coping with shocks, food security, vaccines, and opinions. The WBMS surveys were conducted with the intention of monitoring how the situation in Viet Nam changed since the onset of the COVID-19 pandemic in the country, with the first survey conducted in June-July 2020 and the fifth survey conducted in

March 2021, with no more than three months passing between each round.

The SDGCW 2020-21 is a nationally representative survey containing data on children and their families on a much more extensive set of indicators covering areas of health, nutrition, education and child development and protection, amongst others. The survey is part of the Multiple Indicator Cluster Survey (MICS) series and provides a multisectoral perspective of child deprivation at the time of data collection, and a picture of the situation during the second and third waves of the COVID-19 pandemic. As a one-off survey conducted in the months of November 2020 to February 2021, it does not offer, nor does it aim to offer, the same opportunity to determine what changes have taken place throughout the pandemic.

As the WBMS does not focus on children in the same way as the SDGCW 2020-21, and does not provide a means of identifying households with children, the WBMS findings were used to paint an overall picture of Vietnamese households. The situation of households with children and families was determined through analysis of the SDGCW 2020-21, triangulated with the findings of the qualitative research.

Data analysis included the following sub-components:

- **A trend analysis** to assess the situation of children and households across a selection of indicators that were shared across the available WBMS rounds, focusing on how a selection of key child and family-relevant indicators evolved over time. This included a timeline of key developments in the COVID-19 context in Viet Nam, including cases of outbreaks and health/policy response measures.

- **Descriptive statistics** of key indicators relevant to children and families across the thematic areas of focus.

- **Multidimensional deprivation analysis** to uncover the multiple and overlapping deprivations faced by children, at different stages of the life-cycle, including the direct and indirect risks faced by children because of COVID-19[39], and create poverty/deprivation profiles at national and sub-national levels. This analysis provided an updated overview of poverty, deprivation, and vulnerabilities of children and which may already reveal, in part, the impact of COVID-19. Using SDGCW 2020-21 survey data, this analysis employed UNICEF's rights-based Multiple Overlapping Deprivation Analysis (MODA) methodology[40] to measure and analyze the deprivations faced by children in the areas of nutrition, health, WASH, education, child protection, information, other child-relevant sectors, and determine the breadth and severity of multidimensional poverty faced by children with sensitivity to age, sex, location, and other individual and household

39 Karpati, Elezaj, and de Neubourg 2020.

40 de Neubourg et al. 2013.

characteristics. The selection of parameters was based on the standardized, cross-country CC-MODA definitions[41] and international standards from, amongst others, WHO and UN-habitat. As such, this analysis component is presented as an abbreviated form of the MODA tool and was limited to key analysis indicators at the national level and at the level of regions, comprising: 1) headcount rate of children deprived in studied dimensions, 2) deprivation headcount rate, average intensity of deprivation, and adjusted deprivation headcount rate at the level of the cities and province, 3) top combination of three dimensions which are most frequently experienced simultaneously per age group.

Table 2 presents the selected dimensions, indicators, and thresholds used to measure child well-being in Viet Nam. Applying the life-cycle approach, results are disaggregated by three age groups (0-4 years, 5-11 years and 12-17 years), as children have different needs across various stages in their life. Children aged 0-4 years old may be deprived in a total of five dimensions and children aged 5-17 years old may be deprived in a total of six dimensions. More details on the definition of indicators and deprivation thresholds can be found in Annex IV.

41 *Cross-Country MODA Study: Multiple Overlapping Deprivation Analysis (MODA). Technical Note* n.d.

Table 2. Dimensions, indicators, deprivation thresholds for the multidimensional poverty analysis among children aged 0-4, 5-11, and 12-17 years

Dimension	Indicator	Threshold	0-4 years	5-11 years	12-17 years
Nutrition & health	Exclusive breastfeeding	0-5 months: Child was not exclusively breastfed.	X		
	Minimum acceptable diet	6-23 months: Child was not meeting WHO requirements for minimum acceptable diet (meal frequency and diversity)	X		
	Prenatal care	0-23 months: Mother did not receive adequate pre-natal (4 visits + blood pressure, urine sample and blood test).	X		
	Vaccinations	12-35 months: Child did not receive full vaccinations according to schedule.	X		
Child development	Attendance to early childhood education	36-59 months: Child did not attend any early childhood education.	X		
	Availability of children's books and toys	2-4 years: Child had no toys (homemade or bought from shops) or books to play with in the household.	X		
	Adult-child interaction	2-4 years: No 15Y+ household member engaged in activities with the child.	X		
Education	School attendance	5-17 years: Child was not attending school.		X	X
	Primary school attainment	11-17 years: Child had incomplete primary education.		X	X
Water	Drinking water source	0-17 years: HH main source of drinking water was unimproved (WHO).	X	X	X
Sanitation	Toilet type	0-17 years: HH used an unimproved toilet facility (WHO).	X	X	X
	Handwashing	0-17 years: HH had no handwashing facilities with soap and water.	X	X	X
Housing	Overcrowding	0-17 years: HH had on average more than two people per sleeping rooms.	X	X	X
	Materials of the roof and floor	0-17 years: The exterior roof and floor were made of natural or rudimentary materials.	X	X	X

3.4. Qualitative research

Research objectives

This research component aimed to gain insight into perceptions of caregivers, children, service providers, and members of specific vulnerable groups (including persons with disabilities, rural and poor families, persons with informal working background, migrants) on the socio-economic effects of the COVID-19 pandemic including effects across the thematic areas listed in Section 1.1. This research was intended to complement existing research on the socio-economic impacts of COVID-19 on children and families since the major pandemic outbreak and policy responses starting in April 2021. The findings were intended to triangulate outcomes from the quantitative data analysis, exploring recurrent themes that emerged from the quantitative analysis in greater depth, as well as those which are not fully captured or not possible to capture in the quantitative data.

Sampling strategy and data collection

The study sites were Ha Noi, Ho Chi Minh City, Da Nang, and Bac Giang province. The sampling procedures of this study built on those of the first rapid assessment of socio-economic impacts of the COVID-19 pandemic on children and families.[42] The selection of research participants followed purposive and convenience sampling procedures.

The total number of instruments and participants are summarized in Table 4 and Table 5, Annex I, section I.III. Research participants were selected following the characteristics outlined in the respective tables. Considering feasibility constraints due to changing COVID-19 restriction policies at the time of data collection, Focus Group Discussion (FGD) were carried out in Bac Giang, in addition to In-depth Interviews and Key Informant Interviews (KII). In-depth interviews and KIIs were carried out in Ha Noi, Da Nang, and Ho Chi Minh City remotely or in-person, depending on feasibility and consent of the participant.

In total, the study included 23 caregiver participants from Bac Giang (including 16 FGD participants, five service provider key informants, and two in-depth interviewees). In Ha Noi, Ho Chi Minh City, and Da Nang, the study included 14 caregiver participants and five service provider key informants, yielding a total of 42 participants. In total, 65 individuals participated in the qualitative study. All interviews and discussions were transcribed verbatim for qualitative analysis.

Participant selection aimed for equal representation of both female and male participants across all groups of participants. Among mothers, fathers, and caregivers, participant selection additionally aimed for representation of caregivers of different age cohorts, such as children aged 0-5 years, 6-14

42 United Nations Children's Fund 2020e.

years, 15-17 years. Selection of frontline workers for key informant interviews focused on representation at the ward level. Commune-level representatives were interviewed in the case of feasibility constraints.

Study participants received a small a thank you gift for their participation, in the form of mobile phone credit or data top-ups, packaged foods/snacks, or bottled drinks. The Ha Noi University of Public Health provided ethical clearance for the study in January 2022. Additional information about ethical considerations and precautions in the context of COVID-19 can be found in Annex II.

Data analysis

Thematic and content analysis were performed on the transcribed interviews to: 1) answer the study's research questions and 2) identify additional important themes and concepts voiced by the participants. Researchers used MAXQDA qualitative data analysis software to code transcripts and perform code structure analysis. Qualitative research analysis findings were triangulated with qualitative analysis and desk review to draw summary conclusions that aim to answer and expand upon the research questions.

3.5. Research limitations

As a mixed-methods study, the triangulation of qualitative and quantitative findings in this study aimed to improve the reliability and validity of both qualitative and quantitative research components. Although the qualitative research outcomes are not statistically representative, these findings aimed to provide in-depth insight and complementary information on topics of interest which arise from the statistically representative quantitative analysis component.

The multidimensional poverty analysis was limited by data, and therefore did not include all potential dimensions of children's rights and wellbeing – such as child protection (including child labour and child discipline), mental health, and participation. It is therefore likely that the share of multidimensionally deprived children calculated was much higher in actuality than the figures in this report.[43] The report transparently communicates these limitations while highlighting the additional available descriptive statistics on these other key areas of child well-being, where relevant.

Other limitations encountered during the research design, data collection, and data analysis processes are outlined in Annex III.

43 The multidimensional child poverty analysis is an individual, child-level study with the child as the unit of analysis. For this reason, data collected for only one randomly assigned child per household (as is the case with the child labour, child discipline, and child functioning modules of the SDGCW 2020-21 dataset), was not included in the analysis, to avoid masking inter-household differences between children.

4. Key Findings

4.1. Multidimensional child poverty during the COVID-19 pandemic

Based on SGDCW data collected between November 2020 and February 2021, findings from the analysis of key indicators and multidimensional deprivation among children provided a proximate baseline measure of the situation of children and families with children during the pandemic and before the onset of the fourth wave to hit Viet Nam, which saw a major surge in cases of infections, deaths and more severe government responses for prevention and mitigation. The analysis employed UNICEF's rights-based MODA tool to uncover the multiple and overlapping deprivations faced by children, at different stages of the lifecycle, and to create poverty/deprivation profiles at national and sub-national levels.

Prior to the fourth wave of COVID-19, just under **one-in-five children aged 0-17 years**, or 19.8 per cent, experienced multidimensional poverty, being deprived in **at least two dimensions of well-being** out of the total number of measured dimensions, representing their unfulfilled rights (see Section 3.3). On average, these children were deprived in 49.5 per cent of all measured dimensions at the same time.[44], [45] Taking into account differences between children with sensitivity to their lifecycle stage, 33.7 per cent of children aged 0-4 years, 13.9 per cent aged 5-11 years and 15.4 per cent aged 12-17 years were counted as multidimensionally poor (Annex IV, Table 9-Table 11). The share of children who were deprived in the individual dimensions and sub-population analyses are explored in more depth in the following thematic sections and in Annex IV.

Table 8 in Annex IV presents the multidimensional deprivation indices at national level and by different profiling variables for children aged 0-17 years old, for children deprived in at least two dimensions at a time. Taking into account both the incidences and intensity of multidimensional poverty and deprivation[46], children living in rural areas were twice as likely to be multidimensionally deprived compared to children living in urban areas.[47] Similarly, children living in the Central Highlands fared the worst among other regions, with both a higher share of children being multidimensionally deprived

44 As per the methodology, children aged 0-4 years old may be deprived in a total of five dimensions and children aged 5-17 years old may be deprived in a total of six dimensions.

45 The average intensity among multidimensionally poor children (*A*) presents the average number of deprivations faced by multidimensionally deprived children as a share of all children considered multidimensionally deprived.

46 The adjusted multidimensional deprivation headcount (M_0) takes into account both the incidence and intensity of deprivation in an index ranging from 0 to 1. Although this index cannot be interpreted on its own, M_0 can be used to compare population groups and geographical regions, with 0 representing no deprivation and 1 a higher level of deprivation among children. In Viet Nam, the M_0 stands at 0.098 at the national level.

47 Rural areas indicate much higher deprivation levels, with a M_0 of 0.119 as compared to 0.053 in urban areas.

(one-in-three, or 33.1 per cent), and these children experiencing a higher level of multidimensional deprivation (52.0 per cent of all possible dimensions measured).[48] Substantial differences were also observed based on ethnicity and wealth quintile of the household. Children who lived in households belonging to the lowest wealth quintile or with household heads from ethnic minorities were more likely to present higher rates of multidimensional deprivation.

These findings suggest that during a period where progress in poverty reduction in Viet Nam had already been stalled by the social and economic fallout of the pandemic, before the onset of intensified public restrictions, persistent deprivations and inequities put a substantial share of children and families at risk of falling further behind in their rights fulfilment.

Unpacking the extent of overlap between different dimensions of child well-being provides insight into the nature of their multidimensional poverty as well as the policies and interventions which may be effective in addressing it. Among children who were considered multidimensionally poor under five years of age at the national level, the deprivations most commonly experienced together were in the Nutrition, Housing and Sanitation dimensions. Some 12.7 per cent of these children were simultaneously deprived in Nutrition, Housing, and Sanitation, while only 16.8 per cent were not deprived in any of these three dimensions (Figure 2). Children aged 5-17 years old presented lower deprivation rates per each dimension compared to the youngest age group, and thus experience a lower extent of overlapping deprivations (see Annex IV). Among children aged 5-11 years, deprivations in the Water, Sanitation and Housing dimensions were most commonly experienced together. However, under 3 per cent of children were deprived in all three at the same time, while around one-in-four children (23.1 per cent) were deprived in Sanitation and Housing. Among children aged 12-17 years, deprivations in Education, Sanitation and Housing were most commonly experienced together, with 8.3 per cent of children of this age group deprived in all three dimensions at the same time (Figure 14).

These findings suggest that, while Viet Nam had largely weathered the negative economic and social fallout of the pandemic by the beginning of 2021, a significant share of children and families with children remained at risk of multidimensional poverty and unmet rights. As the multidimensional poverty analysis was limited by data and therefore could not include all potential dimensions of children's rights and wellbeing – such as child protection, mental health, and participation – it is likely that the share of multidimensionally deprived children was much higher than reported.[49]

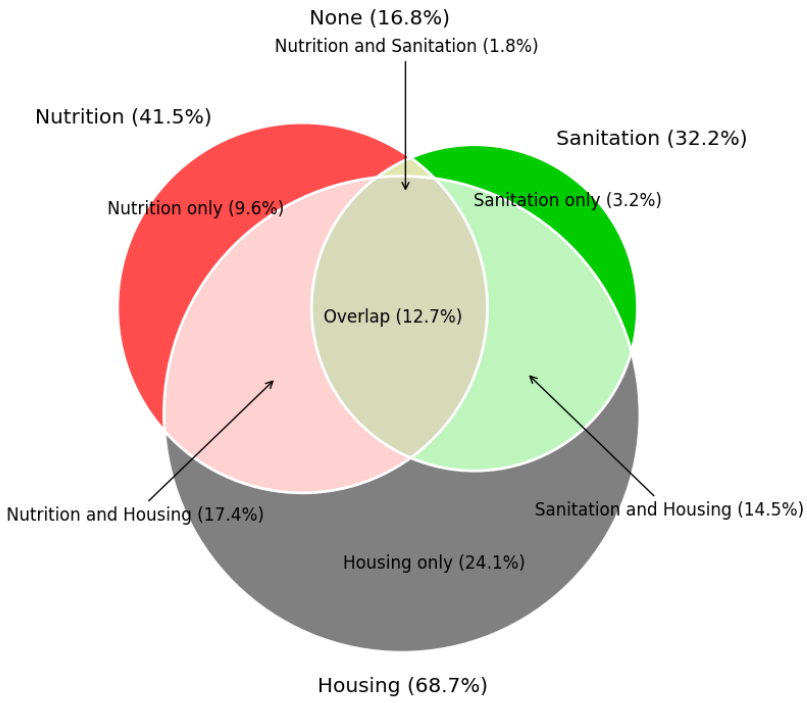
48 At the regional level, Red River Delta performed best with an M_0 of 0.050, while children living in the Central Highlands are worst off with an M_0 of 0.172.

49 The multidimensional child poverty analysis is an individual, child-level study with the child as the unit of analysis. For this reason, data collected for only one randomly assigned child per household (as is the case with the child labour, child discipline, and child functioning modules of the SDGCW 2020-21 dataset), was not included in the analysis, to avoid masking inter-household differences between children.

The rapidly changing nature of the pandemic – including the rising cases of morbidity and mortality, the larger scale and intensity of government responses and the service interruptions in the following months after February 2021 – suggests that the share of children experiencing multidimensional poverty was much higher during this period in particular.

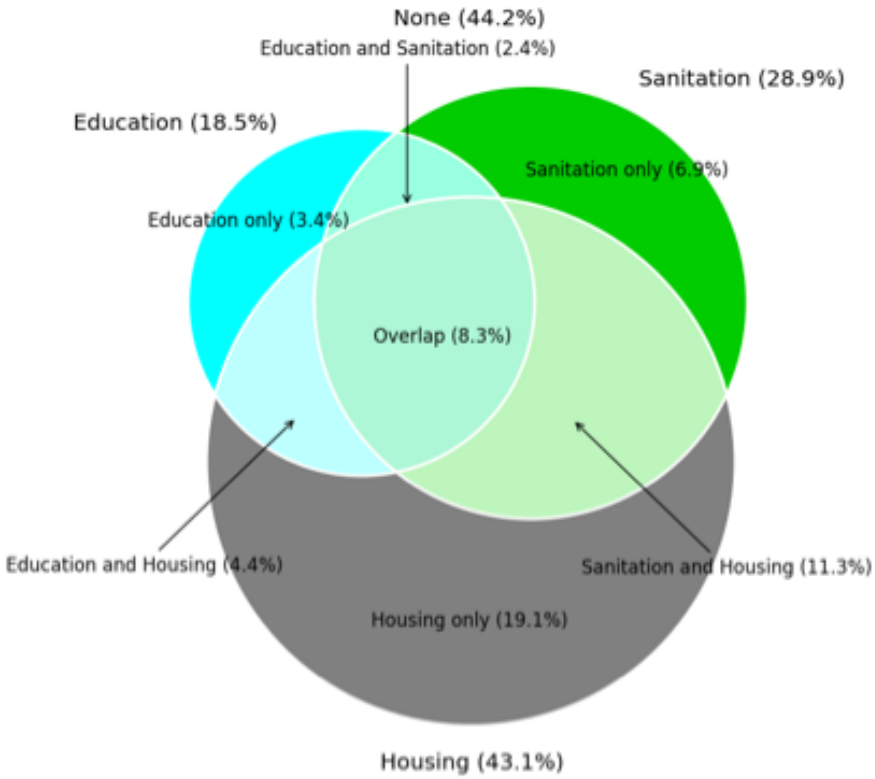
The following sections take a closer look at other areas important to understand the wellbeing of children and families during the COVID-19 pandemic, including: economic shocks, social protection and social assistance, health, nutrition, education and child protection.

Figure 2. Three-way overlap between the dimensions Nutrition/Health, Sanitation and Housing, 0-4 years



Source: Author's calculations based on the SDGCW 2020-21 survey

Figure 3 . Three-way overlap between the dimensions Education, Sanitation and Housing, 12-17 years

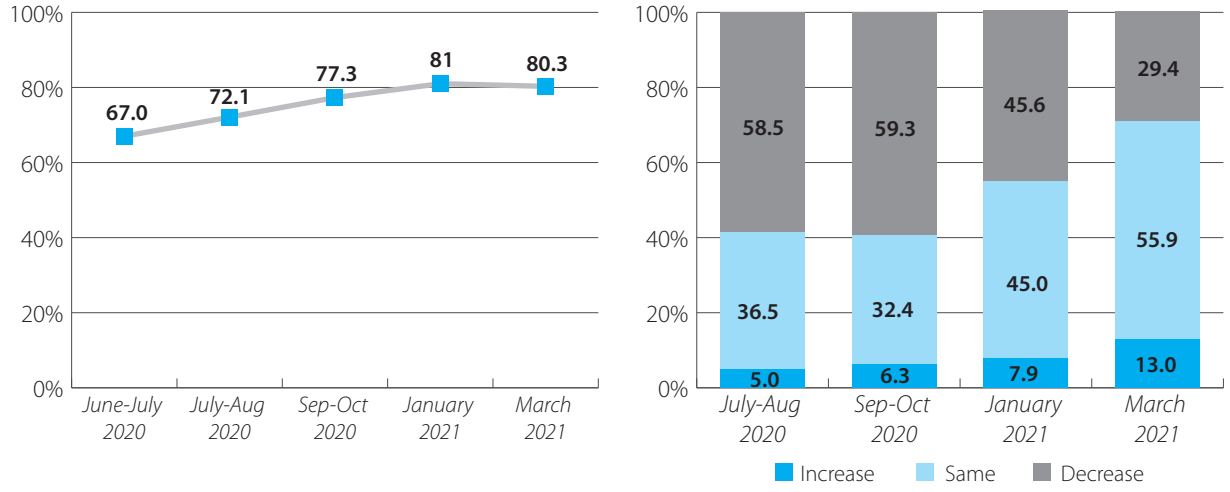


Source: Author's calculations based on the SDGCW 2020-21 survey

4.2. Economic impacts on livelihoods

Evidence showed that an initial economic shock was felt by households in Viet Nam in 2020, but was followed by a steady recovery into early 2021. Between June 2020 and March 2021, only minor changes in household employment occurred among those already employed, with the vast majority of households performing the same job as 'a few months ago' throughout the period. Despite this, Figure 4 shows that only a third of households generated income in the last week when asked in June-July 2020 although this rose to four-in-five households by January 2021, demonstrating a recovery among households after an initial economic shock. For female-headed households, however, although the proportion of households generating an income was similar to male-headed households in 2021, this was preceded by a significantly lower proportion in June-July 2020, followed by a steady increase up to 2021, implying that female-headed households either experienced a larger initial shock than male-headed ones or had an increased need to generate income compared to before the pandemic. Throughout the same period (mid-2020 through to early 2021), a growing proportion of households claimed to have the 'same' or an 'increase' in income compared to a year before with only 29 per cent of households experiencing a decrease in March 2021 compared to 59 per cent in July-August 2020 (also shown in Figure 4).

