



ENDLINE SURVEY AND EVALUATION

**The Integrated Early Childhood Development
Programme 2017-2021 of UNICEF Vietnam**

Mekong Development Research Institute



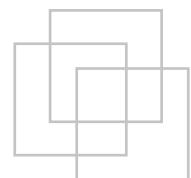
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FINAL ENDLINE REPORT



Endline Survey and Evaluation of the Integrated Early Childhood Development Programme of UNICEF Viet Nam
2017-2021

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ABBREVIATION

| | |
|--------|---|
| CRC | Convention on the Rights of the Child |
| DOET | Department of Education and Training |
| DOH | Department of Health |
| DOLISA | Department of Labour, Invalids and Social Affairs |
| DPI | Department of Planning and Investment |
| ECD | Early Childhood Development |
| ECDS | Early Childhood Development Scale |
| ECE | Early Childhood Education |
| EENC | Early Essential Newborn Care |
| FGD | Focus Group Discussion |
| GSO | General Statistical Office of Vietnam |
| GGA | The Global Guidelines Assessment |
| IECD | Integrated Early Childhood Development |
| IMR | Infant Mortality Rate |
| IYCF | Infant and Young Child Feeding |
| JMP | UNICEF/WHO Joint Monitoring Programme |
| KII | Key Informant Interview |
| MDG | Millennium Development Goal |
| MDCP | Multidimensional Child Poverty |
| MICS | Multiple Indicator Cluster Survey |
| MMR | Maternal Mortality Rate |
| MOET | Ministry of Education and Training |
| MOH | Ministry of Health |
| MOLISA | Ministry of Labour, Invalids and Social Affairs |
| MPI | Ministry of Planning and Investment |
| NIN | National Institute of Nutrition |
| NGO | Non-governmental Organisation |
| NTP | National Targeted Program |
| ODF | Open Defecation Free |

| | |
|-------|---|
| PCFP | Provincial Child Friendly Programme |
| PMG | Project Management Group |
| PMU | Project Management Unit |
| PPS | Probability Proportional to Size |
| RAM | Results Assessment Module |
| SEDP | Socio-economic Development Plan |
| TFR | Total Fertility Rate |
| UNEG | United Nations Evaluation Group |
| U5MR | The under-5 mortality rate |
| VHLSS | Vietnam Household Living Standards Survey |
| WASH | Water, Sanitation and Hygiene |

EXECUTIVE SUMMARY

Background

In the absence of a strong mechanism for inter-sectoral and multi-sectoral coordination of Early Childhood Development (ECD) services, UNICEF implemented the Integrated Early Childhood Development programme (IECD) to strengthen the enabling legal and policy environment for IECD at national level, in cooperation with the Ministry of Labour, War Invalids and Social Affairs, and in 27 selected communes of 9 districts in three projected provinces namely Dien Bien, Kon Tum, and Gia Lai. The pilot model which ran from 2017 to 2021 will generate further evidence and policy options for a nationwide IECD scale-up in the next phase.

The IECD programme aims to simultaneously achieve (i) UNICEF's country programme IECD outcome, (ii) IECD-linked long term and immediate objectives cooperation projects between UNICEF and the Ministry of Labour, Invalids and Social Affairs (MOLISA) and with the Ministry of Health (MOH), and (iii) UNICEF's provincial projects' long-term and immediate objectives on IECD. The outcome and objectives help to realise UNICEF East Asia and Pacific's commitment to the SDGs in full alignment with its 2018-2021 Strategic Plan goals.

Purposes and Audiences of Endline Survey and Evaluation

Since the programme is set to complete its pilot cycle in the three provinces, an endline survey and evaluation are needed to draw out lessons learnt for the nationwide scale-up.

The end-line survey and evaluation report are subjected to achieve the following objectives:

- To conduct a survey capturing the status of the IECD programme indicators in a quantitative manner which will also capture effects of Covid-19 in project provinces
- To evaluate the programme effectiveness, efficiency, scalability and sustainability
- To provide the lessons learnt and recommendations for the central and local governments, as well as UNICEF in replication and scale-up of the model at a national scale

The intended audience of the endline survey and evaluation include:

- The Ministry of Labour, Invalids and Social Affairs (MOLISA), especially the Department of Child Affairs
- UNICEF Management and the Programme Team
- Provincial People' Committees (PPCs) of three project provinces and PPCs of other provinces/cities in Viet Nam

The brief timeframe of the endline survey and evaluation is as below:

| No. | Time | Task |
|-----|--------------------------|------------------------------|
| 1 | April 2021 – July 2021 | Inception phase |
| 2 | July 2021 – October 2021 | Data collection and analysis |

| | | |
|---|------------------------------|---------------------------------|
| 3 | October 2021 – December 2021 | Report writing and presentation |
|---|------------------------------|---------------------------------|

Methodology of Endline Survey and Evaluation

The Endline Survey and Evaluation employs mixed methods, including qualitative and quantitative methods, to collect data for calculating endline value of the interested programme indicators. Desk review focuses on two major components: IECD programme design & implementation status and impacts of COVID-19 pandemic on programme implementation. The review explores the existence of a certain number of IECD supportive policies and coordination/ integration between sectors to assess the current situation of ECD in Viet Nam and help form qualitative inquiry areas which focus on assessing the programme effectiveness, efficiency, scalability and sustainability.

The quantitative surveys were conducted with three groups of respondents, including households, commune official staffs and local ECD service providers, including commune health centres and preschools. Due to the fact that COVID-19 pandemic affected one project district namely K'Bang in Gia Lai province, the survey area shrinks from 27 communes to 24 communes. Endline survey was, therefore, conducted in 24 communes of 8 districts in 3 projected provinces with total of 960 households, 24 commune staffs and 51 ECD service providers. To make the endline statistics comparable with baseline statistics, the research team reran the baseline statistics to cover only 24 communes. Quantitative analysis is performed using STATA.

For the qualitative method, the team conducted in-depth interviews (KII) with representatives of Project Management Unit (PMU) at provincial – district – commune levels and local ECD service providers in the project locations. The research team also organized focus group discussions (FGDs) with four groups of parents/primary caregivers (two male groups and two female groups) who had children aged 0-8 in Dien Bien and Kon Tum. For each province, the research team randomly selected one district and one commune to conduct qualitative study. Totally, 27 KII and 12 FGDs were conducted. Qualitative analysis is done using Grounded Theory and a four-step analytical strategy derived from Thematic Content Analysis.

Programme Evaluation

Effectiveness

Key evaluation questions:

- Has the programme achieved the targets and results set out in the programme design at the outset?
- What is the governance structure of the programme and how effective this structure was for service delivering, coordination, and collaboration?

Replying to the above questions, the programme's effectiveness is rated as 'Satisfactory' for the following reasons:

- In six areas of focus, namely Child health, Education, Child protection, Peace building and social cohesion, Access to and use of IECD services and Implementation of IECD programme, the programme achieves an improvement in almost all indicators, except

for the decline in the percentage of local health workers able to perform IYCF counselling (from 65.7 per cent to 48.7 per cent). The decrease is attributed to the reduced training rate, which comes from the fact that not every health worker in the center received IYCF training; and in the year 2021, under the COVID-19's pandemic impact, no IYCF training has been conducted.

- More than 95 per cent of service providers in project areas rate the IECD programme as quite useful and very useful.
- Strong coordination mechanisms and monitoring systems exist in the project locations. At the central level, the IECD programme has created a clear working structure and well-shaped coordination mechanism. Compared with the baseline, the linkages between stakeholders are strong in the sense that the central government provides technical support to the local government and the local government, in return, reviews and provides the central government with evidence of the interventions' effectiveness.
- Vulnerable and marginalized children benefit from the IECD programme in different ways. For example, in Dien Bien province, 9 models managing disadvantaged children are established in project communes.

However, even though there has been improvement in some indicators' performance, the improvement will need further investment and support is to continue to reach the target. For example, the percentage of people in humanitarian situations who access safe drinking water increases from 30.1 per cent to 49.4 per cent, but the target rate for the whole programme area is 100 per cent. Also, the programme's implementation are hindered by climate change, natural disasters in the sense that the devastating flood in 2019 affected a wide area covering Gia Lai and Kon Tum province and put people's lives in jeopardy. Also, language barriers make it hard for parents/ caregivers to comprehend the training content and gender stereotypes discourage fathers from participating in the training and club meetings

Efficiency

- How economically resources or inputs (such as budget, expertise and time) are converted to results?
- Did the programme manage to achieve all or some of its objectives within established timeframes and costs?
- Did the programme demonstrate some flexibility in adapting to any change in environment in terms of political, legal or socio-economic aspects?

The efficiency of the IECD programme is rated as "Moderately Satisfactory" for the following reasons:

- Most participants in the qualitative study agreed that project implementation is as cost effective as originally proposed. First, the cost sharing policy between the donor (UNICEF) and the recipients (project provinces) is considered relevant and effective in ensuring compliance and delivery of operations. Second, the budget was fairly distributed between components and between localities. Third, despite funding constraints, financial resources were utilized as efficiently as possible, resulting in the achievement of most important objectives.
- All three provinces achieve a high disbursement rate, at higher than 90 per cent, which implies that almost all project activities are delivered and associated expenses are disbursed according to the plan.

- Regarding the objective achievement, three provinces manage to achieve improvement in at least two thirds of the quantitative indicators within the established timeframes and costs.
- The programme demonstrates certain level of flexibility to adapt to environmental changes such as Covid-19 pandemic. As an example, UNICEF invested in digital equipment for PMU and provincial partners to conduct online meetings/training during the period when social distancing was tightened.

However, key issues affecting the assessment of efficiency include:

- The financial resource is not sufficient to achieve all objectives set in the originally planned vision, which is more ambitious. This leads to modifications of some activities and adds complexity to the implementation process.
- The received funding opportunity is not equal across programme components. While some components such as early essential newborn care or holistic parenting have good funding, other components are in need of more fund.
- Resource mobilization was not as successful as expected so there is not much of a flexibility in adjusting the programme to adapt to socio-economic trends and emerging needs of people. For example, despite attempts to take a high-tech approach in reaching the most vulnerable children in remote areas, UNICEF could not deploy the mobile technology tracking system called Mobile Integrated Early Childhood Development (MIECD)¹ in 27 project communes due the substantial amount of additional budget required.

Sustainability

- Are there prospects for further development of related interventions after the end of the programme cycle, even across project locations?
- Are local governments in project locations committed and simultaneously capable of maintaining the IECD operationalization model by the end of the programme cycle?
- Do capacity building activities within the IECD programme positively affect sustainability and have they been systematized and institutionalized?

The sustainability of the IECD programme is rated as “Satisfactory” for the following reasons:

- Given that the programme was deliberately built upon local needs and capacities, several core elements inherited from the IECD programme have been systematized and institutionalized for continuous implementation. First, child protection interventions hosted by DOLISA (the Nobody's Perfect" model, developed child protection systems, case management for marginalized children, ...) have been formalized into national and provincial action plans to be maintained regardless of UNICEF's support. Second, impacts of the education sector (the Social Emotional Learning (SEL) curriculum, GGA and ECDS tools) are very likely to persist as having been nationally adapted by MOET. Last, with regards to the health sector, some key activities that belong to the fixed roles and responsibilities of the service providers will continue to be carried out, including

¹ MIECD is an artificial intelligence-driven analytic system that provides complete decision support for appropriate and timely actions at critical points of care to save mothers and children's lives through data warehousing, predicting, data mining and advanced analysis

height and weight measuring (for children below 5), vitamin A and vermifuge distributing, postpartum mother visiting, early stimulation counseling. Multiple micronutrients for young children, multiple micronutrients for pregnant women, detection, and treatment of children with severe acute malnutrition are put into the nutrition benefit package that has officially been formulated at MOH and advocated to be covered by government insurance.

- The cross-level and cross-sectoral coordination mechanisms are considered a distinguished element of the IECD programme and have been constantly reinforced throughout the implementing period. UNICEF has helped facilitating smooth vertical cooperation between provincial, district, communal and village stakeholders specifically in terms of establishing action plans in alignment with targeted objectives; carrying out capacity building for service providers; monitoring and documenting achieved results through field visits, periodic meetings, and progress reports. The multi-sectoral collaboration in each level of subnational government is also maximized, reflected by the representation of different technical fields (health, education, child protection, ...) in both IECD management boards and in IECD activities (training, communication sessions, ...). While the IECD steering committees at provincial, district, and commune levels may disband at the end of the programme, the established communication system and network, which in this case is closely-connected and well-functioning, will continue to be utilized for further activities.
- There exists a genuine willingness and a continuing commitment of beneficiaries, local governments and service providers to sustain IECD models in the coming phases. At the local government level, project provinces and UNICEF have discussed together to find a way moving forward with the IECD models in the coming phases. In fact, additional children-related indicators are successfully integrated into the provincial annual and 5-year social and economic development plans to demonstrate the provinces' ownership to sustain investment on children.
- Capacity-building for teaching staff has been proven to be impactful, which further highlights the potential sustainability of ECE interventions.

However, there are also several factors seriously affecting the programme's sustainability that needed to be well taken into considerations:

- Child nutrition related objectives are presenting major difficulties for sustainability since the programme is targeting the most vulnerable population groups with poorest socioeconomic conditions.
- A stable financing mechanism to cover treatment costs for severely acute malnutrition can become an intolerable burden for project provinces in the absence of UNICEF's funding source.
- IYCF capacity building training at endline are less accessible for healthcare workers than before.
- The Covid-19 is putting a substantial amount of burden on medical staff at all levels, leaving them no time for other roles and priorities.

Scalability

The scalability of the IECD programme is rated as "Satisfactory" for the following reasons:

- Beneficiaries and provinces show their willingness to continue participating in programme activities, but more attention would be put on resource allocation for Covid-19 prevention.
- 100 per cent of service providers involved in the survey claim that they would recommend the IECD model to be implemented in other communes/localities.
- Enabling actors at national and provincial level all express their enthusiasm by mapping out detailed plans for model upscaling in the next phase, but there is rising concern about the shortage in both current financial and human resources.
- PMU at all levels have high confidence in the applicability of the IECD model in non-program areas, but some modification in the design and approach methods should be made for each locality.
- Abundant evidence for replicability in non-program districts exists within three provinces.
- Covid-19 pandemic is anticipated to affect the implementation of the programme's activities only, not the long-term objectives and planning.

Recommendations

There are some proposed recommendations for sustaining the achieved results of the IECD programme as well as facilitating smooth replication of the models in non-program areas, for example:

For UNICEF:

- Work with the three provinces to identify successful lessons and discuss ways to turn plans to maintain and replicate programme's outcomes into concrete actions;
- Organize multistakeholder conferences to use the programme evaluation results to inform policy and suggest future adjustments from what works and what does not work in the pilot model;
- Continue to invest in capacity building activities for relevant stakeholders when possible, especially in the area of health and nutrition;
- Technology can be further leveraged in order to generate more widespread impacts. It has been proven that smartphones and social media are very popular information channels even in mountainous provinces thanks to high Internet/mobile phone coverage in Vietnam. Therefore, it would be strategic to make good use of technology in order to eliminate geographical barriers to people living in remote and isolated areas;
- The design of any future programme should take into accounts cross-cutting issues like climate change, economic shocks, and gender equality. In order to establish highly practical and not overly ambitious objectives, it is important to carefully consider financial factors and pay greater efforts in doing costing for each intervention package.

For the central government:

- Continue to foster coordination between sectors and across levels in order to optimize resources and highlight the role of a holistic approach in IECD;
- Prioritize the needs of the underprivileged in disadvantaged areas in order to reduce regional disparity, thereby realizing development goals in a more focused manner. Support for vulnerable population can be more intensive and diverse in methods. Resources may

not be distributed equally in a mechanical way but should be allocated based on the assessment of people's socioeconomic backgrounds and status;

- Simplify administrative procedures and cut down on cumbersome regulations required during programme implementation to reduce unnecessary burdens created by bureaucracy and paperwork;
- Work closely with UNICEF to provide technical guidance to 63 provinces during implementation of Decision 1437/QD-TTg regarding early childhood development scheme.

For province partners

- Continue to develop concrete action plan to sustain achieved results as well as to replicate IECD models in non-program areas;
- Maintain and nourish the enabling environment for IECD at provincial, district, commune and grass-roots level;
- Promote the exchange of knowledge and experience between intervened and non-intervened communes;
- Interact with the central government and relevant stakeholders for IECD-related policy feedback;
- Mobilize financial resources from diverse sources to allocate adequate funds for committed plans;
- Encourage and support the use of ethnic languages in all communication materials targeting the ethnic minorities who have limited cross-cultural interactive opportunities.

INTRODUCTION



1.1. Country context

Early childhood, from conception to the first eight years, is the period when the brain develops most rapidly and most dependently on both enriching and adverse environments. Early years of childhood form the basis of intelligence, personality, social behaviour, and capacity to learn and nurture oneself as an adult. Many children do not reach their full human potential because of their 'families' income status, geographic location, ethnicity, disability, religion, or sexual orientation. They do not receive adequate nutrition, care, and opportunities to learn.

Despite significant improvements in a range of health and social indicators in Vietnam in recent years, children, particularly children within 0-8 age range remain exposed to multiple deprivations in health, nutrition, education and protection. Moreover, inequities persist in Vietnam between girls and boys, rural and urban and different ethnic groups.

The newly endorsed Law on Children 2016 introduces a number of improvements as compared to the Law on Protection, Care and Education of Children, 2004. Holistic childhood development is articulated in key chapters on specific child rights and state duties. However, holistic early childhood development and rights to early childhood development are not adequately stipulated with legally binding duties and measures for enforcement. The Ministry of Labour, Invalids, and Social Affairs is responsible for coordinating sectoral policies and programmes among concerned ministries and agencies on childhood care and development, which implicitly includes holistic early childhood development. However, there is no coherent, comprehensive Early Childhood Development policy nor an effective coordination mechanism².

Recent economic progress has improved the well-being of millions of Vietnamese children, but not all have benefited equally from such prosperity. There is equity in access to preschool by gender and ethnicity, but it does not necessarily translate into improved learning outcomes for all children. While there are vertical interventions in health, nutrition, reproductive health, and education, little has been done to horizontally integrate services for early childhood development, especially for children from 0 to 3 years old, and particularly at the household level. Even within ministries, there is fragmentation between agencies with low incentives for integration. While the life cycle is an integral part of the social protection system in Viet Nam, the youngest population – especially under '3' – do not benefit from the schemes except for the health insurance. Existing parenting materials, especially for children from 0 to 3, mostly focus on health and nutrition, disregarding child development. Despite the observed increase in the rate of exclusive breastfeeding, it has yet become a practice and boys are more likely to be exclusively breastfed than girls³. Progress has been slowest in reducing malnutrition

² Asian Development Bank (2006). Recommendations for Early Childhood Development in Viet Nam. Period 2006-2010 and the vision toward 2020.

³ General Statistics Office. 2014. Viet Nam Multiple Indicator Cluster Survey.

(stunting), which partly reflects the fact that maternal nutrition remains a problem not addressed adequately in the National Nutrition Strategy. The rates are highest in the Central Highlands and other disadvantaged regions where ethnic minority people live (the Central Coastal region and the Northwest).

Analysis of the Early Child Development Index (ECDI), which is used to determine if children are developmentally on track in four domains: literacy and numeracy, physical, socio-emotional, and learning show disparities. 29.4 percent of children were on track in the literacy-numeracy domain, more in the physical (96.5 %), learning (94.2 %), and social-emotional (91.2 %) domains. However, in each individual domain the higher score was associated with children living in the richest households, with children attending an early childhood education programme and older children⁴.

It is well recognized that there are severe short-term and long-term effects of violence against children. Most immediately, consequences include physical injury, delayed physical growth, damage to the brain, and cognitive and language deficits, with such consequences often being interrelated. In the short term, there are significant impacts on a child's development and adjustment as well as relationships with parents, other adults, and peers – problems such as aggression, withdrawal, isolation, and even self-harm. Unfortunately, in Viet Nam, violence-discipline is widely practiced by parents, with more than seven in every ten children aged 1–14 were found to have experienced physical or psychological punishment at home

1.2. The IECD Programme

UNICEF globally calls for greater integration and synergy across sectors to support integrated programming for children at different stages of the life cycle. The current UNICEF Strategic Plan recognizes specifically the critical importance of the early years on the basis of the latest evidence on the science of brain development: "New scientific research on brain development has brought fresh evidence of the critical importance of early childhood development for future learning achievements, health outcomes and productivity, and the cumulative nature of deficits". An integrated approach to early childhood development (IECD) is not only a global but a national priority in Viet Nam as set forth in the Law on Children 2016. IECD will help the country to achieve a high quality of human capital from the early years of human life, a pre-requisite for sustainable development.

During the programme cycle 2017-2021, with a total budget of 10,584,000 USD the IECD programme was implemented at the national level (to improve the policy framework for IECD) and in 27 selected communes of 9 districts of three projected provinces, namely Dien Bien, Gia Lai and Kon Tum. Of which, Dien Bien is a mountainous province in the Northwest region while Gia Lai and Kon Tum are located in Central Highlands of Vietnam. All three provinces are characterized by a high degree of ethnic diversity and persistent rate of multi-dimensional poverty, evidenced by the high stunting rate and limited access to quality healthcare, nutrition and sanitation services.

The IECD programme aims to simultaneously achieve:

⁴ Ibid

- (1) UNICEF's country programme IECD outcome,
- (2) IECD-linked long term and immediate objectives cooperation projects between UNICEF and the Ministry of Labour, Invalids and Social Affairs (MOLISA) and with the Ministry of Health (MOH), and
- (3) UNICEF's provincial projects' long-term and immediate objectives on IECD.

The outcome and objectives helped to realise UNICEF East Asia and Pacific's commitment to the SDGs in full alignment with its 2018-2021 Strategic Plan goals. To be specific, the IECD programme contributed to the realization of one of three Regional Headlines for UNICEF East Asia and Pacific, namely "*Early Moments Matter*" which puts a strong focus on brain development for young children as a way to build up human capital – the greatest assets of nations.

Table 1. IECD Programme Objectives⁵

| Programme | Main Outcome/ Outputs |
|---|--|
| UNICEF Country Programme Document Outcome 3 | <p>By 2021 in selected areas of the projected provinces, all children and their families, especially the most vulnerable, utilise inclusive and quality IECD services.</p> <p>Main Outputs:</p> <ul style="list-style-type: none"> • IECD-centred Child Survival and Development: Enhanced local capacity to develop and operationalize IECD centred, equitable and inclusive high impact child survival and development packages in focus provinces. • IECD-centred Education: Strengthened capacity of education service providers in focus provinces to deliver quality early learning and school readiness programmes for children under four years. • IECD-centred Child Protection: Enhanced local capacity in focus provinces to develop and operationalise local child protection systems and services, including positive parenting, non-violent discipline. • IECD-centred Social Policy and Governance: Enhanced local capacity to develop and operationalise an IECD centred, equity-focused and inclusive social assistance mechanism in focus provinces |
| UNICEF-MOLISA – Project's Immediate Objective 1 (national level) | <p>Improved national capacity to legislate, monitor and oversee child rights related laws, policies and programmes.</p> <p>Relevant indicator:</p> <p>Availability of a national policy on IECD by 2018.</p> |
| UNICEF Provincial Projects with Kon | <p>By 2021, all targeted children (0-8 years old) and their family members especially those of the most vulnerable groups in the target communes utilise</p> |

⁵ UNICEF Viet Nam. (2016). *UNICEF Viet Nam Country Programme 2017-2021 - Strategy Note*; UNICEF-MOLISA project 2017-2021; and UNICEF's provincial projects with Kon Tum, Dien Bien and Gia Lai provinces period 2017-2021.

| | |
|--|---|
| Tum, Dien Bien Gia Lai (provincial level) | inclusive and quality IECD services to fulfil children's rights to survival, development, education and protection. |
|--|---|

Provincial Project's immediate objectives:

1. By 2021, parents, caregivers, and community members in programme communes have the knowledge, skills and supportive norms to access available IECD services and practice behaviours that support healthy IECD
2. Improved capacity of service providers from related sectors in providing IECD services at all platforms
3. Accessible minimum IECD services in place with acceptable quality for parents, caregivers and children in targeted areas
4. An enabling environment created and maintained for implementation of IECD interventions in the province

IECD stakeholders

IECD program is a joint effort between UNICEF and the Government of Vietnam, with Ministry of Labour – Invalids and Social Affairs (MOLISA) as the lead agency. The coordinating agencies include all organisations working in the field of childhood development, such as:

- Ministry of Health (MOH)
- Ministry of Education and Training (MOET)
- Ministry of Culture, Sports and Tourism (MOCST)
- Ministry of Planning and Investment (MPI)
- Other relevant Ministries and branches
- The National Committee for Children
- Provincial People's Committee

Targeted beneficiaries of the programme

Government ministries/ agencies and social groups at national and subnational levels

Direct beneficiaries: Children, women and other people, especially ethnic minority groups in the 27 communes in the selected 3 provinces (Dien Bien, Gia Lai and Kontum)

Indirect beneficiaries: People in other communes of the 3 provinces, and people in other provinces of Vietnam where the programme model was replicated

Theory of Change

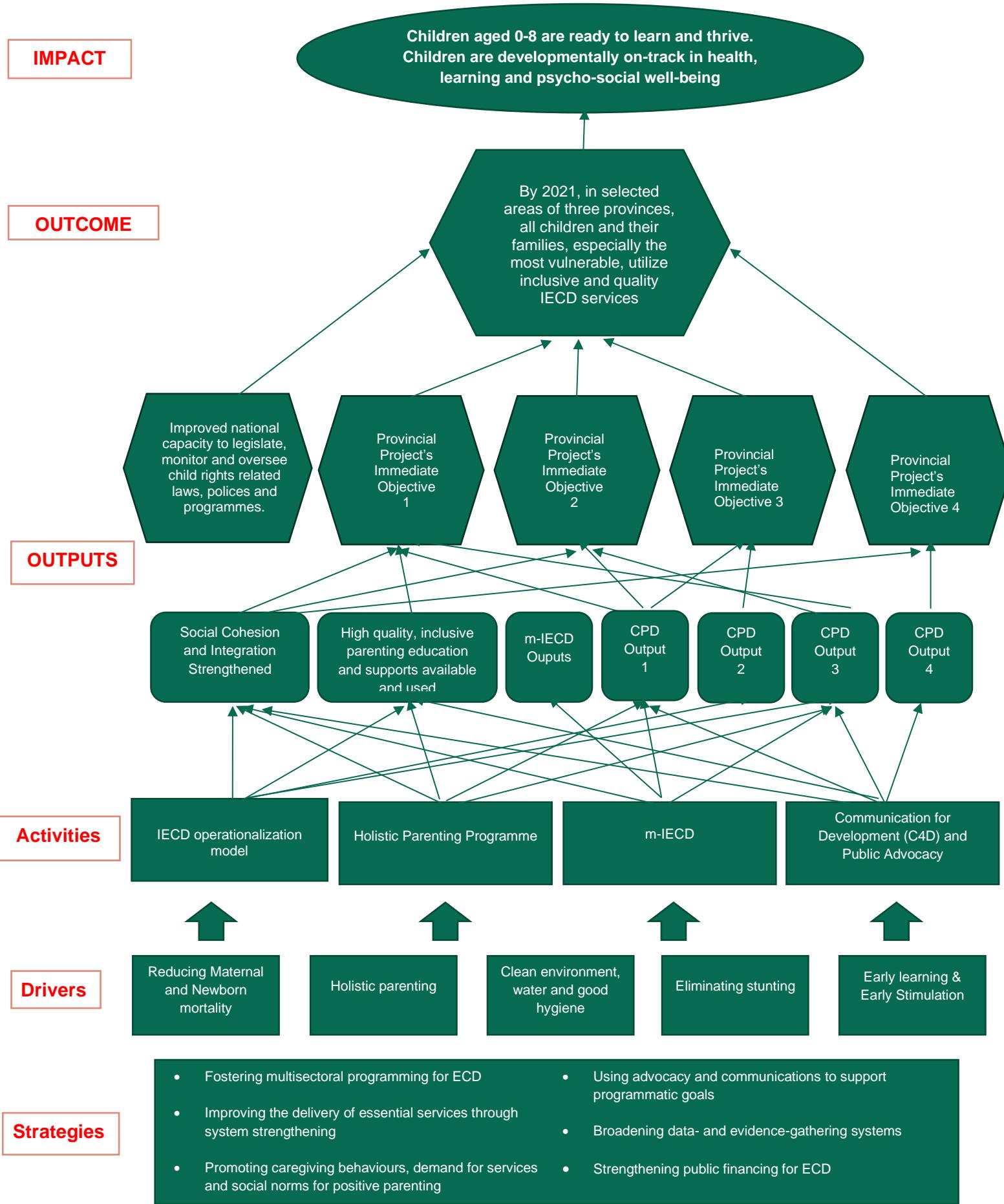
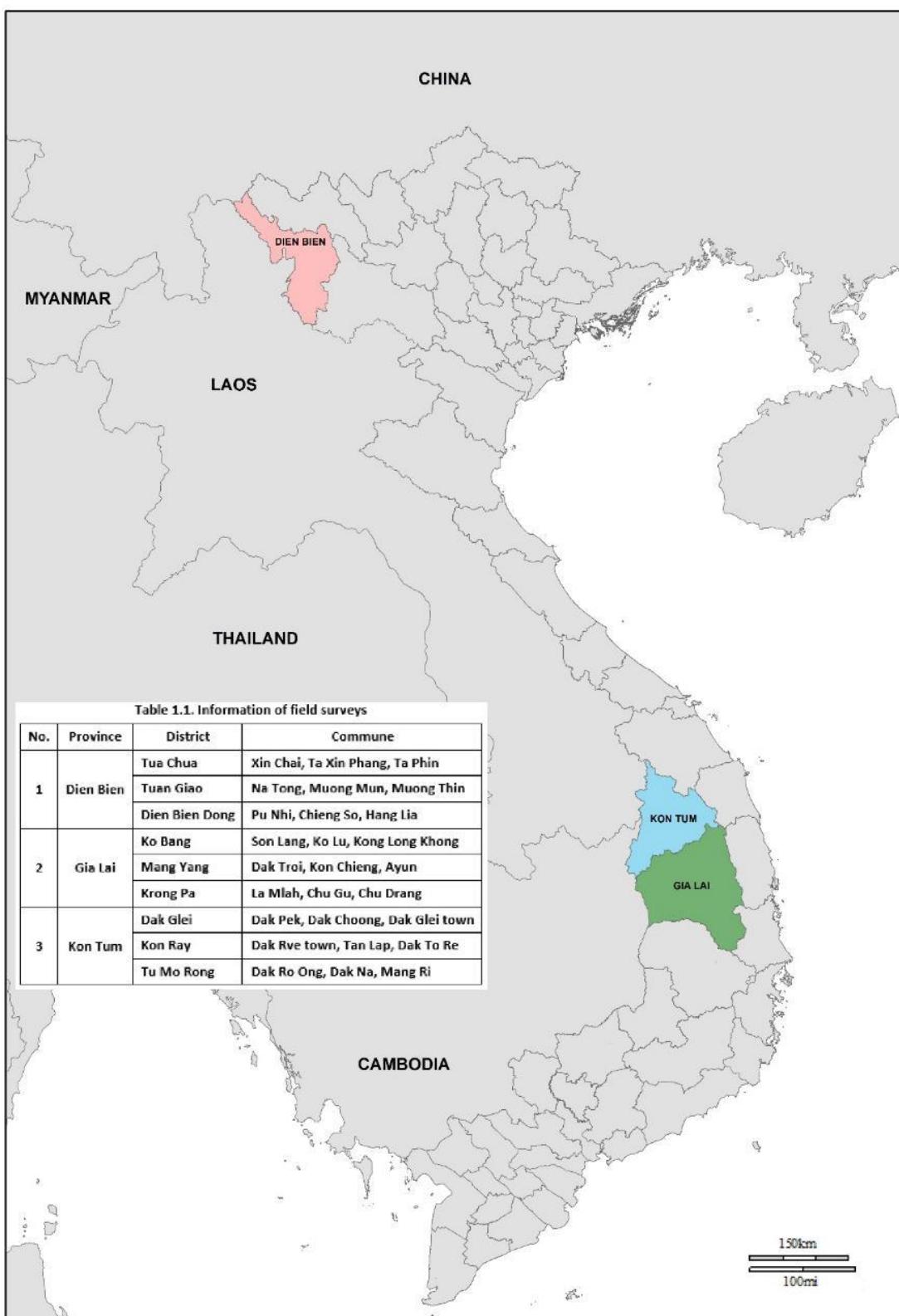


Figure 1. Three project provinces



1.3. Implementation status of the IECD pilot programme in three project countries

According to the mid-term review, the IECD programme has maintained a very good and sustained momentum at both national and subnational levels in the development and institutionalization of an integrated version of ECD. In details, the achieved outcomes are presented below:

- Contribute to the implementation of the National Socio-Economic Development Strategy 2011-2020 and Socio-Economic Development Plan 2016-2020;
- Address the existing gaps and disparities in realizing the rights of all children, strengthen the evidence for policy-making and demonstrate the effectiveness of an integrated and holistic cross-sectoral approach;
- Encourage and enhance shared responsibility among parents/caregivers, families, and social service providers;
- Address multiple disparities in health, nutrition, WASH, education, social protection and child protection to ensure equal access to quality IECD services for vulnerable children
- Address the unfinished agenda of MDGs and SDGs;
- Maximize IECD outcomes and ensure every child in 3 project provinces is healthy, ready to learn and thrive.

