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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Introduction

This policy brief presents the key findings of research that assessed the socio-economic impacts of the COVID-19 pandemic on children and 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 in Viet Nam between 2021 and 2022. The study builds upon the first rapid assessment of the socio-economic impacts of COVID-19 on children and families.1

As of June 2022, more than 10 million cases of COVID-19 have been reported in Viet Nam, with more than 40,000 deaths.2 Since the surge in cases since the fourth wave of the pandemic in April 2021, strict containment measures were enforced in selected cities and provinces in Viet Nam. In response, the Government launched an economic recovery plan through large support packages, fee exemptions, and increased allowances to social protection beneficiaries. It also adopted a clear communication strategy to raise awareness and inform the population about the risks of the virus and protection measures.

The study aimed to answer the following questions:

A. What are the socio-economic impacts of COVID-19 on children, their families, and vulnerable groups?

B. How did children and families cope with the impact of the pandemic and policy response measures, including in terms of formal support, resources, and social capital received?

C. What are the policy recommendations for mitigating the socio-economic impacts of COVID-19 and other crises on children and their families in the short, medium, and long terms?

Methodology

The research employed a mixed-methodologies approach encompassing: 1) a desk review, 2) quantitative research using secondary data analysis of World Bank Monitoring Surveys (WBMSs) 2020-2021 survey data, as well as a multidimensional poverty analysis using Viet Nam SDG Survey on Children and Women (SDGCW) 2020-21 data, collected between November 2020-February 2021 and 3) qualitative research based on in-depth interviews and focus group discussions with caregivers and frontline service providers in child-relevant sectors in Ha Noi, Bac Giang, Da Nang, and Ho Chi Minh City.

2 World Health Organization 2022.
Key Findings

Multidimensional Child Poverty (MCP)

Prior to the fourth wave of the COVID-19 pandemic in Viet Nam, just under one-in-five children aged 0-17 years, or 19.8 per cent, experienced multidimensional poverty in being deprived in at least two dimensions of well-being out of the total number of measured dimensions, representing their unfulfilled rights. On average, these children were deprived in 49.5 per cent of all measured dimensions. Some 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. Children living in rural areas were twice as likely to be multidimensionally deprived compared to those living in urban areas. Similarly, children living in the Central Highlands were the worst off out of all regions, with a higher share being multidimensionally deprived (one-in-three, or 33.1 per cent) and experiencing a higher level of multidimensional deprivation (52.0 per cent of all possible dimensions measured). Substantial differences were also observed based on the ethnicity and wealth quintile of households at the national level. 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. The MCP analysis was limited by data and therefore did not include all potential dimensions of children’s rights and wellbeing, suggesting that the actual share of multidimensionally deprived children was likely higher than reported here. These findings suggest that during a period where progress in poverty reduction in Viet Nam had already been stalled by the pandemic, and before the onset of intensified public restrictions, persistent multiple deprivations and inequities among children and families put a substantial share of children and families at risk of falling further behind in the fulfilment of their rights.

Economic Impact on Livelihoods

The economic slowdown associated with social distancing and lockdown policies led to a reduction in incomes (Figure 1) and the use of negative coping mechanisms. This fall in incomes was due to multiple factors, but was dominated by job losses, reduced wages and business, and was experienced disproportionately in certain economic sectors including services, manufacturing and among the self-employed. Many engaged in negative coping mechanisms, including reduced consumption of food and non-food items and taking on debt (Figure 2).

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3 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.
Figure 1: Household income comparisons

Figure 2: Coping mechanisms of households

Engaged in additional income generating activities
Received assistance from friends & family
Borrowed from friends & family
Took a loan from a financial institution
Reduced food consumption
Reduced non-food consumption
Relied on savings
Did nothing
Grow food for self consumption
Put more efforts on current job
Social Protection and Social Assistance

Social protection responses to meet households’ consumption needs during the pandemic had mixed impacts. Many interview and focus group discussion participants in this study expressed a need for support to access food, purchase medicines, pay for equipment for children to attend school remotely and meet other needs, such as childcare for migrant and freelance workers, and for specialized assistive devices for children with disabilities to participate in remote learning. The State provided various social protection schemes including for the unemployed, those quarantined, poor and near-poor households and general subsidies, but awareness of schemes was limited. The provision of social protection was reduced throughout the pandemic (Figure 3) and many recipients reported that it was inadequate to meet their needs, especially for those who had not recovered economically by the time restrictions had fully or partially lifted. Poor households, informal and migrant workers particularly reported inadequate levels of social protection. Many also referenced barriers that made access difficult or even impossible, such as complicated application procedures, long time delays between applying and getting a response, and a lack of communication from authorities regarding the types of social protection available and how to apply for it.