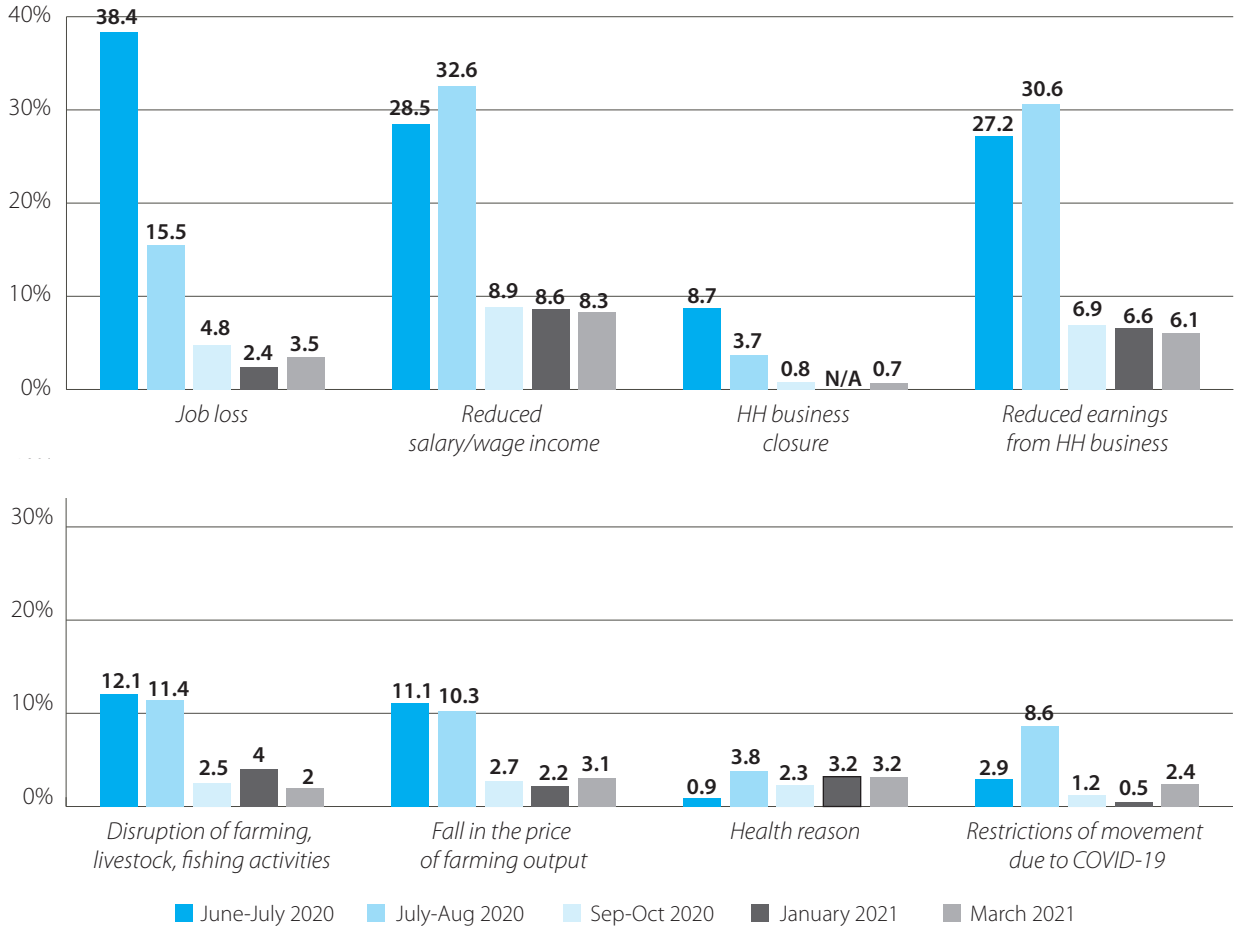
Figure 4. Proportion of households that generated income in the last week (left) and household income compared to this time last year (right)



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21.

Major factors contributed to this initial income shock, although these were decreasingly experienced by households in late-2020 and early 2021. Figure 5 indicates that job losses, reduced salary and earnings were some of the key reasons driving falls in income between February and August 2020. From then until March 2021, reduced salaries and earnings from household business were behind reductions in income, but experienced by fewer households relative to the former period. Urban households were far more likely than rural ones to have experienced reduced earnings from a household business, whereas rural households were much more likely to have experienced reduced income due to disruptions to farming, livestock and fishing activities. Similarly, those in the top 60 per cent of income distribution were far more likely to have experienced reduced earnings from household business compared to households from the bottom 40 per cent of the income distribution in July-August 2020.

Figure 5. Proportion of households experiencing income reductions due to…



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21. Note: Responses here are limited to those who experienced a reduction in income. Respondents were able to select all that applied. For the June-July 2020 round, the reference period is from February 2020 onwards. For every other survey round, the reference period is 'last month'.

"My income reduced quite a lot. I had no work so no income." **– Caregiver of vulnerable children, Ho Chi Minh City**

"I have a large family, but only my husband and I earn money. I have just given birth to a small child, so I cannot work. During the pandemic period, I was not able to do small business at the market. My husband had no job. It hit my family very hard. […] My sales were badly affected because of no imports, no buyers due to the shop closure, lower purchase due to no income." – **Mother (informal worker), Bac Giang**

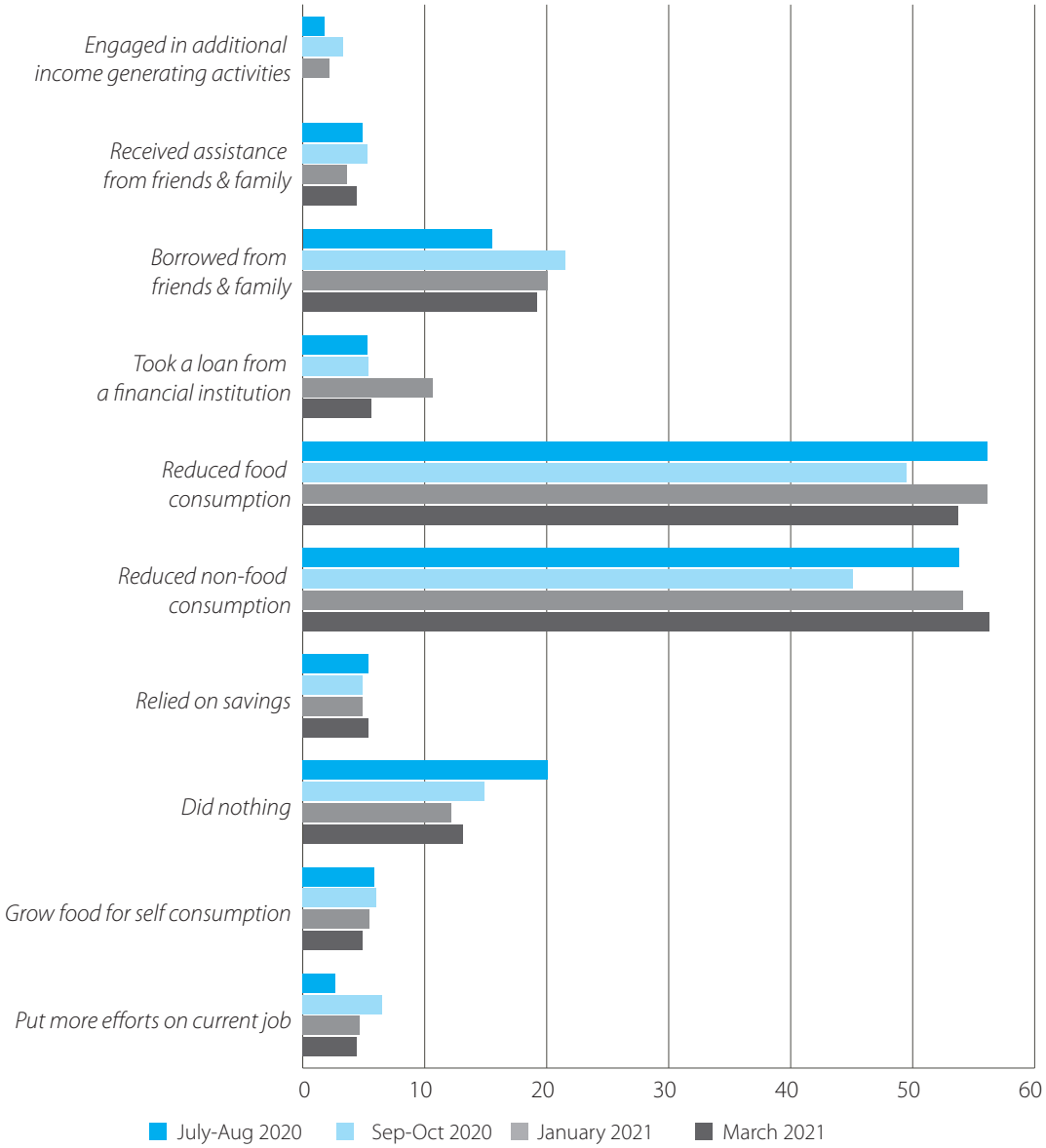
Experience of an economic shock was a common occurrence. Income-generating activities stopped or reduced for most families and households as a result of social distancing and lockdown policies. Particularly struck included those working in the service (such as tourism) and manufacturing/industrial sectors and those self-employed/freelancers for whom employment and livelihoods were permanently or temporarily terminated. Those dependent on functioning import and export markets for their livelihoods were also negatively hit. Some groups, however, were reported to have largely continued their livelihoods including those engaged in agriculture, livestock rearing, those able to work from home and those employed in the public sector. Mixed responses were given regarding how vulnerable groups had faired in the context of this macroeconomic shock, with some reporting that vulnerable groups were already supported by government-provided social assistance, which some claimed was scaled-up in response to the crisis. However, others (the majority) responded that vulnerable groups – such as migrant workers, informal workers, the elderly, poor, disabled and ethnic minority households and families – had experienced the most economically precarious situations. Informal and migrant workers especially were affected by sudden losses of income and the ability to generate income, with all interviewed informal and migrant workers experiencing some level of economic shock which negatively affected access to necessities. No differences were observed between the sampled cities in this respect.

As a result of a reduction in income, households were found to have engaged in negative coping mechanisms from mid-2020 to early 2021. Figure 6 shows how the most common coping mechanisms were related to a reduction in household consumption of food and non-food goods. In July-August 2020 and January 2021, there was a significant difference between urban and rural households engaged in reduced consumption of food and non-food items, with the latter significantly more likely to have reduced consumption in July-August 2020 and urban households more likely to consume less in January 2021. Likewise, a regional difference in coping mechanism was clear for that same period, that was not so disparate in the other time periods. For example, in January 2021 in the Southeastern region approximately three-quarters of households were engaged in reduced consumption of food and reduced consumption of non-food items, compared to the national average of just over half of households. In July-August 2020, households in the Red River Delta were far more likely to have engaged in reduced consumption than other households in the country and households in the Midlands and Northern Mountainous Areas were far less likely. The Kinh majority were significantly more likely to have engaged in reduced consumption than other ethnic minorities. This may be explained by the higher proportion of ethnic minorities present in rural areas relative to the Kinh majority (as discussed above, households in rural areas were found to have been less likely to have experienced an economic shock than urban households).[50] Comparing households from the bottom

50 Epprecht, Müller, and Minot 2011.

40 per cent of the income distribution to those in the top 60 per cent, it can be observed that poorer households were more likely to have engaged in borrowing from friends and family than those from richer households.

Figure 6. Coping mechanisms of households



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21. Note: Respondents were able to select all that applied. The categories available differed in each of the survey rounds but the categories represented here had data across Rounds 2-5 of the WBMSs with the exception of the 'engaged in additional income-generating activities', which was not available for March 2021 (Round 5).

"During that time, I had no work. No money to send home. I am mother, so I must care about it. But what I could do without income? Before the pandemic, I could save some money for my son. However, during the isolation period, there were no savings. It was even not enough to eat. […] During the pandemic, the income was not stable. Lack of income. Less work at the fishing port. Thus, I sent home less. Still twice per month but less each time." – **Mother (informal migrant worker), Da Nang**

"I had to borrow to pay for daily expenses. […] It was impossible to go to work or to do the housework for other people. I was off work since early August for 4 months. [..] The work reduced a lot. During the 4 months, I had to borrow from different sources to pay for daily expenses. I lived hand to mouth." **– Mother (informal worker), Ho Chi Minh City**

These negative coping mechanisms were further reflected in the qualitative data. Reduction of expenses, particularly on non-essential items, as a response to reduced engagement in income-generating activities was very common. Use of savings to pay for expenses was also common, although many respondents claimed they had no savings and therefore did not have this option. Although many shared that they had reduced their consumption as a household, many participants discussed how they still managed to meet their needs, with exception of some poor and near-poor households who claimed to have unmet economic needs. Included within this reduction in expenditure was a reduction in food consumption, but this was not the case for those owning livestock or engaged in farming, who were able to consume food as usual.

Financial borrowing, both formal and informal (from family and friends), was common. In some limited cases, families borrowed money to pay debts on previously borrowed money. Examples of relatives giving money rather than lending it were also common. Migrant workers who had been sending money home, including for caretaking of children, experienced additional difficulties. In one case, a study participant reported reduced financial support sent to their children's caregivers due to reduced income during the pandemic, while another changed personal spending patterns to guarantee its child's tuition and meals.

Formal and informal support also provided a means of coping. For those with relatives living in rural areas, they often reported receiving in-kind support including rice, fruit, vegetables and sometimes even fish. Many examples were found of families diversifying their livelihoods to cope by, for example, selling rice and engaging in street vendor work. For informal and migrant workers in Da Nang, they cited how landlords had allowed them to delay rent payments or even not pay at all. A respondent in Ha Noi, cited how a landlord had reduced the rent payment to support the family. Lastly, access to social protection was regularly identified as a coping mechanism and is discussed in detail later in the report. No differences were observed between the sampled cities in this respect.

4.3. Social protection and social assistance

Participants expressed a need to generate income to continue consumption at pre-pandemic levels. Many expressed a wish to return to work and earn an income once again. The ability to afford foodstuffs to improve the quality and quantity of meals was also cited. Further, the need to pay for their children's schooling was also regularly cited and often combined with a wish for government to re-open schools as soon as possible. To a lesser extent, participants discussed the ability to afford the more general economy of the household, including consumption of non-food items. A minority of cases existed in which there was no expression of needs. No particular region or social group was associated with economic needs; economic needs were expressed by the majority of participants.

"I don't think there is any [social protection support]." – **Informal worker/caregiver (freelance vendor), Da Nang**

"The government had a package to support self-employed workers of VND 1.5 million per person." **– Mother (migrant worker), Ho Chi Minh City**

There was a general awareness of State provided social protection and social assistance among most of those interviewed but not among everyone. However, numerous examples of no awareness were found across all four of the sampled areas, but this was not associated with any particular social group. Among those who were aware of available social protection schemes, participants cited financial support programmes, including for those that are quarantining, for those unemployed, and social insurance for those employed, among others. Participants had been made aware of these programmes through various sources including TV and word of mouth.

A broad range of social protection and social assistance schemes and the respective sources were referenced by participants. Poor and near-poor households reported receiving cash support from the government as a result of their income status. Unemployment insurance allowance (also referred to as 'unemployment allowance') was also widely cited by participants, understood by them to have been provided by private insurers and purchased by employers. Many participants referenced receiving in-kind food support, such as rice, noodles, fruit, vegetables and canned fish, from multiple sources including local government, residential and neighbourhood groups, relatives in the countryside, ward officials, local people's committees, charities and social organizations, and the church, the latter of which being a source cited only by participants in Ho Chi Minh City. Unique to informal worker in Da Nang was an example of their child's school providing a support grant to the household. Further, unique to Ha Noi was reference to a government policy to subsidize electricity bills as part of state COVID support. Many references to receipt of social protection and social assistance were made but without reference to the type of social protection this was.

Trends in receipt of social protection and social assistance differed considerably throughout the pandemic, with a greater proportion of households receiving government support earlier on in the pandemic compared to later and a change in the types of social protection and

"Due to the financial difficulty, we had to cut down on family expenses significantly." **– Father, Bac Giang**

"We had family members in the countryside sending rice and food to us, so it helped a bit." **– Caregiver in quarantined area, Da Nang**

"The landlord exempted or reduced the rent for tenants for several months when it's impossible to go to work." **– Migrant worker caregivers (freelance), Da Nang**

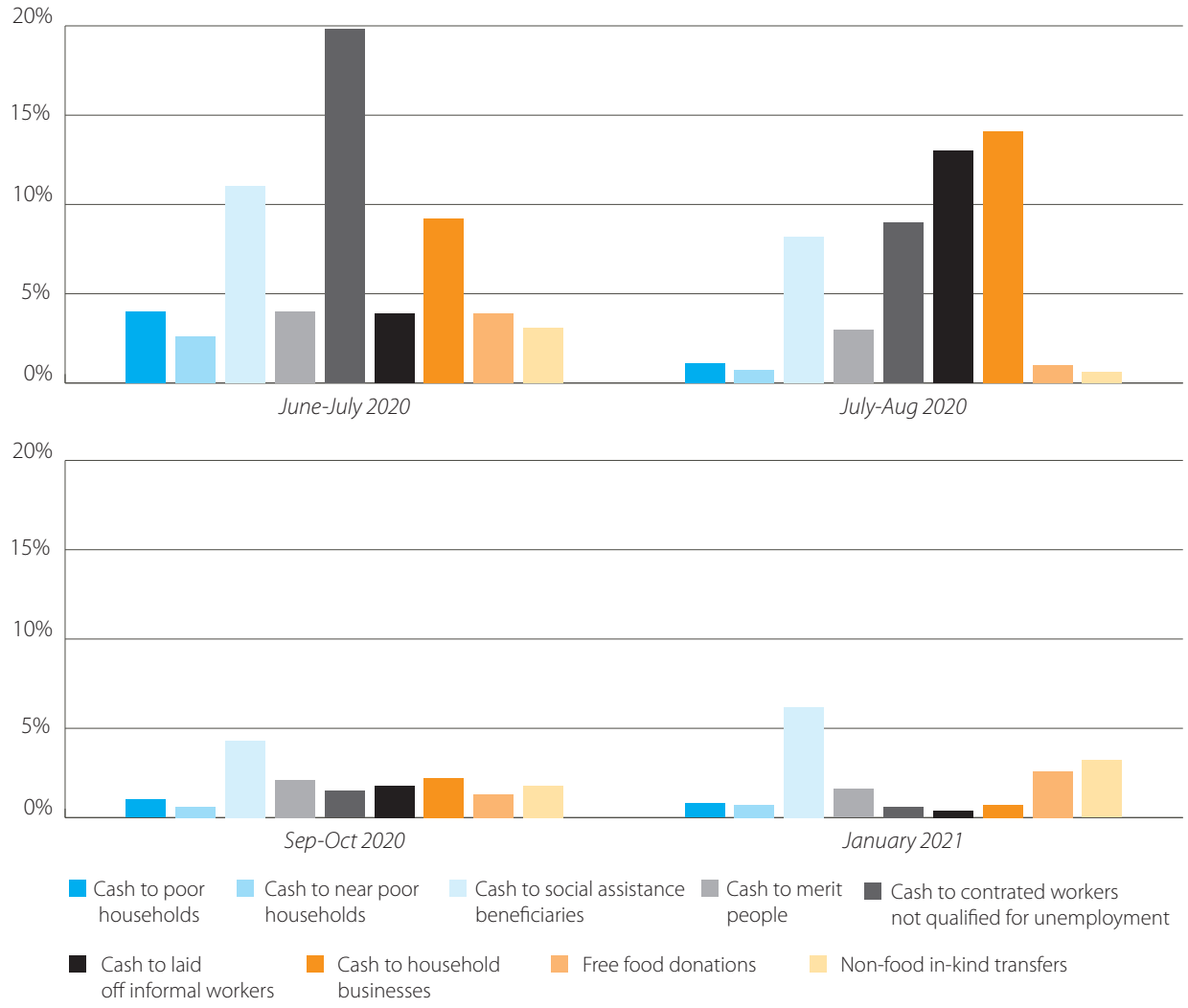
social assistance that were predominantly delivered. It can be observed in Figure 7 that households were more likely to receive social assistance in June-July 2020 and July-August 2020 compared to September-October 2020 and January 2021. In both September-October 2020 and January 2021, receipt of social protection was negligible at no more than 3.2 per cent of households for any given type of social assistance with the exception of cash assistance to social assistance beneficiaries at 4.3 per cent and 6.2 per cent respectively, although this was a considerable drop from the 11.0 and 8.2 per cent of households in June-July and July-August 2020.

Trends in the other significant types of social assistance, including cash to contracted workers, household businesses and laid off informal workers, also changed across the surveyed time period. In June-July 2020 the most common form of social assistance was cash provided to contracted workers that have not qualified for unemployment benefits, of which approximately a fifth of all households received. This form of social assistance, however, followed a steep decline in provision as it more than halved to less than a tenth of households receiving it in July-August 2020 and then just over and under a percentage of the population for September-October 2020 and January 2021 respectively. A similar pattern is seen for provision of cash to household businesses, for which a tenth and over a tenth of households received for the first two survey periods but dropping substantially to 2.2 per cent and 0.7 per cent of households in the latter two survey periods.

Lastly, cash to laid off informal workers was insignificant across most survey periods, with the exception of July-August 2020, in which 13 per cent of households received this. A disaggregation of the findings according to area, region, ethnicity, gender and income distribution has not been provided here due to the already small sample sizes of the populations who received the different categories of social assistance. Findings from the SDGCW 2020-21 revealed that 52.3 per cent of households with children were both aware of external economic support and had at some stage received it, although it is not possible to determine whether this access had occurred throughout the pandemic period. Both the poorest and richest quintiles were above the average at 57.2 and 58.5 per cent respectively.[51]

51 General Statistics Office and UNICEF 2021.

Figure 7. Proportion of households receiving support from the government or international organisation by type of assistance



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21.

When asked about their experiences in 2021, some reported to have experienced barriers in applying for social protection and social assistance. Participants shared various struggles including applying but waiting and never hearing back as to whether the application had been accepted, struggling to apply in the first place due to the complexity of the application process and extensive procedures and standards and even perceiving that their hometown had not been targeted for social protection. In one case, a participant shared how they had not even attempted to apply because they found the process too complicated. Another barrier that was shared included a recent relocation, which had meant that they were not yet registered with the

"Barriers [to social protection] may include distance, complicated and infeasible application process because of many procedures and standards, etc." **– Caregiver and recipient of social protection/social assistance in Ha Noi**

"The [social protection application] procedure went through the ward to the district level so it was clear and precise." – **Caregiver of vulnerable children (poor household) in Da Nang**

"The procedures [for social protection application] were so complicated so I decided not to register for it." **– Caregiver who stayed in a COVID-19 quarantine centre in Ho Chi Minh City**

local authorities and therefore did not receive any communications regarding social protection. In contrast, some participants stated that they had applied for social protection and had experienced no issue in the process. However, cases of successful and untroublesome application to social protection and social assistance were also shared by participants, although in one case the beneficiary had had their employer apply for social protection on their behalf.

Most respondents reported that the support from the Government was insufficient to meet needs. Respondents who received social protection claimed it was not adequate to meet their needs. Some participants compared the transfer value to the monetary value of key foodstuffs such as a bag of rice, demonstrating that the transfer value allowed for very little additional consumption. Poor households, informal workers and migrant workers particularly reported the inadequacy of the social protection they were receiving, and yet other participants considered vulnerable households to have gained further social protection support since the beginning of the pandemic and therefore did not recognize the unmet needs of these households. Some felt that the transfer values were so small that it would be better to target more vulnerable households and increase the transfer value for them. Some reported how in-kind transfers such as canned fish and instant noodles were insufficient with the cans providing enough for one meal and the instant noodles lasting only half a month.