At national level, the programme has supported the Ministry of Labour, Invalids and Social Affairs (MOLISA) to draft the national scheme for ECD which was later approved by the Central Government under Decision no. 1437/QD-TTg. This creates enabling environment with strong political commitment to scale up the programme nationwide through the ministerial budget. To date, 58 out of 63 provinces have developed their own approved provincial ECD action plans for implementation of the Prime Minister's approved national IECD scheme document.

At subnational level, a multi-sectoral governance mechanism has been established at provincial, district, commune and village level in order to initiate and facilitate the implementation of project activities as well as holistic ECD services. Comprehensive ECD services/interventions are being delivered coherently through **the four main platforms** (*i) the commune health centres, ii) local preschools, iii) community-based IECD clubs, and iv) individual households*). Of these, communal IECD clubs are functioning as the main powerhouse of sectoral collaboration in services delivery. Of the **38,000** children and families (including vulnerable children) targeted to utilize IECD services for the entire duration of the project, **53,543** parents /child care givers and children have been reached by 2020. The development of a Viet Nam-contextualized Social Emotional Learning (SEL) Programme has been piloted in 174 preschools in the three UNICEF focus provinces, benefitting 9,398 preschool children (51% boys and 49% girls). The NPP Rapid Assessment also shed light on the effectiveness of the holistic parenting programme, which helped change parent and caregiver's practices. Facilitators of the programme (mostly Kinh) claimed to have greater cultural understanding of ethnic minorities thanks to active listening and sharing of parenting experiences. Furthermore, capacity-building interventions contributed to an improvement in the delivery of ECD services by frontline staff.

These achievements explain the fact that the IECD programme has been on course to successfully achieve its programme targets. Despite that, the programme is also facing certain

challenges during its implementation, including high rate of absenteeism due to language barrier and scheduling conflicts, insufficiently skilled facilitators and limited budget.

2020 – 2021 provincial work plan

In terms of the key outcomes expected to achieve at the end of 2020 and at the end of 2021 in three project provinces (Dien Bien, Kon Tum and Gia Lai), the 2020 – 2021 work plan will continue to:

- Provide services and equipment with the application of mobile technology, digital technology, indicators to track and evaluate the implementation process;
- Create favourable environment and conditions to deploy the interventions of the IECD in districts and communes;
- Harness the use of evidence from research and documentation of lesson learnt to inform policy advocacy and strengthen sectoral management.

Experiences and lessons from the IECD model in the three provinces will be used for replication of good practices for achievement of equity of ICED access, benefiting all disadvantaged children in Vietnam.

The national scale up of the IECD programme (approved by the Prime Minister) is projected to happen between 2021 and 2025. The specific objectives of the scheme for the 2021-2025 period had already been mentioned in the previous section.

1.4. The endline survey and evaluation

Objectives of the end-line survey and evaluation

A baseline survey was conducted and completed in October 2018 to establish a set of values for all indicators at the starting point of the programme. Now that the programme is set to complete its pilot cycle in the three provinces, a final evaluation of the results is needed to draw out lessons learnt for the nationwide scale-up.

The end-line survey and evaluation are subject to achieve the following objectives:

- To conduct a survey capturing the status of the IECD programme indicators in a quantitative manner which will also capture effects of Covid-19 in project provinces
- To evaluate the programme effectiveness, efficiency, scalability and sustainability
- To provide the lessons learnt and recommendations for the central and local governments in replication and scale-up of the model at a national scale

Scope of work

The survey and the evaluation focus on national level at the three project provinces of Dien Bien, Gia Lai and Kon Tum. The survey and evaluation will look into how the programme has performed on its all indicators and if the programme is effective, efficient and sustainable/scalable with its current design and governance.

The thematic areas include integrated holistic parenting, services on health, nutrition, WASH, education and governance systems of the programme.

1.5. Structure of the report

The report begins with objectives of the IECD programme and an overview of IECD enabling environment in Viet Nam, provided in Chapter One and Chapter Two. Chapter Three outlines the methodology and provides details of necessary approaches in the fieldwork inclusive of endline survey and the qualitative research design. Chapter Four presents key results of the quantitative and qualitative endline evaluation. Four criteria in programme evaluation namely Effectiveness, Efficiency, Sustainability, and Scalability are expanded upon in Chapter Five. Chapter Six discusses some cross-cutting issues related to human rights such as ethical considerations in research and gender mainstreaming. Limitations of the endline survey and evaluation are briefly mentioned in Chapter Seven before the last chapter about Conclusion and Recommendation. Other relevant documents can be found in the Appendix.

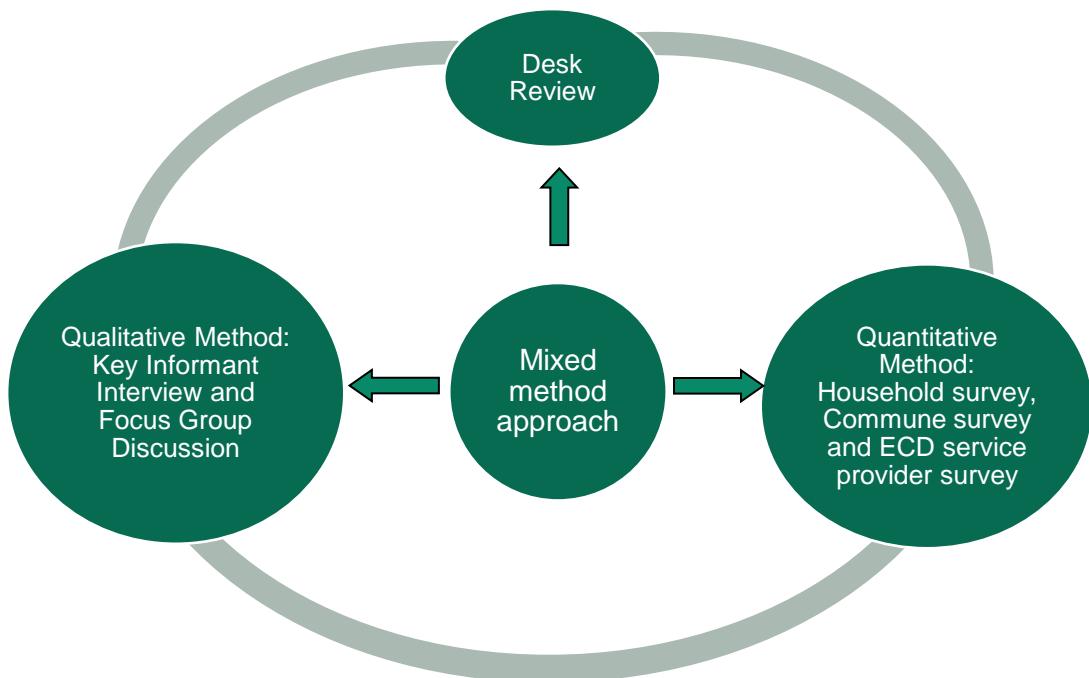
METHODOLOGY

2

2.1. Overall description of approach

To collect data, a mixed-method approach, including desk review, quantitative and qualitative method is applied in this endline survey and evaluation. In addition, a participatory approach is also employed, by engaging all relevant stakeholders and beneficiaries in the process of identifying key findings, conclusions and recommendations. In specific, the quantitative method involves the use of Household Survey, Commune Survey and ECD Service Provider Survey; and the qualitative method comprises of Key Informant Interview and Focus Group Discussion.

Figure 2. Mixed-Method Approach



Source: MDRI endline survey and evaluation, 2021

In order to undertake a broad, comprehensive assessment of the outcome and impact of the outputs produced by the IECD programme, the research team draw upon the following evaluation matrix:

Table 2. Evaluation matrix

| | |
|---|--|
| <p>EFFECTIVENESS</p> <ul style="list-style-type: none"> - Achievement of programme's targets - Governance structure - Enabling environment for IECD services - Improved awareness of beneficiaries | <p>EFFICIENCY</p> <ul style="list-style-type: none"> - Budget disbursement - Optimization of outputs - Flexibility in adapting to change in environment in terms of political, legal or socio-economic aspects |
| <p>SUSTAINABILITY</p> <ul style="list-style-type: none"> - Prospects for further development of interventions after project's completion - Governance mechanism/Enabling environment - Willingness and commitment of stakeholders - Capacities of local service providers | <p>SCALABILITY</p> <ul style="list-style-type: none"> - Willingness of stakeholders - Applicability of IECD model in non-program areas - Evidence for replicability/budget allocation by the local government |
| <p>Cross-cutting themes: Gender, human rights and equity</p> <ul style="list-style-type: none"> - Evidence of a gender equality perspective including gender sensitive and child sensitive data, participation, approaches, indicators, targets and results - Evidence on human rights and child rights-based approaches of the programme including on participation and role of duty bearers and right holders, esp. of socially marginalised groups, results achieved, intervention approaches - Equity: equity considerations in the programme design and implementation, participation of vulnerable groups, the differential benefits of different groups etc. | |

The research team employed a six-point rating scale for four evaluation criteria (effectiveness, efficiency, sustainability, and scalability) as below:

Table 3. Programme evaluation rating scale

| Rating scale | Rated Quality Criteria |
|--------------------------|---|
| Satisfactory | |
| Highly Satisfactory (HS) | Outstanding in all areas, no shortcomings |
| Satisfactory (S) | Good, minor shortcomings |

| | |
|--------------------------------|---|
| Moderately Satisfactory (MS) | Satisfactory; moderate shortcomings but does not fall in any major area |
| Less than satisfactory | |
| Moderately Unsatisfactory (MU) | Significant shortcomings; and/or falls in at least one major area |
| Unsatisfactory (U) | Major shortcomings; does not satisfy criteria in several major areas |
| Highly Unsatisfactory (HU) | Severe shortcomings; does not satisfy criteria in any major area |

2.2. Desk review

Desk review focuses on two major components: IECD programme policy, institutional socio-economic environment, design & implementation status and impacts of COVID-19 pandemic on programme implementation. The review explores the existence of certain number of IECD supportive policies and coordination/ integration between sectors to assess the current situation of ECD in Viet Nam and help form qualitative inquiry areas which focus on assessing the programme effectiveness, efficiency, scalability and sustainability.

The research team consult with and obtain necessary documents from UNICEF Viet Nam and key stakeholders e.g., other UN staff, key national and sub-national government agencies, and other relevant partners such as civil society organizations/ NGOs.

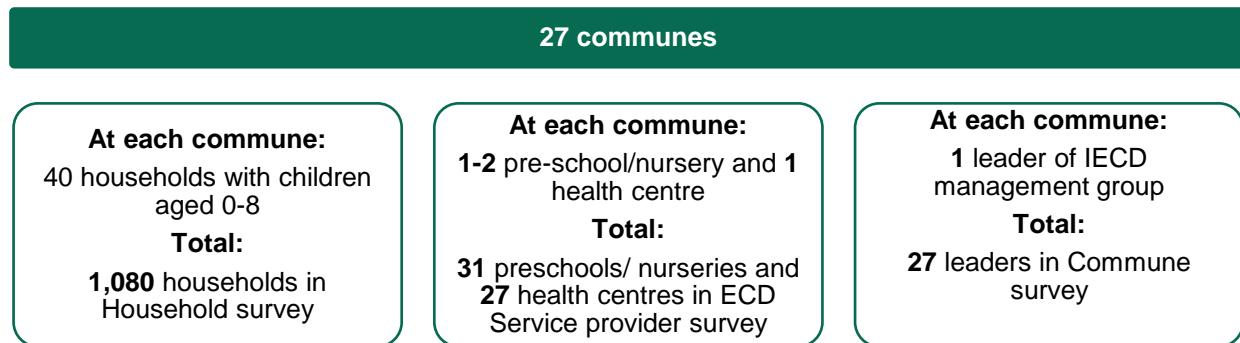
2.3. Quantitative Method

Quantitative surveys gather information from households, local service providers and communities where IECD services are available. Impacts of Covid-19 outbreak on the programme outcomes in project provinces are also quantified, to possible extent. Same as baseline survey, the quantitative surveys include the following questionnaires to gather sufficient indicators of interest:

- A household survey with those having children age 0-8;
- A local service provider survey with pre-schools/nurseries, ECD centres, commune healthcare centres;
- A commune survey to gather information at commune level of ODF certification, m-IECD module covered communes, availability of IECD services.

Sampling strategy

Figure 3. Components of Quantitative Survey



Source: MDRI Inception Report, 2021

Household Survey

It is essential to re-survey the intervention group, so the research team propose to conduct the household survey with the same size and as many repeated households as possible (1,080 households in 27 communes). In case children in any of the 1,080 households grow out of 0-8 age range or move out of the community, such households are no longer qualified for the survey and replaced with a new household that has children aged 0-8 living in the same village.

Step 1: Preparing the list of official and reserve households

The list of baseline-surveyed households serves as the official list. The research team obtained the reserve list of households living in the same village and having children aged 0-8 from database of Department of Child Affairs, Ministry of Labour, War Invalids and Social Affairs.

Step 2: Selecting the households for interview

Baseline-surveyed households are considered qualified for this endline survey if they have children aged 0-8 at the time of the survey. The research team invited as many as possible the qualified baseline-surveyed households to interview (official households). We randomly selected other eligible households from the reverse list in case of impossible interviewing any repeated households. Similar to the baseline survey, the total number of surveyed households in each village (or enumeration area-EA) is 20 (or 40 for each project commune) and the total sample size is 1,080 households in 27 communes.

Service Provider Survey

The research team re-surveyed the service providers (preschools and commune health centres) that participated in the baseline assessment.

Commune Survey

The commune questionnaire was filled up by one respondent who is knowledgeable of the project at the commune level as identified from the qualitative study. All communes in the programme were surveyed, except for the three communes in K'Bang district (Gia Lai province) which were affected by Covid-19 pandemic and removed from the survey.

Survey Design

The household questionnaire captures the after-intervention status of the household's socio-economic characteristics; profile of children aged 0 to 8 broken down into 5 sub-groups with different indicators measured for each targeted group⁶; KAP questions regarding IECD services, parenting practices; etc. The service provider questionnaire (separately designed for pre-schools and health care centres) collects information regarding availability of ECD services at endline period, capacity/facilities of service provider and its personnel, etc. The commune questionnaire covers information that cannot be collected at household level such as ODF certification, m-IECD modules, WASH services, etc.

In general, the endline questionnaires inherit most of the contents from the baseline survey tools with an aim to generate reasonable comparisons between the two periods. However, MDRI also added some questions specifically designed for the endline assessment (Covid-19 related questions, programme evaluation). Furthermore, in close consultation with UNICEF technical experts, the research team made several other changes in the questionnaires to describe the interventions more precisely.

From October 27, 2021 to November 15, 2021, the quantitative survey took place in 3 project provinces, in which MDRI enumerators successfully interviewed 960 eligible households and obtained responses from the representatives/leaders of 24 communes, 27 preschools/nurseries and 24 health centres. The number of completed surveys is less than the initial proposal in Figure 3, due to the fact that COVID-19 pandemic affected one project district namely K'Bang in Gia Lai province. As a consequence, the survey area reduced from 27 communes to 24 communes.

Table 4. Summary Count of Endline Surveys Collected

| Survey | Household | Commune | Preschool and Nurseries | Health Centre |
|------------------|------------------|----------------|--------------------------------|----------------------|
| Dien Bien | 360 | 9 | 10 | 9 |
| Kon Tum | 360 | 9 | 11 | 9 |
| Gia Lai | 240 | 6 | 6 | 6 |
| Total | 960 | 24 | 27 | 24 |

Source: MDRI endline survey and evaluation, 2021

2.4. Qualitative Method

To assess the programme effectiveness, efficiency, scalability and sustainability, the qualitative study seeks answers to the following questions:

Effectiveness:

- Has the Programme achieved the targets and results set out in the programme design at the outset?
- What is the governance structure of the programme and how effective this structure was for service delivering, coordination, and collaboration?

Efficiency:

⁶ 0 – 6 months; 6 - 23 months; 24 – 35 months; 36 – 59 months; 5-8 years. Three first groups then can be aggregated to analyze for the group of the first 1000 days.

- Did the programme manage to achieve all or some of its objectives within established timeframes and costs?

Scalability and sustainability:

- Are there prospects for further development of related interventions after the end of the programme cycle, even across project locations? If not, then why?
- Are local governments in project locations committed and simultaneously capable of maintaining the IECD operationalization model by the end of the programme cycle?

To answer the above questions, two qualitative methods were used to collect information: Key Informant Interview (KII) and Focus Group Discussion (FGD). At national level, the research team interview key informants from Ministry of Labour, Invalids and Social Affairs (MOLISA), Ministry of Health (MOH) and Ministry of Education and Training (MOET). In each of three project provinces, we interviewed 01 Provincial PMU Leader, 01 Officer from Department of Labour, Invalids and Social Affairs, 01 Commune PMU Leader, 01 Commune Child Protection Officer, 01 Pre-school Principal and 01 Head of Commune Health Centre; and conducted 01 FGD with Provincial PMU members, 01 FGD with representatives of IECD Operation Board at district level, 01 FGD with male parents/caregivers and 01 FGD with female parents/caregivers. The total of KIIs and FGDs is summarized in the table below:

Table 5. Number of KIIs and FGDs in 3 provinces (Dien Bien, Gia Lai & Kon Tum)

| Informant | No. of KII in one province | No. of FGD in one province | Total in three provinces |
|--|----------------------------------|-------------------------------|--------------------------|
| National-level: Key informant/representative from: - MOLISA; - MOET; - MOH; - UNICEF (2 IECD programme staffs); - Other stakeholders: NGOs (ChildFund, Save the Children, World Vision...) | 1 2 1 2 3 | 0 | 9 KIIs |
| Provincial level: Key informant / representative from: - IECD programme PMU - DOLISA | 1 1 | 1 | 6 KIIs and 3 FGDs |
| District level: Key informant / representative from IECD Project Management Unit (District Department of Health, Education & Child Protection...) | 0 | 1 (3 people/group) | 3 FGDs |
| Commune level: Key informant / representative from: - Commune IECD Project Management Unit Leader; - Commune-level Child Protection Officer; | 1 1 1 | 0 | 12 KIIs |

| | | | |
|--|--|---------------------------|---|
| - Commune-level Pre-School Principal; - Commune-level Health Clinic Leader | 1 | | |
| Household level: Key informant from: - Local Parent/Caregiver - (In combination with household observation of 1-2 households) | 0 | 2 FGDs (6-8 people/group) | 6 FGDs (3 with males and 3 with females) |
| TOTAL | 27 KIs and 12 FGDs in 3 provinces | | |

Source: MDRI endline survey and evaluation, 2021

2.5. Data analysis

Quantitative analysis was performed using STATA. In addition to its well-known capability of analysing data, STATA did a great job by offering a package (igrowup_stata) to determine the stunting rate among children under 5 (in Indicator 1). To be specific, with built-in reference data for height measurement from population, the package calculates z-score for the height for age anthropometric indicator. Children whose height-for-age is more than two standard deviations below the median of the reference population are considered short for their age and are classified as moderately or severely stunted. The package was developed by WHO and can be found via this link: <https://www.who.int/childgrowth/software/en/>.

Descriptive statistics are used to present the data and findings are presented in tables attached with the dataset, in comparison with baseline values. Given that the survey area in the endline was reduced from 27 communes to 24 communes, the research team re-run the baseline statistics for the reduced area to be comparable with endline statistics. Furthermore, due to several revisions made in some endline questions that were not totally consistent with baseline, computation formula in such cases was also adjusted accordingly to generate better proxy. Therefore, comparisons between baseline and endline statistics for indicators with changes should be made with caution.

Figures and analyses are presented in the Chapter 4 of the report, which also addresses and to some extent accounts for the differences between disaggregated groups based on location, gender of the household head/ primary caregiver, household wealth quintile, educational level of the household head/ primary caregiver, etc. Following MICS 6 reporting guidelines, indicators with a small number of observations are displayed using the following rules:

- For indicators with fewer than 25 observations: the number of observations will be displayed in the table, but the percentages should not be calculated or discussed. If a percentage is based on fewer than 25 unweighted cases for any category of an indicator, the category should be kept and ‘(*)’ should be put in place of the percentages;
- For indicators with between 25 and 49 observations, the percentages should be shown in parentheses in the table and interpretations will be limited.

Given that the surveys were implemented in 24 project communes where in each commune, only 1-2 preschools and 1 health centre were surveyed, the issue of small number of observations is commonly faced. And percentages, if calculated in indicators at the commune level and relevant comparisons, need to be analysed with great caution.

Qualitative analysis was done using Grounded Theory and a four-step analytical strategy derived from Thematic Content Analysis. First, all data collected from KIIs and FGDs were transcribed, organized according to pre-determined questions. Second, the data was subjected to an open-coding process without prior assumption of any theoretical frameworks. Key themes were then distilled and extracted. Third, the research team investigated themes identified and made necessary adjustments to refine them, e.g. ‘difficulties of the PMU at the commune levels’, “reporting frequency of the PMU” and “family level barriers to ECD participation”. Last, data were kept and stored by theme, from which direct quotation was used in writing the report.

2.6. Evaluation risks and limitations

Despite the thorough preparation, there existed some limitations to the assessment. The research team were aware of potential risks and limitations to derail an evaluation and made efforts to anticipate and account for external dangers.

Table 6. Methodology Constraints

| No. | Risks/Challenges | Mitigation Measures |
|-----|--|---|
| 1 | Absence of a comparison group, which is faced by both the baseline assessment and this survey & formative evaluation. | The research team proposed to have a longitudinal study design and make a before-after intervention comparison in the same group. Therefore, the team tried to go to the same districts and communes that were studied in the baseline assessment. Also, the characteristics of the intervention group observed in the baseline survey could be controlled in the endline survey for the analysis of changes in the outcomes. |
| 2 | Beneficiaries including parents/ caregivers and children may benefit from programme for different time periods, due to the rolling nature of the programme. Children growing out of 0-8 age group no longer benefit from the programme; and a 1-year-old child has shorter programme experience than a 5-year-old child. | The research team proposed to aim for a balance in age groups in the sampling design and indicator calculation. Also, the research made comparison within the same age group where relevant during data analysis. |
| 3 | Not every repeated household from baseline may be eligible for the endline survey for the following reasons: <ul style="list-style-type: none"> - The household has left the commune and relocated to another commune for living - The children of the household have grown out of 0-8 age group and no longer benefit from the IECD programme | The research team understood that this risk is unavoidable. The team tried to interview all the eligible repeated households to the best of our ability, for example by making careful logistic preparation, contacting the local village leader in advance to schedule an appointment with the household and persuading the household to participate in the survey. In fact, 643/962, |

| | | |
|---|---|---|
| | | equivalent to 67 per cent of interviewed households were repeated from baseline, which is an acceptable rate for this study. |
| 4 | <i>What this assignment does not cover:</i> The survey and evaluation could not cover quantitatively the spill-over effects of the programme, where local government has made efforts to learn from the programme models and expand to other communes and districts | Due to COVID-19 and budget constraints, the survey and evaluation had to focus on the programme selected locations. This may underestimate the programme total results, especially in quantitative aspects. |

LITERATURE REVIEW

3

3.1. Legal and policy context

Vietnam context and legal environment

The Constitution of the Socialist Republic of Viet Nam in 2013 declares that children are protected, cared and educated by the State, family and society, having the right to be involved in issues of children. Vietnam was the first country in Asia and the second in the world to ratify the Convention on the Rights of the Child (CRC) in 1990. Vietnam is also committed to achieving the UN Global Millennium Development Goals (MDGs) as well as Sustainable Development Goals (SDGs) by 2030, which requires constant efforts and assiduous attention to children development. The **Law on Children** (2016) is a noteworthy effort of the Vietnamese government in creating a solid legal foundation to safeguard child rights and improve the provision of comprehensive children development in all terms of physical, intellectual, mental and ethical aspects. Before that, the **Law on Child Protection, Care and Education** (2004) and the **Education Law** (first issued in 2005) had laid the cornerstone for the construction of supporting policies in child protection, care and education. Throughout the two-decade period between 2001 and 2021, three Action Plans for Children at the national level have been adopted with increasingly ambitious objectives and specific targets regarding child nutrition & health, child protection, education, and participation of children in child-related issues.

Table 7. National Action Plans for Children by period

| Year | Policy/Law/Programme/Action Plan | Highlights/Objectives |
|------|--|--|
| 2001 | National Action Plan for Children 2001-2010 | To create optimum conditions to fully meet the needs and basic rights of children, prevent the dangers of harming children, and to build a safe and healthy environment for Vietnamese children to have the opportunity to be protected, cared for, educated and develop in all fields. |
| 2012 | National Action Plan for Children 2012-2020 | To build a safe, friendly and health living environment for children so that they can better realize their rights; to incrementally narrow the living condition gap between different groups of children and children in different regions; and to improve the quality of life and create equal development opportunities for all children. |
| 2021 | National Action Plan for Children 2021-2030 | To ensure the implementation of children's rights and children's comprehensive development in order to meet the requirements of supplying high-quality human resources for socio-economic development and international integration; to create safe, healthy and friendly environment for children, contributing to the fulfilment of the 2030 Agenda for Sustainable Development. |

Policy framework

Policies on Early Childhood Development (ECD)

Early childhood in this assessment is understood as the period from conception to the first eight years of a child. This is the time that formulates personality, social behaviour, intellectual

and social capacity of a person because the brain develops most rapidly and most dependently on enriching/adverse environment during the very first years. For such reasons, early childhood care and development is considered a vital prerequisite not only for the comprehensive growth of children but also for the strengthening of human capital in general.

Realizing the significance of early childhood development (ECD), the government of Vietnam has approved the Scheme for total development of children during early years in family and community during 2018 – 2025 under Decision no. 1437/QD-TTg dated October 29 2018, with a special focus on 0-8 year-old children. The scheme desires to achieve the following targets for the 2021-2025 period:

- 90% of the up-to-8-year-old children have access to services in support of comprehensive development according to demands and suitable to age-groups for health care, education, nutrition, nurture care, child protection and social welfares;
- 90% of the cadres involved in child-related activities at medical examination and treatment establishments, educational institutions, child-nurturing establishments, child protection service- providing establishments, community-based cadres, parents and child tenders are provided with relevant knowledge and skills to support and care for the child comprehensive development;
- 90% of the provinces and centrally run cities build and maintain the networks for connection and level transfer of child comprehensive development caring services; monitor and assess demands of up-to-8-year-old children and experiment the model of child comprehensive development care at families and communities.

The scheme addressed the necessity of a cross-sectoral collaboration and information sharing between government ministries and UN agencies/non-governmental organizations to foster integrated ECD services at families and communities and develop a monitor and evaluation framework for ECD indicators.