Figure 3: Proportion of households receiving support from the government or international organization by type of assistance
Health and Nutrition

Already prior to the fourth wave, 70 per cent of children aged 0-35 months in Viet Nam did not meet minimum standards for diet and feeding practices, or for age-specific prenatal care and immunization. 4 Although access to medical treatment was nearly universal throughout the pandemic to date, social distancing and service disruptions led to lost or delayed access to routine services, such as antenatal care and immunization. Caregivers reported the following barriers to access: 1) fear or inconvenience, 2) high out-of-pocket expenditures for test kits and medicine, 3) unavailable routine and emergency services and 4) crowding out as private clinics closed and health centres were overloaded. People’s coping mechanisms included informal financial support for health-related expenses, not seeking care (or not reporting infection status of caregivers and children).

UNDP 2021 data suggested, nationally, that more than half of households had to reduce food consumption at each meal (51 per cent) and almost 18 per cent of households lessened the number of meals consumed, with the most severe food shortages reported by households with children, migrants, and laid-off workers. Ethnic minority, female-headed and poor households were most likely to worry about having enough to eat. While nearly all qualitative research participants were able to purchase food or received food as in-kind informal or formal support, many were unable to easily access or afford nutritious foods for their children of the same quantities or quality as pre-pandemic. This situation was particularly acute from informal workers and migrant worker caregivers, who reported reduced meal sizes, less nutritious and varied diets for children, while breastfeeding mothers consumed less nutritious foods and/or substituted breastmilk with formula. Caregivers in Bac Giang and Ha Noi stated that the lack of school meals disrupted their children’s diet, while migrant workers worried about not being able to guarantee or monitor their children’s nutrition from afar. To cope, caregivers: 1) reduced food expenditures and meal sizes, frequency, and/or quality, 2) borrowed money or sought informal support, 3) obtained formal food support, 4) reduced expenditures in other areas and 5) engaged in farming or fishing.

Mental Health

The fourth wave of the pandemic in 2021, lockdowns and social distancing undoubtedly worsened the state of mental health and psychosocial issues among children and families. July 2021 data found that more than 66 per cent of households worried about the impacts of COVID-19, with experiences varying from depression to irregular anxiety. Female-headed households and migrants living in crowded conditions were also found to...
have disproportionately experienced mental health issues. Caregivers and their children in all four study sites reported experiences of stress, fear, worry, loneliness, frustration, and poor sleep due to fear of infection, as well as long periods of remote learning, social distancing and lockdowns. These were exacerbated by the lack of physical exercise, as well as stressors including reduced income, unemployment, and additional caretaking duties. None of the interviewed caregivers sought professional support to cope or was aware of where to seek counselling services. Social workers in Bac Giang, Da Nang and Ha Noi confirmed that poor awareness, service availability, and social stigma continued to limit uptake of mental health services.

Education and Learning

**School closures threatened to widen education gaps.** In 2021, the rate of educational deprivation for rural children was almost twice that of urban peers. Children aged 5-11 years from the two lowest quintiles had a deprivation rate three times higher than their peers from the three highest wealth quintiles. Due to the pandemic, online or remote learning was inevitable but not necessarily accessible to all children. Caregivers often relied on family members or neighbours to enable children to attend classes remotely. Two reasons were: 1) lack of learning devices such as computers, smartphones and 2) lack of adequate internet connectivity. Furthermore, certain working parents sent children to hometowns to live with grandparents. These children were more likely to lack adequate learning equipment and support. Early childhood education centres were also closed without alternative remote modalities in many cases, threatening to widen the gap for the already disadvantaged children including those living in rural areas, boys, children living with a female-headed household head, ethnic minorities, and children living in the poorest families.