Overall, social protection and social assistance provided by the State was limited and impractical although there were some strengths associated with it too. Awareness of available social protection was mixed but the government did provide a large selection of support, although many programmes were provided to a very small proportion of the population and overall support (measured by the proportion of the population in receipt of each social protection programme) decreased over time. Many (but not all) struggled in some way with the application process for social protection, citing issues of the long wait before a response, the lack of response and the complexity of the application process, which did partially undermine overall uptake. Lastly, the support that was provided was considered inadequate as it did not meet the needs of those who depended on it. Recommendations were made by participants for the State to increase social protection support in the form of an increased transfer value for both financial and in-kind support and a focus on poor and vulnerable households.

4.4. Health

COVID-19 severely disrupted the health care system in Viet Nam due to the increased demand that the pandemic has created for COVID-19-specific care during severe social distancing and isolated lockdown policies. As a result, routine services faced delays or suspension, and both provision and uptake of disease treatment were de-prioritized in response to the surge of COVID-19

infections and related illness.[52]

Concurrently, Viet Nam's swift and well-coordinated vaccination campaign demonstrated its capacity to respond to large-scale public health crises. Mass COVID-19 immunisation roll-out was slow over the course of 2021 and thwarted by limited availability of vaccines, rising numbers of infection cases, as well as the evolving nature of virus variants.[53] In the second half of 2021, the Ministry of Health's swift and ambitious vaccination campaign to reach herd immunity with a target of 75 per cent of the population being fully vaccinated was successful, with 77 per cent of the population being fully vaccinated by February 2022. As of July 2022, Viet Nam is among the countries with the highest share of the population being vaccinated in the world, at 81 per cent, and 61 per cent of the population having received one booster.[54] As of July 2022, the percentage of persons having received at least three doses is 65 per cent in Ho Chi Minh City, 62 per cent in Ha Noi, 46 per cent in Da Nang, and 87 per cent in Bac Giang. This includes 84-98 per cent of children aged 12-17 years, who are fully vaccinated. [55]

Child health was particularly undermined during the pandemic due to the reduced access to routine maternal and child health services, including those related to immunization.[56] This is of particular concern, as findings from the multidimensional poverty analysis using SDGCW 2020-21 data showed that, during the pandemic period, health and nutrition were priority areas of concern for children aged 0-4 years in Viet Nam, with **70 per cent of children aged 0-35 months deprived in terms of either not having met minimum standards for diet and feeding practices, or for age-specific prenatal care and immunization,** at the national level (Annex IV: Figure 10, Figure 11). Among these children, 27.9 per cent of children aged 0-23 months had mothers who did not receive timely or adequate prenatal care, and 58.3 per cent of children aged 12-35 months had not been fully immunized according to their age (Annex IV: Figure 10, Figure 11). Disadvantaged children suffered the most from these circumstances. Inequalities between top and bottom earners, as well as the Kinh majority and non-Kinh minority, remained.[57] In the first waves of the pandemic, children's health care requirements, such as vaccinations, were not sufficiently addressed in general, but especially so for those living in remote regions.[58]

"…I see [others] complaining about travel problems. In the period of social distancing, when people are restricted from going out, it is quite difficult for them to go to the doctor as they have to go through the quarantine checkpoint, to declare medical conditions and sometimes to have a certificate from the ward. Therefore, in emergency cases or cases where there are young children […] it is also a difficulty in accessing medical services. When entering the hospital, people have to take a quick test to confirm that they do not have Covid. It is also a burden for poor families, whose income is still limited and, of course, for ordinary families, this is also a nuisance for them." – **Mother (social protection/assistance non-recipient), Ha Noi**

52 Nguyen, Nguyen, Duong, et al. 2021.

53 France24 and Asian Development Bank 2021; World Health Organization 2021.

54 World Health Organization 2022.

55 VNExpress and The National Center for Covid-19 Prevention and Control 2022.

56 United Nations Children's Fund 2020e.

57 World Bank and Australian Aid 2021.

58 United Nations Children's Fund 2020e.

"My children had less severe illness. I got the most severe infection. We informed the medical centre, and they assigned staff to visit and advise via calls. The doctor provided me with advice. In general, they provided daily advice. It was very good advice. However, at that time, it was a bit worrying because when I had difficulty breathing and called an ambulance, no one answered the calls." – **Male caregiver, Ho Chi Minh City**

"In general, the medicine price increased in the pharmacies only. I was partially subsidized when visiting the healthcare centre and hospital because we were a near-poor household." – **Mother of vulnerable children, Ho Chi Minh City**

"The disabled people, poor households, the homeless, and the people without support will be at high risk of the Covid-19 epidemic because people do not have access to mass media and education." – **Caregiver of a vulnerable child (poor household), Da Nang**

Accessibility of basic health services during COVID-19

The proportion of households with at least one member who needed medical treatment in the seven days preceding the WBMS survey increased between June-July 2020 and March 2021 by nearly 7 percentage points, from 30.1 to 36.9 per cent, and which likely increased further with the fourth and fifth wave of the pandemic following this data collection period (Annex V: Figure 15). While these figures represented a significant strain on the public health system in Viet Nam, access to medical treatment was nearly universal throughout the pandemic period until March 2021, with upwards of 96 per cent of households able to access medical treatment between June-July 2020 and March 2021 (Annex V: Figure 16).

The majority of interview and discussion respondents in all four study sites had no major difficulties accessing health services when needed during the course of the pandemic, and that they were generally satisfied with the services available. Nearly all interviewed caregivers shared that they, their children, or other family members contracted COVID-19 since the beginning of the fourth wave and were able to access COVID-19 specific services in a timely manner or were able to manage their treatment at home. When needed, participants sought to access services for their children or other family members at the ward health centre/department, at hospitals, from pharmacies, or from mobile medical stations which were established in communities by the local government to provide rapid responses to the rising number of COVID-19 cases. In Ho Chi Minh City, several caregivers were able to contact doctors and other medical services by phone for treatment guidance, remote monitoring of illness, and for medical prescriptions. Frontline healthcare workers in all four study sites shared that mobile medical stations and additional support from volunteers and military healthcare staff helped to partially relieve a significant strain on medical workers while expanding service access at the grassroots level.

Barriers to accessing basic healthcare services shared by caregivers in all four study sites included: 1) reduced demand for service uptake due to fear of contracting the virus at hospitals and health stations, and due to fear of not being able to receive visitors if hospitalized; 2) hesitation to use services due to long waiting times and high out-of-pocket expenditures for additional mandatory procedures for COVID-19 prevention at hospitals, including purchasing and taking test kits onsite, and submitting health declaration forms; 3) delayed or unavailable routine and emergency services, including health checks and antenatal care; 4) high out of pocket expenditures for the purchase of medicines and test kits from pharmacies due to social distancing policies and rising medicine prices; 5) crowding out as many private clinics closed, while public hospitals and health stations dealt with an overload of patients. In Ha Noi, caregivers shared the difficulty of accessing medical services for themselves or their children due to additional checkpoints during the

social distancing period, which required submitting declarations of medical conditions and a certificate from the ward before being permitted to travel to see the doctor. Vulnerable groups, including poor and near-poor households, were especially affected by these barriers.

A minority of respondents reported significant difficulties accessing basic routine health and maternal and child health services. Frontline workers in Bac Giang shared that children's routine immunisation and health/nutrition monitoring and supplementation for mothers and children were interrupted or suspended during the pandemic period. In Ha Noi and Da Nang, frontline workers reported that while basic diagnostic and treatment services for pregnant mothers and children continued during the pandemic, including via remote counselling, they were deprioritized in favour of pandemic prevention efforts. This led to significant strain on the medical workforce. In Ho Chi Minh City, the ward health station received support from collaborators at the hamlet level to continue vitamin supplementation and growth/nutrition monitoring for children under age 5 years. Frontline workers in all four study sites reported disruptions and indefinite suspensions to the health station's activities, including to counselling for pregnant women, face-to-face trainings, and outreach activities.

Coping mechanisms

The majority of interviewed caregivers shared that they were more conscious of their health and made efforts to inform themselves about the pandemic and adhere to prevention measures to cope with reduced accessibility and demand for health services. A small number of respondents cited the need to borrow money and rely on informal support networks, or seek private healthcare to access basic, routine, and emergency health services to cope with reduced service availability and affordability during the pandemic period, thereby incurring higher out-of-pocket expenditures. In isolated cases, parents resorted to caring for their child at home and not reporting their child's COVID-19 status, out of fear that they would not be able to accompany him/her to the isolation centre. Others cited hesitation to self-report cases of infection due to the added financial burden of quarantine without adequate formal financial support. These instances may have led to potential negative coping mechanisms and added barriers to accessing adequate and timely health care.

"Pregnant women were the most worried, they had their mental health declined. The reason was that they could not have regular antenatal check-ups. […]. At that time, I did not dare to let them into the station for fear of infection. That made pregnant women at that time even more worried. During the pandemic, the station supported a birth at home. They called the station to ask for support and the midwife came to handle the baby, cut the umbilical cord and transferred them to a higher-level hospital. Psychological stress affected pregnant women according to my subjective opinion. There were also some premature births. At that time there were many heart-breaking things."
– **Frontline health station staff, Ho Chi Minh City**

"During the stressful period of the pandemic, in April, my wife was still pregnant, so it felt uncomfortable as she could not go out. I took her to the hospital for antenatal care; however it became more difficult (to do so) during lockdown. Private clinics were closed, so we had to go to big hospitals, however they did not allow many people in. Doctors did not want to take risks (being penalized for opening) therefore they closed their private clinics at that time. That was why we had to go to hospitals." – **Father who stayed in a COVID-19quarantine centre, Da Nang**

4.5. Nutrition

Exacerbated by social distancing and lockdown measures during the pandemic, food insecurity became an increasing concern. Despite studies predicting that the impact on access to food in Viet Nam would be small,[59] data from UNDP in 2021 suggested that over half of households had to reduce food consumption at each meal (51 per cent) and almost 18 per cent of households reduced the number of meals consumed. 2021 survey data suggested that the most severe food shortages were reported by households with children, but shortages were also common among migrant households and those for whom members were laid off from work.[60] Figure 8 shows how there was a marginal decrease in the proportion of households worrying about having enough to eat in the last 30 days between mid- and late-2020 among all socio-economic groups but that the rates between these groups differed substantially. Ethnic minority, female-headed and bottom 40 per cent of the income distribution households were far more likely to have worried about having enough to eat. On the other hand, Kinh majority, male-headed and top 60 per cent of the income distribution households were less likely to have worried about having enough to eat.

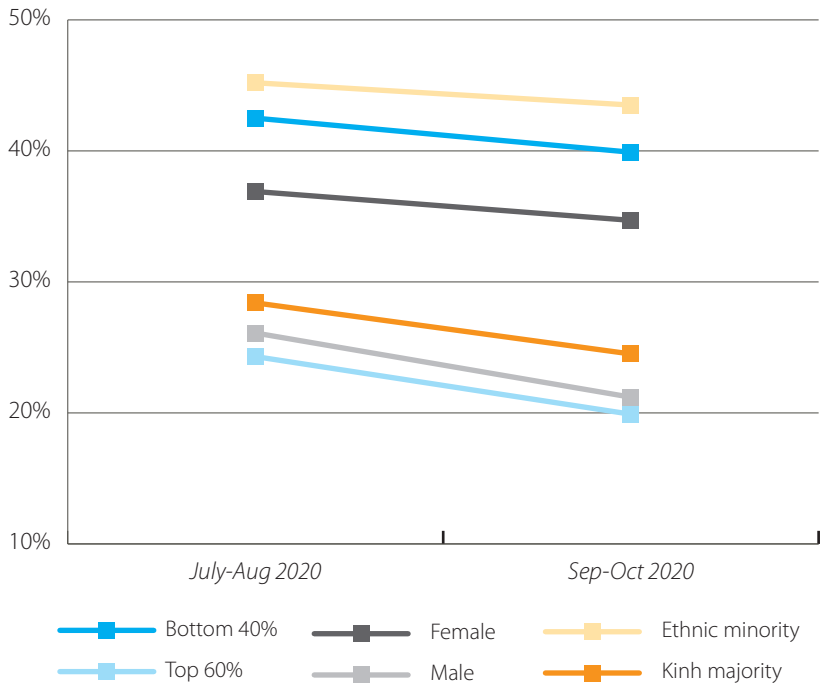
As this data covered the period prior to the severe outbreak starting in April 2021, it is highly likely that the share of households worrying about not having enough to eat was higher during the fourth wave of the pandemic and more stringent social distancing policy responses. Qualitative research in Ha Noi, Bac Giang, Da Nang, and Ho Chi Minh City affirmed these concerns among the majority of interviewed caregivers. While nearly all participants stated that they were able to purchase food at the marketplace or via online order, or received food rations as in-kind informal or formal support, there was a shared concern about not being able to easily access staple foods in the same quantities or of the same quality as prior to the pandemic. A larger number of caregivers in Bac Giang and one in Ha Noi shared that, while they and others in their community had no concerns about accessing food due to working in agriculture, they remained concerned about food quality and meal compositions. A minority of interviewed caregivers in all four study sites experienced no change to their regular food intake, access to nutrition services, or child feeding practices.

"Compared to before the pandemic, food at that time was limited as sources of supply could not enter the province. Our main source is Quang Nam province, but back then trucks were not allowed to travel between Quang Nam and Da Nang. However, food was still available in supermarkets, but only for those who were quick enough."
– **Mother, Da Nang**

59 Vu et al. 2021.

60 UNDP 2021b.

Figure 8. Proportion of households worrying about not having enough to eat in the last 30 days



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21.

Many families in Viet Nam coped with the reduced accessibility and/or affordability of staple foods, alongside a rising loss of income and unemployment, by making changes to their nutritional intake and child feeding practices. The nutritional quality of meals provided to children in terms of the diversity of food and essential nutrients was found to have reduced in the early phases of the pandemic in 2020.[61] The longer lockdowns in 2021 compared to the previous year may suggest that the decline in nutritional quality became more severe. This is of particular concern, as 2020-21 national-level data finds that more than half of children aged 0-5 months (54 per cent) were not exclusively breastfed and/or were not meeting minimum acceptable diet standards (59.1 per cent) (Annex IV: Figure 10). These contribute to 70.4 per cent of children aged 0-4 years who faced serious deprivations in nutrition and health in the critical, first 1,000-days window of early childhood development (Annex IV: Figure 11).

These findings were confirmed by a significant share of interviewed caregivers in the four study sites. While the majority of caregivers made efforts to prioritize

"My daughter didn't have enough fish, meat or vegetables to eat. She could just eat whatever was available, no milk […] My biggest difficulty at that time was the lack of food. My baby was thinner and craved for everything. […] When she was sick, she lost weight. During this period, she only ate rice and breastfed, nothing else. I also asked people around here for help to buy [milk product] for her, but it's hard for them to buy the right kind she used to eat. […] I ordered whatever available. I accepted whatever they delivered to me, even if it was almost expired or was not as expected. Having something to eat was good enough." – **Mother (social assistance recipient), Ho Chi Minh City**

"At first, we only reduced our portion size, not the baby's. My daughter was given top priority, so she was not hungry." – **Mother (migrant worker), Ho Chi Minh City**

"During the pandemic, we must cut down on food due to limited income. I could not go to the market, so I had little breast milk for my child." – **Mother, Bac Giang**

61 United Nations Children's Fund 2020e.

"During the social distancing period, if someone got sick, it was very complicated to get health examination at hospitals as before treatment, a Covid test is required. In my family, my daughter-in-law had cancer. She had to check her health monthly. During the pandemic and social distancing, it was more difficult to have a health check and buy medicines. We must invite family doctors for health check home visits." – **Father, Bac Giang**

"*Each prescription costed more than VND1 million. I had no money at that time. I had to call some acquaintances to borrow money. They were willing to lend me money to save my life. I have not paid them so far. They said I could leave it for now, and repay them gradually when I had income.*" **– Mother who isolated at home (informal worker), Ho Chi Minh City**

and maintain their children's nutritional intake compared to the pre-pandemic period, these efforts were impacted by reduced income and affordability or accessibility of nutritional foods for their children. Changes in feeding practices were observed in some caregivers, especially among those belonging to vulnerable groups (including informal workers and migrant workers), with children being given reduced meal sizes, less nutritious and varied diets, and breastfeeding mothers consuming less nutritious foods and/or substituting breastmilk with formula.

Caregivers of school-going children in Bac Giang and Ha Noi also stated that the lack of school meals presented a disruption to their child(ren)'s diet and routine, and that it was harder to meet their nutrition requirements at home. This also applied to children of migrant parents, who faced the added burden of not being able to guarantee or monitor their child's nutritional intake directly. One caregiver in Bac Giang, who was an informal worker, shared that they received food support from local authorities, but that this support had been discontinued in 2021.

"The children didn't go to school, so we combined breakfast and lunch into one meal.[…] At that time, it was also due to mental stress, breast milk was not very regular." – **Mother (freelance worker), Ha Noi**

***"**Before the pandemic, my son had lunch at school which offered good meals and menu. During the pandemic, I sent my son back to my hometown for my parents to take care of him. His meals and eating habit were not maintained well.**"** **– Mother (migrant worker), Bac Giang**

Some 12.7 per cent of children under age 5 years in Viet Nam who were deprived of their rights in terms of nutrition and health, were also multidimensionally deprived in terms of their access to safe sanitation and housing (Figure 2). These multiple and overlapping deprivations faced by children during the pandemic, alongside disruptions to basic nutrition services, risked stalling progress made in reducing acute and chronic nutritional and physical development deficiencies, including childhood stunting and wasting. Supporting these findings, frontline workers in Bac Giang shared that children's routine nutrition/growth monitoring and vitamin supplementation programmes for mothers and children were interrupted or suspended during the pandemic period. In Ha Noi, Da Nang, and Ho Chi Minh City, efforts were made to continue nutrition programmes through remote channels and grassroots collaboration, but they remained deprioritized in the pandemic context.

Caregivers in all four study sites, who cited concerns with nutrition, coped with reduced access and affordability of staple and nutritional foods by: 1) reducing the frequency or number of meals or the quantity of food per meal; 2) consuming lower quality foods such as instant noodles or; 3) borrowing money to purchase food or relying on informal support networks including charities; 4) relying on formal food support; 5) foregoing meals to prioritize their children's nutrition in the context of low resources; 6) reducing expenditures in other areas to prioritize food spending; 7) engaging in farming practices or fishing to supplement the household food supply. These coping mechanisms were especially prominent among caregivers in poor and vulnerable households – migrants, informal workers, poor and near-poor households. Household expenditure cuts were a common coping mechanism to deal with reduced income and loss of jobs, and food was the most common area to reduce spending. Nationally, four out of five households reduced expenditures, with 71 per cent of those doing so reducing food expenditure. This was most severe among vulnerable households including those with small children and those who are out of work for months, particularly migrants.[62]

"Before the pandemic, our meals were fine. During the pandemic, we had to reduce meals. For instance, before we ate 3 meals, but now we only had 2 main meals. If we maintained 3 meals as before, we could not afford it. We also bought less foodstuff." - **Male caregiver of a vulnerable child (poor household), Da Nang**

"During the pandemic, my family faced a lot of difficulties. My husband and I could not earn income. We mainly used the food and foodstuffs available at home. There was a time when my family had to resort to other types of food. We used instant noodles for main meals for about 2 months." – **Mother, Bac Giang**

"The number of meals did not decrease, but the quality of the meals decreased. We didn't have as many food options as we used to, and we had to use more frozen food. At that time the price of food sold in supermarkets increased greatly." – **Father, Ho Chi Minh City**

"During the pandemic, I did not have enough food. I saved food for my daughter, so I didn't have anything to eat. Thus, the quality of breast milk was not guaranteed. […] I didn't think I should eat to have nutritious milk for lactation. I was breastfeeding but lack of food, so my body was much weaker." – **Mother (recipient of SA/SP), Ho Chi Minh City**

"In the pandemic, first, we could not hold the nutrition classes. Second, we missed the June vitamin A supplementation in children." – **Frontline worker, Ho Chi Minh City**

"The healthcare centre's programs are still performed when the time arrives, but the number is not guaranteed.[…] In the past, providing vitamin A to children was done once a week, now fortnightly, and divided into time [slots] to ensure social distancing." – **Frontline worker, Da Nang**

"During the period of social distancing, the nutrition care program will be interrupted. However, consultation will be carried out in many other forms such as by telephone or online." – **Frontline worker, Ha Noi**

62 UNDP 2021b.

4.6. Education and Learning

From the onset of the outbreak in 2020, Vietnamese children faced challenges of accessibility and quality of learning as schools switched from remote to in-person and back to remote learning. School closures were nationally implemented in early 2020, with selective closures and re-openings over the courses of 2021, until most schools were re-opened by early May of 2022.[63] Following this, school closures were mandated only if the infection rates in the province where the school is located were high. School closures were thus enacted provincially.[64] The guidelines for the re-opening of schools were strictly implemented.[65] Schools had to enforce the 5K practices: wearing of nose-and-mouth covers, disinfection, maintaining safe distances, no gatherings, and providing health declarations.[66] Further, schools could not allow children to share learning equipment in class. Social distancing had to be ensured at all times and children were instructed to wash their hands regularly. This means schools required additional space and facilities to welcome children back to school. According to UNESCO (2021), 30 per cent of schools lacked WASH services and could thus not operate.[67]

During the school closure period, most children pursued their schooling through distance learning methods. The remote learning options ranged from learning apps, television, radio or online via computers, tablets, or mobile phone, and were often supplemented by teacher or school-organized learning groups on mobile chat apps.[68] These teaching methods added pressure to the teachers as well as to the students, due to difficulties monitoring children's learning progress at home who did not always have access to these learning devices or did not know how to use them. These conditions are likely to exacerbate existing inequities in education in the short and long-terms and worsen existing barriers to access.

Although primary schooling attainment increased over the years, this progress was stalled during the pandemic. As Table 7 (Annex IV) shows, primary school attainment for children aged 12 to 17 years in 2021 was high, with only a 1.5 per cent national rate of non-completion. For children at the age of 11, the completion rate was substantially lower. Nationally, 7.9 per cent of the children at the age of 11, who were at secondary schooling age, have not yet completed primary school. There are two possible reasons for this; children who have started school later than expected and others who have repeated a class. The following section on the findings of education-related qualitative

63 AMRO 2022.

64 Le et al. 2021.

65 UNICEF Viet Nam 2022.

66 Anh Kiet 2020.

67 UNESCO and UNICEF 2021a.

68 Kath Ford, Nguyen Thang, and Le Thuc Duc 2021.

analysis will discuss how the pandemic could be exacerbating this. In terms of school attendance, there is a greater incidence of non-attendance among secondary schoolers which can be explained by the free and compulsory primary schooling.