Policies on child health and nutrition

Vietnam has made impressive progress towards improving children's health and nutritional status in the past few decades, evidenced by the accomplishment of the MDG targets on child healthcare and maternal health on a national level. In particular, the reduction of child stunting rate, the under-five & under-one mortality rate as well as maternal mortality rate was considered satisfactory. This has been done thanks to the endorsement of an array of supporting policies, many of which happened during the implementation of the IECD programme. Some of the most important and recent policy updates include:

- The Promulgating Programme for Nutrition Care in the first 1000 days of life for prevention of maternal and child undernutrition and improvement of Vietnamese people's height, under Decision no. 1896/QD-TTg dated 25/12/2019. Given the birth of this programme, the significant role of the first 1000 days (the period between conception and children's 2nd birthday) in building blocks for brain development and long-term health has been realized and called to greater investments and attention;
- Intervention Programme to reduce mortality rate among the children under five years old by 2030, under Decision no. 1493/QD-TTg dated 10/09/2021. The programme will be implemented nationwide, according to the roadmap and in line with the issued strategies and policies with priority given to difficult mountainous areas and ethnic minority.

Accompanying the new adoption of recent policies, previously issued law and strategies should also be mentioned:

- For example, health insurance has been made free for children under 6, children from poor households, children from minor ethnic groups living in difficult socio-economic regions, children living in extremely difficult socio-economic regions and children living in island communes and districts, under the Law on Health Insurance (which is amended from the Law on Health Insurance no. 46/2014/QH13 dated 13/06/2014 and the decrees and circulars guiding the implementation thereof);
- The Ministry of Health (MOH) also issued regulations on Early Essential Newborn Care (EENC) for vaginal delivery in 2014 and for C-section in 2016, which should be applied for all relevant health care facilities across the country;
- The National Nutrition Strategy National Nutrition Strategy for 2011-2020, with a vision toward 2030, under Decision no. 226/QD-TTg dated 22/02/2012 has also achieved critical results in improving and balancing diet in both quantity and quality, ensuring hygiene and reducing child malnutrition, especially child stunting by 2020.

The National Institute of Nutrition with the support of the SUN Civil Society Alliance of Viet Nam, UN agencies and other partners is currently working on the finalization of the National Nutrition Strategy for 2021-2030 with a vision toward 2040. This legal document is expected to support more equitable, resilient and sustainable food and health systems and continue elevating baby and infant health through proactive promotion of breastfeeding and reduction of childhood stunting. By the time of writing this report, essential nutrition interventions such as micronutrient supplementation for young children and pregnant women; detection and treatment of children with severe acute malnutrition are being incorporated into the nutrition benefit package by MOH to be covered by the national health insurance system.

Beside nutrition, water, sanitation and hygiene are indicators that are closely linked to education, skills development and stunting. Adequate investment in WASH would optimize Viet Nam's competitiveness in the regional and global market and accelerate its achievement of the SDGs (UNICEF, 2020). In the roadmap towards SDG by 2030, the government of Vietnam is also taking decisive actions to improve access to safe and equitable drinking water, sanitation, and hygiene (WASH), with high priority placed on rural areas. Such political will is reflected by the launching of the National Strategy on Rural Clean Water Supply and Hygiene till the year 2020, under Decision no. 104/2000/QD-TTg dated 25/8/2000 with an objective that "All rural people shall have access to national-standard clean water with the minimum volume of 60 litres/person/day, use hygienic latrines and well practice personal hygiene and protect environmental hygiene in villages and communes". To implement the strategy, the government issued the National Targeted Programme (NTP) of Water and Sanitation for Rural Development for 1998-2005, 2006-2010, 2011-2015 and later the NTP of New Rural Development for 2016-2020. These policies put a strong emphasis on the supply of clean water and adequate hygienic latrines at educational establishments, hospitals, clinics, offices and markets; controlled environmental hygiene in villages and communes through concentrated husbandry and livestock; as well as the protection of underground and surface water.

Policies on Early Childhood Education (ECE)

ECE in this report refers to education services for children up to 6 years of age (pre-primary education). By this mean, ECE includes 3 main categories – crèches (3 months old - 3 years old), kindergarten (3 years old – 6 years old), and young sprout schools (a combination of crèches and kindergarten).

According to the Education Law, the overall objective of pre-primary education is “to help children develop physically, emotionally, intellectually and aesthetically, in order to shape the initial elements of personality and to prepare children for the first grade”. However, the delivery of ECE services for children under 3 and children aged 3-6 is different in essence, with the former typically embraces childcare while the latter incorporates the broader concept of both “care” and “education” to introduce children to a school-type environment for preparatory education purposes (ILO, 2012).

In Vietnam, preschool levels are not mandatory among children entering primary education. However, the Ministry of Education and Learning (MOET) is making constant efforts to raise public awareness of ECE and enhance school readiness for preschool children. Notably, the revised Education Law 2005 (first issued in 1998) stipulated that pre-primary education for 5-year-old children shall be made universal.⁷ Before that, in 2002, the Prime Minister had approved Decision no. 161/2002/QD-TTg to promote the socialization of education and diversify ECE services (public/private) (Vu, 2021).

The latest version of the Education Law, which passed on June 2019 and took effect since July 2020, contains many important modifications relating to ECE:

- ECE officially recognized as the first level of Vietnam’s national education system for the first time;
- Free preschool tuition for 5-year-old children in villages and communes with exceptional difficulties, ethnic minority areas, remote and isolated area. Preschool children at 5 years of age beside those regulated above and students at lower secondary education level shall be exempted from tuition based on road maps specified by the Government;
- Preschool teachers must possess at least a pedagogical college diploma (before – intermediate pedagogical degree). Furthermore, according to Circular no. 26/2018/TT-BGDDT, preschool teachers since November 2018 must be able to use at least one foreign language (preferably English or ethnic language for ethnic minority areas).

Between 2018 and 2021, with the technical support from UNICEF, the Vietnamese government and MOET have also been introducing new legislation to heighten recognition and commitments towards ECE. To name a few:

- Decision no. 1677/QD-TTg dated 03/12/2018 approved the ECE development project for the 2018 – 2025 period which promotes child-centered approach and encourages socialization of ECE services to meet diverse needs of children. This legal document, according to the representative of MOET, became a fundamental for 63 provinces of Vietnam to build their own development plans;

⁷ Universalization of education is a process of organization for every citizen to study and reach a minimum educational level under the State's regulations (Decree 75/2006/NĐ-CP)

- Decree 105/2020/NĐ-CP (a replacement of Decree 06/2018/NĐ-CP) provided funding support to feed preschool children (\$USD 100/month/45 children); allowance for teachers; equipment, toys and teaching aids for private kindergartens in industrial zones;
- Other circulars and guides issued by MOET between 2020 and 2021 to enact competency frameworks and promulgate professional standards for ECE, including but not limited to: Circular no. 52/2020/TT-BGDDT regarding preschool regulations, Circular 49/2021/TT-BGDDT on organization and operations of independent childcare centres, kindergartens and preschool classes; among others.

These are remarkable changes that show growing recognition and commitments towards the advancement of equitable ECE services at the national level.

Policies on children's rights to protection

Viet Nam has made efforts to harmonize domestic law with the provisions of the Convention and other international treaties to which Viet Nam is a party implementing the programmes in relation to children's rights to protection. It is defined as the rights to be protected against all forms of labour exploitation, sexual exploitation and abuse, drug abuse, neglect and abandonment, kidnapping and trafficking; be protected from unjustified interference in mail and privacy; protected against torture, beatings and abuse when violating a law or detained (UNICEF Vietnam, 2016).

The Law on Children (2016), the Labour Code (2019), the Penal Code (2015), and the Law on Domestic Violence are among the country's powerful legal documents that recognize and have contents related to children's rights to protection. In addition to these laws, there are also a number of regulations, decisions and directives introduced to comprehensively intensify children's rights to protection, presented in the below table:

Table 8. Child protection related policies

| Year | Theme | Policy/Law/Program/Action Plan |
|-------------|---|---|
| 2012-2030 | Integrated child protection (child protection as a sub-objective) | <ul style="list-style-type: none"> • National Action Programme for Children (2012-2020 period, 2021-2030 period) |
| 2012 | Child protection (child protection as a main focus) | <ul style="list-style-type: none"> • National Programme on Child Protection for 2016-2020 |
| 2016 | Child safety and injury prevention | <ul style="list-style-type: none"> • Child Accident Prevention Programme for 2016-2020 |
| 2017 | Child abuse prevention | <ul style="list-style-type: none"> • Directive 18/2017/CT-TTg on Strengthening Preventive and Responsive Solutions on Child Abuse and Violence Against Children • National hotline 111 for reporting child abuse, harassment and other forms of violence against children |
| 2016-2021 | Child labour prevention | <ul style="list-style-type: none"> • National Programme on Prevention and Minimization of Child Labour for 2016–2020 • National Programme on Prevention and Reduction of illegal child labor in 2021-2025, with a vision towards 2030 |
| 2019 | Violence against children | <ul style="list-style-type: none"> • National Action Plan on prevention and combat violence against children and child abuse for the 2020-2025 period, under Decision 1863/QD-TTg |
| 2021 | Child protection online | <ul style="list-style-type: none"> • National Programme on child protection on network environment |

Policies related to ethnic minority children and children with disabilities

Aside universal policies for every child across the country, the Vietnamese government does regulate specific policies targeting highly marginalized and vulnerable groups of children such as ethnic minority children, children with disabilities, HIV-infected children and children living in poor households. There were Programme 135 and 30a targeting ethnic minorities to improve living conditions on some expected outcomes namely poverty, income, agriculture production, housing conditions, and access to basic public services.

Most recently, the country issued the new National Targeted Programme (NTP) for ethnic minority which aims to boost socio-economic development in ethnic minority-inhabited and mountainous areas in the 2021 – 2030 period (first phase rolled out in 2021 – 2025). The programme is the biggest NTP ever approved by the National Assembly with a total budget of up to \$USD 9 billion for the implementation period of 10 years. It has 10 component projects encompassing such aspects as health care, education, gender equality, infrastructure, housing, WASH, cultural values, communications, sustainable agriculture and forestry production, and so on.

On the other hand, other supporting packages and policies for ethnic minority children and children with disabilities include:

- To ensure adequate living conditions:
 - ✓ Social assistance policies (monthly social allowances) for beneficiaries of social protection including orphanage children, abandoned children, HIV-infected children living in poor households and children with disabilities currently being taken care of in social work centres, under Decree no. 136/2013/NĐ-CP (now known as Decree 20/2021/NĐ-CP);
 - ✓ The scheme on caring helpless orphans, neglected children, HIV/AIDS infected children, victims of chemical toxic, serious disable children and children that are affected by natural disasters and community-based disasters in 2013-2020, under Decision No. 647/QĐ-TTg.
- To foster education development:
 - ✓ Priority policies in enhancing the participation of students with disabilities and ethnic minority children in the national schooling system, as prescribed in the Education Law;
 - ✓ Preserving the learning and teaching of ethnic minority languages in general education institutions and in continuing education centres, under Decree no. 82/2010/NĐ-CP;
 - ✓ Education Development Master Plan for children from very-low population ethnic groups for 2010-2015, under Decision no. 2123/QĐ-TTg. The beneficiary of the plan includes preschool children aged 3-5 from 9 minor ethnic groups namely O Du, Pu Peo, Si La, Ro Mam, Cong, Brau, Bo Y, Mang and Co Lao living in 6 provinces: Lao Cai, Ha Giang, Dien Bien, Lai Chau, Nghe An, Kon Tum;
 - ✓ Priority policies in enrolment and learning support for preschool children, school and university students from very minor ethnic groups, under Decree No. 57/2017/NĐ-CP;

- ✓ Additional lunch allowances for preschools in extremely difficult villages, communes, in coastal areas and islands, under Decree 105/2020 /ND-CP (replacement of Decree 06/2018/ND-CP).
- To foster socioeconomic development:
 - ✓ Socioeconomic Development Master Plan for people from 4 minor ethnic groups, namely Mang, La Hu, Cong and Co Lao for 2011-2020 (under Decision no. 1672/QĐ-TTg dated 26/11/2011 approved by the Prime Minister). Specific targets for reducing the stunting rate among children under five are included.

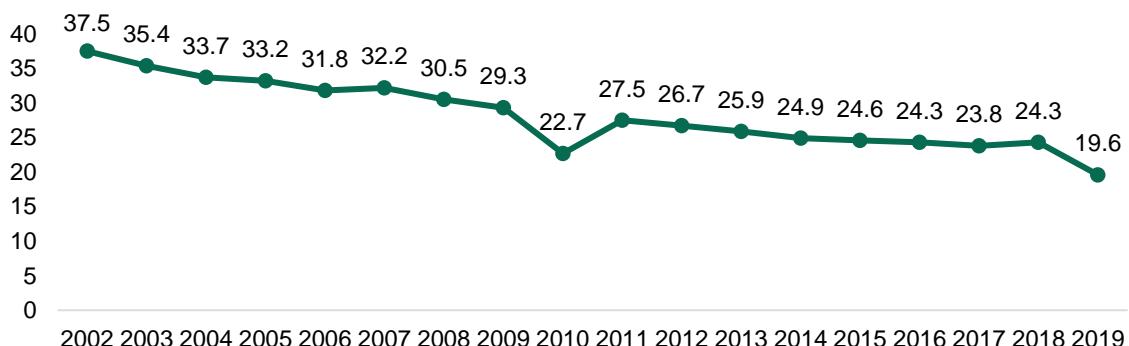
3.2. Situation analysis of early childhood development in Vietnam

Despite the existing legal frameworks with many supporting policies on children, the current situation of children's lives especially in highly disadvantaged areas still consists of many daunting challenges due to inequitable ECD service delivery.

Child health and nutrition

Between 2002 and 2019, Vietnam witnessed a nearly 18% decrease in the national stunting rates of children under 5 (Figure 4).

Figure 4. Prevalence of stunting, height for age (% of children under 5)



Source: National Institute of Nutrition (NIN)

Success in reducing the child mortality rates can also be observed at a national level through consistent downward trends over time. By 2019, the national average IMR and U5MR of Vietnam are 14‰ and 21‰ respectively⁸, which more than halved the previous decade's results.

Despite these achievements, inequalities still exert a huge influence on the life and health of many children, especially marginalized and vulnerable ones. The gap in the prevalence of stunting between the Kinh and ethnic minority children is large and appears to be widening. According to a report from the World Bank, 31.4% of ethnic minority children were stunted in

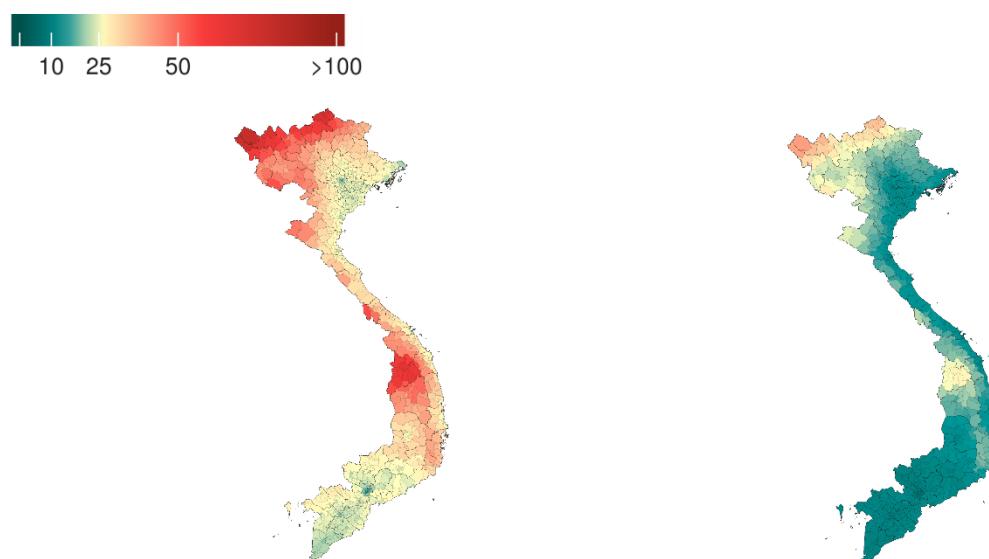
⁸ The Population and Housing Census 2019. Retrieved from <https://vietnam.un.org/en/28931-results-population-and-housing-census-0142019>

2015, which doubled the rate of the Kinh (15%) and also exceeded the national average at 17.5%. The percentage point difference between the two population sub-groups also increased from 2010 to 2015, indicating that the disparities grew greater over time (Mbuya, Atwood, & Huynh, 2019). Similar patterns have also been translated to the underweight and wasting rates. Malnourished children are mainly concentrated in mountainous areas of Vietnam, including the Northern areas and Central Highlands (Mbuya, Atwood, & Huynh, 2019).

On the other hand, Vietnam is also currently facing the “double burden” of childhood malnutrition, understood as the coexistence of both over-nutrition (overweight and obesity) in big cities like Hanoi and Ho Chi Minh city, alongside under-nutrition (stunting and wasting) in mountainous areas (Harris et al., 2020). More than one in four urban children are overweight or obese, according to the National Nutrition Survey conducted in 2020, with the average nationwide prevalence of 19%, more than doubled the figure in 2010 (8.5%) (National Institute of Nutrition, 2020)

The variation in mortality rates across subnational units can be as large as fivefold (Burstein et al., 2019). To be specific, child mortality, despite undergoing a downward trend over time, still saw high visibility in the Northern regions, followed by the Central Highlands (Figure 5). The U5MR rate of the rural areas is also twice as high as that of the urban areas, at 25‰ & 12‰. Ethnic minority children are 3.5 times more likely to die before the age of 5 than their Kinh counterparts⁹. That does not include the missing data on the number of neonatal and stillborn deaths, especially in mountainous rural areas largely populated by ethnic minorities (UNICEF).

Figure 5. Mortality rate per 1000 live births, 2000 (left) & 2017 (right)



Source: Healthdata

When it comes to reproductive health, inadequate and limited access to healthcare services still cause 46 maternal deaths per 100,000 live births, as recorded in 2019 (2019 Population and Housing Census).

⁹ <https://www.unicef.org/vietnam/children-viet-nam>

Early education

As displayed by the data from the Ministry of Education and Learning (MOET) in Table 9, the number of both teachers and children at preschool level has constantly increased over time. By the school year 2019-2020, Vietnam has 15 thousand preschools (nurseries and kindergartens combined), accommodating 5 million children aged 0-6.

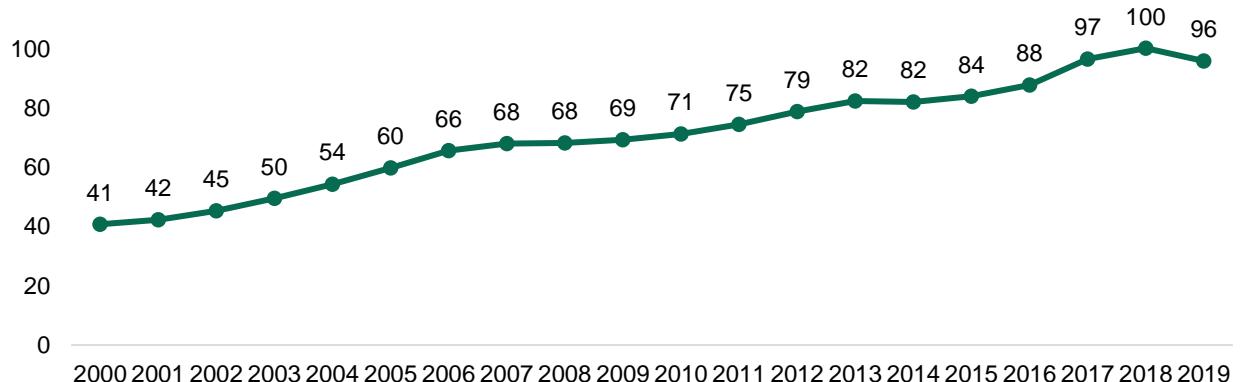
Table 9. Pre-primary education in Vietnam

| School year | 2014 - 2015 | 2016 - 2017 | 2018 - 2019 | 2019 - 2020 |
|-------------------------------|----------------------------|------------------|------------------|------------------|
| 1. Pre-primary schools | 14,203 | 14,881 | 15,476 | 15,041 |
| 2. Classes | 170,135 | 188,582 | 187,574 | 190,318 |
| 3. Teachers | 277,684 | 316,616 | 326,332 | 336,783 |
| 4. Children | | | | |
| Total | 4,416,852 | 5,085,635 | 5,173,192 | 5,095,037 |
| In which | Female | 2,060,135 | 2,367,122 | 2,466,510 |
| | Ethnic minority | 779,478 | 874,823 | 921,229 |
| | Children with disabilities | N/A | N/A | 6,172 |
| | | | | 5,654 |

Source: MOET

Notably, the enrolment rate of preschool children also grew considerably over the past two decades and reached 96% by 2019 (Figure 6), which is 2.3 times higher than the period's starting point. This result clearly suggests the effectiveness of the Vietnamese education universalization programme.

Figure 6. Preschool enrolment rate (% gross) in Vietnam (5-year-old children)



Source: The World Bank

Unlike most low-income countries, Vietnam prioritizes public investment in education with relatively equal apportion of budget to pre-primary education compared to higher levels. As a telling example, while Indonesia and Vietnam – both being lower-middle income countries allocate 20% of its state budget to education, the share of the total budget to pre-primary education was 2% and 16%, respectively (Zubairi & Rose, 2017). Similarly, it is estimated by World Bank that 0.62% of Vietnam's GDP was spent on pre-primary education – higher than the OECD average of 0.54% (World Bank , 2018).

In recent years, the Vietnamese government, with the technical support from UNICEF, has been boosting large investment in upgrading preschool teachers' pedagogical capacity and integrating social and emotional learning (SEL) into the educational curriculum. To be more specific, The MOET has successfully endorsed the SEL Programme with the adoption of the

Global Guidelines Assessment tool (GGA) and the East Asia Pacific ECD Scales (ECDS) in the Vietnam context. The GGA toolkit allows education professionals to systematically examine and improve the quality of their ECE services whereas the ECDS serves as an evidence-based instrument for government agencies to monitor the impact of their ECE policies on preschool children and communities in order to better plan for the following period. The master training on SEL – GGA - ECDS has been conducted for 195 education officials, school managers and teachers of all 63 provinces for further nation-wide application through cascade training.

Even though Vietnam is “on track” to improve its pre-primary education policies, many challenges remain unresolved. The first and foremost one is regional gaps in preschool education quality including access to learning and availability of materials and teachers in disadvantaged localities (Kataoka et al., 2020). To be more specific, although the government distributes higher per-capita education spending for regions with poor socio-economic conditions, the actual investment results greatly depend on the financial capacity and commitment of the respective governments at local levels (Kataoka et al., 2020). Furthermore, the shortage of qualified teachers is another major concern, especially in rural and remote areas. Teachers in rural regions do not receive proper training and are not frequently supervised by a government body. The situation is even worse in mountainous areas where trained teachers/caregivers are seriously lacking (Dinh, 2019). Research findings also unfold the fact that many teachers are still struggling to adapt to the holistic child-centred educational philosophy, which could also be a factor affecting ECE development (Phan, 2018). Last but not least, a large number of children below the age of three are still mainly taken care of at home, by grandparents or parents. There is a window of opportunity for ECD interventions to make an impact on an individual’s body and mind during the first three years, yet the proportion of under-three-year-old children attending nurseries in 2018 was only 28% (Abbott et al., 2019), which is considered low. Boyd and Dang (2017) attributed this situation to the ineffective cohesion between teaching programmes for different age groups at pre-primary level.

Children’ rights to protection

Despite improved legal framework in children’s rights to protection, inadequate public awareness of child discipline and poor practical implementation in communities still prevail. According to a report published by MOLISA, of 2000 recorded child abuse cases in 2018, 75% is ranked sexual abuse (MOLISA, 2018). It was also reported by GSO and UNICEF that more than seven in every ten children aged 1–14 were found to have experienced physical or psychological punishment at home (GSO & UNICEF, 2020-2021). Boys are 4% more likely to be a victim of violence discipline, compared to girls. Violent practices are more common among Khmer ethnicity and people living in the Southeast region. The exercise of corporal punishment is deeply rooted from the cultural belief “Spare the rod and spoil the child” in which ensuring children obedience is core to good parenting.

A study found a close correlation between age, educational attainment, socio-economic conditions and attitude of mothers/primary caregivers versus violent disciplinary practices (Trang & Nguyen, 2014). To be specific, smaller age, lower educational level, poorer wealth, and negative attitudes towards partner violence/physical punishment are believed to contribute to higher likelihood of violent discipline. Women having more children are prone to violent disciplinary practices (Trang & Nguyen, 2014) yet the total fertility rate (TFR) is higher among less educated, poor women, which further exacerbates existing disparities.

Le, Vu and Maternowska (2018) attributed violent discipline in Vietnam to three major key drivers: (i) powerful structural factors (poverty, gender inequity, migration, and socio-economic status), (ii) institutional factors (incomprehensive child protection system, weak school governance), and (iii) cultural norm.

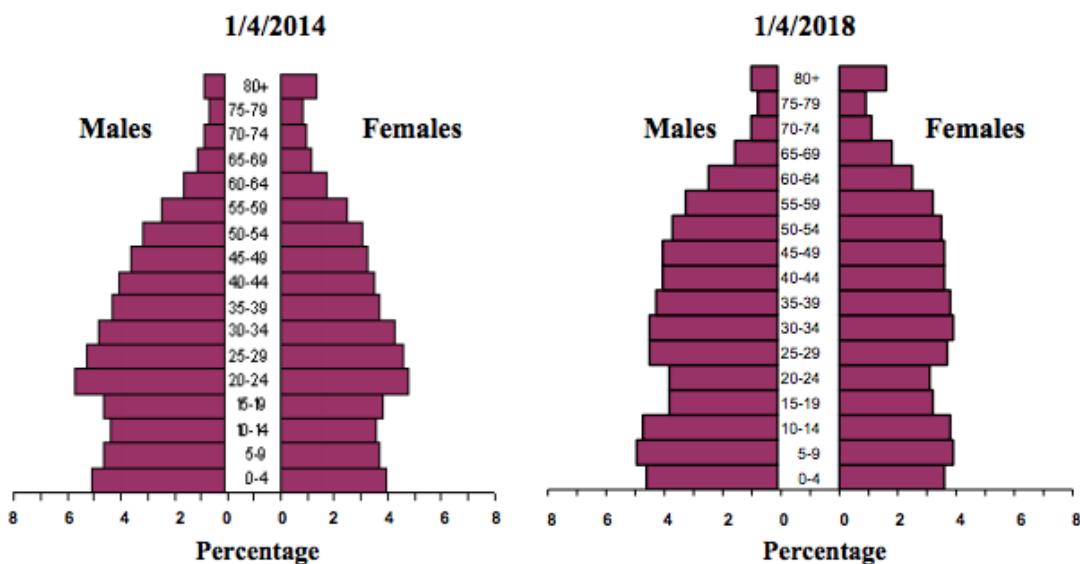
In short, Vietnam still faces daunting challenges in terms of safeguarding children's well-being and family sustainability due to varying socio-economic conditions and weak delivery of social service (Spence & Nguyen, 2021).

3.3. Demographic context

Vietnam population

The total population of Viet Nam in 2019 reached 96,208,984, in which men accounts for 49.8% (47,881,061 people). The Viet Nam Population Pyramid 2018, compiled from the Population and Family Planning Survey of 1/4/2018 shows that the proportion of old age groups is gradually growing larger, which implies the process of "population aging". The total dependency ratio of Vietnam in 2018 was 48.5%, meaning that on every 100 persons in working age (15 – 64 years old), there are approximately 50 dependent persons (under 15-year-old children and 65-and-above adults).

Figure 7. Vietnam's population pyramid, 1/4/2014 and 1/4/2018



Source: General Statistics Office of Viet Nam, Major findings: The 1/4/2018 time-point population change and family planning survey

Vietnam has more than 26.3 million children under 16 years old with the sex ratio being 114 boys per 100 girls (Le T. H., 2020).

Child population by age group and ecological areas

The total population of children from birth to eight years old in 2019 was 14,576,466, which is 15% higher than ten years before (in 2009). There is no major difference in the number of children divided by age, as can be seen in Table 10.

Table 10. Distribution of 0-8-year-old children population, by age and gender (2019)

| Age | Total population | Male | Female |
|-----|------------------|-----------|---------|
| 0 | 1,374,616 | 720,785 | 653,831 |
| 1 | 1,549,722 | 813,068 | 736,654 |
| 2 | 1,513,707 | 794,019 | 719,688 |
| 3 | 1,693,756 | 887,753 | 806,003 |
| 4 | 1,687,525 | 884,854 | 802,671 |
| 5 | 1,674,351 | 875,977 | 798,374 |
| 6 | 1,946,503 | 1,018,752 | 927,751 |
| 7 | 1,714,248 | 895,976 | 818,272 |
| 8 | 1,422,038 | 744,580 | 677,458 |

Source: 2019 Population and Housing Census, GSO

The distribution of children across geographical areas also follows the country's overall trend. In particular, among six ecological zones, the Red River Delta and Southeast regions are the most densely populated regions, with 1,060 persons per km² and 757 persons per km², respectively. On the contrary, The Northern Midlands and Mountain areas and the Central Highlands regions had the lowest population density, at 132 persons per km² and 107 persons per km², respectively.