**The quality of learning online was inferior to that of schools.** Many caregivers were concerned about children’s ability to learn, pay attention in class, and their sedentary nature. While teachers and schools cooperated with caregivers to ensure student engagement and learning progress, many children had lost interest. Major concerns revolved around: 1) the limited ability of parents and teachers to monitor their children’s learning and 2) children’s health risks resulting from excessive screen time and 3) limited effectiveness in encouraging children to learn remotely. Teachers also observed a decrease in students’ attention spans. Moreover, not all teachers were trained in using (assistive) online learning devices.

**Cooperation was crucial in overcoming the challenges of online learning.** Teachers experiencing connectivity issues or a lack of teaching equipment received support from their institutions or were permitted to teach online from classrooms. Students without learning devices received printed learning material.
materials or extensive catch-up sessions during school re-openings. Revision sessions were often provided to all children during the first weeks of school re-opening.

Child Protection

School plays a major role in child protection and care activities. With school closures during the pandemic, children were often left alone at home when parents needed to work or to other commitments. Migrant workers unable to return home faced greater difficulties. Job losses and/or income declined and limited social contact led to higher levels of stress and anxiety in many families. In-depth interviews affirmed these risks to children and suggested increased exposure to physical and psychological violence (inter-partner conflict and violence towards children) within families. Especially disadvantaged population groups – including the poor, near-poor, informal workers and migrants – were more likely to experience violence or abuse due to additional economic and caretaking pressures. Furthermore, the risk of online abuse and addiction to electronic devices and gaming was an increasing concern of service providers and caregivers as a byproduct of (online) distance learning.

Water, Sanitation, & Hygiene (WASH)

According to the SDGCW 2020-2021 survey, prior to the pandemic, only 1.9 per cent of households in Viet Nam did not have access to improved water sources. The main reasons why households were unable to access sufficient quantities of water included unavailability of water at the source, inaccessibility of water sources and water salinity. Furthermore, 89.9 per cent of households in Viet Nam had access to improved non-shared sanitation facilities. Nearly all households had a handwashing facility in the household, although 7.2 per cent had no water and soap or detergent available. While the vast majority of the population strictly followed pandemic-related health measures, some people did not use personal protective equipment as it was deemed uncomfortable and/or not supplied for free. Moreover, policy priorities shifted during the pandemic, leading to the suspension of several programmes at service provision level, including: 1) the monitoring of water access and quality, 2) supervision of environmental sanitation and 3) monitoring of rubbish collection points. Environment companies responsible for (medical) waste collection were not able to guarantee regular and timely collection and transportation. In Ha Noi, it was observed that toilet facilities in schools were not always adequately equipped with sufficient toilet paper and hand soap.

Parental Care & Decision-Making

Social distancing and lockdowns caused householders to stay at home and revisit living arrangements. Some households were more fortunate than
others to have both parents stay at home and divide chores more equitably. Nevertheless, some caregivers (migrant workers in particular) could not return home due to travel restrictions, leaving the remaining caregiver fully responsible. In most cases, however, children helped more around the house.

Caregivers faced pressures of an uncertain income and managing children at home. Due to the lack of day-care options, households usually sought out family members for caretaking assistance. Children were sometimes left with grandparents as parents were migrant workers, worked in the city and/or were unable to care for the child during the day. Day-care options were provided by some employers later in the pandemic, but were not universal.

**Vulnerable Children**

For children who were attending or residing in centres/schools which provided food and/or boarding, ensuring 5K regulations during the pandemic meant that a large share of children were not able to socialise, to remain at residential facilities or retain regular access to nutritious meals. As of July 2022, the pandemic had left up to 4,461 Vietnamese children orphaned, of whom 193 children had lost both parents. Mental health challenges were especially acute for vulnerable children, as staff at social protection centres and schools for children with disabilities often lacked capacities/training for providing psychological counselling and therefore were not able to sufficiently support these children and adolescents. Facilities for vulnerable children in all four study sites were highly reliant on donors to cope with the new and additional resources needed during the social distancing period. However, resources available were not always adequate to ensure normal operations before, during and potentially beyond the pandemic period. Children living and/or working on the streets were among the key risk groups, as the economic shock both pushed more children to seek incomes whilst also limiting the opportunities available. School closures and service disruptions limited the safety nets available to these children. Challenges also persisted with ensuring children with disabilities’ access to appropriate assistive devices to continue their learning remotely, although official and charitable support attempted to close this resource gap in select cases in Ha Noi and Ho Chi Minh City.