According to the findings of the SDGCW 2020-21 survey and multidimensional deprivation analysis (Table 7), and supported by data from the March 2022 Young Lives COVID-19 Phone Survey[69], disparities in access, attendance and achievement persisted throughout the pandemic period. Children who were living in rural areas, the Mekong River Delta, the Southeast and Central Highlands, ethnic minorities, and children from the poorest quintiles all faced greater levels of deprivation. Issues of education during the pandemic were further discussed via key informant interviews and FGDs in Ha Noi, Da Nang, Bac Giang, and Ho Chi Minh City. Teachers, principals and caregivers expressed their concern about children left behind academically, due to pandemic-induced challenges. This was especially relevant for young children, due to the closure of early childhood education centres without remote or other alternatives. During the pandemic period, 19.1 per cent of children aged 3-4 years were not attending an early childhood education programme (Annex IV: Figure 10), and 21.9 per cent of children aged 2-4 years were not developmentally on track (based on SDGCW 2020-21 data; Annex V, Table 12). Children living in rural areas, boys, children living with a female-headed household head, children of ethnic minorities, and children living in the poorest families were most likely to be deprived in terms of their early childhood development or not be developmentally on track.

"Now they had to study online, sometimes I was busy taking care of the younger child and couldn't keep a close eye on the studies of older children. Thus, they didn't further concentrate on the study despite their teachers' reminders. Sometimes my children took a nap when their teacher taught online, the teacher couldn't know, so how can my children absorb knowledge as well as when going to school." - **Caregiver in quarantine, Ha Noi**

Key challenges

At the onset of the pandemic, teachers had to rapidly adjust to a new form of remote teaching. Teachers learned how to use online video communications, pre-recorded lessons, and handle distracted and uninspired students behind a screen, in the majority of situations without any formal training. In the mornings, children would attend classes to learn new subjects, and in the afternoons, they would study individually. Alongside remote teaching, teachers implicitly or explicitly depended on familial involvement to oversee the children's self-study. However, many parents interviewed in the study struggled to balance monitoring their children's progress in school with ongoing work and caretaking obligations or lacked the necessary education to help the child. When parents were able to assist children with remote learning, caregivers in Ho Chi Minh City as well as in Bac Giang reported often having to prioritize the younger child because they were more concerned about their learning losses. Furthermore, caretakers of younger children were put under additional stress because there was no pre-school remote learning programme.[70] According

"For families who can afford it, online learning was simple. But for families in difficult circumstances or families of unskilled workers, they did [not] have the means for their children to study online. I once visited a family to see 2-3 sisters sharing a phone while studying online. The older sister studied first, the younger ones studied later and even had to drop out because they didn't have a computer to study." - **Frontline worker, Support Centre for Women and Children, Ho Chi Minh City**

69 Scott et al. 2022.

70 Pre-school was initially offered in Ha Noi through private initiative of schools but later removed by Ministry according to a non-recipient of SP/SA caregiver from Ha Noi.

"School closures made small families like us very worried because there was no one to take care of children. Their education was interrupted, their living habits changed, and their eating was not as good as at school." **- Migrant caregiver, Bac Giang**

"But when students are used to online learning, the school is worried that they will not focus on studying but chat on the students' chat group. I see that students don't skip class, but they don't focus on studying. And it is very sad that a class only lasts about 35-40 minutes, in such a short time students cannot interact with the teacher because the teacher does not name enough students to speak. Teachers often ask weak students to speak more. There are students who go to online class on time, and when class ends, they also take attendance on time, but they do their own thing or ask permission to go to the bathroom a lot, which proves that interacting with students through online classes is very difficult." - **High school principal, Da Nang**

to the Ministry of Education and Training, 4.4 million pre-school children were affected by school closures with little to no online alternatives in 2021-2022.[71]

Accessibility and affordability of remote learning

Many parents, teachers, and schools voiced their concern about their children's access to online learning platforms during the interviews. According to the respondents, either a lack of learning devices or a poor internet connection was the cause of this worry. Caregivers, mostly from Bac Giang, mentioned their reliance on family members to borrow devices and in some cases, children would access their remote learning platform at their friend's place leading to difficulties with monitoring their children's learning progress. Respondents from the other cities said they were generally able to access digital devices to facilitate their children's remote learning.

Due to the pandemic, the loss of employment became more widespread, and in some cases, caregivers had to move back to their hometown or send their children to their grandparents to cope with the additional time and financial burden of caretaking. According to a working caregivers from Ha Noi, this made access to schooling even more difficult, due to the technological divide between urban and rural areas. Furthermore, children who stayed with their grandparents in their hometown were more likely to be without adequate learning equipment, and also received less assistance for their learning as their grandparents were less familiar with their use.[72] Other caregivers from Bac Giang, Ho Chi Minh City and Ha Noi also shared this experience. Frontline workers cited the added risk of children of migrant workers not attending or dropping out of school due to their parents' income reduction or unemployment, thus needing to return to their hometown.

"When the pandemic broke out, parents had no income and lost their job, and children must follow their parents back to their hometown. Therefore, the possibility of being absent from school was high." - **Frontline worker, Support Centre for Women and Children, Ho Chi Minh City**

"There are students whose parents are in the armed forces on duty, they are forced to return to their hometown and their grandparents cannot support their studies. If grandparents can support students' learning, that's good, but if not, students have to go to school or ask someone to help in their hometown. In our school, there are some cases like that, and when it comes to the exam, the school sends the exam to the children in their hometown." - **High school principal, Da Nang**

71 Viet Nam News 2022, 4; UNESCO and UNICEF 2021a.

72 As reported by a high school principal of Da Nang.

Among the study participants, several coping mechanisms were applied to limit learning losses in cases of inaccessible learning devices. Some teachers were allowed to go to the school if they had connectivity issues, while others were sent technicians to improve connectivity or could borrow devices from school. For students, a strong community solidarity on sharing devices was expressed by most participants. In cases where this was not possible, schools sent the learning material printed out and/or provided devices for students to borrow. In Da Nang and Ho Chi Minh City, key informants shared that teachers would also organize catch-up sessions the first weeks of school re-opening. Key informants shared that this allowed for children in difficult situations to rely on their community and schools to keep up with their education.

Remote learning experiences

Both interviewed caregivers and key informants shared a primary concern that the remote learning experience made it very easy for children to be distracted, and that it was difficult to keep children engaged while also closely monitoring their progress. The most common challenges reported related to children's self-study, were the lack of understanding, motivation and the abundance of distractions. While participants often shared that schools, teachers and parents worked together to keep children engaged and motivated to learn from home, it was inevitable that children would lose focus and motivation. Major concerns revolved around 1) the limited ability for parents and teachers to monitor their children's learning; 2) their children's health risks resulting from excessive time spent looking at screens; 3) limited effectiveness of encouraging their children's motivation and interest in learning remotely.

In all observed cities, communications between parents and teachers were regularly mentioned as a way to coordinate the monitoring of children's learning between teachers and parents. Parents could also join classes so that they could help their children during remote learning, or have individual sessions with teachers to discuss issues. In Ha Noi, an elementary school teacher discussed the struggle and even initial opposition of certain parents in regards to monitoring children's learning or stepping into the role of a teacher at home. Similarly, caregivers of vulnerable children in Da Nang and caregivers in collective isolation centres in Ho Chi Minh City struggled because children would listen more to teachers and be more disciplined around them.

"There is a connection between the school and the teacher: if there is any lesson that the child does not understand, we ask the homeroom teacher, the teacher is also very enthusiastic to explain. I joined the Zalo group with the teacher to daily update the children's learning situation and send the homework that the children have completed to the teacher for grading. If the child's homework is not good, the teacher will notify the parents separately." **- Caregiver in a quarantined area, Da Nang**

"I don't know about the Government support package. Actually, I only heard of the packages in the ward for Covid victims, but I have never heard of any support for children and women. However, I have seen the support of the whole society to ensure children have equipment for online learning to some extent." **- Secondary school Principal, Ho Chi Minh City**

"Online learning is like a double-edged sword. It has both benefits and harms. When learning online, children get an early access to information technology. However, if their parents could not control them, they would be more exposed to games, social networks and easily lured by bad actors." – **Male Caregiver, Bac Giang**

"Scolding is very common. I am working with parents on parenting skills. I was told that they have scolded, cursed, and often mentally abused their children. If children disobey, they are forced to kneel or stand up against the wall. Most parents have beaten their children." - **Frontline worker, Support centre for Women and Children in Ho Chi Minh City**

"The poor, the near-poor, the disabled, the ethnic minorities, and the homeless, etc. are also at high risk of violence and sometimes at risk of abuse, just like girls and underage children will be sexually abused. At the same time, the risks also include human trafficking, sexual slavery, and labour abuse." – **Caregiver of vulnerable children (poor household) in Da Nang**

"Even me, many times when I came home from the market, I was tired and stressed with the money problem - lack of money, repaying debt. So sometimes I turned my temper to scold my children. But I only yelled at my children, not beating them." **– Caregiver/ freelance worker, Ha Noi**

Caregivers in all four locations voiced their concern about the long-term effects of remote learning on their children's daily routine, their educational progress and their learning achievements. Caregivers expressed concern for their children's future and were concerned about their children's physical and emotional health since children felt "crammed" at home and couldn't see their friends. While at school, children were stimulated by the teacher and their peers. The majority of caregivers were concerned that their children used to be eager to learn, while now, online learning has consumed that enthusiasm. Consequently, children may be discouraged from pursuing their education, as was the case with a Bac Giang student who was admitted to a university but quit shortly after the school year started due to not being able to cope with remote study.

Teachers from all three cities and one province also shared their struggle with remote teaching, especially with regards to student-teacher interactions. This was as a consequence of the more restricted teaching time and large classes. Even though teachers tried to limit the time spent behind the camera, they found many instances where children would provide excuses to not participate or turn off their camera, potentially to play games. Decreasing attendance has been mentioned but drop-outs were not as common. In terms of performance, most teachers or principals mentioned better grades among some students, with greater parental involvement being a likely explanation. In Ho Chi Minh City, a school principal revealed that achievement criteria were lowered in order not to discourage children who would score badly. On the other hand, a number of key informants and caregivers were concerned that students who were performing poorly before school closures were at risk of being further left behind due to the pandemic's negative implications for teachers' ability to monitor their education and for the students' engagement in learning.

From the few positive experiences, male caregivers from Bac Giang were more positively inclined towards remote learning than their female counterparts. Other caregivers agreed that children would develop better computer skills, which is relevant even at a young age towards lessening the digital divide. Others added that children were developing skills in self-discipline through their self-study. Another positive observation was the greater time caring for their child and that children were happy to see their family more.

The experiences which have been shared about access, affordability, remote learning and even re-opening of schools have shown common trends. While all schools followed the 5K government health guidelines, some parents were still worried about sending their children back to school, especially in urban areas. Schools in Ha Noi, for example, allowed children in quarantine (F0) to follow class through a camera while the other children were at school (F1).

All measures were taken to resume in-person schooling and limit the loss of the children's foundational years, but key informants in all four locations expressed the need for support from the government in terms of provision of personal

protective equipment (PPE) and testing kits in schools. A caregiver living in the quarantined areas from Da Nang also mentioned the need to vaccinate children above 5 years old to allow their children to resume normal activities as quickly as possible, in order to reduce the burden on parents. Other suggestions were reductions in out-of-pocket expenses due to the additional financial burdens.

4.7. Child Protection

Evidence from the first three phases of the COVID-19 pandemic in 2020 and 2021 demonstrated that the pandemic had an adverse effect on the protection of children. Social distancing diminished the ability to escape from any abuse or perpetrator at home which increased due to financial and psychological stress caused by the pandemic. The pandemic and disruption of social services also made it more difficult to seek help or protection from volatile home environments.[73] A 2020 study in Ha Noi, Ho Chi Minh City and Vinh Phuc province found that 3.4 per cent of the study participants reported violence towards children during the first phases of the pandemic.[74] 2021 survey data found that, on average, 6.4 per cent of households reported family conflicts due to the pandemic amounting to 13.2 per cent in urban areas. Male-headed households reported a 23 per cent higher prevalence for family conflict compared to female-headed households.[75] As a result of the fourth wave of the pandemic, disruption of public services, social isolation for prolonged periods, and disruptions to childcare routines intensified pressure on caregivers and revealed heightened risks to children.

Experiences of violence against children and gender-based violence

As children spent more time at home, those living in vulnerable or precarious households were exposed to the potential hazard of spending increased time in volatile conditions. Quantitative analysis of the SDGCW 2020-21 data suggested that around **two in three children aged 1-14 years in Viet Nam were exposed to psychological aggression, and around one-in -10 were exposed to extreme physical discipline** (64.3 per cent and 11.4 per cent, respectively; see Annex V, Table 13).[76] Children living in the South-East were at a significantly higher risk of psychological discipline compared to all other regions (72.8 per cent compared to 42.0 in Red River Delta). Boys were significantly more at risk of both psychological and physical discipline compared to girls.

As for children in general, I see that many families are in very difficult circumstances, so I hope the Government will support these children and their families, for example, in terms of tuition fees, books, so that children have better conditions to go to school. – social assistance **non-recipient/ caregiver, Ha Noi**

73 FAO et al. 2020.

74 United Nations Children's Fund 2020b.

75 UNDP 2021.

76 The SDGCW measures both psychological aggression and physical punishment from caregivers towards children in the last month before the survey. Psychological aggression includes shouting, yelling, or screaming at child or calling child dumb, lazy or another name. Physical discipline is defined as hitting the child on the bottom or elsewhere with a belt, brush, stick; hitting/slapping the child on the face, head or ears or beating the child up as hard as one could.

"It took a lot of time, manpower, and effort to look after the children when they stayed home. It was a difficulty faced by small families. Moreover, it was a big risk that children were exposed to online games when studying online." – **Male caregiver, Bac Giang**

In-depth interviews affirmed these risks to children and suggested that exposure to physical and psychological violence within families with children did increase during the COVID-19 pandemic. Caregivers in all three regions reported that, even if they did not have first-hand experiences in all cases, job loss and/or income decline, school closures and limited social contact led to higher levels of stress and anxiety in many families. Caregivers reported witnessing or hearing about both inter-partner conflict and violence towards children intensifying as a result of these stressors. Key informants at the service provision level suggested that especially disadvantaged population groups, including the poor, near-poor, informal workers and migrants, were more likely to experience any type of violence or abuse due to facing additional economic and caretaking pressures.

Awareness and Accessibility of Support Services

Key Informants in Bac Giang and Ho Chi Minh City suggested that the severity of cases of violence varied throughout the different waves of the crisis due to swift local responses. As the pandemic progressed, in all provinces, information about the hotline 111 was commonly shared for reporting child abuse and domestic violence. Local volunteer groups provided counselling and psychological support, mobilized financial resources, and organized recreational activities, physical training and sports in order to help and support disadvantaged children. Depending on the nature of the incident, local committees, health workers, social organizations/centres (Children's Right Protection Association, Child Protection Association, Women's Union, Youth Union), ward police or (district) courts could also be contacted.

"For example, a grandmother or mother buying scraps cannot leave a child alone at home because no one will take care of it. There are also risks and danger, so the mother or grandmother is forced to bring the baby to work. In case parents sell lottery tickets on the roadside, they also bring the children along and the children also help." – **Frontline worker, Ho Chi Minh City**

In Bac Giang and Ho Chi Minh City, interviewed frontline workers reported receiving additional financial and in-kind support from non-governmental organizations and individuals to organize child care and protection activities during the pandemic period. On the other hand, frontline workers in Ha Noi and Da Nang reported that training, support and awareness-raising activities were suspended during the pandemic, due to limited or redirected resources. Key informants in all four study sites reported that the main bottlenecks in service provision during the pandemic revolved around financial, human, and physical (infrastructure) resource limitations. In Ha Noi and Ho Chi Minh City, key informants highlighted critical human resources gaps in the social service workforce which were exacerbated due to activity suspension during the pandemic. Limited staff and training opportunities for social workers on how to handle child- and family-related cases led to bottlenecks in both service uptake and provision.

"When they stayed home, there were other risks such as electricity, water, traffic accidents if running to the road." – **Male caregiver, Bac Giang**

Frontline workers in all four locations implied or stated that public awareness of channels of support in case of protection violations improved during the pandemic. While awareness among interviewed caregivers was not universal, several caregivers in Ha Noi, Da Nang, Bac Giang and Ho Chi Minh city were aware of sources of support in case of protection violations, including the

police, 111 hotline, the People's Committee, health stations and the ward authority. A number of caregivers additionally listed informal online sources, chat groups, and other social media as forums for reporting, receiving advice, and learning about sources of support for cases of violence. This may have led to service uptake and provision bottlenecks, as these forums did not guarantee confidentiality, leading to stigmatization and re-victimization of survivors of violations, and may have diverted attention away from official channels.

Key informants in all four locations shared that children and people in need were not always inclined to ask for help out of fear of social stigma, of sharing sensitive topics (e.g. teenage pregnancy), due to poor awareness or distrust in the timeliness and/or quality of services provided, and due to a general social acceptance for severe discipline. For example, psychological violence, such as scolding, and corporal punishment at school are still widely accepted and practiced. In all four locations, selective service suspension and social distancing also limited access to and uptake of protection services.

"Another difficulty is demand: services are available, but families and children have not really cared about and used them…[because] they do not clearly understand the roles and responsibilities of these organizations/ services; secondly, it is the impact of the pandemic, of social distancing, so they have no conditions to access these services; or people's interest in these services is also limited." – **Frontline worker, Bac Giang**

"Family members stayed together all day, so many things happened. In my opinion, in families which have 2-3 children but didn't have enough money, parents would also be frustrated, they had no money to buy food, etc. Many cases were very miserable, I felt sorry for the children. During the pandemic, people did not go to work, did not earn money. As you can see, a lot of workers from all over the country are living here, but most are poor. But difficulty does not mean we can beat and scold our children. In my opinion, we must have a positive attitude, if the situation is too difficult, we can call the hotline for help. I have seen several people getting helps in this way, but I haven't called yet." – **Caregiver/migrant worker, Ho Chi Minh City**

"I went out to work. My children should self-study. I never hit my children. My wife got angry when teaching the children, so she hit them… I think my wife is not a teacher, so sometimes she was out of control when the child neglected her learning like that. Everyone acted the same." – **Caregiver of vulnerable children, Ho Chi Minh City**

"Before the pandemic, the role of officers in charge of children's affairs in the ward was still unclear and insignificant. Families having problems related to their children didn't know how to seek support, who the social worker is, and what phone number to contact. In my opinion, first, support from children support officers in ward and commune agencies is extremely fuzzy. People will seek advice through [chat] groups on Zalo, Facebook, parent groups, doctor groups, or Zalo groups of children support organizations and centres." – **Frontline worker, Ho Chi Minh City**

"I felt worried. I was afraid that I or my family member would be infected with Covid. That anxiety was also contagious to other people. Also, since I couldn't go back to visit my family in my hometown, so I was sad and worried." – ***Mother/ freelance migrant worker, Ha Noi***

"Before the pandemic, the children went to school and had chances to exchange with their friends, have fun, do physical exercises. During the social distancing period, they were greatly affected as they could not play outside, and they used phones, watched TV, used computers instead. It made children more susceptible to depression, addiction to games and online habits." – ***Mother, Bac Giang***

"If learning in person, he would meet many friends. When staying home, he was sad because he could not see his friends. When he went to classes, he met his friends. He was more excited. He could learn and remember more easily." – ***Mother, Ho Chi Minh City***

Emergent risks

School closures deprived children from their usual social interactions and forced caregivers to face the additional pressure of full-time childcare amidst economic hardship. Children were also exposed to a more extended use of the internet due to social distancing measures and additional time on the internet and digital devices because of remote learning. The majority of interviewed caregivers in Bac Giang, Ha Noi and Ho Chi Minh City were highly concerned about their children's increased exposure to risks online, including addiction to online gaming, engaging in risky behaviour, and exploitation. This concern was particularly prevalent among caregivers of adolescents. Caregivers in all four locations shared their difficulties with mitigating these risks through supervision, due to conflicting caretaking and work commitments.

School plays a major role in child protection and care activities. With school closures, children were often left alone at home when parents needed to go to work or tend to other commitments. Migrant workers who were not able to return to their hometown faced greater difficulties with managing their children's care. The caregiving rights were handed over to grandparents, housekeepers, or older children. Therefore, children faced a higher risk of being abused, harassed, kidnapped, and abandoned. To cope with the additional burden of childcare, frontline workers in Ho Chi Minh City shared that some caregivers and caretakers were forced to bring their babies and small children to work. With children spending more time at home and with inconsistent supervision during school closures, they were also more likely to be at risk of injury and accidents.

4.8. Mental Health

Mental health problems, including anxiety and depression, have been at the forefront of negative consequences of the pandemic among all age groups in Viet Nam. For children and young adults, 2020 data found stress, anxiety and depression had all increased because of the pandemic. A disproportionate burden of poor mental health was found among children living in restricted areas, young women, and those from ethnic minorities. SDGCW 2020-21 data similarly shows that, during the pandemic period, around 2.0 per cent of children aged 5-17 years experienced functional difficulty, with the highest share of children having experienced difficulty in the domain of anxiety (0.6 per cent) followed by learning, remembering, and accepting change.[77] Boys were marginally more likely to experience these functional difficulties than girls. Children in ethnic minority households, in the poorest households, and/or living with mothers who had lower educational attainment, were at a higher risk of experiencing functional difficulty. However, a recent comprehensive study suggested that the number of children and adolescents who experienced mental health problems in Viet Nam may have

77 General Statistics Office and UNICEF 2021.

been much higher, with one-in-four surveyed students (or 26 per cent) having reported current symptoms associated with moderate or high-risk of mental health problems. These figures were further linked to experiences of social and academic pressure. Compounding risk factors included being a girl, attending high school, belonging to an ethnic minority, and belonging to LGBTQ+.[78] Providing access to mental health services for children and young adults is essential in avoiding the negative consequences of mental health on their long-term developmental, health, and life outcomes.[79]

The fourth wave of the pandemic in 2021, lockdowns and social distancing have undoubtedly worsened the state of mental health and psychosocial issues among children and families. In July 2021, UNDP's Rapid Impact Assessment Round 3 (RIM3) found that over 66 per cent of households worried about the impact of COVID-19, resulting in mental health issues varying from depression to irregular anxiety. Female-headed households were more likely to experience mental health problems, at 82 per cent compared to 63 per cent of male households. Some indicators showed far more serious negative outcomes for female-headed households, such as finding it hard to sleep and consistently worrying throughout the day. Migrants who were living in crowded living conditions were also disproportionately experiencing mental health issues.[80]

These findings were confirmed by the qualitative research data, with caregivers in all four study sites universally having reported experiences of mental health problems among themselves, their children, and in their community. Caregivers and their children varyingly experienced stress, worry, and frustration due to fear of their loved ones becoming infected, as well as due to the long period of social distancing and lockdown. Children and caregivers feared for their health and wellbeing in the face of an uncertain pandemic course, with many reporting difficulty sleeping. These experiences were exacerbated by the lack of opportunities for social interaction and physical exercise, as well as stressors including reduced income, unemployment, difficulties managing additional caretaking duties and monitoring children's schooling at home. As a result, caregivers in all four study sites also reported experiencing more frequent instances of conflict between members of the household and with their children. Migrant workers in particular cited that their stress, anxiety and loneliness was compounded by not being near their relatives, children and loved ones.