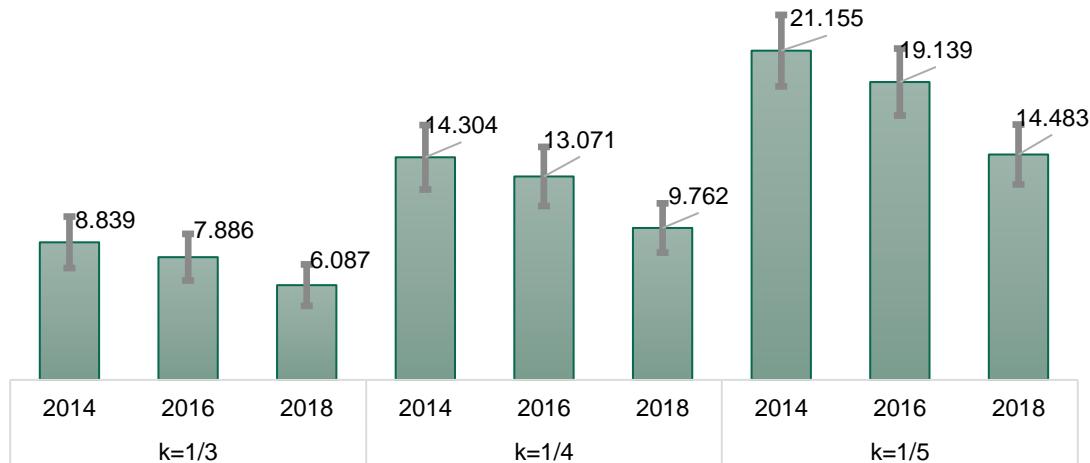
The population of children from birth to eight years old comprises of ten different ethnic groups including the Kinh, Tay, Thai, Muong, Khmer, Hoa, Nung, Mong, Dao, Gia Rai and other ethnic groups.

Socio-economic context

Viet Nam is concerned with multidimensional aspects of poverty and not just with the lack of financial resources and access to basic goods. Derived from the multidimensional poverty framework, Vietnam also developed a well-defined model for multidimensional poverty in children which is believed to provide a complete and comprehensive depiction of child poverty in Vietnam. This model comprises of eight basic welfare domains including health, nutrition, education, housing, clean water/sanitation, child labour, recreation and social inclusion. It reflects the ecological and synergy of integrated childcare emphasizing the connections between each aspect. For example, having secured a family income does not guarantee that the child may have access to health care and education.

The most recent report conducted by GSO and UNICEF in 2020 calculated multidimensional child poverty (MDCP) using data from the Vietnam Household Living Standards Survey (VHLSS) 2018. In particular, the deprivation score was estimated from 0 (no deprivation in indicators) to 1 (deprivation in all indicators). Children are considered multi-dimensionally poor if their score is higher than the cut-off threshold.

Figure 8. MDCP rate (%) with 95% confidence interval (k = cut-off threshold)



Source: GSO & UNICEF (2020) – Calculation based on VHLSS data

A comparison of a three-year period shows that regardless of the cut-off threshold, the MDCP rate has been decreasing appreciably from 21% in 2014 to 14% in 2018, meaning that children's lives have continued to be improved. However, closer scrutiny into the differences in MDCP rates across population subgroups signals existing inequalities among children with different demographic and socio-economic characteristics. As illustrated in the below table, children with the following background or characteristics are particularly more likely to suffer from multidimensional poverty:

- Children in the 0-2 age group;
- Living in the Central Highland & Northern Midlands and Mountain regions;
- Residing in rural areas;
- Belonging to ethnic minority groups such as H'Mong, Dao, Tay, and Kho Me;
- Raised in households whose household heads' education level was low.

Table 11. MDCP rate by child characteristics and socio-economic context

| | Year 2014 | Year 2016 | Year 2018 |
|--------------------------------------|--------------|--------------|--------------|
| Overall | 21.2 | 19.1 | 14.5 |
| Age group | | | |
| 0 - 2 years old | 33.2 | 30.0 | 26.4 |
| 3 - 4 years old | 29.3 | 28.4 | 20.4 |
| 5 years old | 21.5 | 18.2 | 13.8 |
| 6 - 10 years old | 14.0 | 12.5 | 9.0 |
| 11 - 15 years old | 17.7 | 15.6 | 11.5 |
| Gender of the child | | | |
| Boys | 21.7 | 19.1 | 14.8 |
| Girls | 20.6 | 19.2 | 14.2 |
| 6 economic regions | | | |
| Red River Delta | 7.0 | 5.4 | 3.9 |
| Northern Midlands and Mountain areas | 40.2 | 34.5 | 29.3 |

| | | | |
|--|------|------|------|
| North Central and Central Coastal areas | 19.0 | 20.4 | 13.8 |
| Central Highland | 41.2 | 32.8 | 25.4 |
| South East | 9.6 | 10.5 | 6.6 |
| Mekong River Delta | 27.4 | 21.5 | 15.6 |
| Area of residency | | | |
| Urban | 8.9 | 8.4 | 5.0 |
| Rural | 26.8 | 23.6 | 18.6 |
| Ethnicity | | | |
| Ethnic minority | 61.2 | 52.5 | 46.4 |
| Tay | 30.0 | 22.1 | 18.3 |
| Thai | 56.6 | 44.2 | 31.1 |
| Khmer | 62.0 | 32.6 | 35.7 |
| Muong | 28.5 | 24.8 | 13.1 |
| Nung | 39.6 | 25.8 | 17.1 |
| H'Mong | 90.6 | 86.3 | 81.4 |
| Dao | 69.7 | 53.9 | 43.8 |
| Kinh/Hoa | 12.7 | 10.8 | 6.8 |
| Gender of household head | | | |
| Male | 22.0 | 19.3 | 15.1 |
| Female | 18.1 | 18.6 | 12.1 |
| Education level of household head | | | |
| No diploma | 41.9 | 39.2 | 32.8 |
| Primary | 22.8 | 19.7 | 14.5 |
| Lower secondary | 14.2 | 13 | 10.9 |
| Upper secondary | 9.3 | 10.8 | 9.6 |
| Elementary/Intermediate Trade | 6.7 | 6.8 | 3.9 |
| College+ | 4.1 | 3.2 | 2.9 |

Source: GSO & UNICEF (2020) – Calculation based on VHLSS data

In short, there is a strong correlation between child poverty and socio-economic conditions. Multidimensional poverty affects the lives of Vietnamese children, most severely to those in disadvantaged rural and distant communities.



VOLUME I:

**ENDLINE SURVEY -
INDICATOR RESULTS**

KEY FINDINGS



4.1 Socio-economic characteristics of households and primary caregivers

This part provides an overall picture of socio-economic characteristics of household heads and primary caregivers involved in the endline survey. The survey was designed to gather basic information about households (represented by household wealth index) and individual characteristics (gender, ethnicity and level of education of household heads and primary caregivers).

To calculate the household asset-based wealth index, the research team applied the principal-components approach of Filmer and Pritchett (2011)¹⁰, similar to the baseline methodology. The index is computed based on household ownership of different kinds of assets, including: access to electricity, television, refrigerator, radio, bike/electric bike/electric scooter, motorbike, car, access to internet, computer/tablet, telephone/mobile phone, livestock/poultry, bank account/e-wallet, access to improved water, access to improved latrine and a house with solid floor, solid roof, and solid wall. The final score index is used to classify the household rankings divided into five quintiles, of which a higher score is equivalent to higher accessibility to the assets. With regard to asset ownership, 97.4 percent of households participating in the endline survey reported to have access to electricity. Moreover, a majority of households owned motorbikes and phones, with the percentage of 91% and 88.4% respectively. Meanwhile, only around 20 percent of them possessed a refrigerator and bicycle. It seemed that beneficiary households in the endline survey gained better access to most kinds of assets compared to the baseline.

¹⁰ According to Filmer and Prichett (2001), the principal-components approach is used to determine the weights for an index of the asset variables. In this approach, an index is constructed as the first principal component of a vector of assets of households such as durables and housing conditions. Filmer and Scott (2008) and Kolenikov et al. (2009) conclude that rankings of various measures of welfare, including outcomes for education, health care, fertility, child mortality, and the labor market, are very similar to the ranking of asset indices.

The principal component approach defines a weight index in terms of the first principal component of the variables used. The wealth index, denoted by A_j for household j is computed as follows:

$$A_j = \sum_p a_p \left(\frac{x_{pj} - \bar{x}_p}{s_p} \right) \quad (1)$$

where x_p denotes the asset p , and \bar{x} denotes a mean of household in the sample. s is a standard deviation of asset x_p , and the p -dimensional vector of weight is chosen to maximize the sample variance of A , subject to $\sum_p a_p^2 = 1$. The weight a is also called the vector of scores of asset variables, which can be estimated using principal-components analysis. Higher value of the asset index means a higher access to the asset. The asset index is standardized to have a mean of zero and standard deviation of one.

Out of 961 surveyed households, only 15.5 per cent of them recorded female as the household head, of which most are from Kinh ethnic. The average of household size in the endline survey remained the same as in baseline (nearly 5.2 people per household).

In general, a higher percentage of primary caregivers reported to be fluent in Vietnamese than in the baseline survey (82.4 per cent), with Kon Tum accounted for 94.2 per cent. Particularly, primary caregivers with ability to speak Vietnamese are more likely to receive a high level of education, evidenced by 90.6 per cent completing high school (and over) in comparison with 67.2 per cent without qualifications. Women with the role of primary caregivers account for nearly three fourths in the total sample of 961 households. This implies that women still take the central role in 0-8 aged child-rearing, but this rate tends to decline in comparison with the situation 3 years ago.

Regarding the educational qualification of primary caregiver, approximately 34 per cent of caregivers acquired no qualification, while only 16.7 per cent claimed to finish at least high school (or even higher) degree. There is a lower rate of primary caregivers without any degree that participated in the endline survey compared to those from the baseline. Notably, caregivers from households with the lowest wealth quintiles tend to be less likely to complete high school (5 per cent out of 206 households) than households in the highest wealth quintiles (40 per cent out of 192 households).

Table 12. Demographic characteristics of participating households at endline

| | Primary caregiver can speak Vietnamese | Female caregiver | Female household head | Primary caregiver without qualification | Primary caregiver completed high school or higher | Number of households |
|--------------------------------------|--|------------------|-----------------------|---|---|----------------------|
| Unit | per cent | per cent | per cent | per cent | per cent | households |
| Total | 82.4 | 71.0 | 15.5 | 33.9 | 16.7 | 961 |
| By province | | | | | | |
| Dien Bien | 71.2 | 54.8 | 7.9 | 42.4 | 18.4 | 354 |
| Kon Tum | 94.2 | 86.4 | 18.6 | 24.2 | 20.3 | 360 |
| Gia Lai | 81.4 | 71.7 | 21.9 | 36.0 | 8.9 | 247 |
| By household head's gender | | | | | | |
| Male | 85.8 | 72.4 | | 33.7 | 16.4 | 812 |
| Female | 63.8 | 63.1 | | 34.9 | 18.1 | 149 |
| By household head's ethnicity | | | | | | |
| Kinh | 68.9 | 60.0 | 54.8 | 19.3 | 26.7 | 135 |
| Thai | 94.6 | 58.8 | 4.1 | 32.4 | 18.2 | 148 |
| H'Mong | 58.8 | 54.6 | 3.1 | 49.0 | 17.0 | 194 |
| Gia Rai | 84.6 | 81.8 | 15.5 | 40.9 | 13.6 | 110 |
| Ba Na | 88.6 | 79.3 | 12.9 | 33.6 | 5.7 | 140 |
| Xo Dang | 96.6 | 89.7 | 14.5 | 24.1 | 10.3 | 145 |
| Gie Trieng | 98.6 | 85.7 | 7.1 | 41.4 | 27.1 | 70 |
| Other | 100.0 | 89.5 | 10.5 | 5.3 | 36.8 | 19 |

| By household head's highest level of education | | | | | | |
|---|-------|-------|------|------|------|-----|
| Never been to school | 68.7 | 63.8 | 27.9 | 55.3 | 11.0 | 409 |
| Primary school | 90.8 | 77.3 | 4.4 | 25.6 | 7.7 | 207 |
| Secondary school | 94.9 | 74.2 | 6.0 | 13.8 | 9.7 | 217 |
| High school | 91.4 | 70.7 | 6.9 | 13.8 | 58.6 | 58 |
| Elementary vocational school | 66.7 | 100.0 | 0 | 33.3 | 66.7 | 3 |
| Secondary vocational school | 100.0 | 80.0 | 0 | 0 | 80.0 | 5 |
| Professional secondary | 89.5 | 73.7 | 10.5 | 10.5 | 63.2 | 19 |
| Vocational college | 0 | 0 | 0 | 0 | 0 | 0 |
| College | 94.4 | 88.9 | 22.2 | 11.1 | 72.2 | 18 |
| University | 93.8 | 81.3 | 18.8 | 0 | 81.3 | 16 |
| By number of children 0-8 years old per household | | | | | | |
| One child | 84.7 | 73.3 | 12.8 | 36.4 | 14.8 | 445 |
| Two children | 81.9 | 68.7 | 19.2 | 28.2 | 21.2 | 386 |
| Three children | 72.6 | 69.5 | 13.7 | 46.3 | 12.6 | 95 |
| Over three children | 85.7 | 71.4 | 14.3 | 31.4 | 0 | 35 |
| By wealth index | | | | | | |
| Lowest quintile | 67.0 | 68.9 | 14.6 | 56.3 | 4.9 | 206 |
| 2nd quintile | 72.2 | 62.8 | 12.8 | 38.9 | 9.4 | 180 |
| 3rd quintile | 87.9 | 71.6 | 17.9 | 30.0 | 14.2 | 190 |
| 4th quintile | 90.2 | 75.7 | 17.6 | 30.1 | 15.0 | 193 |
| Highest quintile | 95.3 | 75.5 | 14.6 | 13.0 | 40.1 | 192 |
| By highest level of education of the primary caregiver | | | | | | |
| Pre-primary or none | 67.2 | 76.7 | 16.0 | | | 326 |
| Primary school | 90.3 | 68.9 | 14.6 | | | 206 |
| Secondary school | 90.0 | 68.0 | 14.9 | | | 269 |
| High school and over | 90.6 | 66.9 | 16.9 | | | 160 |

Source: MDRI endline survey and evaluation, 2021

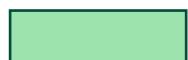
PICTURE AT ENDLINE

| No. | Indicator name | Baseline data (2018) | Target (2021 – Dien Bien province) | Target (2021 – Gia Lai province) | Target (2021 – Kon Tum province) | Endline data (2021) |
|-----|--|--|---|--|--|--|
| 1 | Percentage of children under five who are stunted (%) | 50.2 | N/A | N/A | N/A | 34.1 |
| 2 | Percentage of children receiving early stimulation and responsive care from their parents or caregivers (%) | 58.6 | N/A | N/A | N/A | 60.3 |
| 3 | Proportion of the population having an improved sanitation facility (%) | 26.2 | N/A | N/A | N/A | 46 |
| 5 | Number of communes with functioning IECD services | 0 | N/A | N/A | N/A | 10 |
| 6 | Number of pregnant women who receive iron and folic acid supplementation | 14/62 | N/A | N/A | N/A | 18/49 |
| 7 | Number of communities certified free of open defecation as a result of UNICEF and partner support (leveraged/indirect) | 4/24 communes | N/A | N/A | N/A | 5/24 communes |
| 8 | Number of schools that practice daily group handwashing in the reporting year only, as a result of UNICEF direct support and/or leveraged through national programmes. | 24/28 preschools and nurseries 9/23 primary schools | N/A | N/A | N/A | 27/27 preschools and nurseries 14/24 primary schools 20/24 communes reach score |
| 9 | Existence of integrated early stimulation, protection and nutrition intervention package targeting 0 to 35 months old children | 17/24 communes reach score 2 (Initiating) 7/24 communes reach score 1 (Weak) | N/A | N/A | N/A | 3 (Developing) 4/24 communes reach score 2 (Initiating) |

| No. | Indicator name | Baseline data (2018) | Target (2021 – Dien Bien province) | Target (2021 – Gia Lai province) | Target (2021 – Kon Tum province) | Endline data (2021) |
|-----|--|--------------------------------|---|--|--|-----------------------------------|
| 10 | People in humanitarian situations who access safe drinking water as per agreed sector/cluster coordination standards and norms | 542/1,800 people | N/A | >50 | N/A | 849/1,719 people |
| 11 | Percentage of local service providers including health workers, kindergarten teachers and ECE care givers in the project locations able to perform IYCF counselling and early stimulation exercises (%) | 65.7 | 100 | 100 | 100 | 48.7 |
| 12 | Proportion of ECD centres that provide Integrated ECD services based on national standards (%) | 17.9 | N/A | N/A | N/A | 44.4 |
| 14 | Municipalities that implement local protocols for the protection of children from violence, abuse and neglect | 3/3 provinces 9/9 districts | N/A | N/A | N/A | 3/3 provinces 9/9 districts |
| 15 | Number of child protection workers in UNICEF-supported communes who provide case management in line with national standards | 113 workers | At least 10 | At least 09 | At least 10 | 121 |
| 16 | Number of Social Work Service Centres (in project locations) applying national standards are established and functioning at provincial and district levels | 4 | 1 at provincial level and 1 per district | 1 at provincial level and 1 per district | 01 at provincial level and 01 per district | 4 |
| 17 | Percentage of parents and caregivers of children aged 0-8 years in project locations who believed that responsive and non-violent parenting is the best for their children (%) | 28 | 90 | 90 | 90 | 38.5 |
| 18 | Percentage of children aged 6-23 months in project locations received age-appropriate nutrition and early stimulation/learning from parents/caregivers (%) | 7.6 | At least 70 | At least 70 | At least 70 | 11.4 |
| 19 | Percentage of parents/primary caregivers of children aged 0-8 years in project the project locations who practise non-violent discipline and responsive parenting (%) | 11.2 | 70 | 50 | 50 | 20 |
| 20 | Percentage of children aged 36-59 months in project locations on-track in at least three or four developmental domains (MICS IECD index: Literacy-numeracy, physical, social-emotional and learning) (%) | 74.2 | >50 | At least 75 | 75 | 77.9 |

| No. | Indicator name | Baseline data (2018) | Target (2021 – Dien Bien province) | Target (2021 – Gia Lai province) | Target (2021 – Kon Tum province) | Endline data (2021) |
|-----|--|-------------------------|---|--|--|---------------------------|
| 21 | Percentage of children aged 0-23 months in project locations who are put to the breast within one hour of birth (%) | 52.8 | N/A | N/A | N/A | 56.6 |
| 22 | Percentage of parents/caregivers in project locations who engaged with their children aged 0-4 years (under 5) in activities to promote responsive care including early stimulation (%) | 56.8 | N/A | N/A | N/A | 59.8 |
| 23 | Percentage of women aged 15-49 years with a live birth in the last 2 years in project locations who were attended by skilled health personnel during their most recent live birth (%) | 55.2 | N/A | N/A | N/A | 61.3 |
| 24 | Percentage of women aged 15-49 years with a live birth in the last 2 years in project locations who were attended during their last pregnancy that led to a live birth at least four times by any provider (%) | 18.2 | N/A | N/A | N/A | 26.8 |
| 25 | Proportion of births in project locations that were delivered at a health facility (%) | 55.5 | N/A | N/A | N/A | 62.8 |
| 26 | Percentage of boys and girls aged 6-8 years who know where to report violent incidents involving themselves and other children (%) | 75.3 | 90 | 90 | 90 | 75.1 |
| 27 | Percentage of households having children aged 0-8 years in the project locations who have learning materials (children's books and playing things) at home (%) | 44.4 | N/A | N/A | N/A | 48.2 |
| 28 | Percentage of parents and caregivers of children aged 0-8 years in project locations receiving ECD related communication materials (%) | 20.6 | N/A | N/A | N/A | 42.9 |
| 29 | Percentage of parents and caregivers of children aged 0-8 years who know and can list the benefits of all areas of IECD and know where to find supports (%) | 46.7 | >60 | 90 | 90 | 56.3 |
| 30 | Percentage of parents/caregivers who believe that all children at the right age, regardless of background and abilities, should receive IECD services, equally (%) | 87 | N/A | N/A | N/A | 97.8 |

| No. | Indicator name | Baseline data (2018) | Target (2021 – Dien Bien province) | Target (2021 – Gia Lai province) | Target (2021 – Kon Tum province) | Endline data (2021) |
|-----|--|--|---|--|--|---|
| 31 | Percentage of ECE centres, including family-based childcare groups in project locations which have minimum IECD equipment and early learning/stimulation services for young children (%) | 82.1 | 80 | 80 | 80 | 81.5 |
| 32 | Proportion of pre-schools/IECD centres with WASH facilities meeting national/JMP standards (%) | 12/28 preschools and nurseries 0/24 commune health centres | TBD | 50 | TBD | 11/27 preschools and nurseries 2/24 commune health centres |
| 33 | Availability of co-ordination committee and mechanism on IECD at provincial, project districts and communes | 100 | 1 at provincial level, 3 at district level and 10 at commune level | 1 at provincial level, 3 at district level and 9 at commune level | 1 at provincial level, 03 at district level and 09 at commune level | 100 |
| 34 | Availability of Provincial IECD Action Plan 2018-2021 with budget allocation for implementation | 2/3 provinces | Available | Available | Available | 3/3 provinces |
| 35 | Existence of a monitoring system for tracking the progress of the IECD models implementation | 2/3 provinces | Available | Available | Available | 3/3 provinces |



Improved



Not improved

Summary of key findings from the endline survey

The Programme has been implemented in a turbulent environment. This includes changes in provincial PMU staff and government officials that had worked together to develop the Programme. This was further exacerbated with the Covid-19 pandemic which caused the Programme to adjust multiple activities. Despite these factors, IECD is evaluated as a successful programme.

Two thirds of the key indicators covering three main sectors namely nutrition & health, education, and child protection have shown improvement from its benchmark values. Financial resources were utilized efficiently, resulting in the achievement of most important objectives. There were some areas that did not show as impressive performance as the others at the time of the endline evaluation, namely IYCF or early stimulation. To a certain extent, the Programme has incorporated the human right-based programming, gender equality and equity principles and approaches in its design and implementation.

When comparing provinces, Dien Bien's figures remain the lowest in most measures, but the province has made significant progress since the baseline period, particularly in healthcare. Kon Tum has maintained a consistent level of performance throughout all thematic areas, making steady improvement. Gia Lai, on the other hand, is frequently an outlier.

Detailed evaluation of key indicators, broken down into themes, is presented below.

4.2 Child Health

Infant and Young Child Feeding

Indicator 11

Percentage of village health workers and commune health workers at grass root levels in the project locations are able to perform Infant and Young Children Feeding (IYCF) counselling

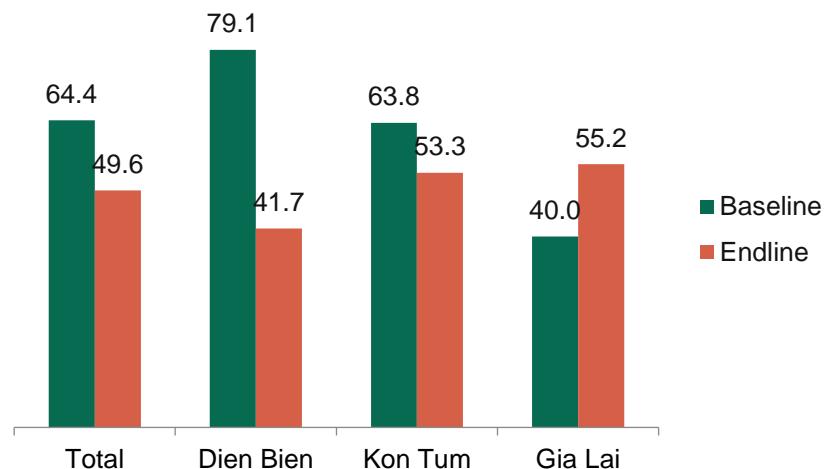
Proper Infant and young child feeding (IYCF) can promote their optimal growth and development, especially in the critical window from birth to 2 years of age. IYCF counselling by skilled local health workers plays an essential role, particularly for first-time parents as they closely accompany mothers from pregnancy till delivery and during childcare. UNICEF highlights that communication alone is insufficient to improve breastfeeding and complementary feeding practices and emphasizes that counselling and support by skilled health workers at grassroots levels contributes a lot to the improvement.

To assess the capability of the community health workers in IYCF counselling, the survey questionnaire asked the head of the commune health centres how many of their healthcare staff at commune and village levels were able to perform IYCF counselling. That is, they either received training on IYCF or actually performed IYCF counselling for caregivers. In this context, 'training' refers to formal training of all forms provided by nutritionists and experts at higher-level centres, for example district-level or provincial level.

Survey results show that **the percentage of local health workers able to perform IYCF counselling has decreased in the endline compared to the baseline, except for Gia Lai province** (see Figure 9). The decrease is attributed to the fact that the number of the commune

and village health workers able to perform IYCF counselling witnesses a slight increase but the total number of health workers grows at a larger rate. For example, in Kon Tum province, the number of IYCF counselling-qualified health workers declines from 30 to 32 while the total number of health workers increases from 47 to 60.

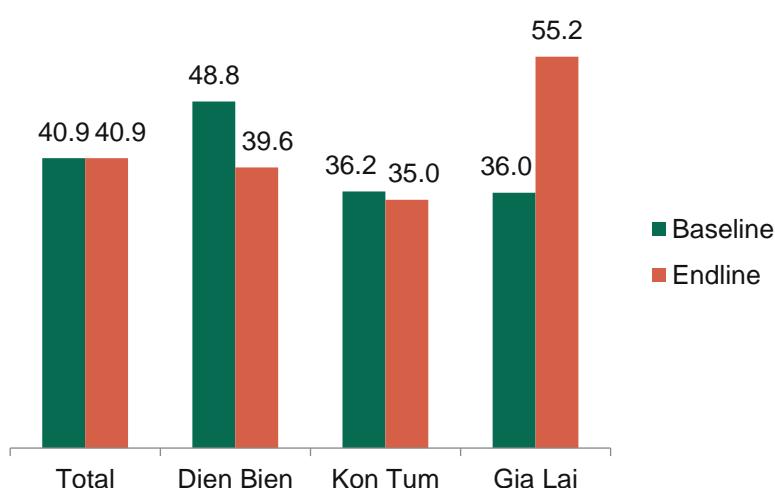
Figure 9. Percentage of village health workers and commune health workers at grass root levels in the project locations are able to perform IYCF counselling (%)



Source: MDRI endline survey and evaluation, 2021

The increase in the percentage of IYCF counselling-qualified health workers in Gia Lai province can be explained by the increase in the training rate (see Figure 10). Dien Bien province, on the contrary, records a reduced training rate and Kon Tum province experiences no change in the rate.

Figure 10. Percentage of village health workers and commune health workers at grass root levels in the project locations receiving training on IYCF counselling (%)



Source: MDRI endline survey and evaluation, 2021

KII with head of the commune health centres in Dien Bien and Gia Lai reveal several reasons for the low training rate. First, not every health worker in the center received IYCF training. Usually only the head or vice head of the center was invited to the training. Second, in the year 2021, under the COVID-19's pandemic impact, no expanded IYCF training has been conducted for health workers who work at the village level as planned. Third, as stated above, there have been new local health workers involved in the healthcare system without IYCF training.

“ *This year I have not participated in any training.*

Other workers in the health center still need more training to improve their capacity.

KII with head of commune health center in Dien Bien province

“

This commune health center has three workers but only me and the vice head were invited to the training. After the training on nutrition, we are more confident in communicating with people about the signs and side effects of the medicine.

This year I have not participated in any training by UNICEF.

KII with head of commune health center in Gia Lai province

Indicator 21

Percentage of children aged 0-23 months in project locations who are put to the breast within one hour of birth

Early breastfeeding provides protection against infection and has been shown to prevent neonatal death due to sepsis, pneumonia, diarrhoea and hypothermia¹¹. Delayed initiation of breastfeeding after the first hour of birth doubled the risk of neonatal mortality¹².

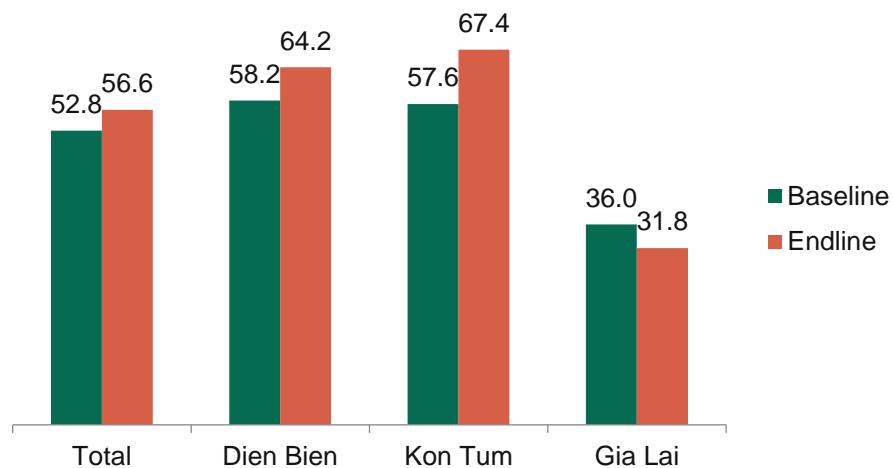
Among 228 children aged 0-23 months surveyed, 220 of them (equivalent to 96 per cent) were ever breastfed at some point and 129 children (equivalent to 57 per cent) were breastfed within one hour of birth. Compared with baseline, the percentage of children aged 0-23 months put to breast within one hour of birth in the endline has increased, except for Gia Lai province (see

¹¹ Victora CG, Bahl R, Barros AJD, França GVA, Horton S, Krusevec J, et al. *Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect*. Lancet. 2016; 387(10017): 475–490. doi: 10.1016/S0140-6736(15)01024-7

¹² Khan J, Vesel L, Bahl R, Martines JC. Timing of breastfeeding initiation and exclusivity of breastfeeding during the first month of life: effects on neonatal mortality and morbidity--a systematic review and meta-analysis. Matern Child Health J. 2015;19(3):468–479. doi: 10.1007/s10995-014-1526-8

Figure 11 **Error! Reference source not found.**). Similar to baseline assessment, Gia Lai witnesses the lowest percentage.