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6 Ministry of Labour, Invalids and Social Affairs 2022; Xuân Đức 2022.
Policy Recommendations

Beyond COVID-19, Viet Nam faces severe and evolving international economic, political and environmental volatility, such as climate change and the recent food and fuel price shocks. The importance of building a rights-based, shock-responsive, 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 build the resilience of families with children throughout and beyond crises. Sector-specific recommendations follow below:

Social Protection and Social Assistance

- **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 to households and how they can apply for it.

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

- **A shock-responsive universal transfer should be introduced to provide emergency assistance in times of shock.** This can provide both a vertical expansion of social protection that tops-up the transfers of those already receiving social assistance, and a horizontal expansion, that widens the targeting criteria to capture a greater proportion of the population. This should be provided through a digital payment but with additional payment mechanisms, such as cash and in-kind delivery, for those without access to banking.

Health and Nutrition

- **Continue funding and expansion of mobile and door-to-door service delivery** to ensure service continuity, especially in hard-to-reach areas.

- **Consider mobile meal delivery or pick-up services to school-going children.** Include options for low-resource households to continue receiving meals.
• **Promote** the importance of continued **utilization of health and nutrition services** even during crises.

• **Expand the package of social protection and assistance** provided to cover extraneous health and nutrition expenditures and limit high out-of-pocket expenditures, which worsen the financial insecurity already experienced by the most vulnerable.

**Mental Health**

• **Develop capacity for mental health support and counselling** in all child-relevant sectors, including in service sectors targeting vulnerable children such as orphans and children with disabilities.

• **Adapt school curricula** to sensitize teachers and pupils to mental health concerns and raise awareness on 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 of support services** to expand access while destigmatizing conversations around mental health and psychosocial wellbeing during and beyond the COVID-19 context.

• **Collect data and conduct research to assess mental health needs** and existing service capacities, to improve service delivery in this sector.

**Education and Learning**

• **Minimize the adverse effects of early childhood education loss.** Public health information campaigns could incorporate early childhood development messaging to increase awareness and convey interactive educational opportunities for young children. Expansion of monetary or in-kind transfers will ensure adequate nutrition and regular health check-ups.

• **Disadvantaged children in primary and secondary schooling need support to catch up on learning.** Provision of free-of-charge revision and catch-up sessions is important, as is ensuring 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.

• **Teacher capacity training must be implemented.** A yearly capacity training programme should be made available to keep teachers up to date on new teaching methods and the skill requirements of job markets.
Child Protection

- Scale-up destigmatizing and awareness-raising campaigns around recognizing child protection vulnerabilities, identifying violations, and where and how to seek support. Integrate modules on child rights in 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 toxic substances and human trafficking. Build parental knowledge on violence against children (online safety) and their capacity to react appropriately through positive parenting, to achieve behaviour change to address violence against children.

- Provide a child protection system for ALL, with tailored and in-depth information depending on the characteristics and age of the children. Conduct research, sociological surveys and polls to grasp the actual needs of children to issue appropriate policies.

WASH

- Ensure that health facilities, schools, and other public spaces have access to safe drinking water and handwashing facilities to improve ability to adhere to COVID-19 safety protocols, and to contribute to improved health and nutrition outcomes as well as school attendance rates.

- Increase (community) awareness of adequate and safe WASH behaviour and the continued importance of adhering to COVID-19 safety protocols. 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

- Social protection expansion to meet pandemic-induced challenges. Provide cash assistance to vulnerable children and organize childcare alternatives for orphaned children, even if cared for by grandparents. Expand existing cash and in-kind transfer support to include large or one-parent households, and households with at least one migrant worker.

- Organize reliable and affordable emergency childcare arrangements for working parents to avoid loss of employment or older children missing out on learning opportunities due to the need to care for younger siblings.

- Enhance parenting and coping messaging in public health information campaigns.
References