Experiences of disconnection from others during the social distancing period were further linked to social stigma associated with fear of infection, and to suspension of traditional familial and community traditions and celebrations.

"If staying home too much, it will cause a lot of conflicts between husband and wife. […] it affected almost everyone, including children. […] Income did not determine everything, but it affected the mental health of the whole family a lot. For example, if a wife has no money, it would affect the relationship between husband and wife, and cause worry, anxiety and irritability." – ***Mother (social assistance recipient), Da Nang***

"Sometimes I felt headaches, fatigue because during the social distancing period, the whole family stayed home, there was no income, so I worried much about it. I also experienced insomnia." ***– Female caregiver (informal worker), Bac Giang***

"*Normally I go back to my hometown once a month to visit my children. Since the Covid epidemic happened, it has been about 6 months that I have not been able to visit my son."* ***– Mother (freelance migrant worker), Ha Noi***

78 Pollack and Dang 2022.

79 Kath Ford, Nguyen Thang, and Le Thuc Duc 2021; United Nations Children's Fund 2020e; United Nations Children's Fund 2021c.

80 UNDP 2021b.

Parents who were migrant workers in Ha Noi and Bac Giang additionally experienced sadness, stress, and worry, due to not being able to return home to visit their family and children during the social distancing period, and these experiences were shared by their children's caregivers as well as the children who could not see their parents. Children of divorced parents were also at risk of psychological crisis due to not being able to see their parent for a prolonged period.

School closures and remote learning for a prolonged period led to mental health issues experienced by both children and caregivers. Caregivers expressed feeling worried for their children's progress in school and lost opportunities during the remote learning period, as well as worry about their child(ren)'s state of mental health due to the prolonged period of staying at home without being able to interact with their friends. Parents additionally shared their concern regarding the negative health and psychological effects, as well as potential risks of exploitation and abuse, of their children spending more time than usual watching television, being online, and gaming. Children in all four study sites reportedly experienced mood changes during the period of social distancing, as well as heightened stress and anxiety about maintaining their progress in school, or lost motivation for continuing their remote learning. These findings point to a risk of a negative feedback loop between poor mental health among school-going children, and educational attendance and/or achievement, which was worsened due to the prolonged period of remote learning. A 2021 comprehensive study on mental health among adolescents in Viet Nam also identified academic pressure as a key stressor which affected poor mental health.[81] According to SDGCW 2020-21 data, children in the 5-17 years age group who were not attending school were more than twice as likely to experience functional difficulty in terms of concentrating, accepting change, anxiety, depression, and making friends.[82] Some caregivers reported that, even after the lifting of social distancing measures, they still experienced anxiety and fear due to fear of infection or re-infection, and especially for their children who were returning to school and had not been vaccinated. In a small number of cases, caregivers were concerned that their child had difficulty re-adjusting to socialising and exercising outdoors after social distancing restrictions were lifted. Frontline social and health workers in all four study sites confirmed that psychophysiological health and safety was one of the main risks faced by children during the pandemic and social distancing period.

Coping mechanisms

Caregivers and children coped with poor mental health during the pandemic and social distancing period by comforting each other at home, talking with their friends and loved ones by phone and online, occupying themselves with caretaking and housework, exercising at home, watching television, and

81 Pollack and Dang 2022.

82 General Statistics Office and UNICEF 2021.

engaging in hobbies or learning new skills at home. Caregivers encouraged children to interact with friends and family over telephone and chat, and tried to engage them in conversation, activities, and games at home. The shared experience of the pandemic may also have strengthened community relationships and informal networks of support. Caregivers in all four study sites cited instances of improved community support and solidarity as a result of the pandemic, and a small number of caregivers in Ho Chi Minh City, Da Nang and Ha Noi shared that they experienced positive effects on their mental health and wellbeing from the increased amount of time they were able to spend with their children at home, such as by sharing meals together.

A small number of caregivers in Da Nang and Ho Chi Minh City reported receiving spiritual support from their community leader, or local government to cope with experiences of stress and anxiety during the social distancing period. However, none of the interviewed caregivers sought out psychological support from a professional during the course of the pandemic, or were aware of where to seek professional psychological counselling when in need. Frontline social workers in Da Nang, Bac Giang and Ha Noi confirmed that poor awareness and social stigma continue to limit uptake of mental health services, even if they were available.

4.9. WASH

According to the SDGCW 2020-2021 survey, only 1.9 per cent of households did not have access to improved water sources, 0.4 per cent in urban areas and 2.8 per cent in rural areas. Of households using unimproved drinking water sources, 0.4 per cent took up to and including 30 minutes to collect water and return. The main reasons why households were unable to access sufficient quantities of water include unavailability of water at the source, inaccessibility of water source and water salinity. Around four out of ten households had E.coli contamination in their drinking water. However, 77.7 per cent of households treated their water appropriately. Furthermore, 7.9 per cent of households in Viet Nam used unimproved toilet facilities while 89.9 per cent had access to improved non-shared sanitation facilities. In addition, 10.7 million people (10.15 million in rural areas and 550,000 in urban areas) in Viet Nam still practiced open defecation.[83] The total WASH expenditure stood at VND334,385 per capita (USD14.4 per capita) in 2018. In 2020-21, 97.9 per cent of households had a handwashing facility of which 7.2 per cent had no water and soap or detergent available in the specific place.

There is limited data on the availability of WASH facilities in schools. Yet, UNICEF does provide support at the provincial level with approximately 3,000 households in six communes and 60 schools benefiting from upgraded WASH

83 UNICEF 2020a.

"Heads of village and youth union visited and encouraged us. In-charge healthcare officers also talked and encouraged us over the phone." ***– Mother, Bac Giang***

"Normally, I come home from work tired and do nothing. In the period of social distancing, I had more free time. After doing all the housework, I had free time to plant trees and flowers and spent more time with my children and family." ***– Father, Ho Chi Minh City***

"The most useful thing is to talk with my wife and children. For friends and family, it's like asking how everyone doing. For example, if I have a problem, I will tell my wife and my family. It is also a way to relieve by listening to people's advice and suggestions." – ***Father, Ha Noi***

"There are not many private social work offices.[…] in terms of psychological counselling, in Viet Nam, people are still not used to being mentally ill and to visit a psychotherapist. The network of psychological counselling service providers has not expanded and deepened, so in Viet Nam, the habit of having a psychological treatment has not yet formed." ***– Social worker, Ha Noi***

facilities, ceramic water filters and hand washing and hygiene promotion activities. According to 2019 data, 18,000 children practiced healthy WASH behaviours and enjoyed a cleaner school environment.[84] The COVID-19 pandemic had major impacts on the access to accessible and affordable WASH products and services in Viet Nam which is discussed below.

Access to clean water and improved sanitation facilities

Access to adequate WASH facilities and PPE in homes and public spaces is critical during public health crises such as the COVID-19 pandemic. Interviewed frontline workers in the four study sites confirmed that, in all four study sites, access to clean water and improved sanitation is nearly universal, and that handwashing and general hygiene practices improved during the pandemic period.

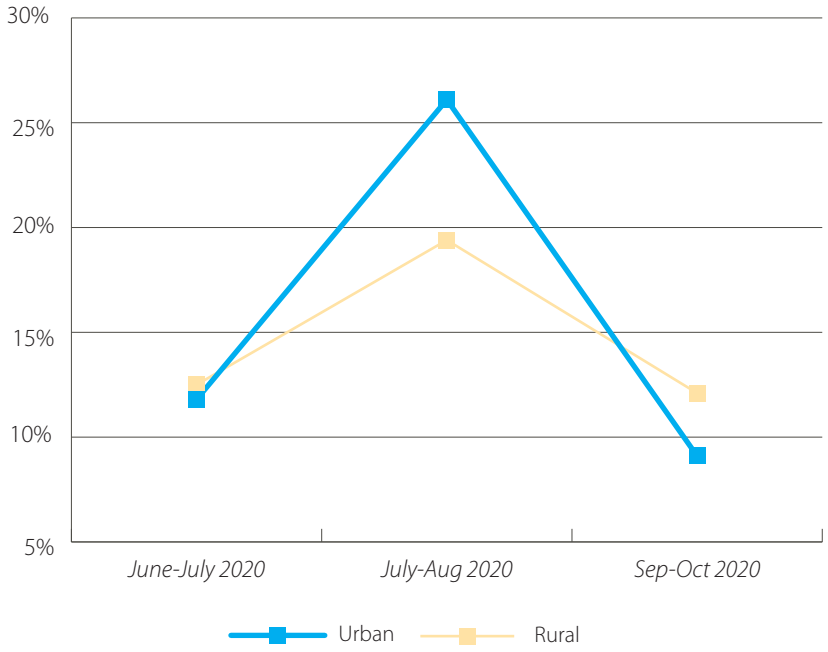
Key informants noted several exceptions to clean water access in urban areas. A WASH officer in Ha Noi revealed the increased risk when using self-managed water tanks. When households or apartment dwellers were responsible for directing water into their private storage tanks, it was their own decision whether to maintain the water tank and treat the water source. As a result, the continuity of water access and water quality could be compromised due to degradation of the pump control, poorly connected pipelines or tank lids that fail to close properly. Especially disadvantaged and poor households did not have the means to build clean water tanks and safe and adequate sanitation facilities. In Da Nang, in general, during the months of July and August, households often needed to buy bottled water due to brackish, saline alum contaminated water.

Adherence to preventive public health measures

The early phases of the COVID-19 pandemic, and associated social distancing restriction policies, saw significant changes to the individual preventive behaviour. Both quantitative and qualitative findings suggested that individual adherence to preventive measures may have waned over the course of the pandemic. WBMS data (Figure 9) revealed that in July-August 2020, the proportion of respondents washing their hands more often increased compared to July 2020. Especially in urban areas, 26.1 per cent of respondents changed their behaviour and washed their hands with soap more often. However, in September-October 2020, a significant decrease in handwashing was observed.

84 UNICEF 2019.

Figure 9. Proportion of persons who washed their hands more often compared to last month by urban/rural



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21.

With regards to wearing face masks and using hand sanitizers, the majority of people followed the rules very strictly. However, some people did not use personal protective equipment such as protective clothing because it was not comfortable and not supplied for free. A health officer from the District Health Centre in Ha Noi identified the limited funding as one of the main constraints. Moreover, at the early stage of the pandemic, households were not always able to buy masks or cleaning products due to massive hoarding. In Da Nang, a caregiver shared that if ready-to-use products were too expensive, local people could make products themselves, following instructions on how to make sanitizers with 90 per cent alcohol.

In Ha Noi, communities sometimes didn't comply with the safety measures due to the social constrictions of the pandemic, especially among those living in isolated areas. In fact, social distancing made it more difficult to buy cleaning and disinfecting products. Furthermore, in Da Nang, a number of infected people thought they could not be re-infected and did not fear post-COVID health issues. Thus, some people treated themselves at home without medical declaration while other households were not aware.

"The last outbreak made us closed from May to September 2021 so we couldn't perform testing for any water samples. Besides, the staff of the medical centre had to go support the anti-pandemic activities, perform COVID testing for people, trace and coordinate F0 or help strengthen the work in isolation areas. Still, we try to encourage our staff to maintain the household water inspection, they will survey the residual chlorine and pH monthly." - **Public Health Officer in Ho Chi Minh City**

"The medical centre could not distribute disinfectants for free, because at that time even we did not have enough to use, so some units and some sponsors came to support us. Even the Medical Centre lacked protective gear, masks, disinfectant water, and chlorine." – **Public Health Officer in Ho Chi Minh City**

Challenges with service provision

During the pandemic, priorities shifted, leading to the suspension of several programmes including, 1) monitoring of water access and quality; 2) the supervision of environmental sanitation; and 3) monitoring of garbage collection points.

Key informants noted multiple challenges with waste management during the health crisis in all provinces. Throughout the pandemic, there was an excessive amount of additional (medical) infectious waste. In addition, waste increased due to the higher number of online orders as a result of social distance restrictions. Environment companies were overloaded, not being able to guarantee regular and timely garbage collection and transportation. Moreover, medical waste transportation and treatment was very expensive, with treatment costs up to VND 20,000/kg, while waste was transported, on average, five times a day during the peak of the pandemic period. Furthermore, there was a lack of storage space to store the waste. Garbage that has been concentrated for a long time without being collected and processed is a source of environmental pollution. It is recommended that public and private health departments must have an adequate wastewater treatment system while an inspection team checks the operation system and periodically takes water samples for testing.

While the environmental companies were in charge of waste collection, the Ward People's Committee dealt with the violations related the waste management. This implied the decentralization of management. As a consequence, environmental sanitation and other WASH related activities were sometimes poorly coordinated.

"According to Decree 117, water is provided by Ha Noi Clean Water Company, they are responsible for water quality before the meter and after the meter is the responsibility of the water buyer. However, for households and large customers such as companies, schools, and apartments, the role of the District Health Centre is to monitor water quality both before and after the meter. If any party has a water quality problem, the District Health Centre will advise, guide as well as suggest relevant parties to fix the problem. The remedial process and results will be reported to the District People's Committee, Department of Health and Ha Noi CDC." - **Frontline worker, Ha Noi**

In Ho Chi Minh City, the People's Committee had issued a decision saying that medical service providers should collect medical waste of its own, with the Ward People's Committee collecting waste of households with F0 cases. However, public health facilities did not always have the capacity and means to collect medical waste. If they did not have enough human resources, people-founded garbage units would be set up, which were managed by the ward People's Committees. However, people-founded garbage collectors, as well as households, did not have the necessary specialization and therefore were not able to properly sort and manage waste. Due to a lack of funds and its decentralization, only a few households who had the financial means could equip themselves with the necessary materials for proper waste management. The risk of spreading diseases thus increased due to multiplication of infection sources.

In Da Nang, the city funded the sources to support the pandemic prevention. Also the City People's Committee, external sponsors (e.g. companies), and individuals contributed. Because the resources were not enough compared to the number of activities undertaken, a large amount of local budget was also spent.

"Upon the onset of the pandemic in 2020, the Ward People's Committee coordinated with mass organizations to print leaflets to communicate on hand disinfection with soap, give soap, hand sanitizers to local people, and guide them on washing hands properly. … there was a communication on handling waste due to the risk of infection. People were required to put their garbage in their own bags which would be then sprayed with bacteria and collected periodically." – **Frontline worker, Da Nang**

WASH in Schools and Health Facilities

In Ha Noi, key informants observed that toilet facilities were not always adequately equipped with enough toilet paper and hand soap, and that toilets were not always adequately maintained by students. Before re-opening schools, buildings were cleaned and disinfected to ensure safe school environmental sanitation. In addition, the quality of water sources and food safety were closely monitored. Trash cans were provided and garbage collection trucks were allocated to some communes and schools. In Da Nang, militiamen and/or ward police were assigned to scan QR codes for medical declarations, inform people of the rules at school gates, and remind parents to keep safe distances.

"On normal days, when [child] goes to school, I can rest for a few hours at noon after doing housework. During the epidemic, when he stayed at home, I have to look after him and feed him." **- Caregiver of a child with disabilities, Ha Noi**

Implementation and supervision of disinfection also took place in health facilities, public amusement areas, and cultural houses. In health facilities, there were different levels of sanitation and disinfection. For example, within the Medical Centre in Ha Noi, the environmental sanitation and disinfection regime was maintained daily. As for the guidance to the community, the health centre was responsible for providing professional guidance (such as procedures for environmental sanitation, disinfection).

The healthcare centre(s) would organize sensitization campaigns to raise people's awareness of health protection, and thematic programme(s) to protect the health of mothers and children. When it was impossible to organize workshop(s), infographics were shared online about, for example, plastic waste prevention to reduce people's waste discharge. The board for population, family planning and child protection in Da Nang also provided support on vaccinations, first aid, medical examinations, disinfection, and communication on family hygiene.

"Previously, funds would be allocated as per budget estimation which was unknown. Now, it follows the model of urban governance. Each sector would develop its own budget estimation for submission to the District. The District would then submit it to the City for consideration and budget allocation." – **Frontline worker, Da Nang**

"The funding for implementation is limited: low revenue from environmental sanitation services, or limited support from the state. Therefore, it is very difficult for the garbage collection and environmental sanitation team to implement." **- Frontline worker, Bac Giang**

4.10. Parental care, family decision making, duties, responsibilities

The pandemic had a significant impact on households' day-to-day lives. Most parents were forced to stay at home instead of going to work during social distancing, and children were unable to attend school. As a result, families spent more time together. Caregivers from each study site noted that, because of the circumstances and the measures put in place, parents were able to spend more time with their children. Caregivers also assisted children with their schoolwork to a greater extent. In Da Nang and Ho Chi Minh City, caregivers shared that they had to take on more responsibility for the child, whereas teachers would normally do so. Another caregiver from Da Nang thought that their child-care skills had improved.

"Take care of their daily meals. They stayed home all day. When they went to school, I only needed to care about their bathing and afternoon meals. During the pandemic, I had to care about all of their meals (breakfast, lunch, dinner). I had to care about everything. I also performed the work of a teacher and guided my son on his study so that he could catch up when he returned to school later on." - **Caregiver from Ho Chi Minh City**

"Parents and children understand each other better, as we stay home a lot, we get to know each of our children more. And husband and wife get to know each other better, as in the past, we got home late from work and just did our own stuff separately." **- Caregiver in quarantined area, Da Nang**

In other cases, it was more challenging. Some parents were unable to return home due to regulations and were forced to leave their children with grandparents or other family members. One caregiver from Da Nang had to travel frequently for work and could not take care or come near their child without PPE. Parents working from home also experienced difficulties. There was the pressure of earning more, the need to work and take care of children at the same time. Some caregivers mentioned that their mood changes negatively affected their parenting.

Changes in habits also changed how gender roles were perceived. Many caregivers observed a positive change with more support from their husband. The explanation for this was that the spouse had more spare time because he was not working. Not all caregivers agreed and would continue doing most chores. In some cases, one of the caregivers would be less present because of work which left the at-home-caregiver with more responsibilities.

During the pandemic, not only caregivers had to spend more time at home. Nearly all caregivers mentioned that their children helped them with housework because they were home more often. These would be general chores, cooking,

farming work or help taking care of younger siblings. Generally, girls would be helping more at home, even prior to the pandemic but few reported such unequal division of labour. A caregiver from Ho Chi Minh City, however, referred to instances where boys would more often come up with excuses not to help in house chores.

There were few ways for parents to cope with the situation. Family support was the most common form of assistance reported by participants. This refers in particular to the support of grandparents. Many referred to the reliance on grandparents for day care whenever they had to work. Few would even have to work away from their child and send them to the grandparents. One of the other ways parents dealt with the situation was by bringing their children to work. A caregiver in Ha Noi voiced concern regarding bringing their child to work for security and health reasons. The garment company the wife worked for, however, organized for parents to bring along children in case they could not stay home.

4.11. Vulnerable children and children in social protection centres

Schools and centres for vulnerable children

Key informants of schools and centres for vulnerable children in all four study sites shared that efforts were made by the centres/schools, in close coordination with the relevant governmental departments and local authoritative bodies, to ensure essential operations continued as normally as possible during the pandemic period. Frontline workers at centres/schools for vulnerable children in all four study sites shared that pandemic prevention procedures, including social distancing policies, were implemented very strictly at the facilities to protect children and workers. However, this meant that vulnerable children, including children with disabilities, did not have regular opportunities for socialisation, recreation and accessible sport. For children who were attending or residing in centres/schools which provided food and/or boarding, ensuring 5K regulations during the pandemic may have led to a large share of child clients/pupils not being able to remain at residential facilities or retain regular access to nutritious meals. Parents of vulnerable children, many of whom were poor and/or disadvantaged, resultantly also faced a higher burden of care during the pandemic period.

"For boarding pupils, according to the regulations of the Department of Education and Training, it is not allowed to maintain the form of part-boarding. Therefore, at the time the school was closed, the boarding area also stopped working because as the number of pupils in the boarding school was up to 65, it did not guarantee the requirements for epidemic prevention and care. The school did not provide day-boarding because food companies did not operate, so preparing meals for 60, 70 people at a time was a huge problem."
– Frontline worker (School for CWD), Ha Noi

"For children who are mute and deaf during the time of social distancing, they will not be able to study and be taken care of at the facility anymore, but returned to their families." -
Frontline worker (social protection centre), Bac Giang

"Before the pandemic, my husband worked far from home, so he hardly had time to do housework and take care of children. But during the pandemic, he couldn't go to work; thus, he helped a lot in taking care of the children, playing with them and teaching them." **– Female caregiver from Bac Giang**

Challenges which children faced with mental health during the pandemic period, as demonstrated in section 4.8, were especially pertinent for vulnerable children, as staff at social protection centres and schools for children with disabilities (CWD) often lacked capacities for providing psychological counselling and therefore were not able to sufficiently support these children and adolescents. While regular activities at these centres were not always suspended indefinitely, they were often reduced in their frequency, and no new programmes or activities were carried out, as was the case in Bac Giang and Da Nang. In Bac Giang, community counselling and communication programmes were discontinued during the pandemic period, which may have led to potential service access and social participation gaps among already vulnerable children. In Ho Chi Minh City, at a residential care facility for vulnerable children, children without parental care and orphans, additional training sessions were organized for staff to provide spiritual support for children during the pandemic period. As of July 2022, official estimates suggested the COVID-19 pandemic left up to 4,461 Vietnamese children orphaned, of which 193 children lost both parents or guardians.[85] These children faced additional risks to their well-being and mental health.