Figure 11. Percentage of children aged 0-23 months in project locations who are put to the breast within one hour of birth (%)



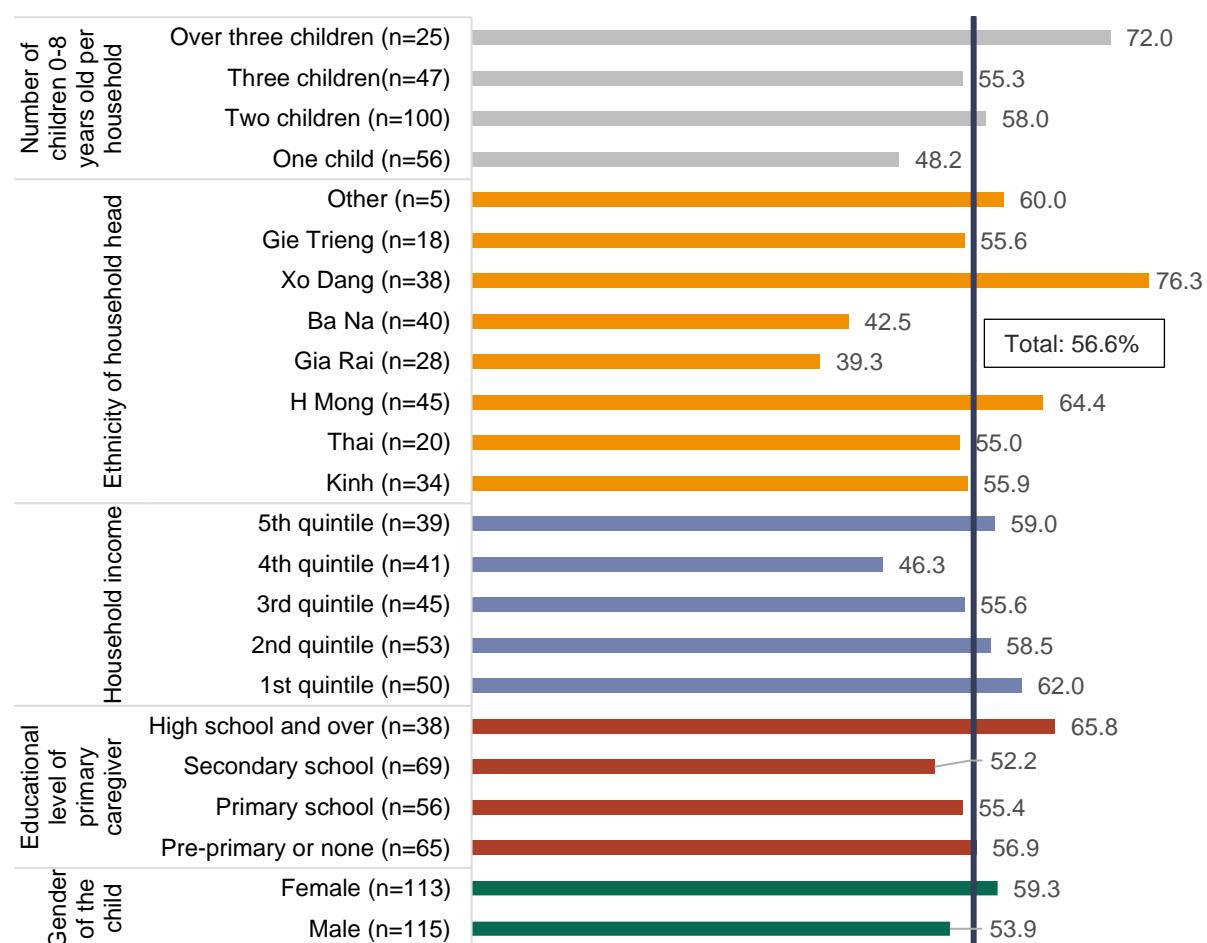
Source: MDRI endline survey and evaluation, 2021

The percentage does not vary much between boys and girls. Early breastfeeding practices tend to increase as educational level of primary caregiver improves, but do not show upward trends as household income raises (see Figure 12).

Initiation of breastfeeding within one hour of birth is more popular among multiparous women than first-time mothers. Mothers who had two or more infants had higher odds of timely initiation of breastfeeding within one hour of birth compared with mothers who had one infant.

Concerning ethnicity of the household head, H'Mong and Xo Dang people practice early breastfeeding very well, evidenced by the higher-than-average percentage of children aged 0-23 months old put to breast within one hour of birth. Kinh, Thai and Gie Trieng people practice quite well and the percentage of the three ethnic groups are very close to the average. Meanwhile, Ba Na and Gia Rai people have very low percentage, which partly explains why Gia Lai province witnesses the lowest percentage. KII with the head of commune health center in Gia Lai province reveals that the low percentage of children from Ba Na and Gia Rai groups put to breast within one hour of birth is associated with the high percentage of home birth observed in these groups.

Figure 12. Percentage of children aged 0-23 months in project locations who are put to the breast within one hour of birth, by population group (%)



Source: MDRI endline survey and evaluation, 2021

Age-appropriate nutrition

Indicator 18

Percentage of children aged 6-23 months in project location received age-appropriate nutrition and early stimulation/learning from parents/ primary caregivers

Inappropriate nutrition and lack of stimulation in the first years of life could lead to dramatic abnormalities in brain development (Shonkoff and Phillips, 2000). Black et al. (2016) estimated the risk of being permanently stunted by malnutrition and the lack of early learning opportunities through early stimulation would threaten the development potential and lifelong health of 43 per cent children under 5 in low- and middle-income countries. Single-sector interventions which represent either ECD or nutrition have contributed to positive child development and/or nutrition status, however, the development and testing of integrated interventions are currently advocated (Hurley, Yousafzai and Lopez-Boo, 2016).

To measure the percentage of children aged 6-23 months receiving age-appropriate nutrition, both baseline and endline survey asked their parents/ primary caregivers about their

breastfeeding as well as complementary feeding practices during the previous day. The survey questions and indicator's calculations are adapted from UNICEF's MICS6 definition of "minimum acceptable diet". Accordingly, a 6-23 month old child is recognized as receiving age-appropriate nutrition if they had at least minimum dietary diversity and minimum meal frequency during the previous day.

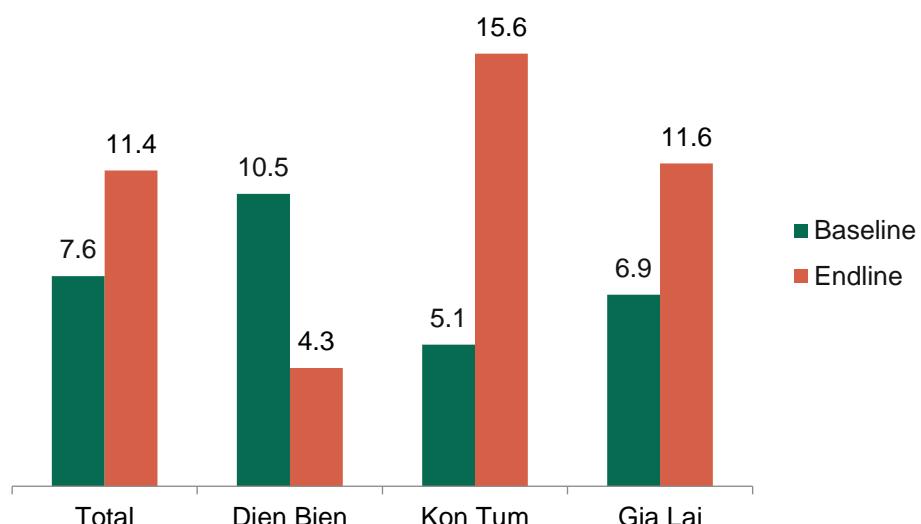
| Minimum dietary diversity | Minimum meal frequency |
|---|---|
| <p>Children receive food from at least 5 of the 8 groups listed below.</p> <ul style="list-style-type: none"> • Breastmilk • Grains, roots, and tubers • Legumes and nuts • Dairy products (milk, infant formula, yogurt, cheese) • Flesh foods (meat, fish, poultry and liver/organ meats) • Eggs • Vitamin A rich fruits and vegetables • Other fruits and vegetables | <p>For breastfeeding children:</p> <ul style="list-style-type: none"> i) Age 6-8 months: Solid, semi-solid, or soft foods at least two times a day ii) Age 9-23 months: Solid, semi-solid, or soft foods at least three times a day <p>For non-breastfeeding children: Solid, semi-solid, soft, or milk feeds at least four times a day</p> |

To measure the percentage of children aged 6-23 months receiving early stimulation, both baseline and endline survey asked their parents/ primary caregivers if anyone in the household practiced certain exercises with their children over the last 3 days. The survey questions and indicator's calculations are adapted from "Care for Child Development - Participant Manual" by WHO and UNICEF. Early stimulation exercises can be either in "Play" or "Communication" group. To be considered as receiving early stimulation, children must receive at least one practice of each group.

| Age group | Play exercises | Communication exercises |
|------------------|---|--|
| 6-8 months old | Give your child clean, safe household things to handle, bang, and drop | Respond to your child's sounds and interests. Call the child's name, and see your child respond. |
| 9-11 months old | - Hide a child's favorite toy under a cloth or box. See if the child can find it - Play peek-a-boo | - Tell your child the names of things and people. - Show your child how to say things with hands, like "bye bye". |
| 12-23 months old | Give your child things to stack up, and to put into containers and take out. | - Ask your child simple questions. - Respond to your child's attempts to talk. - Show and talk about nature, pictures, and things. |

Figure 13 compares the percentage of children aged 6-23 months receiving age-appropriate nutrition and early stimulation from their parent or primary caregiver between baseline and endline. **Survey results show that there has been an improvement in the percentage in endline compared with baseline, except for Dien Bien province.** Kon Tum province and Gia Lai province witness a significant growth from 5.1 per cent to 15.6 per cent and from 6.9 per cent to 11.6 per cent, respectively.

Figure 13. Percentage of children aged 6-23 months in project locations received age-appropriate nutrition and early stimulation/learning from parents/caregivers (%)



Source: MDRI endline survey and evaluation, 2021

The low percentage recorded in Dien Bien province is attributed to both low percentage of children receiving age-appropriate nutrition and in particular, receiving early stimulation (see Figure 14 & Figure 15).

Figure 14. Percentage of children aged 6-23 months in project locations received age-appropriate nutrition from parents/caregivers (%)

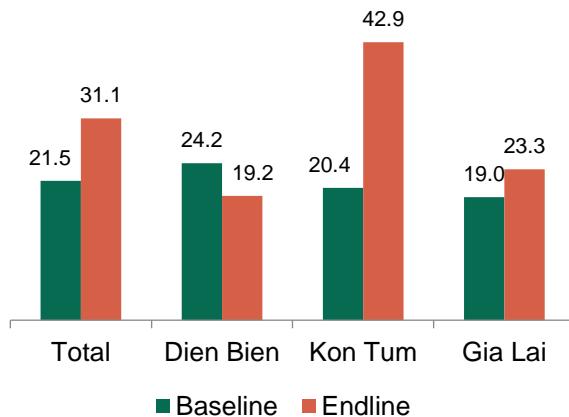
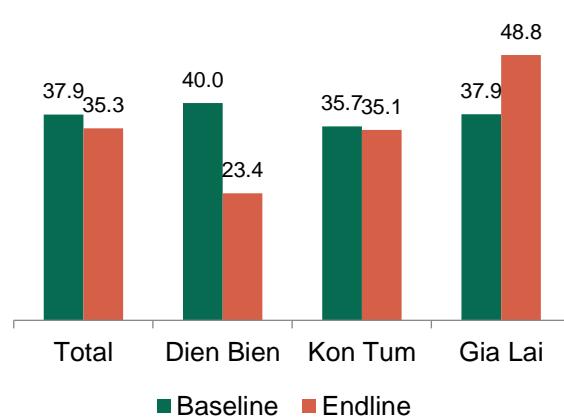


Figure 15. Percentage of children aged 6-23 months in project locations received early stimulation/learning from parents/caregivers (%)



Source: MDRI endline survey and evaluation, 2021

Age-appropriate nutrition

Twice as much as surveyed parents/ primary caregivers are likely to meet the minimum meal frequency than to meet the minimum dietary diversity. Overall in three provinces, 73 per cent of surveyed parents/ primary caregivers feed their children a sufficient number of meals per day while only 34 per cent afford minimum food diversity.

The percentage of children receiving appropriate nutrition does not vary between boys and girls. The percentage shows upward trend as household income increases or educational level of primary caregiver improves (see Figure 16). However, the percentage decreases as the households have more children. That is, multiparous households are less likely to afford age-appropriate nutrition for their children than single-child households.

Concerning ethnicity of the household head, age-appropriate nutrition is more prevalent among Kinh, Thai, Xo Dang and Gie Trieng groups than Ba Na, Gia Rai and H'Mong groups, evidenced by their higher than average percentage. This is a note-worthy finding and suggests an improvement in the nutrition diet among ethnic minority children compared with baseline. FGD with ethnic minority parents indicates that the IYCF counselling is a great help to them in meal preparation.

KII with head of the commune health center in Dien Bien province indicates that H'Mong children's nutritional diets heavily depend on their households' eating habits and economic situation.

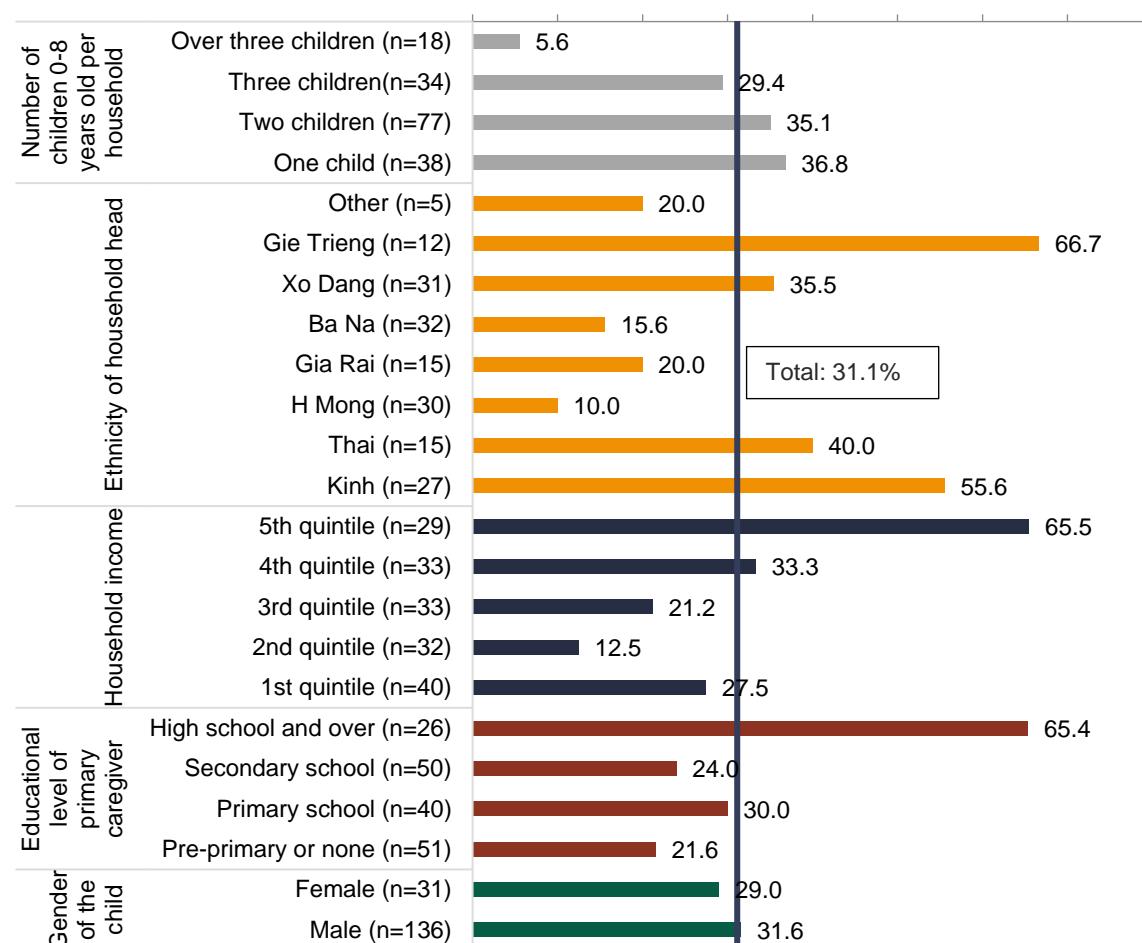
“

Even though the propaganda has been going on, mothers in H'Mong and Kho-mu groups still feed their children with rice earlier than recommended. Also, their diets do not meet the minimum dietary diversity and quantity.

Thai mothers are more likely to follow the recommendations, however, their poverty does not allow them to feed their children well.

KII with head of commune health center in Dien Bien province

Figure 16. Percentage of children aged 6-23 months in project locations received age-appropriate nutrition from parents/caregivers, by population group (%)



Source: MDRI endline survey and evaluation, 2021

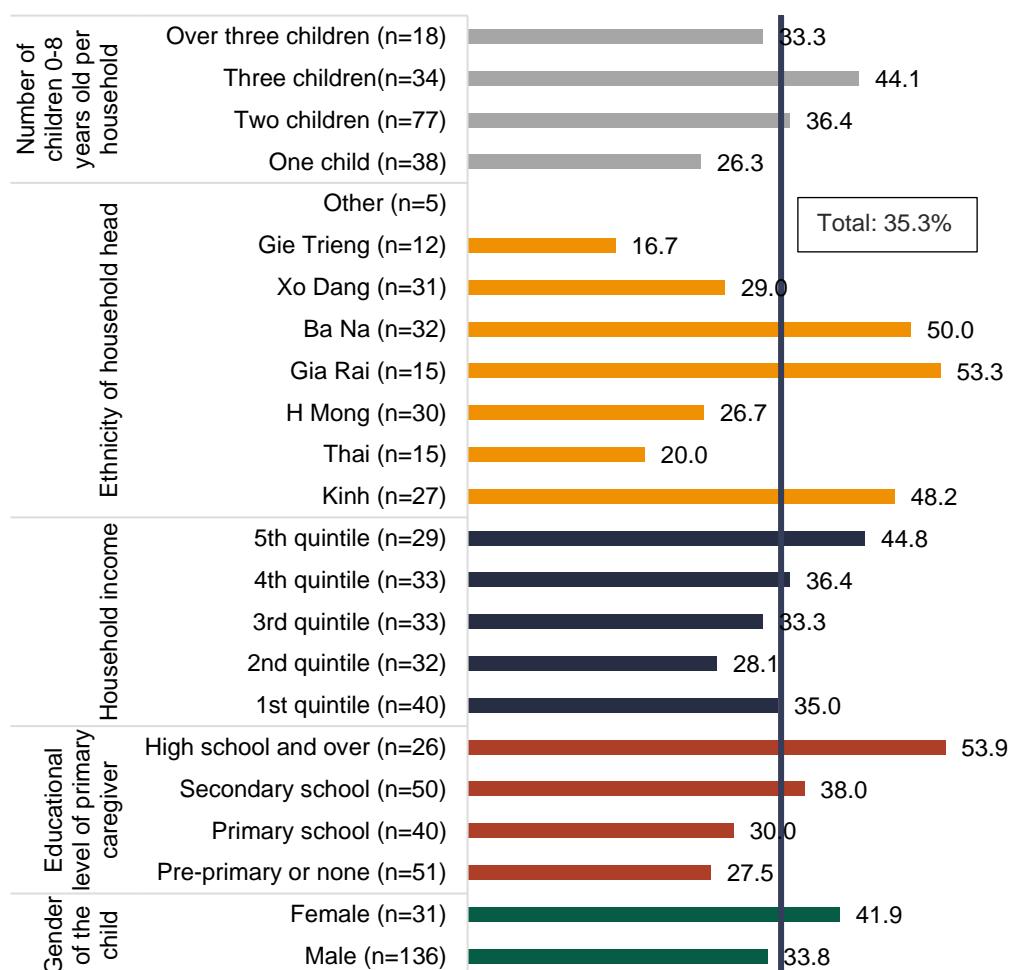
Early stimulation/learning

The percentage of children aged 6-23 months receiving early stimulation/learning from parents/ caregivers declines from 37.9 per cent to 35.3 per cent. To be specific, the percentage of children receiving either “Play” and “Communication” excercises also decline, from 39 per cent to 35.9 per cent and from 92.4 per cent to 89.8 per cent.

The percentage of children receiving early stimulation is slightly higher among girls than boys. The percentage shows a clear upward trend as household income increases or educational level of primary caregiver improves (see Figure 17).

Concerning ethnicity of the household head, early stimulation is more widely practiced among Kinh, Gia Rai and Ba Na people, evidenced by their higher than average percentages of children receiving early stimulation, at approximately 50 and over 50 per cent. On the contrary, less than one third of surveyed Thai, H'Mong, Xo Dang and Gie Trieng people practice early stimulation with their children.

Figure 17. Percentage of children aged 0-3 years in project locations received early stimulation/learning from parents/caregivers, by population group (%)



Source: MDRI endline survey and evaluation, 2021

Child Stunting

Indicator 1 Percentage of children under five who are stunted

Vietnam has achieved significant progress in reducing undernutrition over the past several decades, proven by the fact that the stunting rate among children under five in Vietnam declines from 43.2% in 2000 to 19.6% in 2020¹³. However, ethnic minority groups are being systematically left behind and this is limiting progress on national reductions. Therefore, children's stunting remains an issue in three project provinces where a large proportion of population are ethnic minority groups.

There is a difference in the source of data of children's height between baseline and endline assessment. **The baseline assessment relies on the research team's own measurement**

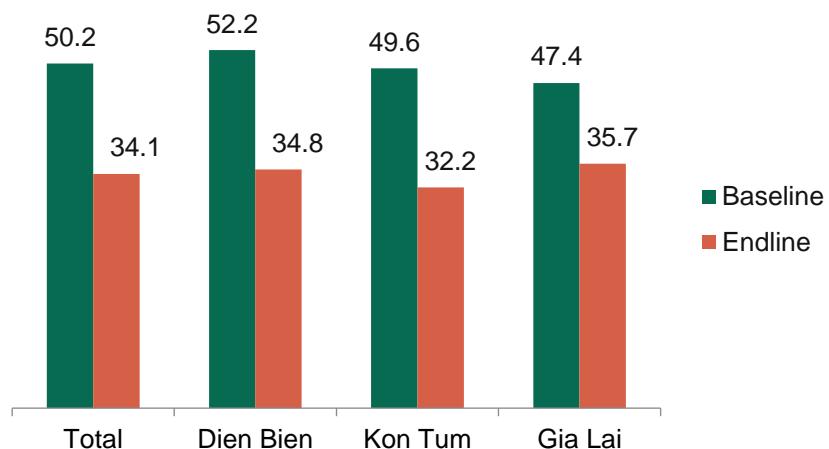
¹³ World Bank. *Prevalence of stunting, height for age (% of children under 5) – Vietnam.* <<https://data.worldbank.org/indicator/SI.STA.STNT.ZS?locations=VN>>

data while the endline evaluation uses data provided by commune health centers. Therefore, comparisons between baseline and endline statistics are made with great caution.

World Health Organization (WHO) Growth Standards are used as the reference point for determining children who were stunted¹⁴. Children whose height-for-age is more than two standard deviations below the median of the reference population are considered short for their age or stunted.

Figure 18 **Error! Reference source not found.** compares the stunting rate among children under five between baseline and endline. **Survey results show that the stunting rate has remarkably reduced in all three provinces.** In fact, at the reduction rate of approximately 5% per year in 3 years of IECD programme implementation, the stunting rate has achieved significant improvement in comparison with national and provincial average reduction rate.

Figure 18. Percentage of children under five who are stunted (%)



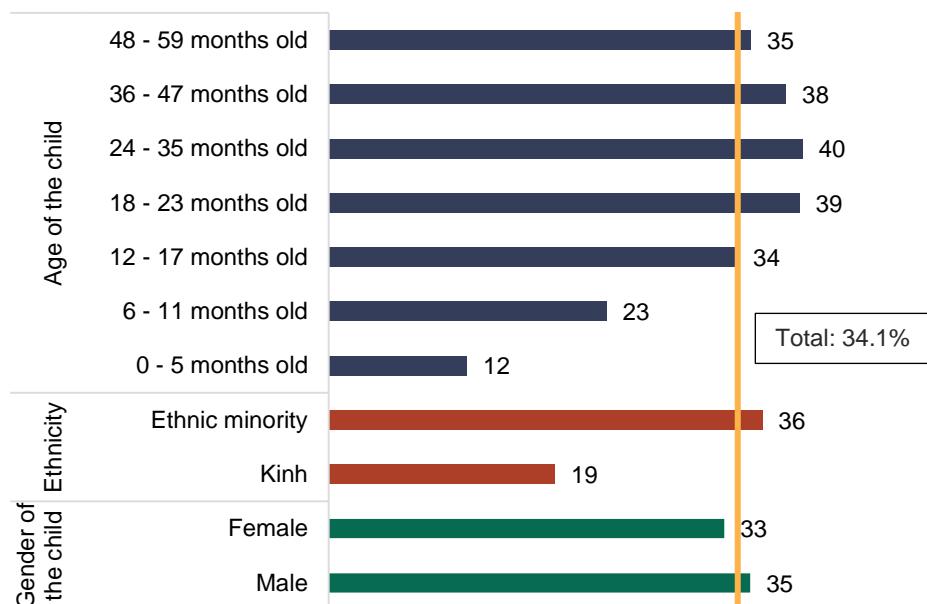
Source: MDRI endline survey and evaluation, 2021

The stunting rate among children under five is attributed to multiple factors, which include but not limit to: (i) IYCF knowledge and practices of parents and primary caregivers (indicator 21); (ii) accessibility to standard WASH facilities (indicator 3); (iii) prenatal care during pregnancy to avoid maternal malnutrition (indicator 6), and particularly (iv) the percentage of children aged 6-23 months receiving age-appropriate nutrition as well as early stimulation (indicator 18). The improvement in such indicators accounts for the reduced stunting rate among young children.

Figure 19 indicates that similar to baseline assessment, stunting is far more prevalent among ethnic minority children than Kinh children. In fact, the stunting rate among ethnic minority children is twice as much as that of Kinh children, at 36.2 per cent versus 18.9 per cent. It is a pity that data provided by commune health centres do not tell the specific ethnic group so the research team does not compare the stunting rate among each ethnic groups.

¹⁴ WHO Multicentre Growth Reference Study Group. *WHO Child Growth Standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: Methods and development*. Geneva: World Health Organization, 2006

Figure 19. Percentage of children under five who are stunted, by population group (%)



Source: MDRI endline survey and evaluation, 2021

4.3 WASH

The types of drinking water and sanitation facilities are important determinants of the health status of children. Proper hygienic practices can reduce the seriousness of major childhood diseases such as diarrhoea.

Indicator 10

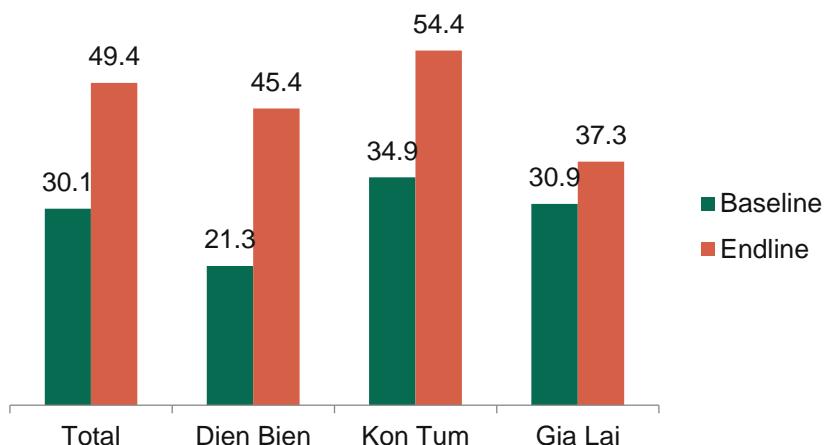
People in humanitarian situations who access safe drinking water as per agreed sector/cluster coordination standards and norms

The indicator aimed to explore what kind of water households in humanitarian situations used for drinking. In this context 'humanitarian situations' refers to natural disaster of all kinds that have negative impact on the availability and quality of household water supply. Following international standards stated in MICS tabulation plan, safe drinking water source is considered as any of the following: piped water into dwelling/yard/plot/neighbour, public tap/standpipe, tube well/borehole, protected dug well, protected spring, rainwater, tanker-truck, cart with small tank and packaged water.

In the endline survey, 1,719 people reported finding themselves in humanitarian situation over the past 12 months, of whom 460 are from Dien Bien province, 999 are from Kon Tum province and 260 are from Gia Lai province.

Survey results show that there has been an improvement in the percentage of people in humanitarian situations accessing safe drinking water in all three provinces (see Figure 20).

Figure 20. Percentage of people in humanitarian situations who access safe drinking water (%)



Source: MDRI endline survey and evaluation, 2021

Indicator 3 Proportion of the population having an improved sanitation facility

Following international standards, improved toilet facilities include flush/pour flush to piped sewer system or septic tank; flush/pour flush to pit latrine; biogas; direct double dry pit toilet and ventilated improved pit latrine.

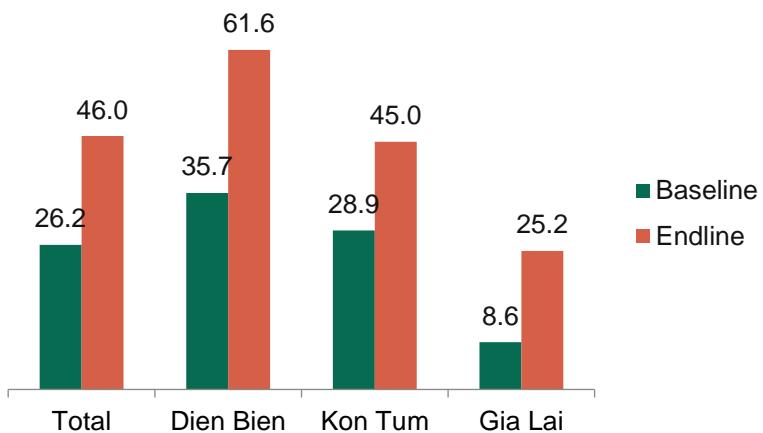
Figure 21 compares the percentage of household member having an improved sanitation facility between baseline and endline. **Survey results show that there has been an improvement in the percentage in endline compared with baseline in all three provinces.**

Similar to baseline, Dien Bien province records the highest percentage of household members having improved sanitation facility, at 61.6 per cent. Flush/pour flush to pit latrine and flush/pour flush to piped sewer system or septic tank are two most popular types of improved sanitation facility in Dien Bien. Noticeably, 27.3 per cent of surveyed household members do not have any facility.

The percentage for Kon Tum is less than that, at 45 per cent although the province has the largest percentage of households having sanitation facility (at 91.9 per cent). Noticeably, 34.1 per cent of surveyed household members use simple pit latrine (dug pit) – a type of unimproved sanitation facility.

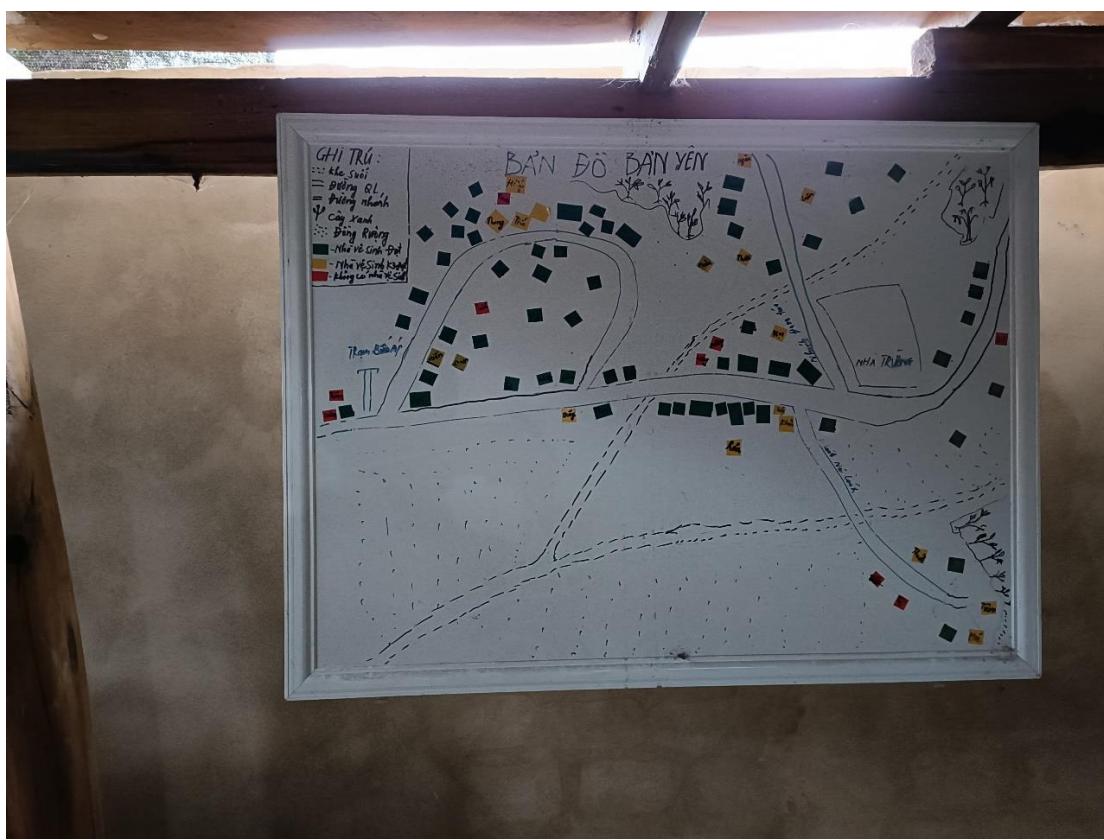
Gia Lai stands lowest in the chart in terms of proportion of population having access to sanitation facility and more importantly access to improved sanitation facility, at 25.2 per cent. Open defecation is still commonly practiced in Gia Lai and made up more than half of surveyed households (51.7 per cent).

Figure 21. Proportion of the population having an improved sanitation facility (%)



Source: MDRI endline survey and evaluation, 2021

Image 1. The map set up by a village leader in Dien Bien to advocate improved sanitation facility (green: qualified facility, yellow: unqualified facility, red: no facility)



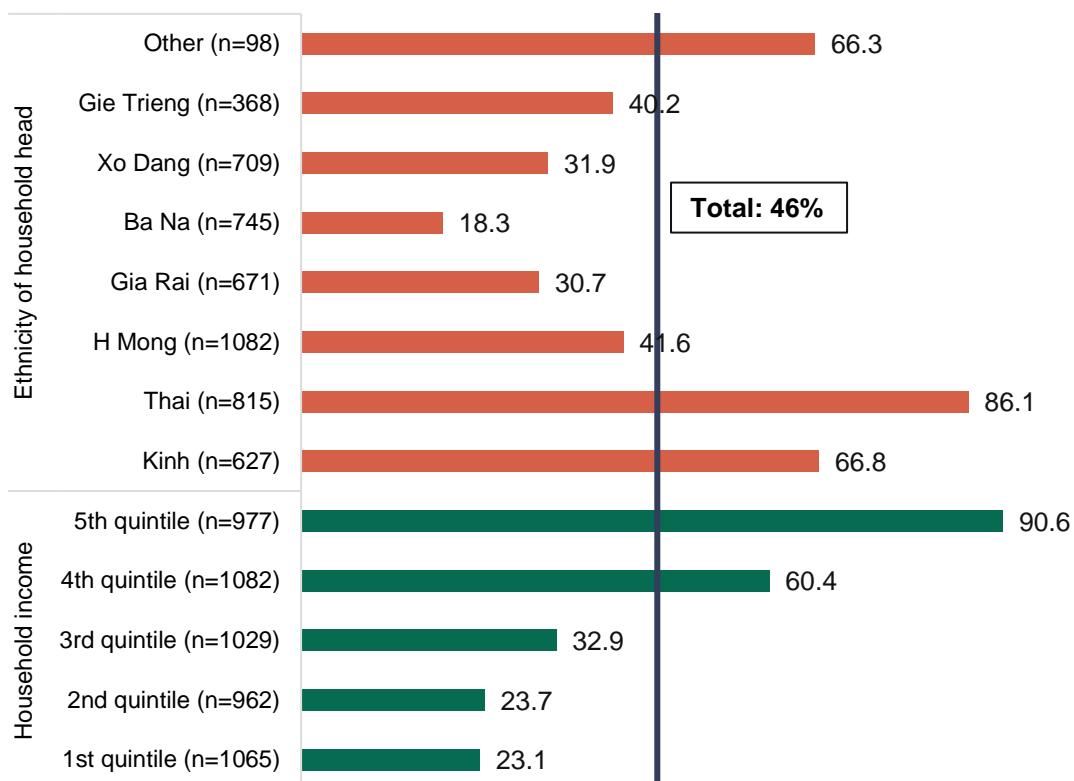
Source: MDRI endline survey and evaluation, 2021

Household access to improved sanitation facility widely varies among ethnic groups, of which Thai ethnic group records the largest percentage of household members with access to improved sanitation facility, at nearly 90 per cent (see Figure 22). Meanwhile, Gia Rai, Ba Na and Xo Dang all stand low, with the percentage ranging from 18.3 per cent to 31.9 per cent. This finding is consistent with the findings in the Viet Nam Rural, Agriculture and Fishery

Census 2016 that Gia Rai and Ba Na ethnic group stand at the bottom of the chart in terms of household access to septic tank or semi-septic tank toilet.

Figure 22 also suggests that access to improved sanitation facility remarkably increases as household wealth improves.

Figure 22. Proportion of the population having an improved sanitation facility, by population group (%)



Source: MDRI endline survey and evaluation, 2021

Indicator 7

Number of communities certified free of open defecation as a result of UNICEF and partner support (leveraged/indirect)

UNICEF in partnership with the Government of Viet Nam is working to achieve Sustainable Development Goal 6 on clean water and sanitation as well as Viet Nam's global commitments to become open defecation free (ODF) by 2025.

In the effort to fulfil the commitment, over the past few years the Viet Nam Health Environment Management Agency has collaborated with UNICEF to pilot "ODF community model", a key component of which is the joint Community-Led Total Sanitation programme between Ministry of Health and many NGOs (such as UNICEF, SNV Netherlands Development Organisation, World Vision, Church World Service, Plan). Dien Bien, Gia Lai and Kon Tum were among seven provinces selected for the programme.

The certification of ODF community for villages and communes is approved by the Chairman of District People's Committee and reviewed after every three years.

Results from endline survey indicate that at the commune level, **the number of ODF-certified communes in three provinces increases from 4 communes to 5 communes** (see Table 13). Similar to baseline assessment, there is no ODF-certified commune in Gia Lai province.

Table 13. ODF-certified communes in three provinces

| Province | Baseline | Endline |
|--|---|--|
| Dien Bien | - Muong Mun (Tuan Giao district) - Muong Thin (Tuan Giao district) | - Muong Thin (Tuan Giao district) - Hang Lia (Dien Bien Dong district) |
| Kon Tum | - Dak Na (Tu Mo Rong district) - Mang Ri (Tu Mo Rong district) | - Dak Pek (Dak Glei district) - Mang Ri (Tu Mo Rong district) - Dak Ro Ong (Tu Mo Rong district) |
| Gia Lai (excluding K'Bang district) | No qualified commune | No qualified commune |

Source: MDRI endline survey and evaluation, 2021

According to the ODF protocol, a commune is ODF certified if 100 per cent of its villages are ODF certified and 100 per cent of its health centres and schools (main branches) have access to water, improved sanitation facility and a designated place for handwashing with soap. The reason why not every commune is certified ODF although more than half of the villages receive ODF certification lies in the unfulfillment of second criteria.

Indicator 32

Proportion of pre-schools/IECD centres with WASH facilities meeting national/JMP standards

The indicator aims to assess the quality of WASH facilities in the school and health centre settings to guarantee a standard physical environment for children. The assessment criteria in use are JMP standards within the framework of WHO/UNICEF Joint Monitoring Programme for Water and Sanitation that supports the inclusion of WASH as part of the SDGs.

Image 2. Handwashing facilities supported by UNICEF in Dien Bien



Source: MDRI endline survey and evaluation, 2021

JMP monitoring system involves a multi-level service ladders that enable countries at different stages of development to track and compare progress. There are separate ladders for water, sanitation and hygiene. Within each category, the core service ladders include three levels: no service, limited service and basic service where the ‘basic’ service threshold corresponds to the SDG indicator (see Figure 23 and Figure 24). In this endline assessment, the ‘basic’ threshold is also selected as assessment criteria. The survey questions are adapted from the 2016 JMP programme document that provides harmonized indicators and core questions to collect data on “basic” water, sanitation and handwashing in schools and health centres.

Figure 23. Basic levels for monitoring WASH in schools

| Drinking water | Sanitation | Hygiene |
|---|--|---|
| <ul style="list-style-type: none"> Drinking water from an improved source is available at the school | <ul style="list-style-type: none"> Improved facilities, which are single-sex and usable at the school | <ul style="list-style-type: none"> Handwashing facilities, which have water and soap available |

Figure 24. Basic levels for monitoring WASH in health centres

| Water | Sanitation | Hygiene |
|---|--|--|
| <ul style="list-style-type: none"> Water from an improved source is available on premises. | <ul style="list-style-type: none"> Improved sanitation facilities are usable, separated for patients and staff, separated for women and allowing menstrual hygiene management, and meeting the needs of people with limited mobility. | <ul style="list-style-type: none"> Hand hygiene materials, either a basin with water and soap or alcohol hand rub, are available at points of care and toilets. |

In 24 project communes, 27 preschools and 24 commune health centres are surveyed, of which 11 preschools and 2 commune health centres have WASH facilities meeting JMP standards. **In comparison with baseline assessment, the number of qualified IECD centres increases from 12 to 13.** To be specific, the number of qualified preschools decreases from 12 to 11 while the number of qualified health centres increases from 0 to 2 (see Table 14).

Table 14. Preschools/health centres with WASH facilities meeting national/JMP standards in three provinces

| | Province | Baseline | Endline |
|------------|-----------|--|---|
| Preschools | Dien Bien | <ul style="list-style-type: none"> - Na Tong commune (1) - Muong Mun commune (2) | <ul style="list-style-type: none"> - Sin Chai commune (1) - Muong Mun commune (2) |
| | Kon Tum | <ul style="list-style-type: none"> - Dak Pek commune (1) - Dak Choong commune (1) - Dak Rve town (2) - Dak To Re commune (2) | <ul style="list-style-type: none"> - Dak Rve town (1) - Dak To Re commune (1) - Dak Na commune (1) - Dak Ro Ong commune (1) |

| | | | |
|-------------------|---|---|---|
| | | - Tan Lap commune (1) - Dak Ro Ong commune (1) - Kon Chieng commune (1) | |
| | Gia Lai (excluding K'Bang district) | | - Dak Troi commune (1) - Chu Gu commune (1) - Mlah commune (1) - Chu Drang commune (1) |
| Health centres | Dien Bien | No qualified health centre | - Na Tong commune (1) |
| | Kon Tum | | - Dak Pek commune (1) |
| | Gia Lai (excluding K'Bang district) | | |

Source: MDRI endline survey and evaluation, 2021

About preschools:

Although 100 per cent of surveyed preschools have at least one usable improved toilet for girls and one for boys, fewer meet the criteria for a basic handwashing facility. That accounts for the wide variety in the number of preschools with qualified WASH facilities among provinces.

The low coverage of basic handwashing facility is attributed to the fact that: (i) preschools have handwashing facility but no soap and/ or water available at the time of the survey; or (ii) preschools have no handwashing facility. This highlights the challenge of designing and maintaining handwashing facilities so that soap and water are available to students for handwashing at critical times, given the scientific evidence that the handwashing practices help to prevent diarrhoea which is responsible for 10 per cent of under-5 child mortality¹⁵.

About health centres:

The main reason for the unqualified WASH facilities in health centres is the lack of usable toilet designated for all types of users, especially for staff and girls/women. JMP standards specify that a commune health centre should have usable and separated sanitation facilities for four types of users: patients, staff, girls/women and people with limited mobility. This issue remains since baseline and has not been well addressed till endline.

Another noteworthy finding is that the newly constructed health centres (such as in Chieng So and Hang Lia commune, Dien Bien province and in Dak Glei town, Kon Tum province) do not have WASH facilities that meet the requirements.

Indicator 8

Number of schools that practice daily group handwashing in the reporting year only, as a result of UNICEF direct support and/or leveraged through national programmes

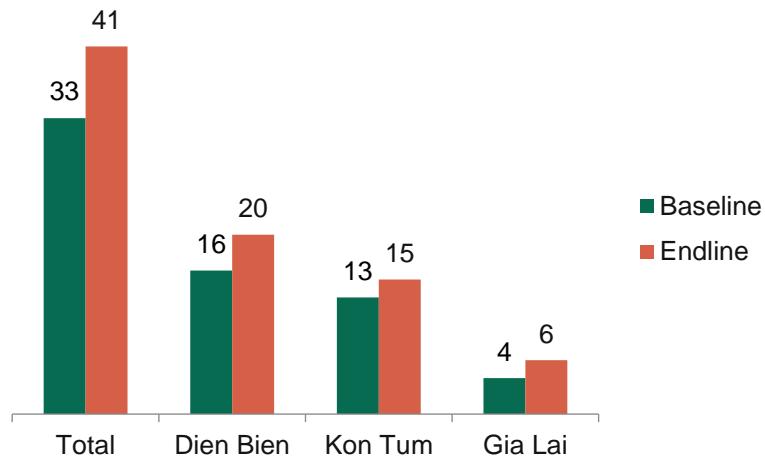
Handwashing is a hygiene practice that plays a critical role in battling diseases and malnutrition. In addition to observing schools if they have a designated facility for group handwashing, the endline assessment did observe the daily group handwashing by students in schools in project communes during the year of survey – 2021.

The sample includes 27 preschools and 24 primary schools whose students have lunch at school, of which 27 preschools and 14 primary schools had their students practice group handwashing before lunch at the time of the survey. **In comparison with baseline**

¹⁵ UNICEF Viet Nam. *Water, sanitation and hygiene*. <<https://www.unicef.org/vietnam/water-sanitation-and-hygiene>>

assessment, the total number of schools that practice group handwashing has increased (see Figure 25).

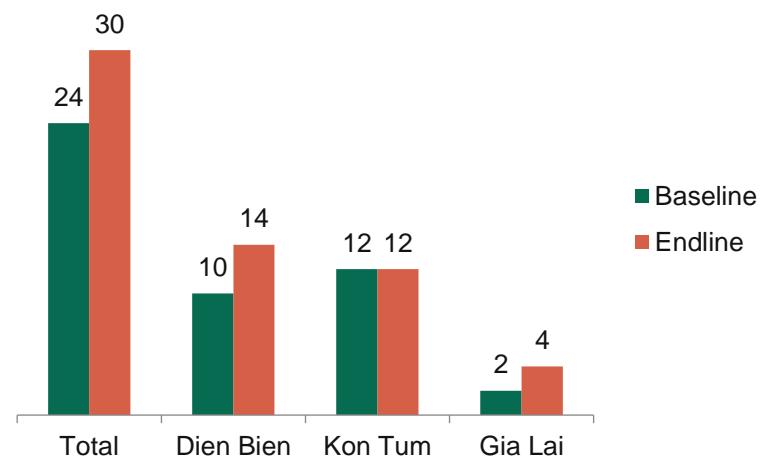
Figure 25. Number of schools that practice daily group handwashing in 2021



Source: MDRI endline survey and evaluation, 2021

Interestingly, the group handwashing practice seems not to depend on the availability of group handwashing facility at schools, evidenced by the fact that schools with group handwashing practice outnumbers schools with group handwashing facility (see Figure 26). This raises a concern whether the current facility at schools are sufficient to guarantee standard handwashing practices.

Figure 26. Number of schools that have group handwashing facilities in 2021



Source: MDRI endline survey and evaluation, 2021

4.4 Child Development

Indicator 20

Percentage of children aged 36-59 months in project locations on track in at least three of four developmental domains (MICS IECD Index: Literacy-numeracy, physical, social-emotional and learning)

Image 3. Children in Kon Tum, taken by MDRI's enumerator



Source: MDRI endline survey and evaluation, 2021

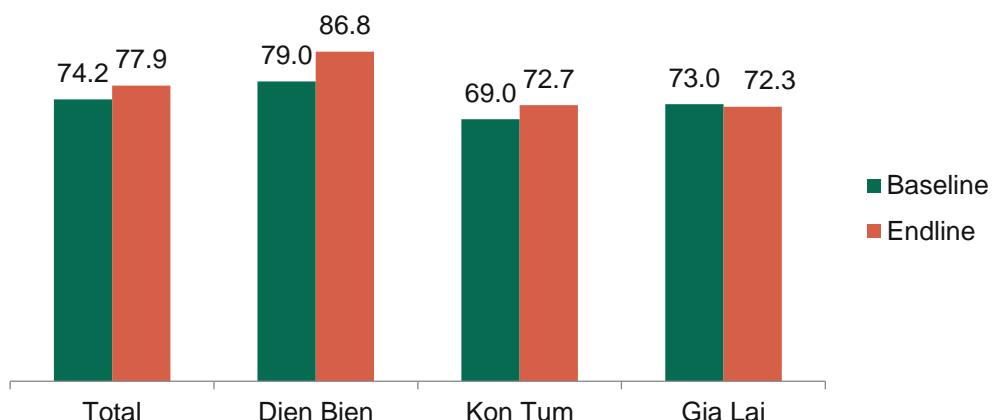
One of the main focuses of the IECD programme is the development of children. This is a continuous process, in which children learn to move, think, speak, feel and communicate to others. Vital domains of a child's overall development include physical growth, literacy and numeracy skills, socio-emotional development, and readiness to learn. In both baseline and endline, the research team use a module of four key questions to explore the developmental status of children aged 36-59 months. These questions are based on the module in the MICS to determine whether children are developmentally on track in four domains:

- **Literacy-numeracy:** Children are identified as being developmentally on track based on whether they can identify/name at least 10 letters of the alphabet, can read at least four simple, popular words, and know the name and recognize the symbols of all numbers from one to ten. If at least two of these criteria are met, the child is considered developmentally on track.
- **Physical:** If the child can pick up a small object with two fingers, like a stick or a rock from the ground and/or the child is not sometimes too sick to play, then the child is regarded as being developmentally on track in the physical domain.
- **Social-emotional:** Children are considered to be developmentally on track if two of the following criteria are met: (i) the child gets along well with other children; (ii) the child does not kick, bite or hit other children and (iii) the child does not get easily distracted.
- **Learning:** If the child follows simple directions on how to do something correctly and/or when given something to do, the child is able to do it independently, then the child is considered to be developmentally on track in this domain.

Figure 27 compares the percentage of children aged 36-59 months in project locations on track in at least three of four developmental domains between baseline and endline. **Survey results show that there has been a slight improvement in the percentage in endline compared with baseline.**

Similar to the baseline assessment, Dien Bien province has the highest proportion of children being developmentally on track, at least three of the four domains (86.8 per cent). Meanwhile no significant difference is observed between Kon Tum (72.7 per cent) and Gia Lai (72.3 per cent). Regarding four domains of child development, the survey results find that more than one third (31.4 per cent) of children are on track in the literacy-numeracy domain, but more so in the physical (97.1 per cent), social-emotional (77.1 per cent) and learning (92 per cent) domains. In each province, the proportion of children on track in the literacy-numeracy domain is also lower than in other domains. Even though literacy-numeracy learning activities could take place in both school setting and home setting, the fact that school closures and reduced school attendance due to COVID-19 have limited children's access to such activities.

Figure 27. Percentage of children aged 36-59 months on track in at least three of four developmental domains (%)

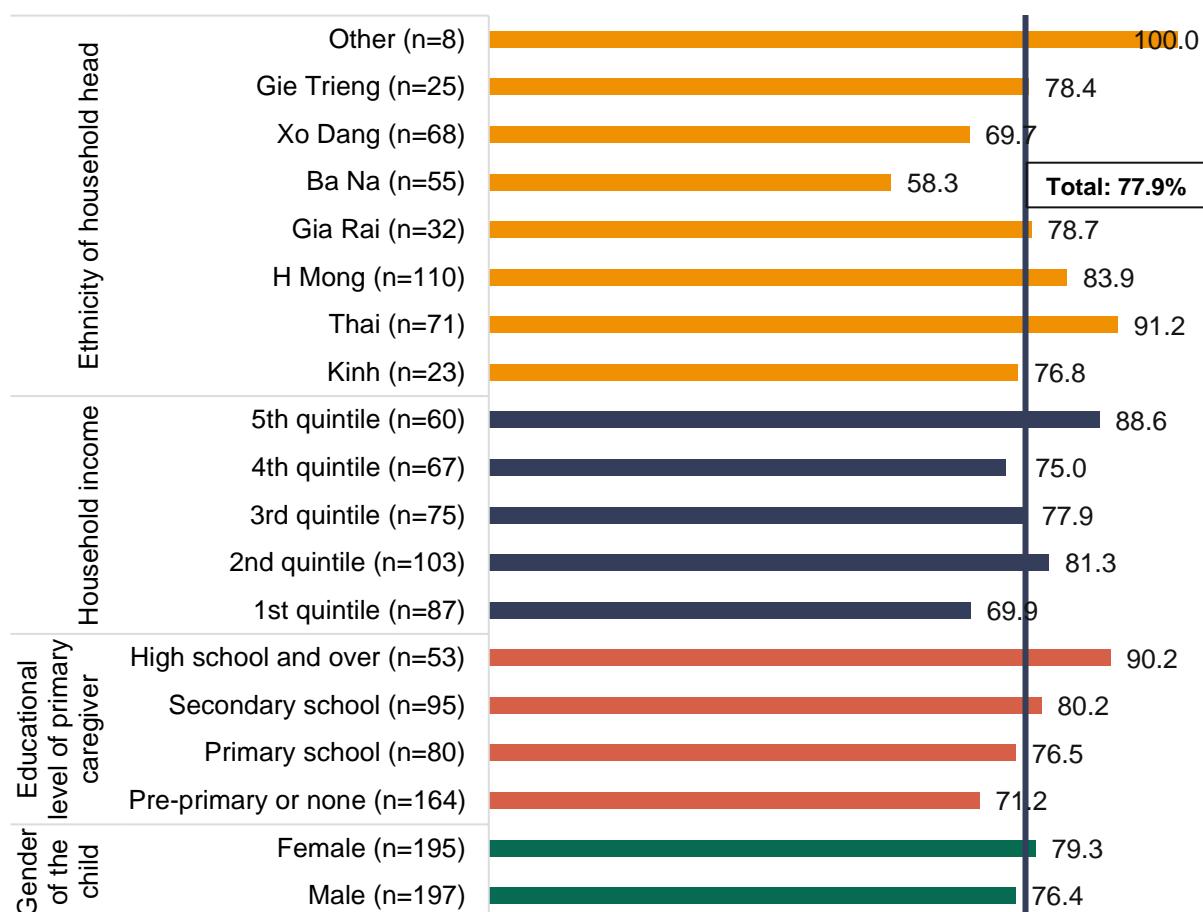


Source: MDRI endline survey and evaluation, 2021

The percentage of children aged 36-59 months on track in at least 3 out of 4 developmental domains widely varies across ethnic groups (see Figure 28). Thai, H'Mong, Gia Rai and Gie Trieng groups have the higher than average percentage. Compared with baseline assessment in which Gie Trieng group stands lowest, Gie Trieng group makes a significant improvement. Meanwhile, the percentage recorded among Xo Dang and Ba Na groups are lower than average.

Figure 28 displays no significant difference in the percentage of children on track in at least 3 of 4 developmental domains observed by children's gender (76.4 per cent for boys versus 79.3 per cent for girls). By wealth index quintiles, the proportion of children in the poorest households on track (69.9 per cent) is lower than those in the richest households (88.6 per cent). Among other wealth index quintiles, there is no remarkable difference. However, a noticeable difference is found between children with primary caregivers' education level being at highschool and higher and those with primary caregivers not completing any education level (90.2 per cent versus 71.2 per cent).

Figure 28. Percentage of children aged 36-59 months on track in at least three of four developmental domains, by population group (%)



Source: MDRI endline survey and evaluation, 2021

4.5 Maternal Health

Maternal health is defined as the health of women during pregnancy, childbirth and the postnatal period. There is scientific evidence to confirm that most maternal deaths are preventable and treatable in the presence of professional healthcare services and a supportive environment. Therefore, improving maternal health and ending preventable maternal deaths is always a top priority to ensure women and babies reach their full potential as well as attaining MDG 4 & 5.

This section identifies key determinants of maternal health care namely supplementation, antenatal care coverage, and institutional delivery; and compares the trends and results among women in different project areas.

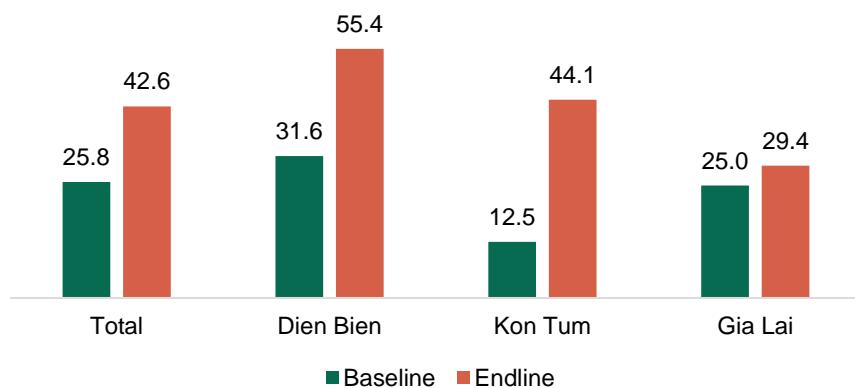
Supplementation

| Indicator 6 | Number of pregnant women who receive iron and folic acid supplementation |
|-------------|--|
|-------------|--|

Due to increased nutritional needs for both the mothers and the babies during pregnancy, expecting women are strongly recommended by WHO to supplement iron and folic acid in order to avoid fatal obstetric complications stemming from micronutrient deficiencies. These micronutrients are only needed in small quantities but are essential for fetal growth and development. As part of the IECD package to be provided under UNICEF interventions, pregnant women in the three project provinces have been covered by the multiple micronutrient supplementation service which aims to increase the micronutrient intake during pregnancy for low-income families.

Endline results indicated a nearly 17% increase in the total number of pregnant women receiving supplementation, compared to baseline (Figure 29). Among different kinds of supplements, iron-folic tablets stood out as the most popular ones (41%), far outweighing the second most chosen option – multiple micronutrient supplements (8%). At baseline, none of the surveyed pregnant women took multiple micronutrient supplements.

Figure 29. Percentage of pregnant women who receive supplementation (%)



Source: MDRI endline survey and evaluation, 2021

Project's impacts have been monumental in Dien Bien and Kon Tum, especially the latter province where the difference between baseline (without intervention) and endline (with intervention) was nearly four-fold. The improvement in Gia Lai, however, was not as impressive as in the other two provinces (only 4% percentage points difference between baseline and endline).

Key informants from qualitative interviews did make some veiled insinuations about the performance of this indicator in Gia Lai:

“

[...] The provision of micronutrient supplements for children and women were often interrupted. The latest interruption happened since July (2021) for pregnant women's supplementation and since May (2021) for children supplementation. It occurs almost every year

KII with head of commune health center in Gia Lai province.

“

[...] The funding advocated by UNICEF for IECD in 2021 was halted because public budgeting and resource allocation prioritized Covid-19 related plans.

KII with PMU representative in Gia Lai province.