"During the period of social distancing: the agency did not receive any support in terms of human resources, financial capacity, those are even reduced due to the pandemic, and agencies/enterprises could not implement support programs…Also, we have no training on how to remotely provide services at all." – ***Frontline worker (social protection centre), Bac Giang***

"I think the best thing was that they did the housework to help their parents. In the past, I used to prioritize their study. My children were busy with school all day, so I just encouraged them to do housework on weekends. During the pandemic, I did not encourage but clearly assigned tasks to them so that they could help their parents with more housework." **– Mother/ informal worker, Ho Chi Minh City**

Facilities for vulnerable children in all four study sites were highly reliant on donor support to cope with the new and additional resources needed during the pandemic and social distancing period. However, resources available to centres/schools for vulnerable children were not always adequate to ensure normal operations before and during the pandemic period. Key informants in Bac Giang cited challenges with inadequate equipment, facilities, human and material resources available to support children in dealing with the new challenges brought on by the pandemic. In Bac Giang, children at the social protection centre struggled to access online learning with old and unusable electronic equipment, which required waiting times to be approved for repair. The added strain on human resources, which often had to work additional hours to ensure adequate care for children, led to management gaps and poor supervision of vulnerable children in some cases. Frontline workers in Bac Giang also received no additional training for the provision of remote services, nor additional financial or in-kind support to continue or

85 Ministry of Labour, Invalids and Social Affairs 2022; Xuân Đức 2022.

adapt activities. Frontline workers at a Social Protection Centre in Da Nang and in Bac Giang shared that charitable in-kind and cash support from businesses, individuals, and non-governmental organizations continued at a reduced level during the pandemic period, and no additional funding or support was received to manage the extra financial and human resource burden of the pandemic prevention measures. Key informants in Ho Chi Minh City shared that, while essential resource gaps during the pandemic were met through a combination of state and charitable support, they faced problems with shortages after restrictions were lifted as support waned. Policy restrictions stipulating the number of allowed staff members on site also presented a significant strain on human resources.

Key informants at centres for vulnerable children in Da Nang highlighted the urgent need for more financial support to support the livelihoods of child clients of the centre, and to guarantee essential goods and services for vulnerable children and persons, such as nutrition and medical expenses, as well as support for mental wellbeing. The need for improved programming to promote integration of the centre's clients, such as through career counselling and vocational training, was also highlighted by key informants in Da Nang and Ha Noi. The need for improvements in infrastructure and additional capacities to provide vocational training was also highlighted by frontline workers at a school for disabilities in Ha Noi. Key informants in Ho Chi Minh City noted the urgent need to institutionalize programmes for building emotional resilience and control to prepare children for handling stress and situations of volatility.

"Due to financial constraints, a number of families let their children wander around begging for food, selling goods on streets. After the pandemic, some children kept doing the job. […] Since last year, there were almost no cases being transferred to the centre. During the pandemic, it was strictly controlled. […] The centre did not receive any children street vendors anymore."
– **Frontline worker (social protection centre), Da Nang**

Children living and/or working on the streets

Children living and/or working on the streets were among the key risk groups, as the economic shock, which hit vulnerable households the hardest, pushed more children to seek incomes (a negative coping mechanism), whilst also limiting the social and economic opportunities available to these children. Closure of schools and disruption of basic public services, alongside social distancing policies, also limited the safety nets available to these children. During the pandemic period, SDGCW 2020-21 data showed that, nationally, 6.9 per cent of children aged 5-17 years were involved in child labour[86] at the time of data collection, including 9.4 per cent in Ho Chi Minh City alone, 4.5 per cent in the North Central and Central Coastal area (encompassing Da Nang), 3.6 per cent in the Red River Delta (encompassing Bac Giang province), and 3.1 per cent in Ha Noi.[87] Girls, children living in rural areas, and children of ethnic minorities were most at risk of being involved in child labour. Children living in the poorest wealth quintiles (12.3 per cent) were twice to four times as likely to be involved in child labour as children living in the two richest wealth quintiles. Children living and/or working on the streets are highly vulnerable to safety

"…for pupils with multiple disabilities and having two or more disabilities in addition to the visual impairment, their long absence from school will affect their learning results because pupils with multiple disabilities take a lot of time to develop a skill. Because the school was closed and they could not go to school, their skills would disappear and almost reduce to zero."
– Frontline worker (School for CWD), Ha Noi

86 According to the SDGCW 2020-21, child labour is defined as "children involved in economic activities above the age-specific thresholds, children involved in household chores above the age-specific thresholds, and children involved in hazardous work".

87 General Statistics Office and UNICEF 2021.

"In-kind support included cake, milk. In general, there was less support in 2021 than in 2020." – **Frontline worker (social protection centre), Da Nang**

"*We were very lucky as during the outbreak, we received the great attention of the government in terms of medical supplies, tools, and pandemic prevention skills. The Ward and the District provided vegetables and fruits. The sponsors and the businesses also supported the village…. [However] it is very difficult to recruit [caregivers and caretakers], affecting the psychology of the children and of the staff. When the pandemic broke out, [there were infectious cases] so they felt anxious and insecure."* **– Frontline worker (Social Protection Centre for vulnerable children), Ho Chi Minh City**

violations, exploitation, trafficking, and other forms of abuse. According to a key informant, the social protection centres received almost no cases of street children and child vendors in Da Nang, due to restrictions during the pandemic which led to these children being transferred to their home locality. This policy may have limited the risks of exploitation and to personal safety these children faced on the streets. However, without adequate financial and social support, these children remained highly vulnerable to further exploitation and other risks, as well as to the dire circumstances which may have pushed them into the streets and/or working conditions in the first place.

Children with Disabilities

SDGCW 2020-21 data found that 1.2 per cent of children aged 2-4 years, and 1.9 per cent of children aged 5-17 years, in Viet Nam faced at least one functional difficulty. Children with disabilities faced specific vulnerabilities during the pandemic due to the social distancing restrictions, which, if lacking proper assistive devices, limited their opportunities for engaging in distance learning, and further limited access to necessary rehabilitative health care services, among other disruptions. Additionally, teachers for children with disabilities faced the difficulty of adjusting to online teaching.

Key informants at a school for children with disabilities in Ha Noi shared that adequate financial and in-kind support was received to allow for adapted continuation of regular activities during the pandemic period, including for disease prevention and adherence to 5K regulations. For example, through the coordination of the Department of Education and local authorities in the locations where pupils lived, all blind school pupils received computers and 4G sim cards to ensure access to education materials as well as network access. Although efforts were made to send necessary textbooks and school materials to children who had returned to distant provinces during the social distancing period, accessible textbooks remained limited in number and would require significant additional central funding allocations to ensure universal access.

Challenges also persisted with ensuring pupils' access to appropriate assistive devices to continue their learning remotely. Although charitable donations attempted to close this resource gap in this case, access to assistive devices for online learning was still not universal and not sustainable. Children with multiple disabilities who required more direct interventions and care, who were not attending an accessible school, and who were living in more remote areas, were likely to have been at a greater disadvantage during the pandemic period.

Frontline workers in Bac Giang shared that while State support for vulnerable children to purchase personal items, at VND1,800,000 per year, was not sufficient to meet their need, especially in the pandemic context. Similarly, frontline workers at a school for children with disabilities in Ha Noi shared that the government support package, such as Decree 81 on the provision of

uniforms and procurement of learning facilities for pupils with disabilities, was helpful, especially in combination with government-provided social assistance for poor and near-poor households, and for households with a child/person with disabilities (Joint Circular 42). However, the support may still have been insufficient to offset the cost of specialized living expenses and school supplies required by children with disabilities, which far exceeded those of children without disabilities, and centres for children with disabilities remained highly reliant on the joint support from government, non-governmental, and philanthropic sources.

"Circular 42 stipulates very clearly: parents will use this money to buy school supplies for pupils. For blind pupils like at our school, for example, if this regulation is strictly followed, each 9 months of school year, the children will be supported about more than 10,000,000 VND. I think this amount helps parents a lot in paying for their studies and preparing utensils and equipment for their children" **– Frontline worker (School for CWD), Ha Noi**

5. Conclusion and Recommendations

In the third year of the COVID-19 pandemic, it is clearer than ever that risk-informed policy and programming to guarantee the rights, well-being and dignity of children as well as families must evolve beyond reactive and short-term policy measures. The COVID-19 public health emergency – alongside macroeconomic shocks, environmental and climate change-related disasters and other covariate shocks that Viet Nam has experienced since the beginning of the pandemic – has demonstrated that the definition of what constitutes a 'vulnerable' population is subject to rapid and substantial change in the face of large-scale crises. With at least one-in-five children in Viet Nam having experienced multidimensional deprivations of their rights and wellbeing in the midst of an ongoing public health crisis with severe consequences for human development, it is imperative to consider all children – including those considered vulnerable according to standard definitions of poverty, and those not currently identified as vulnerable – but who nevertheless are at risk of being left behind due to current and future crises. Special attention should be given to expand the coverage and adequacy of social protection and assistance, closing the digital divide, bridging the access gap for populations belonging to rural areas, ethnic minorities, migrant families, people with disabilities, and provide adequate resources to centrally address gender equity at each stage of policy and implementation.

Beyond the pandemic, Viet Nam is not exempt from international socio-economic, political, and environmental volatility currently at the forefront of the global discourse, such as recent food and fuel price shocks. The importance of building a rights-based, shock-responsive, and gender and life-cycle sensitive social protection system to protect livelihoods and build the resilience of households and families with children cannot be overstated. Improving social spending to protect and promote investments in human capital lies at the centre of any forward-looking strategy to build back better and strengthen the relationship between the State and citizens throughout and beyond this current health crisis.

The findings of this report demonstrate that protracted and widespread shocks can have devastating impacts on the wellbeing of communities relying on informal work, daily earnings, and work with poor protections. Therefore, a comprehensive social protection floor should not only guarantee everyone with a minimum income, but also ensure that every citizen has access to basic services including health, nutrition, education, WASH, and protection. Complementary interventions across related sectors are therefore pivotal in these efforts. The findings of this research underline the importance of increasing the resilience of families to future shocks through risk-informed programming and budgetary management in all child-relevant sectors. This will guarantee that risks are adequately assessed and controlled.

Policy recommendations are further elaborated below according to respective thematic area.

Social Protection and Social Assistance

The State provided various social protection schemes including for the unemployed, those quarantining, poor and near-poor households and general subsidies, but awareness of schemes was found to be limited and many recipients reported it did not meet their needs. Many also identified barriers that made access difficult or even impossible such as complicated application procedures, long delays between applying and getting a response, and a lack of communication from authorities regarding the types of social protection and applications for it. Recommendations for improving social protection are as follows:

- **Social protection awareness mechanisms need to be established**, such as letters from local government to households, describing what financial and in-kind support is available and how they can apply for it.

- **A simple, more inclusive and responsive shock-responsive targeting mechanism is necessary to ensure system effectiveness in responding to the needs of families and children in times of crisis. Importantly, broadening the existing narrow targeting criteria and mean-tested schemes is critical, alongside the subsequent simplification of beneficiary identification, application and eligibility assessments, delivery processes and mechanisms. This can be achieved through the introduction of a universal transfer to provide emergency assistance in times of shock, particularly for families with children.** This can provide both a vertical expansion of social protection that tops-up transfers to those already receiving social assistance as well as a horizontal expansion, that widens the targeting criteria to capture a greater proportion of the population. This digital payment should include additional payment mechanisms, such as cash and in-kind delivery, for those without access to financial services. A comprehensive, easy to use and accessible Management Information System (MIS) should facilitate these processes and be used consistently for administration and management at all levels of service administration and delivery.

- **Simple and accessible application systems need to be introduced, accompanied by capacity development at the local level to support those who may need help in making applications.** Beyond simplification of bureaucratic procedures and investing in a comprehensive and accessible MIS, it is necessary to rapidly identify the most vulnerable populations and facilitate their self-registration through an online application.

Education

Inequality in education persisted during the pandemic, according to quantitative and qualitative research findings. Nonetheless, most children were able to participate online because of State, school, and community support.

The greatest challenge for schools and the Government of Viet Nam will be to recover academic losses experienced during the period of school closures and ensure positive educational attainment trends.

Minimize the adverse effects of early childhood education losses given the lack of suitable alternatives during school closures, with significant consequences for young children's language, socio-emotional, physical, and cognitive development. The following recommendations should be considered during and beyond the pandemic.

- Integrate early childhood development messaging into public health information campaigns to increase awareness and communicate stimulating learning alternatives for young children.
- Make adaptations to early childhood education to maintain continuity of learning activities to avoid prolonged pre-school closures.
- Expand monetary or in-kind transfers to ensure adequate nutrition and regular health check-ups.
- Organize reliable emergency childcare arrangements for working parents.

In primary and secondary education, it will be critical to ensure the quality of education and the ability to catch up. While some of the following recommendations have already been implemented, they are not widespread.

- Provide free-of-charge revision and catch-up sessions, especially to vulnerable children and those excluded from remote learning.
- Provide alternative delivery modes for complementary services such as school feeding or health check-ups.
- Strengthen coordination mechanisms between schools and parents to ensure sustainable and participative remote-based learning.
- Ensure remote-based learning reaches disadvantaged children by use of low-tech and low-connectivity learning materials.
- Consider school fee exemptions for children from vulnerable households to avoid lower enrolment and attendance rates or school dropouts.

Lastly, **teachers should receive adequate resources and capacity training, including mental-health training**. This will smooth children's transition between in-person and remote schooling and support students who struggled during the remote learning period. Moreover, this will allow teachers to support children who have difficulties discussing mental issues with caregivers.

Health, Nutrition and Mental Health

It is imperative to sustain essential nutrition and growth-monitoring care service delivery through adequate allocation and management of financial, human and infrastructural resources in health and nutrition-specific as well as complementary sectors.

- Continue funding and expansion of mobile and door-to-door service delivery which was an effective model implemented during the social distancing period, to ensure service continuity especially of antenatal care, routine immunization, nutrition counselling, supplementation and growth monitoring services.
- Integrate awareness-raising and destigmatizing outreach campaigns to promote the importance of continued utilization of health and nutrition services even during crises.
- Consider mobile meal delivery or pick-up services to all school-going children, including options for low-resource households to continue receiving school meals.
- Expand the social protection and assistance package provided to cover extraneous health expenditures and limit high out-of-pocket expenditures, which worsen the financial insecurity already experienced by the most vulnerable populations.
- Consider making mental health and psychosocial wellbeing a central thematic focus in future school curricula, as well as build capacity for psychological support in all child-relevant sectors, including in service sectors targeting vulnerable children and children with disabilities.
- Provide mental health support through in-person and remote modalities to access needed counselling services.
- Adapt school curricula to sensitize teachers and pupils to mental health concerns and how/where to seek support.
- Expand the availability of free and inclusive sports and recreational activities during and after school hours, in close coordination with public health and education sector authorities.
- Raise awareness on mental health support services, such as 24-hour helplines, to expand access while destigmatizing conversations around mental health and psychosocial wellbeing during and beyond the COVID-19 context.
- Carry out additional data collection and research to assess mental health needs and existing service capacities, to inform adequate interventions

and programming to improve service delivery in this sector.

Child Protection

Poor general awareness and stigmatization of services for child protection necessitates **destigmatizing and awareness-raising campaigns** around recognizing vulnerabilities, identifying violations, and where and how to seek support.

- Integrate modules on child rights into the school curriculum to ensure systematic and regular awareness-raising on domestic and gender-based violence, sexual and reproductive health and rights, child marriage and teenage pregnancy, bullying, online abuse (including within gaming), abuse of alcohol, cigarettes, toxic substances and human trafficking.

- Scale-up communication and sensitization activities to enhance parental awareness and knowledge on violence against children and their capacity to act appropriately through positive parenting to achieve behaviour change to address violence against children.

- Build community engagement to raise public awareness about potential risks and available channels to seek help.

Furthermore, interventions must be adapted to provide **tailored and in-depth information depending on the characteristics and age of the children**. This should be a central component of strengthening and expanding the child protection system to make the services available, accessible, and reliable for all.

- Strengthen the social service workforce and professionalize social work to ensure adequate and sufficient capacity to address social issues arising during and beyond the COVID-19 pandemic context.

- These efforts should be coupled with research and data collection on the social service workforce and its existing capacities to assess the need for training, recruitment, and service strengthening in a timely manner.

- Conduct research, sociological surveys and polls to grasp the actual needs of children to issue appropriate policies.

Review and strengthen existing procedures to improve the effectiveness of policy packages while restoring the trust of the community in seeking support in public institutions.

- Improve coordination and collaboration between actors at all levels (families, schools, communities and social organizations). It is imperative to invest in social service and judicial institutions to work closely with schools, communities and non-governmental organizations to enhance reporting, referrals and continuous monitoring of cases.

- Increase publicity and transparency of policies by making comprehensive guidance documents available to the public.

WASH

While access to adequate WASH is widespread, it should be a priority to **ensure that health facilities, schools, and other public spaces have access to safe drinking water and handwashing facilities.** This will enhance the ability to adhere to COVID-19 safety protocols and contribute to improved health and nutrition outcomes as well as school attendance rates.

- Strengthen the implementation, oversight and regulation of WASH service delivery during the pandemic, while reinforcing multisectoral collaboration.
- Implement a monitoring and evaluation system to assess the access to safe water and sanitation facilities in schools and health facilities.
- Ensure access to separate female and male WASH facilities and hygiene education in schools.

The evolving nature of the pandemic highlights the need to **promote community awareness of the adequate and safe WASH behaviour and the continued importance of adhering to COVID-19 safety protocols**.

- Sensitize households and local communities on how to treat adequately water and improve its quality.
- Ensure continued access to clean drinking water, especially in remote areas.
- Provide information and awareness campaigns in schools, to promote children's engagement in encouraging caregiver and community adherence to COVID-19 safety protocols.

Parental care

Caregivers who participated in interviews shared common challenges with regard to caring for children during the pandemic, especially during periods of social distancing. Particular groups of the population felt neglected in the social support packages, especially households with numerous children, one-parent households, households in which at least one caregiver is a migrant worker, and households in which grandparents care for children. Some recipients of social support felt it was insufficient to cover common necessities. For that reason, the most common coping mechanism observed was the reliance on communities for support. The Vietnamese population tended to create its own support system, while relying on governmental support sparingly. This points to the potential of harnessing the interconnectivity of communities and

informal networks to promote awareness of and thus access to available social protection and assistance packages. The following recommendations could support households to address challenges mentioned during interviews.

- Integrate parenting and coping messaging into public health information campaigns.
- Improve communications concerning and access to existing support packages.
- Consideration of cash assistance to vulnerable children and organization of childcare alternatives for orphaned children, even if cared for by grandparents or alternate guardians.
- Expand existing cash and in-kind transfer support to include large households, one-parent households, and households with at least one migrant worker.
- Organize reliable emergency childcare arrangements for working parents to avoid loss of employment or having older children miss out on learning opportunities due to the need to care for younger siblings.

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Annex I: Underlying methodological framework

I.I Thematic areas guiding the research questions of the mixed methods study

Table 3 Thematic areas explored in the mixed methods analysis

Thematic areas	Analytical focus
Health	▪ Accessibility and affordability of basic health services, including maternal and child health (MCH) care services and immunization.
Mental health and psychosocial wellbeing	▪ Experiences of (toxic) stress, poor mental health, depressive symptoms of caregivers and children during the pandemic period including during self-isolation and/or home quarantine, and influencing factors. ▪ Coping mechanisms of caregivers and children to maintain mental health and psychosocial wellbeing. ▪ (Unmet) needs for psychosocial support during the pandemic period. ▪ Impact of caregivers' mental health on the wellbeing of their children.
Nutrition	▪ Accessibility and affordability of basic and routine nutrition services (including growth monitoring and counselling and acute malnutrition prevention and management) ▪ Changes to feeding practices of young children (breastfeeding and complementary feeding including frequency, size and quality of meals) and influencing factors ▪ Changes to household food security and diet quality and diversity
Education and Learning	▪ Accessibility and affordability of alternative (remote) learning modalities with a focus on vulnerable groups and the digital divide ▪ Advantages, disadvantages, and effects of remote learning programmes on children ▪ Equity and inclusivity of online learning programmes for vulnerable groups of children including children with disabilities, ethnic minorities, children from poor households, migrant background, etc.

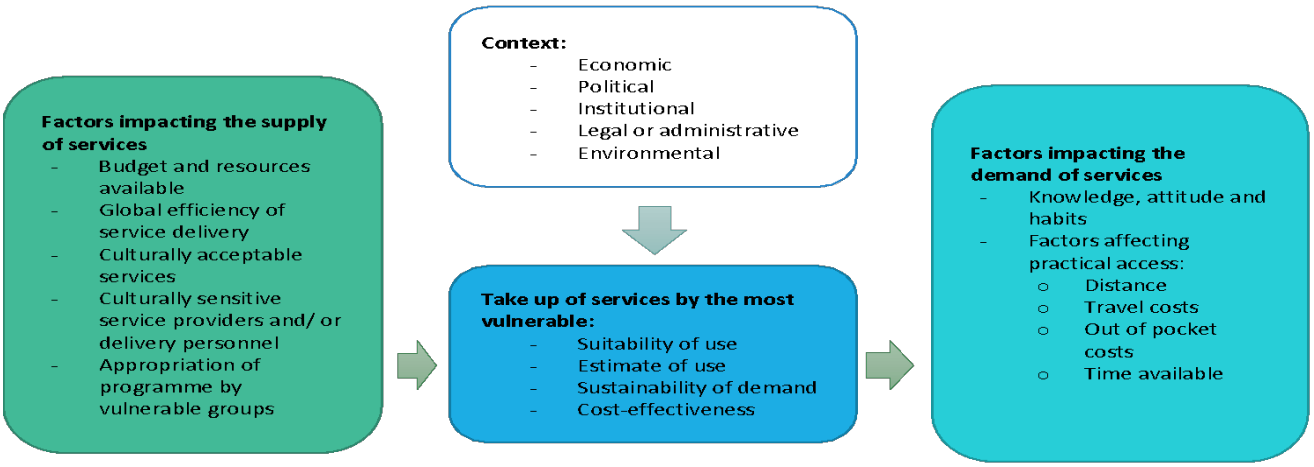
Child Protection	▪ Accessibility and affordability of support/social/counselling services for children and caregivers in vulnerable situations ▪ Emergence of new risks, emerging vulnerabilities, and factors influencing experiences of violence against children, including gender-based violence or domestic violence (GBV/DV), in the context of the pandemic ▪ Risks and vulnerabilities pertaining to online and offline exploitation, abuse, as well as child labour
WASH	▪ Accessibility and affordability of water, sanitation and hygiene products and services for pandemic safety, as well as of personal protective equipment (PPE)
Parental Care	▪ Changes to parental care of children as a result of COVID-19 contraction or quarantine ▪ Coping mechanisms of parents to care for children in the pandemic context ▪ Needs and availability of support services for parental care
Social Assistance	▪ Strengths and gaps in COVID-19 related social assistance schemes and support ▪ Positive changes in the resolution #68 issued by the Government on 1st July 2021 and all other relevant policies and schemes on social assistance compared to the resolution #42 issued on 9th April 2020) ▪ Remaining gaps in social assistance and specific recommendations considering the needs for social assistance for families with children, children of poor migrant families and informal workers
Gender differences in family decision making, duties and responsibilities	▪ Gender roles including additional burdens of childcare and house chores on women, mothers, and girls due to COVID-19

I.II. Conceptual framework underlying the general approach of the study

The equity-based and human-rights approach. Despite the progress made by Viet Nam, numerous challenges remain towards the accomplishment of the SDGs and COVID-19 has put more pressure on the realisation of these goals for all under even greater pressure than before. The achievement of these goals and the realization of the rights of children, youth, women, PWDs, and the elderly, as enshrined in the related international agreements such as the UN CRC, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), CRPD, UN Universal Declaration on Human Rights and others, require multisectoral and integrated interventions. Beyond the moral aspect, the equity- and human-rights-based approach is coherent with the operational gains derived from better targeting those who need it most.