Child Delivery

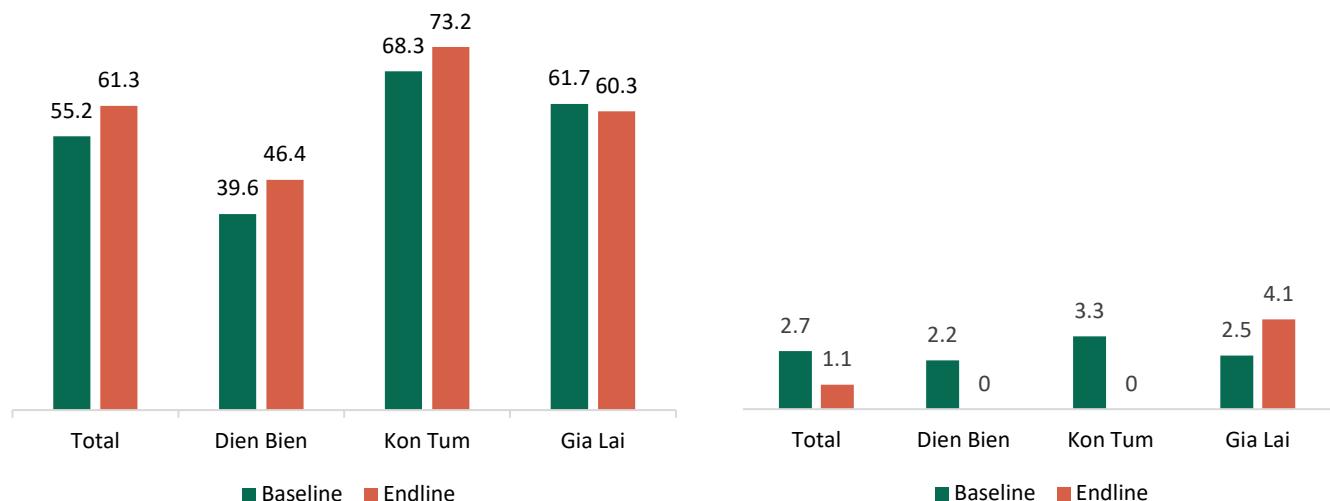
Indicator 23

Percentage of women aged 15-49 years with a live birth in the last 2 years in project locations who were attended by skilled health personnel during their most recent live birth

Rigorous research has proven that skilled birth attendance can help reduce MMR rate as most maternal and neo-natal deaths occur during delivery or immediate post-partum period. Skilled birth attendance encompasses a health care professional (such as midwife, doctor, obstetrician, nurse,...), an enabling environment (adequate medicines, equipment, supporting system and policies), and community acceptance of obstetric services.

To evaluate Indicator 23, the quantitative survey asked women aged 15-49 years with a live birth in the last 2 years if they were assisted by at least one skilled attendant during the most recent live birth. Among the surveyed women, 61% were attended by at least one trained attendant (doctor, nurse, midwives) and only 1% went through a delivery without any assistance. The respective figures for baseline were 55% and 2.7%. Both Dien Bien and Kon Tum showed progressive improvement despite the slow rate, surprisingly, none of the interviewed women in these two provinces gave birth alone in the past two years. Unfortunately, Gia Lai was the outlier in this Indicator with a slight decrease in the percentage of women receiving birth assistance by professionals (Figure 30 - left) and also an increase in the proportion of women undergoing the most recent live birth single-handed (Figure 30 - right). However, the latter scenario happened in a relatively small sample size - one Gia Rai household and two Ba Na households whose communities often reside in remote areas and preserve traditional child delivery customs. One possible explanation for Gia Lai's underperformance in this indicator could be the fact that Gia Lai imposed stricter social distancing regulations during the resurgence of the 4th Covid wave, compared to the other two provinces. Also, public reluctance to visit hospitals for fear of infection would be another logical justification.

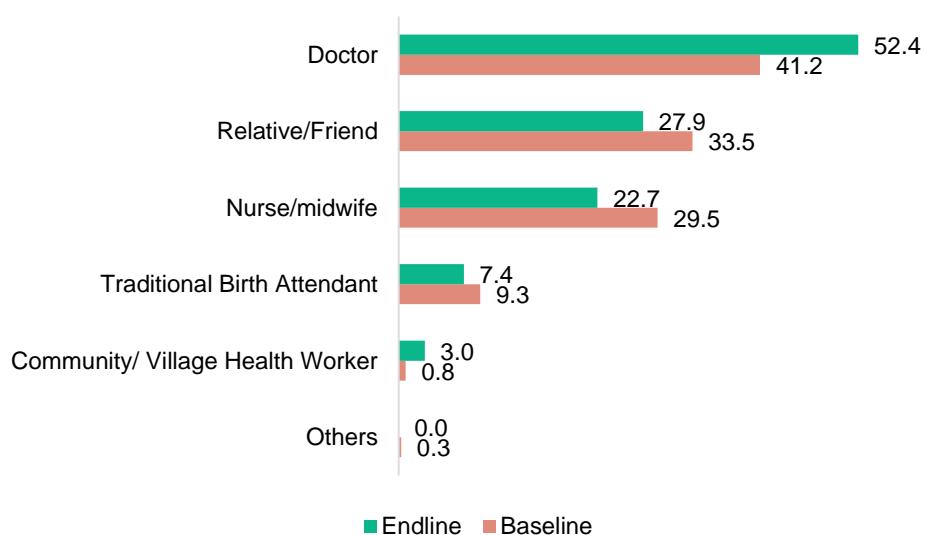
Figure 30. Percentage of women aged 15-49 years with a live birth in the last 2 years in project locations who were attended by at least one skilled personnel (left) and not attended by anyone (right)



Source: MDRI endline survey and evaluation, 2021

An important finding from the endline assessment that might comparatively tell the beneficial impact of IECD interventions is that the presence of skilled personnel such as “doctors” and “community/village health workers” to assist women at delivery experienced a major increase whereas the figures for “relative/friend and traditional birth attendant” witnessed a downward trend throughout a three-year period (Figure 31).

Figure 31. Types of persons assisting at delivery (%)

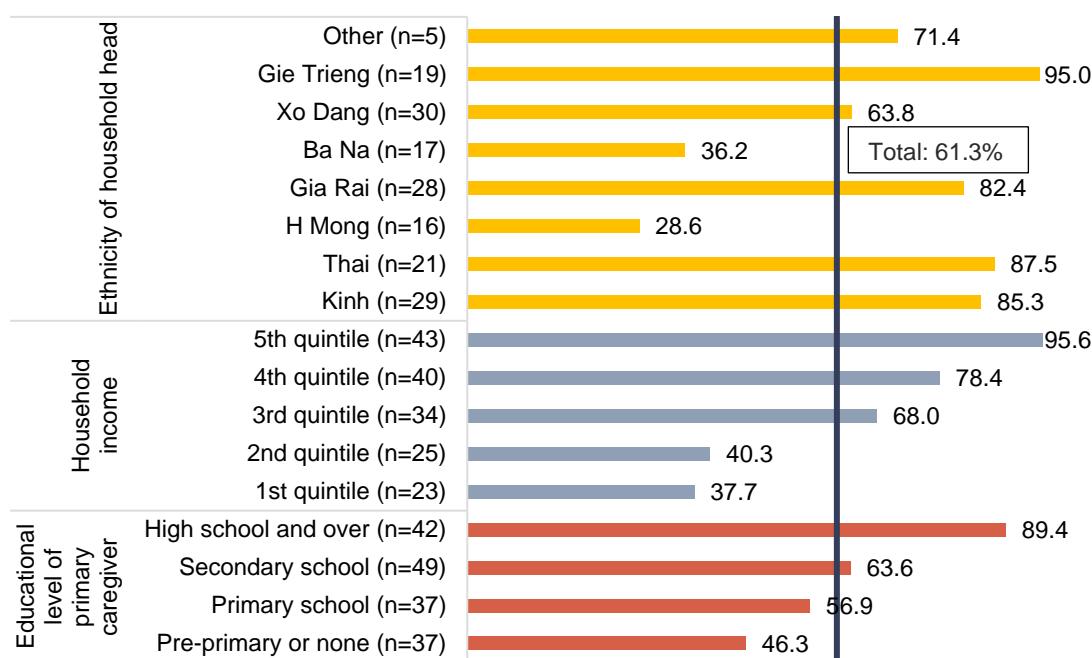


Source: MDRI endline survey and evaluation, 2021

Even for some ethnic groups such as H'Mong and Ba Na who had the lowest rate of skilled birth attendance, fewer H'Mong and Ba Na women were attended by relatives/friends than before while the proportion of women assisted by doctors managed to climb higher from baseline period. This is already perceived as an appreciable improvement.

Disaggregated data presented in Figure 32 may cast light on some of the factors associated with assisted births. A general look at Figure 32 revealed that the percentage of women giving birth with professional staff is proportional to education level and household income. To be more specific, skilled birth attendance is more prevalent among women holding at least secondary school graduate degree and in households that ranked 3rd and above in the wealth quintile. In addition, another striking discovery from the endline result would certainly be the rise of Gie Trieng ethnic group to score the highest (95%) in this indicator, surpassing baseline's top positions of Kinh and Thai people. However, the gap between the highest group (Gie Trieng) and the lowest (H'Mong) at endline is still as large as 66% percentage points.

Figure 32. Skilled birth attendance at endline, disaggregated by ethnicity, income and education level (%)



Source: MDRI endline survey and evaluation, 2021

Indicator 25

Proportion of births in project locations that were delivered at a health facility

Institutional delivery enable doctors to prevent, detect and manage obetric complications arisen during and immediate after giving birth. The Ministry of Health has set the minimum target for this indicator at over 97% and over 85% in disadvantaged areas as in the National Action Plan on reproductive health care, with a focus on the health of mothers, newborns and children during 2021 – 2015 period.

However, reducing home-based delivery rates especially in the upland areas is a major challenge not only because health facilities are harder to access but maternal health care services are also not properly aligned with the social and cultural context of the local people. For example, the Ba Na and H'Mong ethnic group have their customs of giving birth at home with the support of a traditional midwife (usually an old women who were experienced with labor but did not receive any technical training) and often feel reluctant to deliver at a health

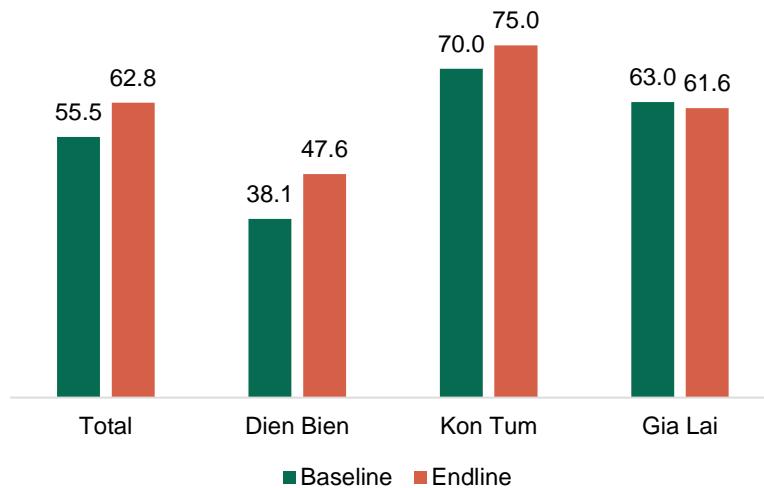
facility due to psychological barriers (feeling embarrassed if having contact with strange people at delivery). With that being said, if an intervention neglects certain cultural preferences or refuses to accommodate traditional practices (ie: allowing relatives to be present at delivery), it is highly likely that institutional delivery will be disregarded despite improved access to quality.

To advocate institutional births, besides communication programs to boost awareness, UNICEF Vietnam also recognizes the importance of capacity building for health personnels at all levels including the traditional midwives at remote villages. This allows three project provinces to gradually increase the rate of institutional births but also to mitigate the risk of family-based delivery, thus potentially contributing to fight inequalities.

Similar to Indicator 23, for this indicator, the quantitative survey asked the information from women who successfully gave birth in the past two years. In this survey, health facility refers to commune health centres, maternity houses, private health facilities, and district hospital/or higher, according to MICS's definition.

As evident in Figure 33, except for Gia Lai province, the percentage of women going to health facilities for child delivery has increased at endline, compared to baseline. Of 269 pregnant women interviewed in the endline survey, about 63% of them were delivered at a health facility, which is 7% higher than baseline's starting point. Despite an overall improvement, Dien Bien remains the province with the lowest rate.

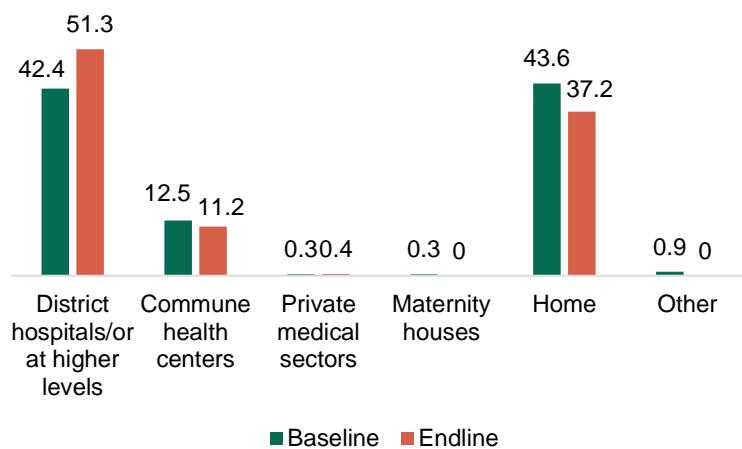
Figure 33. Proportion of births in project locations that were delivered at a health facility (%)



Source: MDRI endline survey and evaluation, 2021

Even though the popularity trend of delivery places does not vary much from baseline with district hospitals and homes being the most selected choices, the ascending shift in favor of the former and the descending pattern of the latter is worth mentioning, implying that project interventions are on the right track (see Figure 34).

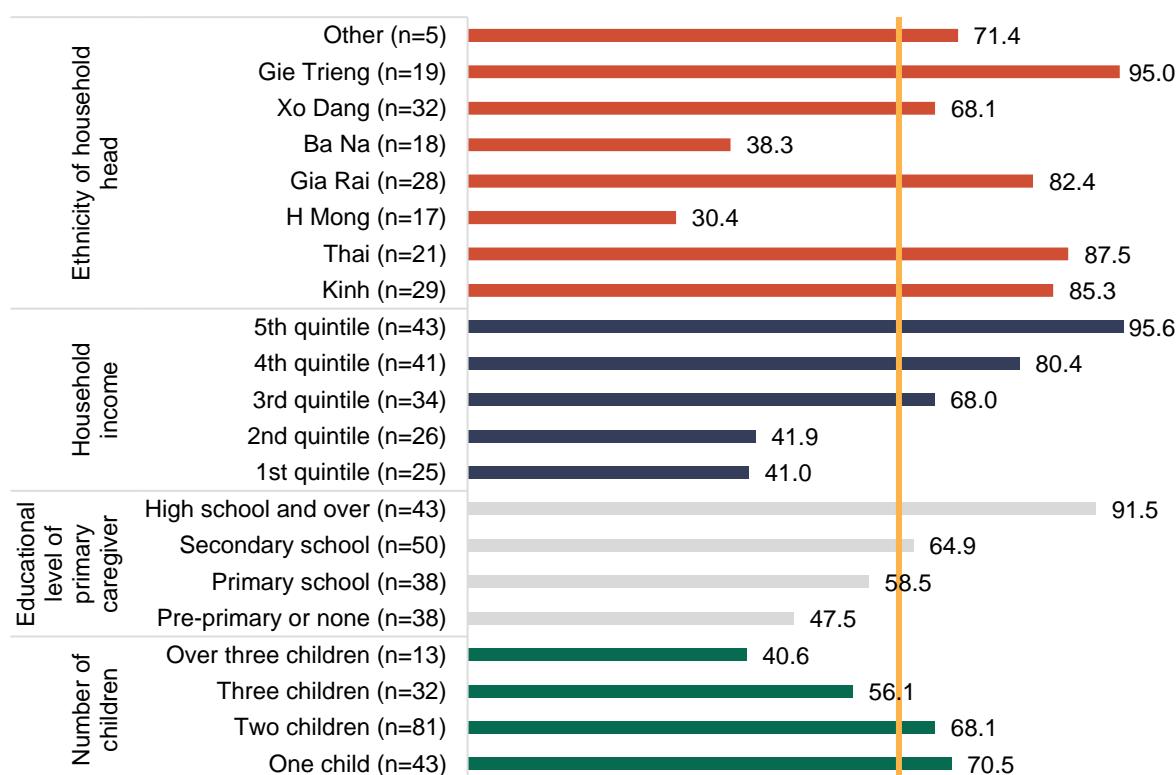
Figure 34. Places of delivery (%)



Source: MDRI endline survey and evaluation, 2021

There is quite a positive correlation between level of education, economic status and the likelihood of facility-based delivery in the three project provinces (see Figure 35).

Figure 35. Institutional births at endline (%), disaggregated by number of children, primary caregiver's education, household income and ethnicity



Source: MDRI endline survey and evaluation, 2021

In particular, women already completed high school and above and/or living in wealthier households (4th quintile and above) reported a higher probability of institutional births, as

illustrated in Figure 35. Comparison across different ethnic groups signifies that giving birth at a health facility is rather common among Gie Trieng, Thai, Kinh and Gia Rai people (> 80%) but not yet preferred by H'Mong and Ba Na communities (< 40%). The substantial gap between ethnicities once again poses a pressing need for all stakeholders to put combating inequality in health care at the heart of their agenda. Last but not least, the number of children per household is also in inverse proportion to facility-based delivery, according to endline results. In other words, women having three or more children are 30% less likely to give birth at a hospital/commune health center than those who have a single child.

Focus group discussion with PMU representatives in Gia Lai province did provide certain justifications for the lower endline result of this indicator compared to baseline as well as some difficulties faced by the programme when trying to influence ethnic minority communities. Notably, the decrease in the proportion of institutional births of Gia Lai province may partly be attributed to the absence of Kbang district in the endline sample size, given the fact that this district has a higher socio-economic status than the other two surveyed districts.

“

[...] Kbang has an advantage that their ethnic minorities are more educated. It is easier to implement activities at health facilities or healthcare programs in Kbang than in Mang Yang district. The people in Mang Yang are mostly Ba Na who are still keeping many traditional customs. For example, in Ayun commune (Mang Yang district), the home-based delivery rate used to be 99%; people did not attend any antenatal visit. However, after implementing the IECD program, the rate started to decline but it is still very difficult for them to travel long distance to the district hospital especially when it is raining. In that case (home-based delivery), the people will call the village health worker/midwife to assist them. That is already a major improvement compared to previous (delivery at home with skilled attendant)

FGD with PMU representatives in Gia Lai province.

Services will continue to be underutilized if the perceived benefits of attending a health facility are not seen by women and their families to outweigh potential harms and costs. Those who have the means to bypass commune level facilities may access higher quality facilities that are further away, potentially reinforcing inequities.

Another sharing of the head of a commune health center in Gia Lai province also gave further hints about positive impacts of the IECD programme in the maternal health sector. When asked about an achievement that is beyond her expectation, she cited UNICEF's contribution to uplift the percentage of women attending prenatal check-ups and delivering at commune health center through the offer of training and travel subsidy to village midwives. This clearly demonstrates that culturally-appropriate maternity care has been incorporated into the programme design in order to better encourage service utilization as well as patient satisfaction.

“

[...] Thanks to UNICEF's interventions such as technical training and travel cost coverage, traditional midwives in upland villages are more motivated to go down here (commune health center) to assist delivery. Before it was only 1-2 cases/month. Now it goes up to 5-7 cases/month

KII with head of commune health center, Gia Lai province.

Prenatal Care Check-ups

Indicator 24

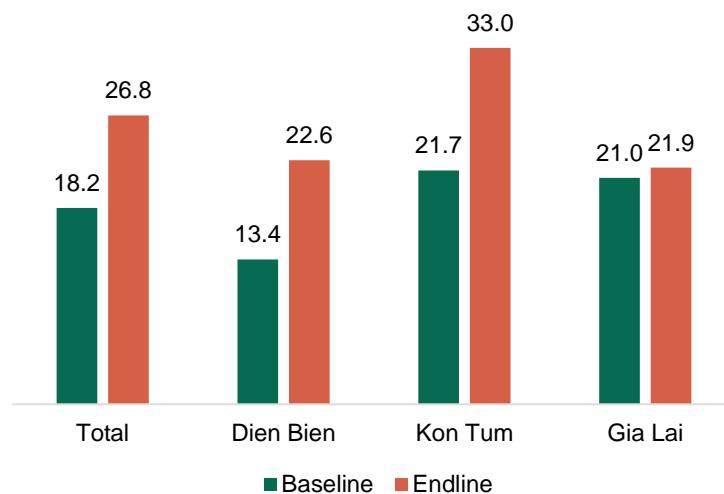
Percentage of women aged 15-49 years with a live birth in the last 2 years in project locations who were attended at least four times by any provider during their last pregnancy that led to a live birth

WHO recommends that all pregnant women shall receive at least four antenatal care check-ups, with the first visit occurring during the first trimester. The “four-times” standard is also included in the Multiple Indicator Cluster Surveys (MICS) under the Global MICS Survey Programme coordinated by GSO and UNICEF Vietnam.

Antenatal visits play a pivotal role in childbirth planning and serve as a critical entry point into the formal health system for rural or ethnic minority women in disadvantaged areas who would otherwise resort to traditional unhealthy behaviors. The endline survey asked the number of prenatal care check-ups attended by women who delivered birth within the two year period preceding the survey.

It can be concluded from Figure 36 that the ICED programme did generate a number of beneficial effects on the antenatal care coverage in general, most notable in Dien Bien and Kon Tum province where the endline rates grew larger by 9% and 11% respectively. Likewise, the number of women who attended at least one antenatal visit also increased from 302/376 surveyed women (80%) to 225/269 (84%) after three years. On the other hand, there has also been a decrease in the percentage of women with no prenatal check-up throughout the last pregnancy from 20% at baseline to 16% at endline.

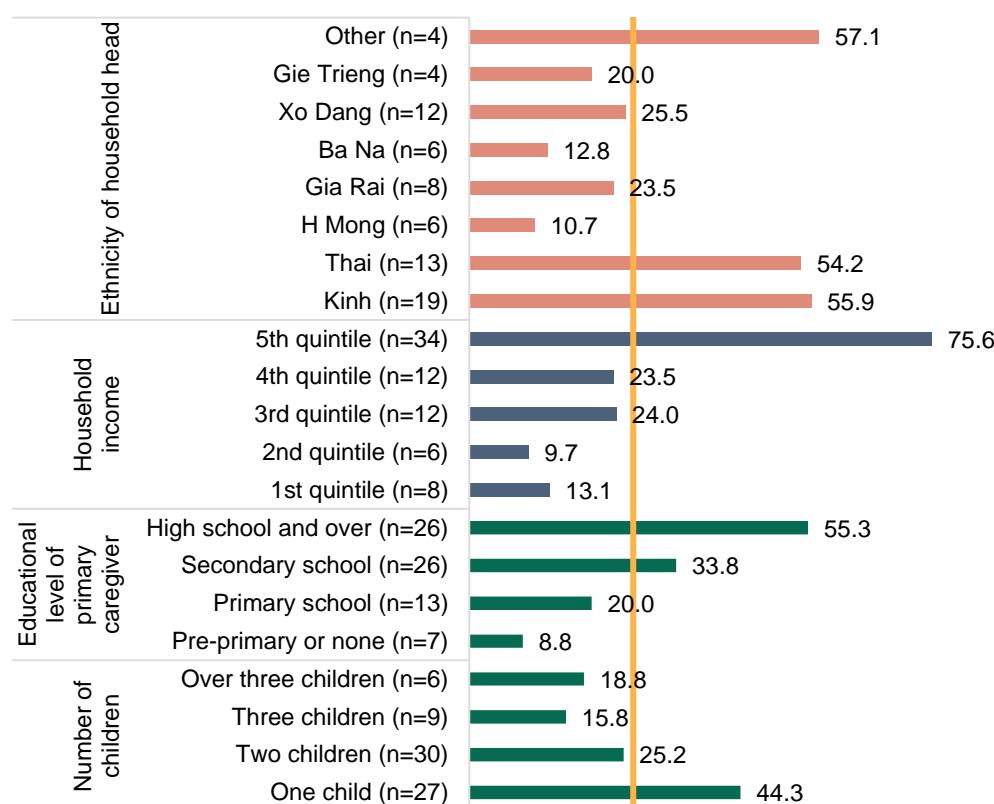
Figure 36. Percentage of women aged 15-49 years with a live birth who were attended at least four times by any provider in the last 2 years in project locations (%)



Source: MDRI endline survey and evaluation, 2021

In acknowledgment of the commendable remarks, existing challenges need to be well taken into accounts. First, despite the upward trend, the overall antenatal care coverage remains low (< 30%). Second, disparities between ethnicity, income status, educational attainment are widely recognized (see Figure 37). The percentage-point difference between the highest value and the lowest can be as broad as 8 times. For instance, the attendance rate of women in the richest group (5th quintile) reached 75.6% while the figures for the lower quintiles were far behind – at 23.5%, 24%, 9.7% and 13.1%, in descending order. Surprisingly, not the lowest quintile but the 2nd quintile group possessed the most limited antenatal care coverage. On a similar pattern, the proportion of women having attended at least four antenatal visits in the latest pregnancy was the highest among those who already graduated from highschool and over (55.3%); and lowest among those without education or just finished pre-primary level (9%). Last but not least, except for the Kinh and Thai, most ethnic groups in the surveyed pool still recorded a relatively low frequency of antenatal care visits (<30%), most apparent among H'Mong and Ba Na communities.

Figure 37. Endline antenatal care coverage (%), disaggregated by number of children, primary caregiver's education, household income and ethnicity



Source: MDRI endline survey and evaluation, 2021

Generally, the endline status of maternal health indicators (6, 23, 24, 25) did validate the efforts of ICED programme implementers in upgrading the overall delivery model. However, there is still a lot of work to be done when it comes to inequality eradication and improved healthcare access, quality and resources for highly vulnerable population subgroups, especially the ethnic minorities (H'Mong, Ba Na, Xo Dang, ...).

4.6 Education

Early childhood education

Indicator 31

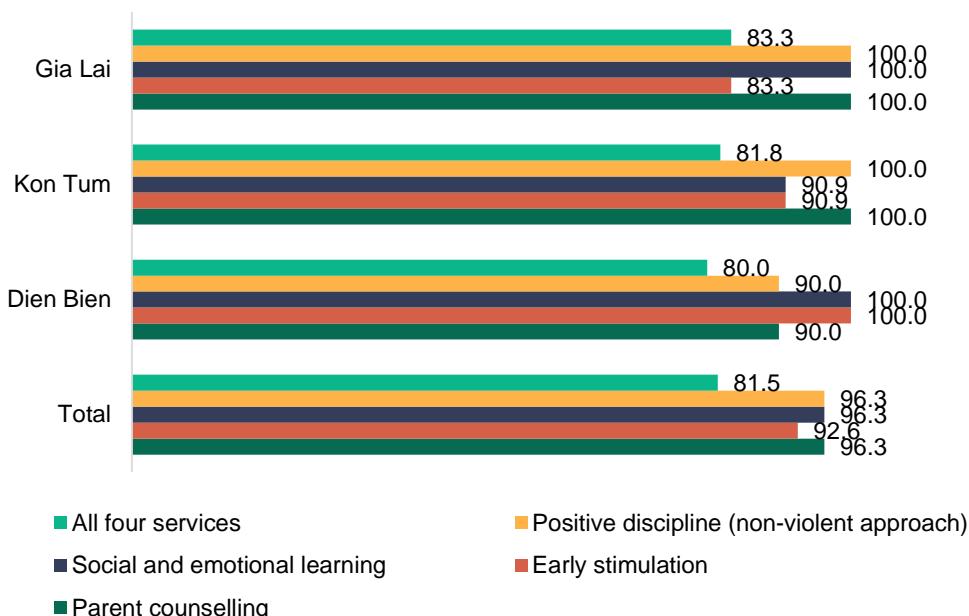
Percentage of ECE centres, including family-based childcare groups in project locations which have minimum IECD equipment and early learning/ stimulation services for young children

One of the UNICEF IECD programme's immediate objectives is that the project's targeted areas will have accessible minimum IECD services in place with acceptable quality for parents, caregivers and children. To contribute to measuring the achievement of this objective, Indicator 31 was set out to record the percentage of ECE centres, including family-based childcare groups in the project areas which (i) have minimum IECD equipment and (ii) provide early learning/ stimulation services for young children.

A preschool is determined to "have minimum IECD equipment" if it has the necessary equipment and facility as required by MOET in two Circulars 02/2010/TT-BGD-DT and 34/2013/TT-BGD-DT. At the time of the endline, **100% of ECE centres, including family-based childcare groups in the three project provinces were found to have minimum IECD equipment.**

To assess the percentage of ECE centres having early learning/ stimulation services for young children, in the baseline, three services were determined, namely parent counselling, early stimulation, and social and emotional learning. In the endline, another service concerning positive discipline (non-violent approach) was added. **The results showed that 81.5% of ECE centres in the three project provinces (22 out of 27 centres) provide all of the abovementioned four early learning/stimulation services.** There are no significant differences amongst different provinces for this indicator. In Gia Lai, all ECE preschools already provide positive discipline, social and emotional learning, and parent counselling services. Early stimulation seems to be the service that is most lacking, with only Dien Bien having 100% of ECE centres providing this service, while the rates of preschools providing this service in Gia Lai and Kon Tum are 83.3% and 90.9% respectively. The newly added positive discipline service was found to be available in all surveyed ECE centres in Gia Lai and Kon Tum, and in 90% of the surveyed centres in Dien Bien.

Figure 38. Percentage of ECE centres, including family-based childcare groups in project locations which provide early learning/stimulation services for young children.



Source: MDRI endline survey and evaluation, 2021

Responsive parenting

Early stimulation

Indicator 2

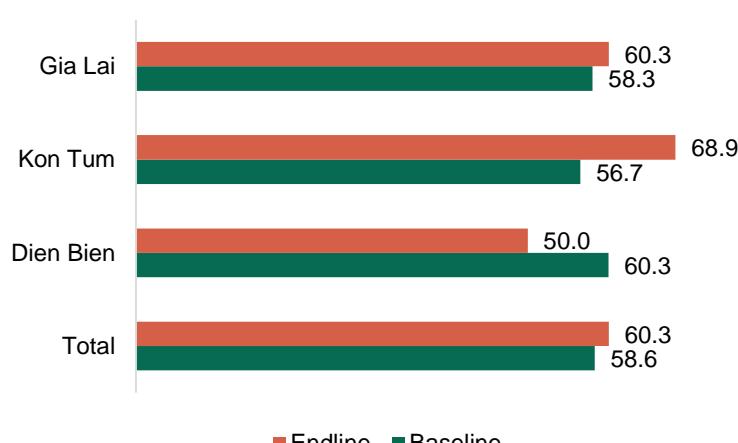
Percentage of children receiving early stimulation and responsive care from their parents or caregivers

Science has long acknowledged the importance of early stimulation for children's development. In the first 3 years, a child's brain develops most rapidly, forming 700 to 1000 neural connections every second. Therefore, during these early years, children need to have parental interaction, so all senses are developed. These early interaction needs to be optimized to ensure full, timely development of the child including social emotional skills (UNICEF).