The equity-based approach, as shown in Figure 1, identifies disparities (according to socio- economic characteristics, urban/rural locations, gender profiles, disability status, etc.) and uncovers the underlying causes of such inequities as well as analyses major bottlenecks in service delivery that impede their resolution. This approach allows for analysis across various domains of service delivery and uptake and helps identify interventions that will most likely result in improved outcomes for most vulnerable populations at the programmatic, policy, and strategic levels.

Figure 10 Conceptual framework for the equity-based approach



Source: UNICEF, 2014, Formative Evaluation of UNICEF's Monitoring Results for Equity System (MoRES).

The human rights-based approach, particularly in light of the framework of the above-mentioned international conventions and agreements, aims at fulfilling the rights of all. The basic rights of children, guaranteed by national legislation and international conventions, include the right to survive, the right to grow up and develop in a healthy way, the right to be educated commensurate with one's personal abilities and preferences, the right to be protected from violence and exploitation, the right to a safe and clean environment, the right to participate in the society and the right to social protection. These rights can be linked to SDG 1, SDG2, SDG3, SDG4, SDG 5 and SDG6 amongst others.

The life cycle approach. In the context of this exercise, the life-cycle approach recognises that the needs of children (and youth) vary according to their lifecycle phase/stage. The analysis will therefore focus on and highlight vulnerabilities, risks, and shortfalls in realization of children's and youths' rights specific to their age: i) early childhood (0-59 months), ii) primary school-going age/childhood (5-10 years); iii) early adolescence (10-14 years); iv) secondary school-going age (15-17 years); and (to a lesser extent) v) late adolescence and youth (18-24 years).

The gender-sensitive approach. This proposal envisages mainstreaming the gender- sensitive approach in four ways: 1. Through sex-disaggregated indicators in primary and secondary data analysis, 2. Carrying out separate/ additional, gender lens analysis in the components assessing the policy framework, and programme and service delivery, 3. By ensuring equal participation of both sexes in the research (with beneficiaries, non-beneficiaries, and service providers) and consultation processes, and 4. By developing recommendations in all deliverables that address systemic barriers to gender equality among both rights holders and duty bearers (esp. social services providers).

The participatory approach. This approach promotes the active involvement of key partners at the national level to ensure ownership of the findings and joint identification of national priorities and context-specific solutions. Active participation from government, academia, civil society, development partners, including children, adolescents, women, and persons with disabilities, are essential to carry out a comprehensive analysis of the sector and ensure uptake of the results. Engagement will be ensured through a series of key informant interviews and focus groups discussions to guarantee the contextualisation of the analysis and to identify the immediate, underlying, and structural causes of child vulnerabilities and deprivations.

I.III Details of qualitative research participants

Table 4 List of participants for Focus Group Discussions (Bac Giang)

Instrument group	**Characteristics** (participants have 1 or more of the following characteristics)
Focus Group Discussions with caregivers of children ages 0-17 years.	
FGD1 **(Male)**	Caregivers of children who lived in quarantined areas, collective isolation centres, or who isolated at home during periods of lockdown.
	Caregivers who lived under social distancing but not in a quarantined residential area.
	Caregivers who are not members of poor list or near-poor households, or a vulnerable group (general public)
	Caregivers of children from poor, near-poor households (members of poor list).
	At least one caregiver of children with disabilities.
	At least two caregivers who have children ages, respectively, 0-5 years, 6-14 years, 15-17 years.
	At least one freelance worker.
	Representation of both formal and informal workers if possible.
	At least one industrial zone worker.
	Representation of both recipients and non-recipients of social protection and/or assistance.
FGD2 **(Female)**	Caregivers of children who lived in quarantined areas, collective isolation centres, or who isolated at home during periods of lockdown.
	Caregivers who lived under social distancing but not in a quarantined residential area.
	Caregivers who are not members of poor list or near-poor households, or a vulnerable group (general public).
	Caregivers of children from poor, near-poor households (members of poor list).
	At least one caregiver of children with disabilities.
	At least two caregivers who have children ages, respectively, 0-5 years, 6-14 years, 15-17 years.
	At least one freelance worker
	Representation of both formal and informal workers if possible.
	At least one industrial zone worker.
	Representation of both recipients and non-recipients of social protection and/or assistance.
Semi-structured in-depth interviews with service providers or frontline workers	
I1	Health frontline service providers (commune/ward level)
I2	Education frontline service providers (commune/ward level)
I3	Child protection/social work frontline service providers (commune/ward level)
I4	Managers and/or teachers of schools for children with disabilities or orphans, social protection centres

I5	WASH officer (commune/ward level)
In depth-interviews	
I6	Informal worker (caregiver)
I7	Migrant worker (caregiver)
Total instruments	**9**

Table 5 List of participants for in-depth interviews and key informant interviews in Ha Noi, Ho Chi Minh City, and Da Nang

	Characteristics	Number of participants
Semi-structured, In-depth interviews with mothers, fathers, or caregivers of children aged 0-17 years (participants may have lived under social distancing measures)		
G1	Participants (caregivers) living in quarantined areas or residential areas	3
G2	Participants (caregivers) who stayed in collective isolation centres	3
G3	Participants (caregivers) isolated at home or lived under district-wide social distancing measure	3
G4	Participants who do not belong to the three above-mentioned groups and are mothers, fathers or caregivers of vulnerable children, such as children from poor, near-poor households, children with disabilities	3
G5	Participants (caregivers) who do not belong to the four above-mentioned groups (general public)	3
G6	Informal workers (caregivers)	3
G7	Migrant workers (parents)	3
G8	Recipient of social protection and/or assistance (caregivers)	3
G9	Non-recipients of social protection and/or assistance (caregivers)	3
Key Informant Interviews with service providers		
G10	Health frontline service providers	3
G11	Education frontline service providers	3
G12	Child protection/social work frontline service providers	3
G13	Managers and/or teachers of schools for children with disabilities or orphans, social protection centres	3
G14	WASH officer	3
Total instruments		**42**

Annex II: Ethical Considerations and COVID-19 Precautions

Ethical protocols and ethical clearance

The Ha Noi University of Public Health provided ethical clearance of this study in January 2022. All research involving caregivers followed strict protocols of ethical considerations[88] and oral consent for participation were obtained from all relevant parties. All instruments were accompanied by clear guidelines to facilitators for how to assess and mitigate any risks to participants. Additional guidelines to discussion and interview facilitators included the following:

- Privacy: Precautions will be used to ensure privacy in interactions with all respondents. The evaluation team will identify safe spaces where discussions and conversations can take place so that others cannot overhear what is being said.
- Voluntary participation: participants will be reminded that their participation is voluntary and there will be no consequences in case they decide not to participate.
- Compensation: participants will be provided with a telephone cellular data top-up to compensate their time and phone costs.
- Anonymity: the names or other identifiable features of participants will not be recorded and participants will be made aware of this.
- Confidentiality: participants will be assured that their confidentiality will be protected and evaluation information will be kept private to the fullest extent allowable by law. Participants will also be supported to understand the importance of their role in keeping confidentiality of other participants.
- Assent: the assent of primary caregivers will be sought in advance for children to participate in the interviews through means of a written invitation/information sheet.
- Informed consent: all participants will be provided with consent forms that inform about the research and use of information. Written informed consent will be sought prior to participation.
- Informed assent: the informed assent of primary caregivers will be sought

88 Ethical Research Involving Children (Child Ethics, 2013), and Ethical Considerations for Evidence Generation Involving Children on the Covid-19 Pandemic (UNICEF, 2020).

in advance for children to participate in the interviews through means of a written invitation/information sheet

- Training of the research team: research teams will receive instruction at data collection trainings in areas such as ethical data collection (e.g. sensitivity toward study subjects, the importance of securing and maintaining privacy, and talking about sensitive topics), informed consent, and referral processes.

Safety precautions in the context of COVID-19

All research involving face-to-face interaction followed strict preventive protocols in place at the time of intended data collection, as defined by the local governance of each selected city/province. The group size of Focus Group Discussions has been limited to 8 participants to take into account these restrictions.

Strict protocols were followed by interviewers and researchers to mitigate any risk of COVID-19 infection in any context where this may be necessary (e.g. wearing a medical nose-and-mouth cover, maintaining a distance of at least 1.5 meters during office work, obtaining vaccinations and presenting a vaccination certificate, and/or a negative rapid test, sanitising telephones and recording equipment, etc).

Annex III: Research Limitations

Sensitivity of discussion topics

Due to the constraints of the study time and resources, the number of focus group discussions had to be limited to those presented in section 3. The heterogeneity of group composition may have limited the ability of researchers to ask questions on sensitive topics pertaining to gender or protection violations. We intended to overcome these questions by asking about general perceptions about these issues in the community, rather than personal experiences of participants, and by seeking in-depth responses on these topics from relevant key informants.

Reliability and validity of qualitative research findings

As only two in-person focus group discussions with 8 members each were possible to be carried out in Bac Giang, in addition to the 14 individual interviews per selected city, there are significant limitations faced with regards to representativeness and generalizing findings at the level of the three cities and province. We intended to overcome this challenge by 1) diversifying the types of experiences that are represented in the focus groups, 2) by asking follow up questions which ask participants to confirm if they believe their experience is unique or shared by others in their circle/community, and 3) by triangulating our data analysis with the findings of the representative quantitative data analysis.

Reliability of quantitative data

The quantitative analysis, due to being collected prior instead of during the fourth wave of the pandemic, may provide only a limited picture of the actual situation of children and families during the fourth wave and subsequent NPI. These findings may therefore not be a directly reliable reflection of the effect of the pandemic on children and families as a result of the pandemic's fourth wave. However, they provide a useful indication of the most vulnerable areas and groups that were observed during earlier waves of the pandemic, and therefore provide insight into what may be priority issues or populations during the more severe fourth wave. The SDGCW 2020-21 data also provides the benefit of having child-specific data across a number of key topics of interest and can serve as a baseline measure of the situation of children and families prior to the fourth wave, to triangulate with qualitative research findings to improve validity in their interpretation.

Qualitative data collection

The data collection phase has encountered the following issues and challenges:

Many participants were hesitant to join the research due to concerns of privacy and unfamiliarity of research, particularly many of them were free laborers, workers and migrants. In such case, providing additional information and building personal

rapport were more effective in gathering the participants and convincing them to take part in the research.

Secondly, setting appointments depended on the availability of the participants, rather than the interviewers' schedule. Many people agreed on specific time and date, but on that schedule, they might not be ready or re- schedule. This was the main reason that led to the slight delay of the survey in Ho Chi Minh city and Ha Noi. The last interview in Ho Chi Minh city was conducted on 22 March whereas in Ha Noi on 31 March as the result of multiple schedule changes.

Thirdly, COVID-19 has made many face-to-face interviews impossible. In Ha Noi, March 2022 was among the peak periods of the pandemic, resulting in the decision of conducting all interviews online. In Ho Chi Minh city, the period from Feb to March 2022 witnessed the Omicron as SARS-CoV-2 variant caused a lot of concerns for the participants to join direct interviews. The pandemic situation was better in Da Nang and Bac Giang, which enabled more face – to – face FGDs and KIIs than the other two cities.

With regard to the method of data collection:

- In Ha Noi: all of the 14 interviews were conducted via online using phone and different apps such as Zalo and Google Meet.
- In Bac Giang: all of the 14 FGDs and KIIs were conducted in person (offline)
- In Da Nang: 10 KIIs were conducted offline and 4 KIIs via online method
- In Ho Chi Minh City: 9 KIIs were conducted offline and 5 KIIs via online method

The online interviews revealed a number of weaknesses, including: some people were not comfortable being "on-call" or "on-camera" and may not present as well as they would in a person-to-person situation; respondents did not feel enough trust; and connectivity issues might happen like Internet connection, phone running out of battery, etc. Even for direct interviews, some respondents such as the healthcare staff or teachers became extremely busy during COVID-19, therefore, the arrangement of interviews might be either at noon (for instance, with the teacher in Bac Giang) or in the evening (for instance, with the head of a healthcare centre in Bac Giang).

Last but not least, the data quality may vary depending on the type of respondents. Many respondents were workers, free laborers, the poor or the migrants, thus, they were less familiar to research and interviews, particularly whom living in rural areas. Compared to other types such as teachers, healthcare officers, children protection officer, etc., they were more uncomfortable in raising voice and sharing opinions. In such case, the researchers needed to be mindful of rapport, creating a friendly environment to build trust to successfully collect quality information.

Annex IV: Multidimensional Poverty Analysis

Analysis Parameters

Table 6 Dimensions, Indicators, Deprivation Thresholds for the multidimensional poverty analysis among children aged 0-4, 5-11, and 12-17 years

Dimension	Indicator	Threshold	0-4 years	5-11 years	12-17 years
Nutrition & health	Exclusive breastfeeding	0-5 months: Child is not exclusively breastfed.	X (0-5 months)		
	Minimum acceptable diet	6-23 months: Child is not meeting WHO requirements for minimum acceptable diet (meal frequency and diversity) WHO requirement for minimum meal frequency is defined as: 2 times for breastfed infants 6–8 months 3 times for breastfed children 9–23 months 4 times for non-breastfed children 6–23 months WHO requirement for dietary diversity refers to the child receiving 4+ of the following food groups: 1. grains, roots and tubers 2. legumes and nuts 3. dairy products (milk, yogurt, cheese) 4. flesh foods (meat, fish, poultry and liver/organ meats) 5. eggs 6. vitamin A rich fruits and vegetables 7. other fruits and vegetables	X (6-23 months)		
	Prenatal care	0-23 months: Mother did not receive adequate pre-natal (4 visits + blood pressure, urine sample and blood test.	X (0-23 months)		
	Vaccinations (full immunization)	12-35 months: Child did not receive all vaccinations recommended in the national immunization schedule according to their age.	X (12-35 months)		

Child development	Attendance to early childhood education	36-59 months: Child does not attend any early childhood education.	X (3-4 years)		
	Availability of children's books and toys	2-4 years: Child has no toys (homemade or bought from shops) or books to play with in the household.	X		
	Adult-child interaction	2-4 years: No household member age 15 or over engaged in any of the listed activities with the child: read books, told stories, sang songs, took outside, played with, named or counted.	X		
Education	School attendance	5-17 years: Child is not attending school (UNESCO Compulsory school age).		X	X
	Primary school attainment	11-17 years: Child is beyond primary school age and has no or incomplete primary education.		X (11 years)	X
Water	Drinking water source	0-17 years: HH main source of drinking water is unimproved (WHO). *Improved*: piped water into dwelling, piped water into yard/plot, piped water to neighbour, public tab/standpipe, tube well or borehole, protected dug well, protected spring, rainwater, bottled water, sachet water. *Unimproved*: unprotected well, unprotected spring, tanker truck, surface water (River/Lake/Pond/ Stream/ Irrigation Channel), other.	X	X	X
Sanitation	Toilet type	0-17 years: HH uses an unimproved toilet facility (WHO). *Improved*: flush to piped sewer system, flush to septic tank, flush to pit latrine, flush but don't know where, ventilated improved pit latrine, pit latrine with a slab, composting toilet. *Unimproved*: flush to open drain, pit latrine without slab or open pit, no facility, bush or field bucket toilet, hanging toilet or hanging latrine, other.	X	X	X
	Handwashing	0-17 years: HH has no handwashing place with soap or other cleansing detergent in the household.	X	X	X
Housing	Overcrowding	0-17 years: HH has on average more than two people per sleeping rooms.	X	X	X
	Materials of the roof and floor	0-17 years: The exterior roof and floor are made of natural or rudimentary materials. *Roof: Unimproved*: thatch/palm leaf, sod, rustic mat, palm/bamboo, wood planks, cardboard, other. *Floor: Unimproved*: earth/sand, dung, wood planks, palm/bamboo, other.	X	X	X

Deprivation headcount rates for single and multiple dimensions

Figure 11. Deprivation headcount ratio (%) by each indicator at the national level, 0-4 years

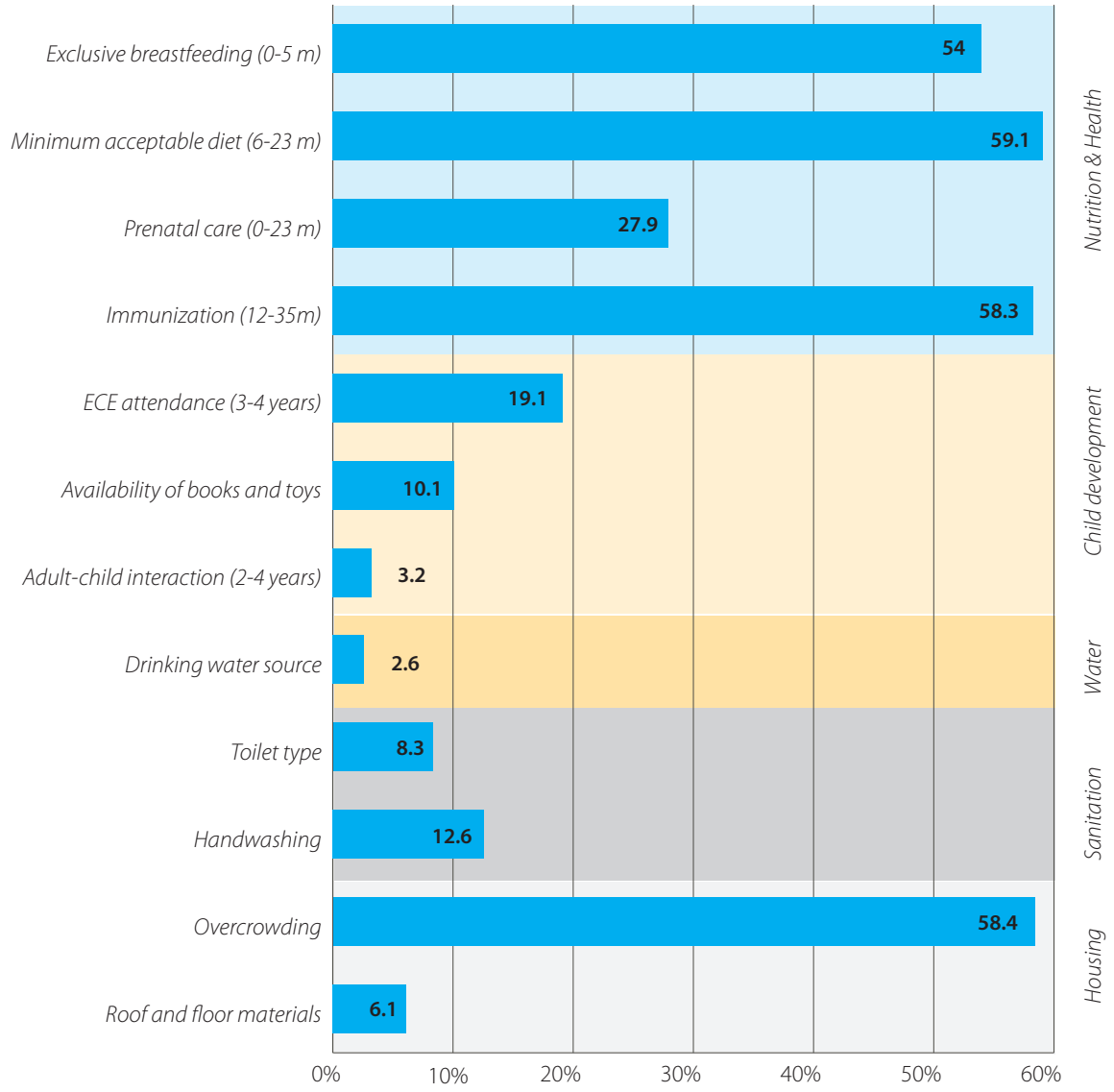
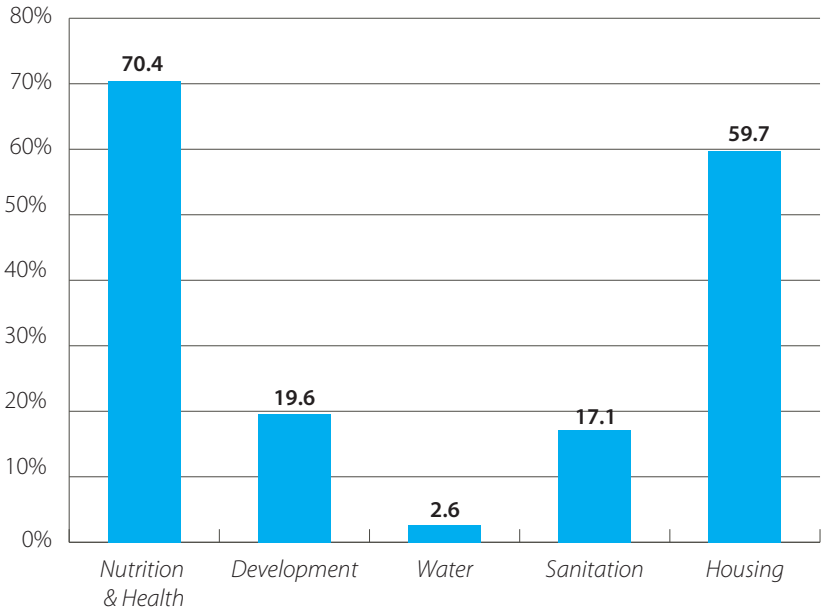


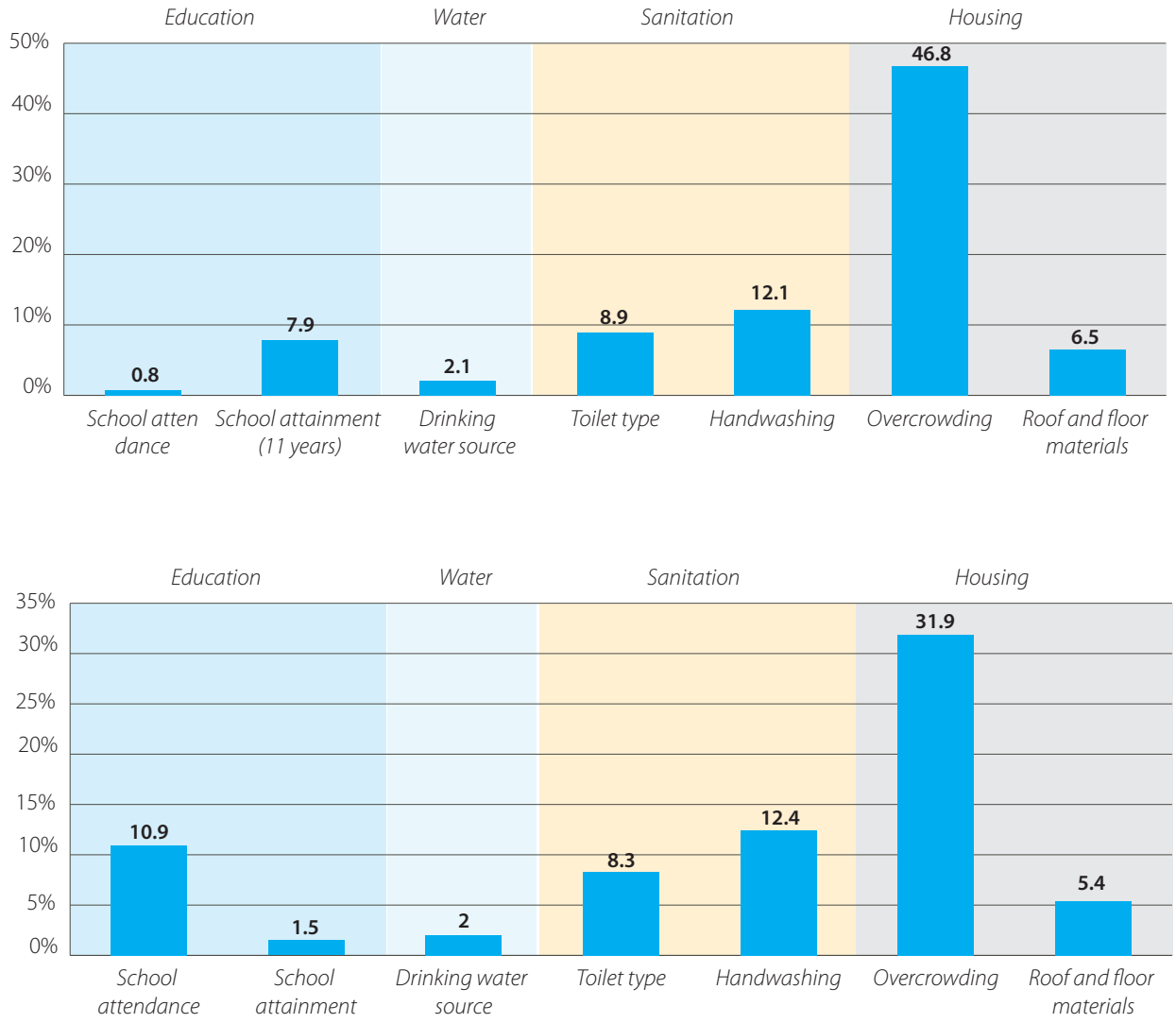
Figure 12. Deprivation headcount ratio (%) by each dimension at the national level, 0-4 years



Source: Author's calculations based on the SDGCW 2020-21 survey.

Among children aged 5-11 years, only 0.8% are not attending school compared to a deprivation rate of 12.1% for children aged 12-17 years (see Figure 12). However, 7.9% of children aged 11 years old did not finish primary school yet opposed to 10.9% of children aged 12-17 years. Similar to the youngest age group, deprivation levels are high in the *overcrowding* indicator with rates ranging from 31.9% to 46.8%. Approximately 2% of children (5-17 years) suffer from deprivation in the indicator *drinking water source*.

Figure 13. Deprivation headcount ratio (%) by each indicator at the national level, 5-11 years and 12-17 years



Source: Author's calculations based on the SDGCW 2020-21 survey.

Subsequently, older children experience the highest levels of deprivation in the housing dimension, 48.6 per cent for children aged 5-11 years and 33.4 per cent for children aged 12-17 years respectively (see Figure 13). The dimension of Sanitation shows a deprivation rate of 17.7 per cent. Furthermore, a considerable proportion of 11.3 per cent of children aged 12-17 years face deprivation in Education.

Table 7 Proportion of children deprived of education (5-17 years)

Deprived in %		Children 5-11		Children 12-17	
Indicators		*School attendance*	*School attainment (11 years)*	*School attendance*	*School attainment*
National	*National*	0.8	7.9	10.9	1.5
Area of residence	*Urban*	1.0	5.1	7.3	1.2
	Rural	0.8	9.3	12.7	1.6
Region	*Mekong river delta*	1.6	10.2	20.0	2.0
	South East	1.6	10.2	15.8	2.0
	Central highlands	1.0	13.4	17.9	4.4
	North central and central coastal	0.5	3.6	6.3	0.2
	Northern midlands and mountain	0.8	8 2	10 4	2.9
	Red river delta	0.2	6.9	2.9	0.4
Sex of the child	*Girl*	1.0	8.3	10.4	1.3
	Boy	0.7	7.6	11.4	1.7
Sex of the household head	*Female*	1.3	13.8	10.7	1.6
	Male	0.7	5.8	11.0	1.4
Ethnicity of the household head	*Ethnic majority*	0.7	6.7	8.8	0.8
	Ethnic minority	1.6	16.2	26.8	6.3
Wealth quintile	*Highest 3 quintiles*	0.8	4.2	4.6	0.6
	Lowest 2 quintiles	0.9	14.1	21.6	3.1

Source: Author's calculations based on the Viet Nam SDGCW Survey 2020-2021

Multidimensional poverty indices by age group and profiling variable

Table 8. Multidimensional deprivation indices (H, A and M0) for children deprived in at least two dimensions at a time, at the national level and by profiling variables, 0-17 years

Children aged 0-17 years				
Multidimensional Indices		**Multidimensional deprivation headcount (*H*), %**	**Average intensity among the deprived (*A*); %**	**Adjusted multidimensional deprivation headcount (M_0)**
National	*National*	19.8	49.5	0.098
Area of residence	*Urban*	11.3	46.3	0.053
	Rural	23.8	50.2	0.119
Region	*Mekong River Delta*	29.6	51.3	0.152
	South East	16.3	46.2	0.075
	Central Highlands	33.1	52.0	0.172
	North Central and Central Coastal	15.4	47.3	0.073
	Northern Midlands and Mountain	27.2	52.8	0.144
	Red River Delta	11.1	44.9	0.050
Sex of the child	*Girl*	19.8	49.5	0.098
	Boy	19.8	49.4	0.098
Sex of the household head	*Female*	15.6	49.5	0.077
	Male	21.2	49.4	0.105
Ethnicity of the household head	*Ethnic majority*	15.2	47.4	0.072
	Ethnic minority	46.1	53.3	0.246
Wealth quintile	*Highest 3 quintiles*	8.5	43.4	0.037
	Lowest 2 quintiles	37.8	51.6	0.195

Source: Author's calculations based on the SDGCW 2020-21 survey.

Table 9 Multidimensional deprivation indices by age group (children aged 0-4 years) and profiling variable

Children aged 0-4 years				
Multidimensional Indices		**Multidimensional deprivation headcount (H), %**	**Average intensity among the deprived (A); %**	**Adjusted multidimensional deprivation headcount (M0)**
National	*National*	33.7	44.2	0.149
Area of residence	*Urban*	24.3	42.1	0.102
	Rural	38.1	44.9	0.171
Region	*Mekong river delta*	40.3	45.6	0.184
	South east	33.0	42.1	0.139
	Central highlands	47.2	46.5	0.219
	North central and central coastal	28.9	42.7	0.123
	Northern midlands and mountain	41.6	47.9	0.199
	Red river delta	25.6	41.4	0.106
Sex of the child	*Girl*	33.6	44.2	0.148
	Boy	33.9	44.3	0.150
Sex of the household head	*Female*	26.7	43.2	0.115
	Male	35.9	44.5	0.159
Ethnicity of the household head	*Ethnic majority*	28.9	42.4	0.123
	Ethnic minority	56.6	48.6	0.275
Wealth quintile	*Highest 3 quintiles*	22.7	40.7	0.092
	Lowest 2 quintiles	50.8	46.6	0.237

Source: Author's calculations based on the SDGCW 2020-21 survey.

Table 10 Multidimensional deprivation indices by age group (children aged 5-11 years) and profiling variable

Children aged 5-11 years				
Multidimensional Indices		**Multidimensional deprivation headcount (H), %**	**Average intensity among the deprived (A); %**	**Adjusted multidimensional deprivation headcount (M0)**
National	*National*	13.9	51.9	0.072
Area of residence	*Urban*	5.1	50.2	0.026
	Rural	18.0	52.2	0.094
Region	*Mekong river delta*	25.2	51.6	0.130
	South east	7.4	50.6	0.037
	Central highlands	27.3	52.6	0.143
	North central and central coastal	9.8	51.5	0.050
	Northern midlands and mountain	20.9	53.7	0.112
	Red river delta	6.1	50.2	0.031
Sex of the child	*Girl*	14.2	52.0	0.074
	Boy	13.6	51.9	0.070
Sex of the household head	*Female*	10.4	52.2	0.054
	Male	15.1	51.9	0.078
Ethnicity of the household head	*Ethnic majority*	9.4	50.9	0.048
	Ethnic minority	39.1	53.3	0.208
Wealth quintile	*Highest 3 quintiles*	2.7	50.0	0.013
	Lowest 2 quintiles	31.6	52.2	0.165

Source: Author's calculations based on the SDGCW 2020-21 survey.

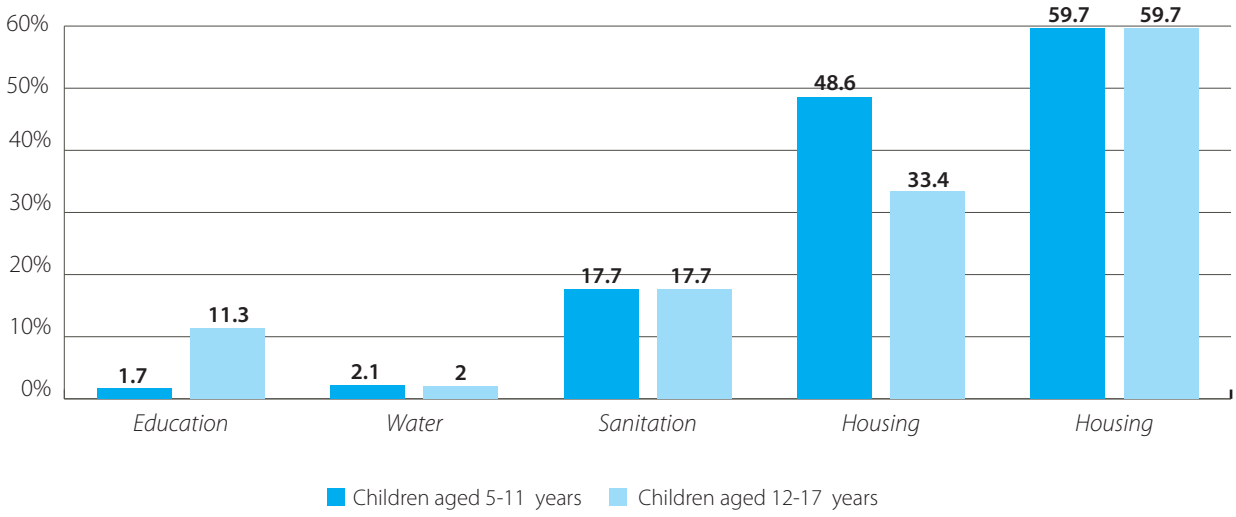
Table 11 Multidimensional deprivation indices by age group (children aged 12-17 years) and profiling variable

Children aged 12-17 years				
Multidimensional Indices		**Multidimensional deprivation headcount (H), %**	**Average intensity among the deprived (A); %**	**Adjusted multidimensional deprivation headcount (M0)**
National	*National*	15.4	57.4	0.088
Area of residence	*Urban*	8.7	54.3	0.047
	Rural	18.6	58.0	0.108
Region	*Mekong river delta*	27.5	57.4	0.158
	South east	13.5	52.4	0.071
	Central highlands	28.3	60.3	0.171
	North central and central coastal	10.2	54.9	0.056
	Northern midlands and mountain	21.2	63.5	0.134
	Red river delta	5.0	52.0	0.026
Sex of the child	*Girl*	15.5	56.6	0.088
	Boy	15.2	58.1	0.088
Sex of the household head	*Female*	14.1	56.9	0.080
	Male	15.8	57.5	0.091
Ethnicity of the household head	*Ethnic majority*	11.2	54.9	0.062
	Ethnic minority	45.3	61.7	0.279
Wealth quintile	*Highest 3 quintiles*	3.9	51.1	0.020
	Lowest 2 quintiles	34.6	58.5	0.202

Three-Way Overlap of Deprivations

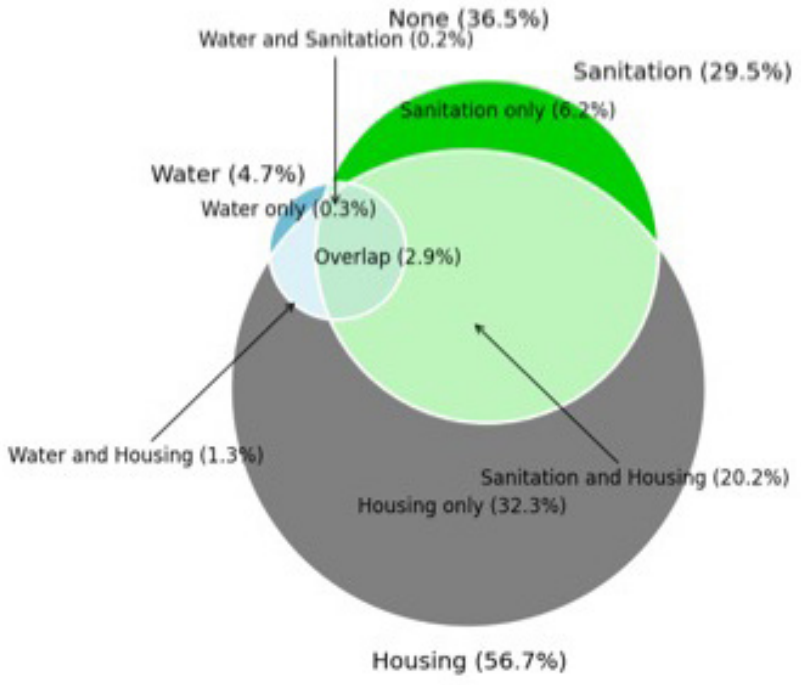
Children aged 5-11 years old present lower deprivation rates per each dimension compared to the youngest age group and thus experience less overlap between deprivations (see Figure 14). Nearly 3 per cent of children are deprived in the dimensions Water, Sanitation and Housing at the same time. Another 36.5 per cent face no deprivation in any of the three dimensions.

Figure 14. Deprivation headcount ratio (%) by each dimension, 5-11 years and 12-17 years



Source: Author's calculations based on the SDGCW 2020-21 survey.

Figure 15. Three-way overlap between the dimensions Water, Sanitation and Housing, 5-11 years



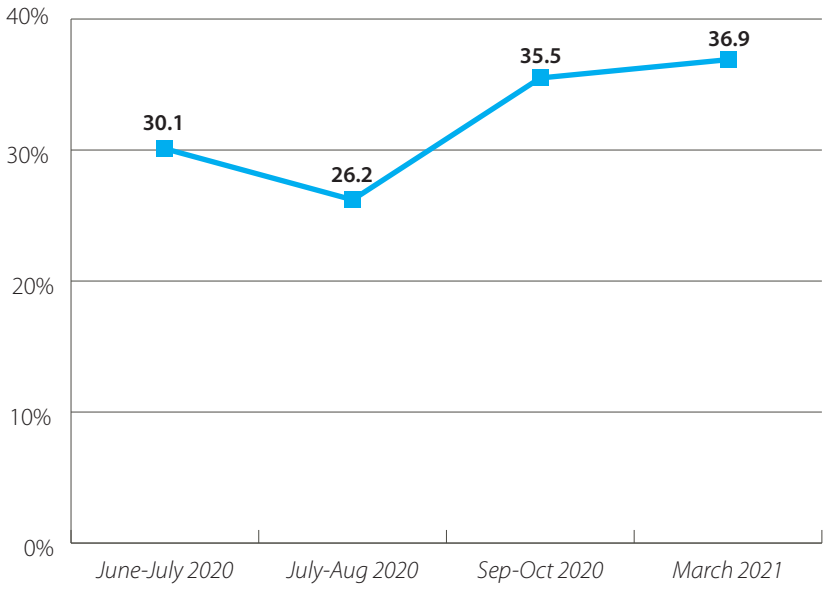
Source: Author's calculations based on the SDGCW 2020-21 survey.

Annex V: Additional tables - Descriptive quantitative analysis

Health

The percentage of households with at least one member who needed medical treatment in the seven days preceding the survey in June-July 2020 accounted for 30.1 per cent (see Figure 15). In July-August 2020, this percentage declined slightly while the proportion increases again from September/October 2020. In March 2021, 36.9 per cent of households had at least one member that needed medical treatment.

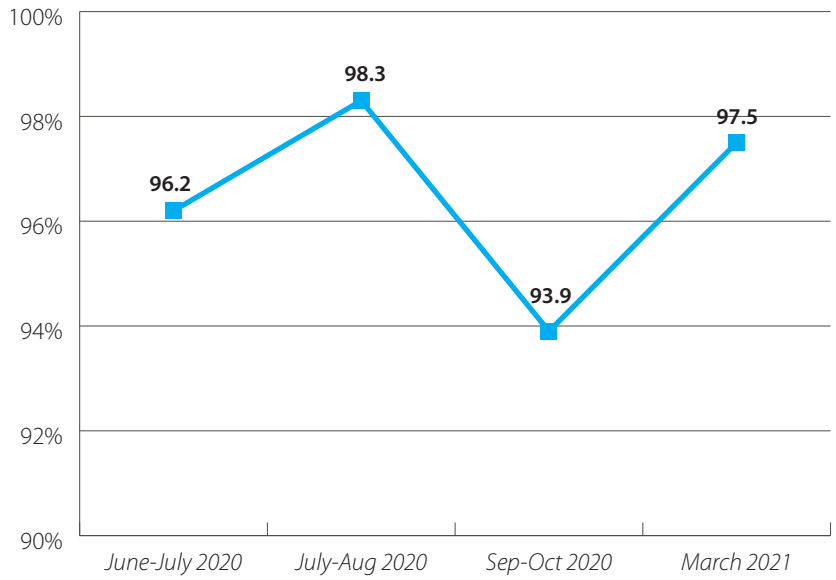
Figure 16. Proportion of households with at least one household member who needed medical treatment in the last 30 days.



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21.

Figure 16 presents the percentage of households that were able to access medical treatment from June-July 2020 to March 2021. Although there are some slight fluctuations observed, in general, more than nine out of ten households were able to access medical treatment. Access to medical treatment was the highest in July-August 2020 (98.3 per cent) and the lowest in September-October 2020 (93.9 per cent). The main raison for not accessing medical treatment was related to stay-at-home restrictions.

Figure 17: Proportion of households being able to access medical treatment



Source: Author's calculations based on World Bank Monitoring Surveys 2020-21.

Early Childhood Development

Table 12 presents the proportion of children that are on track or not based on the early child development index (ECDI). The index measures a child's key age-specific developmental goals in terms of skills, knowledge and behaviour.[89] Mothers or primary caregiver are asked 20 standardized questions on the development of their child, making the index internationally comparable.

It is observed that 78.1 per cent of Vietnamese children aged 2-4 years are on track. Remarkable differences are found based on the regional level. In the Northern Midlands and Mountain areas, 30.9 per cent of children are not on track opposed to 20.9 per cent of children living in the Mekong River Delta. Girls are slightly performing better than boys, with 79.7 per cent of girls on track compared to 76.7 per cent of boys. Moreover, 37.1 per cent of children whose household head belongs to an ethnic minority and 30.5 per cent of children from the two lowest wealth quintiles are not on track.

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Table 12. Proportion of children that are on track or not based on the child development index (2-4 years)

Child development index (2-4 years) (%)		On track	Not on track
National	*National*	78.1	21.9
Area of residence	*Urban*	82.7	17.3
	Rural	76.0	24.1
Region	*Mekong River Delta*	79.1	20.9
	South East	77.2	22.8
	Central Highlands	69.6	30.4
	North Central and Central Coastal	77.2	22.8
	Northern Midlands and Mountain	69.1	30.9
	Red River Delta	87.2	12.8
Sex of the child	*Girl*	79.7	20.3
	Boy	76.7	23.3
Sex of the household head	*Female*	72.2	27.8
	Male	79.9	20.1
Ethnicity of the household head	*Ethnic majority*	81.3	18.7
	Ethnic minority	62.9	37.1
Wealth quintile	*Highest 3 quintiles*	83.6	16.4
	Lowest 2 quintiles	69.5	30.5
Total number of observations		**2,723**	

Source: Author's calculations based on the SDGCW 2020-21.

Table 13. Proportion of children aged 1-14 years old exposed to psychological and physical discipline

Profile		Psychological discipline (1-14 years) (%)		Extreme physical discipline (1-14 years) (%)	
		Exposed	Not exposed	Exposed	Not exposed
National	*National*	64.3	35.7	11.4	88.6
Area of residence	*Urban*	62.8	37.2	10.2	89.8
	Rural	65.1	34.9	11.9	88.1
Region	*Mekong River Delta*	71.5	28.5	9.5	90.5
	South East	72.8	27.3	12.9	87.1
	Central Highlands	59.0	41.0	11.4	88.6
	North Central and Central Coastal	64.0	36.0	17.0	83.0
	Northern Midlands and Mountain	60.6	39.4	7.8	92.1
	Red River Delta	42.0	58.0	8.9	91.1
Sex of the child	*Girl*	62.3	37.7	9.4	90.6
	Boy	66.3	33.8	13.2	86.8
Sex of the household head	*Female*	65.6	34.4	12.9	87.2
	Male	63.9	36.1	10.9	89.1
Ethnicity of the household head	*Ethnic majority*	64.6	35.4	81.3	18.7
	Ethnic minority	62.8	37.2	62.9	37.1
Wealth quintile	*Highest 3 quintiles*	64.2	35.8	10.5	89.5
	Lowest 2 quintiles	64.6	35.4	12.8	87.2
Total number of observations		**9,189**		**9,199**	

Source: Author's calculations based on the SDGCW 2020-21

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Ha Noi Office: **Add:** 304 Kim Ma, Ba Dinh, Ha Noi, Viet Nam
Tel: +84 (0) 24 3.850.0100 | **Fax:** +84 (0) 24 3.726.5520

HCMC Office: **Add:** Unit 507, Sun Wah Tower, 115 Nguyen Hue Boulevard, District 1, Ho Chi Minh City, Viet Nam
Tel: +84 (028) 3.821.9413 | **Fax:** +84 (028) 3.821.9415

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