To measure this indicator, the endline survey used the same criteria adopted in the baseline about "Play" and "Communicate" activities as per the UNICEF and WHO guidelines to assess the percentage of children receiving early stimulation from their parents or caregivers, which is disaggregated by age groups. These practices range from providing ways for the baby to see, hear, and touch their caregivers, to talking to the child and teaching them stories, songs and games.

It is shown that **by the time of the endline, 60.3% of the children aged 0-4 living in the project areas received early stimulation from their parents or caregiver, demonstrating a slight increase of 1.7 percentage points from the baseline indicator** (Figure 39). Kon Tum was the province which witnessed the most improvement of 12.2 percentage point, reaching 68.9% children aged 0-4 receiving both play and communication practices. On the other hand, a decrease of 10.3 percentage point in this indicator was found in Dien Bien. One of the contributing factor to this decrease could be that Dien Bien recorded a significant decrease in the sample size, i.e. the number of children aged 0-4, from 383 children in the baseline to 262 children in the endline, which suggests that some children aged 0-4 who received early stimulation and responsive care reported in the baseline already grew out of this age group at the time of the endline. Moreover, the new households joining the programme might not have received any training since last year due to Covid, hence the decrease in Dien Bien.

Figure 39. Percentage of children 0-4 years who receive early stimulation and responsive care practices from their parents/caregivers



Source: MDRI endline survey and evaluation, 2021

“

I like playing with my child and have a good laugh with her. When it's nap time I now know to tell her a story so she can fall asleep more easily. [...] My daughter is very active and not easy to put to sleep, so I have to tell her stories, such as stories about Tom and Jerry. Gradually she becomes more interested in playing with me.

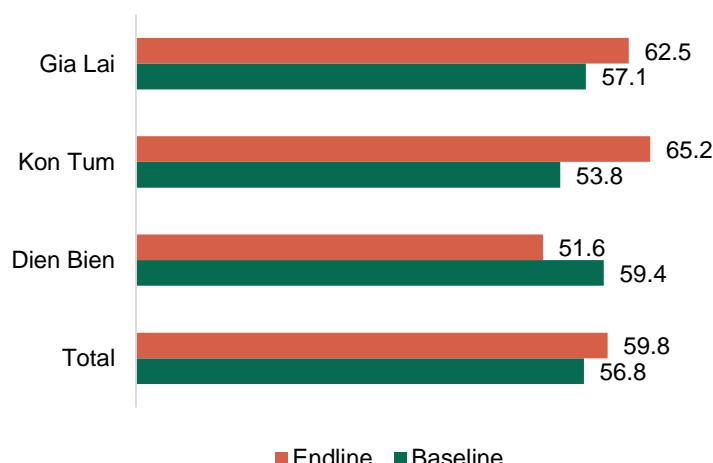
FGD with male caregivers, Kon Tum.

Indicator 22

Percentage of parents/caregivers in project locations who engaged with their children aged 0-4 years (under 5) in activities to promote responsive care including early stimulation

Related to Indicator 21, Indicator 22 measures the percentage of parents/caregivers who practise responsive care and early stimulation on their children aged 0-4 years. **The results at the endline shows an improvement of 3 percentage point in this indicator in the project locations** (Figure 40). Similar trends found in Indicator 21 were observed here. The percentage of parents/caregivers who engaged in responsive and early stimulation activities with their children increased the most in Kon Tum, from 53.8% in the baseline to 65.2% in the endline. Dien Bien again saw a decrease of 7.8 percentage point in this indicator, with the province's sample size lessened by 61 parents/caregivers. Similar to Indicator 2, the possible explanations include the attrition in the households having 0-4 children, as well as the disruption of training activities in the last year due to Covid.

Figure 40. Percentage of parents/caregivers in project locations who engaged with their children aged 0-4 years in activities to promote responsive care including early stimulation (%)



Source: MDRI endline survey and evaluation, 2021

Exposure to learning materials

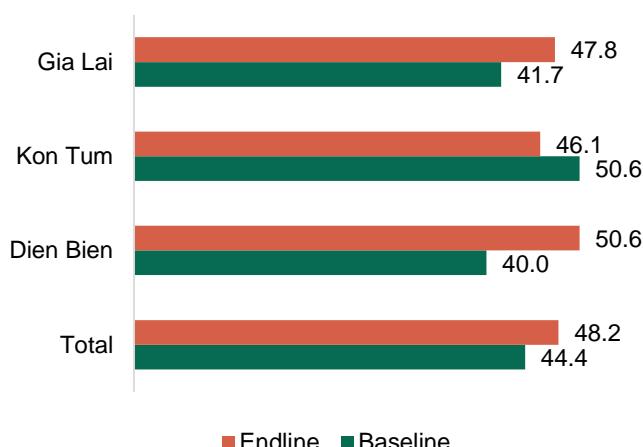
Indicator 27

Percentage of households having children aged 0-8 years in the project locations who have learning materials (children's books and playthings) at home

In addition to the responsive interaction with parents/caregivers, young children need to be exposed to stimulating learning materials such as playthings and books to get the chance to explore and learn to develop cognitive and literacy skills. The UNICEF's Nobody's Perfect Parenting programme's content included instructions for parents to make and use simple toys from household materials to carry out fun and easy play activities with their children. Parents were also encouraged to give their children a variety of materials to play with and picture books to read to.

Similar to the baseline, in the endline survey, parents or primary caregivers having children aged 0-8 years in the project locations were asked if they had children's books, picture books and toys available at home. Playthings are not limited to toys purchased from a store, but also include homemade toys such as cloth dolls, bottles and cardboard boxes etc., or objects and materials found outside the home (rocks, animal shells, leaves ...) which are used by children to feel, touch, pick and name.

Figure 41. Percentage of households having children aged 0-8 years in the project locations who have learning materials (children's books and playthings) at home (%)



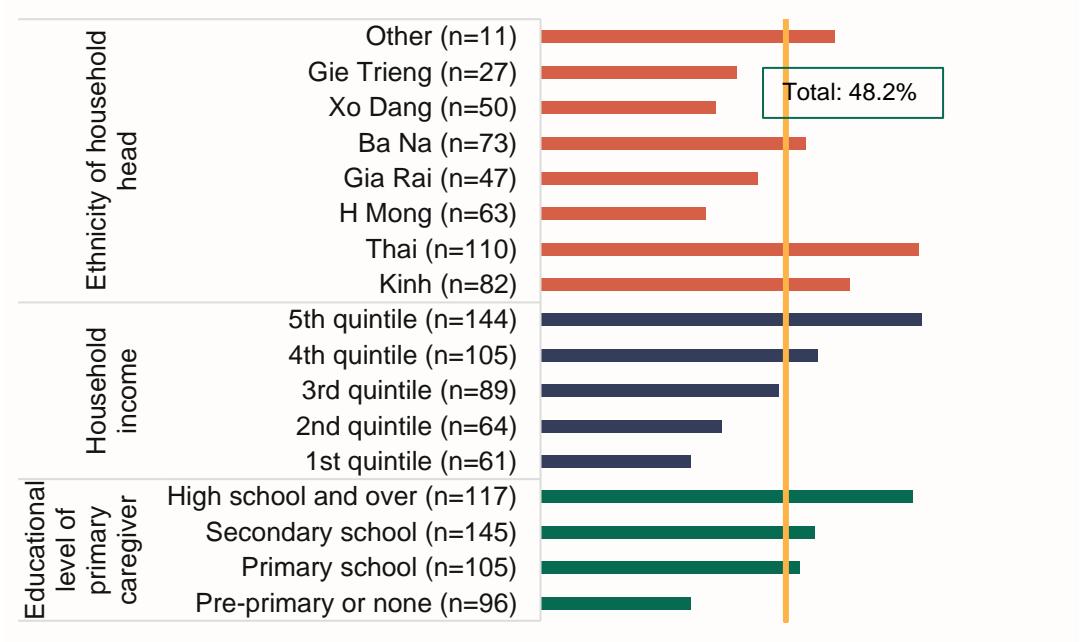
Source: MDRI endline survey and evaluation, 2021

The results show that at the time of the endline survey, **the percentage of households having children aged 0-8 years in the project locations who have children's books and playthings slightly improved from 44.4% to 48.2% in total**. The biggest improvement was found in Dien Bien, with the percentage of households having learning material grew by 10.6 percentage point to reach 50.6% at the endline.

Similar to the baseline trends, the endline data suggests that **the economic condition of the household and the education level of the primary caregivers correlate with the availability of learning materials, including books and play things in the households** (Figure 42). While 75% of the highest income group have learning materials at home, only

29.6% of their counterpart in the lowest income group do. The gap between parents/caregivers with high school and over education level and those with pre-primary and no education is similarly large (73.1% and 29.5% respectively). Accordingly, in terms of ethnicity, the Thai and Kinh are the two leading groups in this indicator (at 70.3% and 60.7% respectively), since Kinh and Thai households are usually in the highest wealth index quintile group and have higher educational levels.

Figure 42. Percentage of households having children aged 0-8 years in the project locations who have learning materials (children's books and playthings) at home by groups at the endline



Source: MDRI endline survey and evaluation, 2021

4.7 Child Protection

Institutional Support Mechanism

Indicator 14

Municipalities that implement local protocols for the protection of children from violence, abuse and neglect

Findings from baseline evaluation indicated that **100 per cent of project regions (from province and district to commune level) committed to implementing local protocols for protecting children from violence, abuse, and neglect since 2018**. Recent reports on the end-of-project achievement of results mentioned that a Child Protection Management Board was established and consolidated from provincial to grass-root level, evidenced by the formation of a Child Protection Committee in all project districts and communes under the direction of Provincial People's Committee. This Child Protection Committee takes the main responsibility for periodic supervision, reviewing and providing support for the provision of child protection services.

“ [...] The Permanent Child Protection Committee was established at all levels with the key purposes of providing support for children suffering from violence or abuse.

FGD with PMU representatives, Dien Bien.

Nevertheless, there is almost no progress in the percentage of children aged 6-8 who would report violent incidents involving themselves and other children to child protection workers compared to 3 years ago has been observed, with nearly none of them reported to seek help from Child Protection Agency (refer to Indicator 26).

Indicator 15

Number of child protection workers in UNICEF-supported communes who provide case management in line with national standards

Case management plays an essential core function in the child protection system and must be closely tied with the national legislative process involving the children's welfare. In most of global guideline handbooks, the term "case management" is defined as the process of organizing and carrying out work to address an individual child's (and their family's) needs in an appropriate, systematic, and timely manner, through direct support and/or referrals, and in accordance with a project or programme's objectives¹⁶. By providing support to address child protection concerns, case management can directly contribute to the core protection purpose of preventing and responding to abuse, neglect, exploitation and violence against children.

In recent years, the case management has gained greater familiarity within Vietnam's child protection at both central and provincial level. To evaluate the improvement of child protection workers' capabilities in delivering case management service, the endline questionnaire asked the communal leaders to update the list of their staff involved in the case management process. It was referred to in Circular 56/2017/ND-CP dated 09/05/2017 that regulates six steps in case management for marginalized children (orphans, children with disabilities, children from poor households, children affected by HIV/AIDS) or children suffering from abuse, violence or neglect. Specifically, the procedure includes:

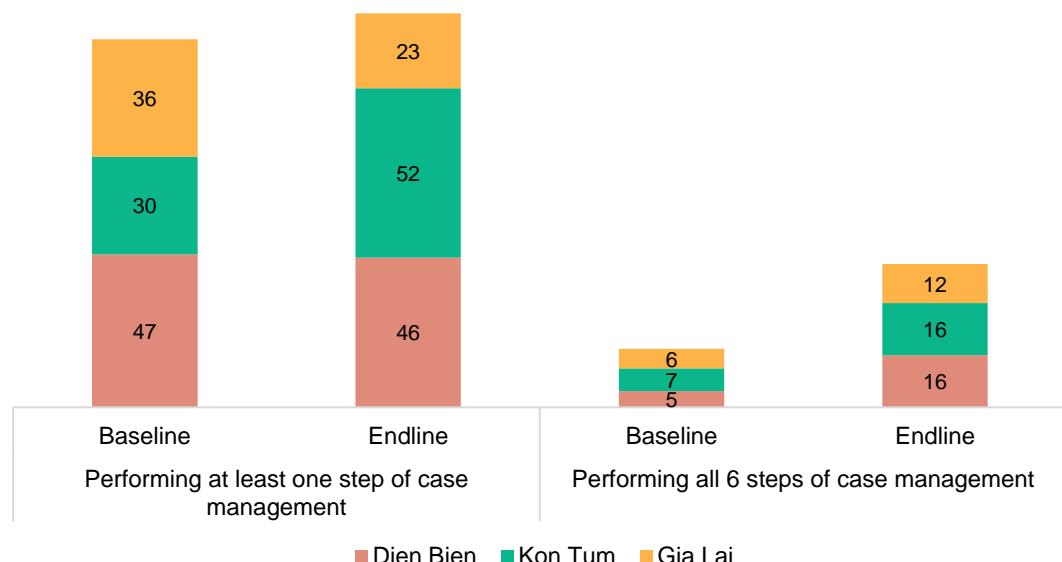
- Step 1.** Receive and record information of the at-risk child
- Step 2.** Identify the child's needs
- Step 3.** Develop a child support plan
- Step 4.** Implement the child support plan
- Step 5.** Monitor and assess the implement of the child support plan
- Step 6.** Record and keep a record of the child after intervention

Figure 43 below indicates the changes in the number of child protection workers in programme areas performing at least one step out of six as mentioned above. There is a positive signal that **the total number of commune-level staff participating in case management service**

¹⁶ Child Protection Working Group (2014). *Inter-Agency Guidelines for Case Management and Child Protection*. The role of case management in the protection of children: A guide for policy & programme managers and caseworkers.

have increased over three years of project implementation, from 113 workers in baseline to 121 in endline. When comparing the status among three provinces, however, it is surprisingly noted that Kon Tum is the only province to record a substantial expansion of child protection staffs, while both Dien Bien and Gia Lai have observed a slight cut-down in their human resources. Despite that, the impressive point would lay on the fact that **child protection officers who can take charge in all steps of case management have doubled in number in all three UNICEF-supported provinces. This would imply that a case manager has currently been capable of handling more steps in the case management process instead of expansion in the number of workers as before.**

Figure 43. Number of child protection workers in UNICEF-supported communes who provide case management in line with national standards



Source: MDRI endline survey and evaluation, 2021

Comparing between districts, the variation in the number of case management workers in Dien Bien and Kon Tum has narrowed down compared with the baseline situation. There is a notable exception that the number of case managers in Tu Mo Rong district (Kon Tum) was reported to be three times higher than other two other districts (Dak Gle and Kon Ray). However, this broad difference is comprehensible considering the district's socio-economic characteristics. According to Kon Tum's PMU head, Tu Mo Rong is the most disadvantaged district among three project areas in the province. Therefore, to meet the requirements of case management service in the district, the number of case managers in Tu Mo Rong has increased significantly in comparison with baseline, from 4 to 31 workers.

Indicator 16

Number of Social Work Service Centres (in project locations) applying national standards are established and functioning at provincial and district levels

Social work was officially classified as a profession in Vietnam in 2010 by Government's Decision No. 32/2010-TTg on Development of Social Work Profession. In the child protection component, social workers take responsibility to assess the problems of children, develop intervention plans and implement case management, especially for children of abuse/neglect. In some cases, social workers have to organize and manage alternative care services for children (for example, kinship care, foster care, adoption, community-based care and institutional care).

Qualitative findings with PMU members at provincial level revealed that there have been almost no changes in the number of Social Work Service Centres applying national standards since the time of conducting baseline survey. To be specific, the baseline assessment pointed out that a provincial-level social work service centre in accordance with legal standards was established in all three provinces and only Kon Tum has one more centre located in the city. Meanwhile, at the time of endline evaluation, Mang Yang (Gia Lai) became the only district that has newly formed a district-level centre, which serves a role as focal point to provide support for social workers in project communes.

Child Awareness

Indicator 26

Percentage of boys and girls aged 6-8 years who know where to report violent incidents involving themselves and other children

Violence against children takes various forms and happens in families, schools and institutions. It could be violent discipline, psychological aggression, physical punishment, child trafficking, economic and sexual exploitation or child marriage. Most of the children typically experience violence at the hands of the people they trust most – their parents or caregivers, teachers, peers and neighbours. In fact, at global scale, three-quarters of the world's 2- to 4-year-old children (around 300 million) are regularly subjected to violent discipline by their caregivers at home¹⁷.

Child discipline with the use of violence in Vietnam remains a high percentage over the years. Results gathered from the recent MICS survey in 2020 – 2021 show that 70.8 percent of children aged 1-14 years experienced any physical punishment and/or psychological aggression by caregivers in the past one month. With violent discipline still a socially accepted norm, children remain especially vulnerable when they have limited understanding of their rights to speak out or seek out for help when violence occurs. All children have the right to protection from violence, regardless of the nature or severity of the act and all forms of violence can cause harm to children, reduce their sense of self-worth, affront their dignity and hinder their development.

The concentration on awareness-raising among children aged 6-8 has been put within the scope of the IECD programme in the effort to put violence against children to an end. The primary aim is to provide 6-to-8-year-old children the knowledge of how to seek assistance in preventing violent incidents involving themselves and other children. In order to capture a general picture of the impact of this intervention, the endline household survey also asked

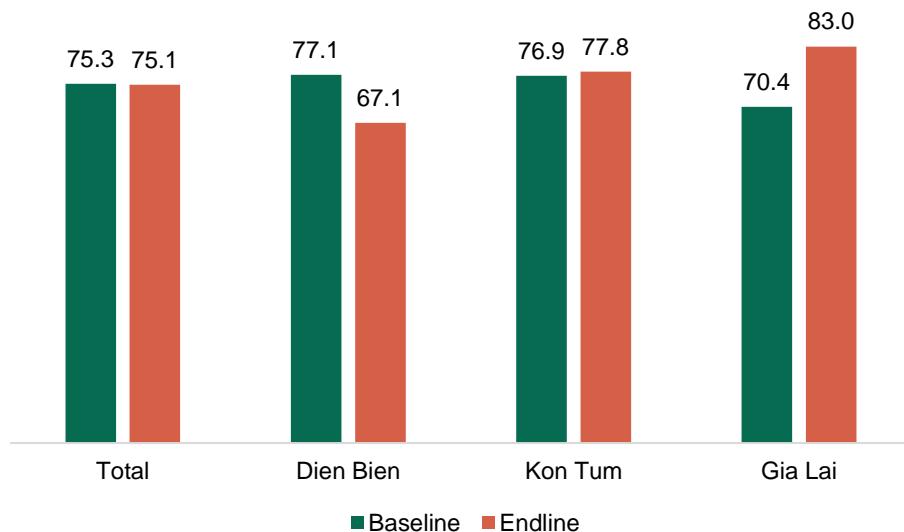
¹⁷ UNICEF. (2017). *Worldwide 300 million children suffer from violent methods of upbringing*. <<https://www.unicef.org/kyrgyzstan/press-releases/child-suffer-violent-methods-upbringing>>

children aged 6-8 where and to whom they would report in case of being exposed to violent actions to compare with the baseline values. The research team has committed in the ethical consideration process that consent from both the children and their caregivers were obtained as a mandatory requirement prior to the interview with children. During the implementation of the interview process, we also took numerous UN and UNICEF's guidelines and standards into consideration as specified in the UNEG Norms and Standards for Evaluation (2016), UNICEF's revised Evaluation Policy (2018) and UNEG Ethical Guidelines for Evaluation (2020).

For the sensitive questions related to violent acts, enumerators asked for permission to interview children without the involvement of their parents or caregivers to avoid children's pressure because in some cases, these acts may come from the family members. In fact, from the research team's experience from baseline evaluation, ethnic minority children often feel shy when talking to strangers and need their parents to stay beside them during the interview. In addition, our enumerators in a commune of Dien Bien Dong missed the opportunity to meet the children in person since they had to stay at school for quarantine and their primary caregivers would answer on their behalf. In other districts and provinces under normal context, the team took the best effort to restrict these "answer-on-behalf" cases for the better reflection of children's awareness.

Overall, the survey results show a slight reduction of 0.2 per cent in the percentage of children aged 6-8 years who claimed that they would report violent incidents involving themselves and other children compared to the baseline. However, there is a remarkable sign that this figure tends to increase over three years for those who would report incidents involving themselves only. Among three project provinces, Dien Bien experienced approximately 10 per cent decline, while a much higher rate of 6-to-8-year-old boys and girls who could point out where to inform if getting attacked physically and verbally than in baseline has been recorded in Gia Lai and Kon Tum. For the situation in Dien Bien, some "answer-on-behalf" cases in Dien Bien Dong due to Covid-19 impacts as mentioned above could become a potential confounding factor causing the 10% decrease at the endline.

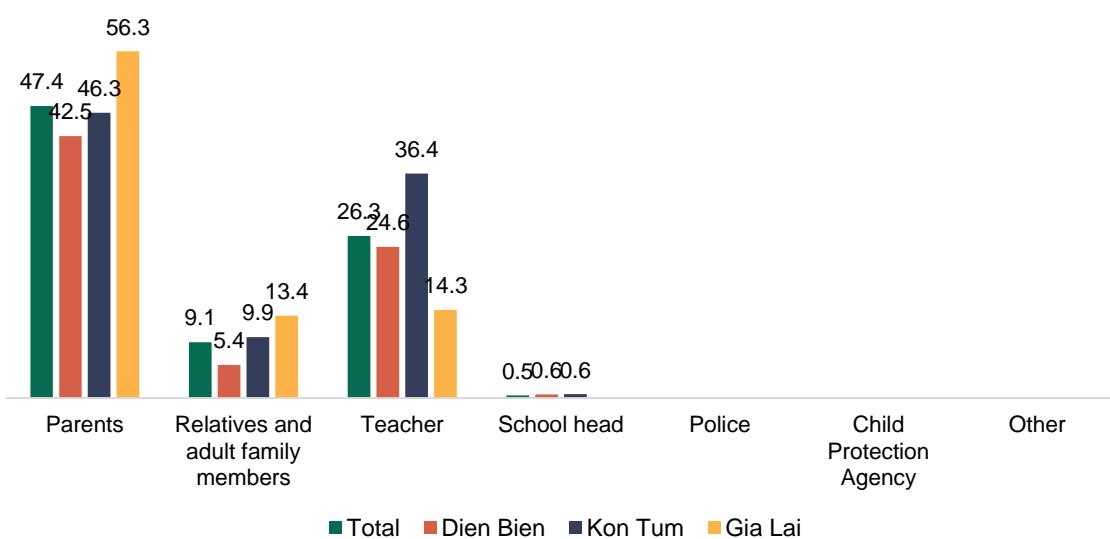
Figure 44. Percentage of boys and girls aged 6-8 years who know where to report violent incidents involving themselves and other children, in comparison with baseline (%)



Source: MDRI endline survey and evaluation, 2021

Regarding the person to whom children would inform the violent incidents, a majority of them (equivalent to 47.4%) chose their parents. The respective figures for “teachers” and “relatives/adult family members” were 26% and 9%. Meanwhile, almost no progress has been made regarding the popularity of the child protection committee among children, evidenced by the fact that nearly none of the surveyed children would think about reporting violent incidents to child protection officers.

Figure 45. Percentage of boys and girls aged 6-8 years who know where to report violent incidents involving themselves, by province (%)

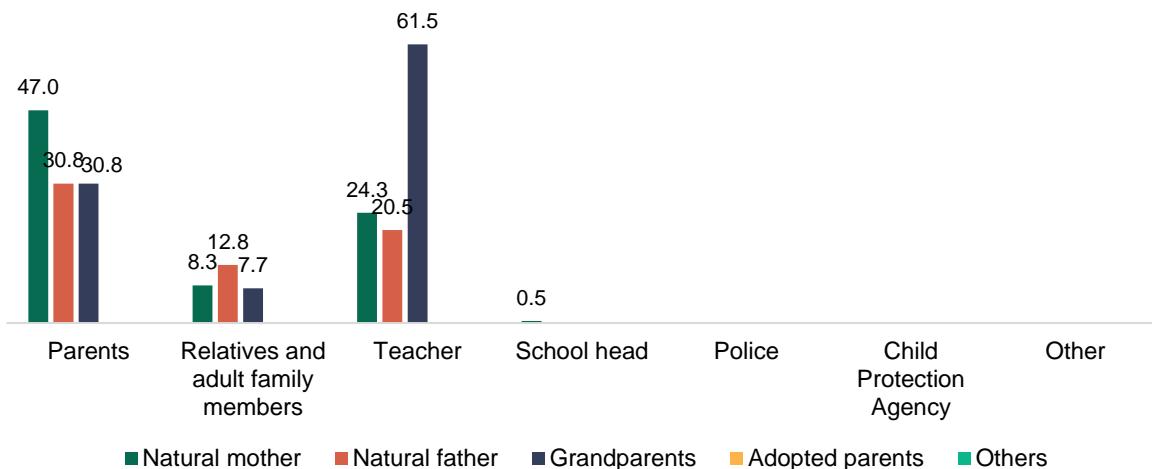


Source: MDRI endline survey and evaluation, 2021

When disaggregated by the children’s relationship with primary caregivers, there is a similar trend with baseline in terms of the variation of their source of support. To be specific, children

having grandparents as their primary caregivers are less likely to ask their parents or other adult family members for help when being in troubles. Instead, more than 60% of the children decided to tell their teachers at school.

Figure 46. Percentage of boys and girls aged 6-8 years who know where to report violent incidents involving themselves, by their relationship with primary caregiver (%)



Source: MDRI endline survey and evaluation, 2021

Non-violent child discipline practice

Indicator 17

Percentage of parents or caregivers of children aged 0-8 in project locations who believed that responsive and non-violent parenting is their best for their children

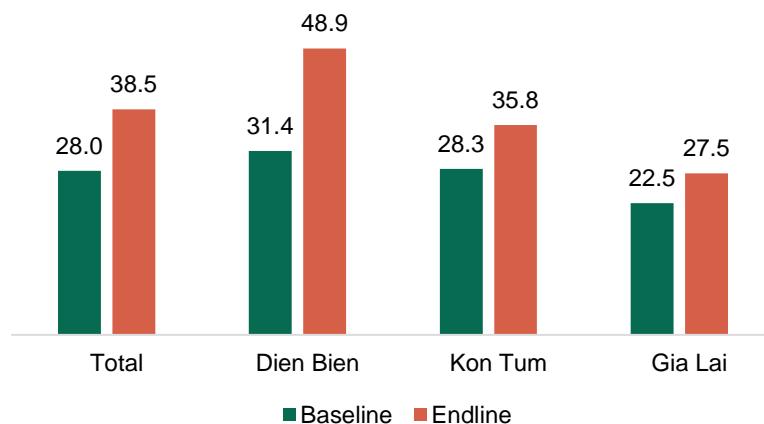
Physical and psychological punishment of children is not a strange or unusual phenomenon. It is part of everyday life in most countries, across most cultures, including Vietnam. It is so normalized that even professionals working with children may not perceive it to be violence (Save the Children, 2008, p.2). Although many studies have pointed to the wide-ranging and long-lasting negative effects of violent discipline practices, for example poorer learning outcomes, and compromised physical and emotional health (UNICEF, 2020, p.14), the problem of violent discipline is still prevalent in Vietnam, especially in more rural, poor areas where parents lack access to information and guidance on appropriate parenting methods.

To tackle this problem, a significant part of the UNICEF's Nobody's Perfect Parenting programme was dedicated to increasing parent and caregivers' knowledge and capabilities to promote responsive caregiving and use of positive parenting techniques and non-violent discipline strategies to create a nurturing, non-violent and safe home settings for children to be able to develop to their full potentials.

To assess the changes in parents' knowledge regarding child discipline after the programme implementation, the research team asked parents or caregivers of children aged 0-8 in the three project provinces whether children should be disciplined by violent practices or not. **The results show that the percentage of parents/caregivers who believe that responsive and non-violent parenting is the best for their children increased in all three provinces, by 10.5 percentage point in total.** Out of the three project provinces, parents/caregivers in Dien

Bien seemed to have acquired the most significant change in knowledge, with an increase of 17.5 percentage point for this indicator.

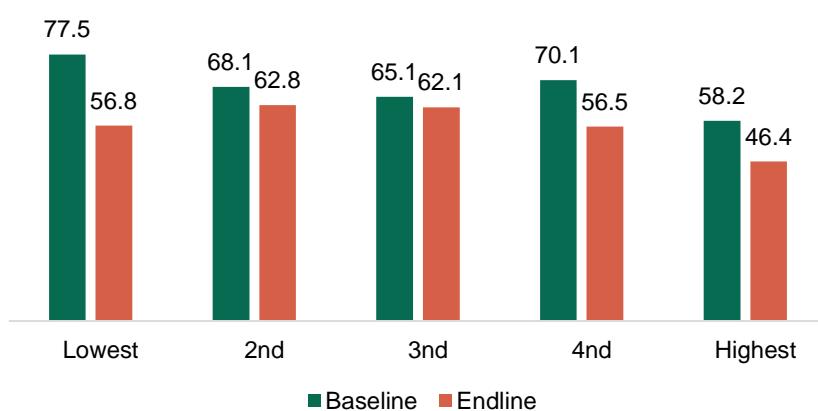
Figure 47. Percentage of parents/ caregivers who believe that responsive and non-violent parenting is the best for their children (%)



Source: MDRI endline survey and evaluation, 2021

Remarkably, the improvement in parents/caregivers' awareness on violent discipline methods was found most significant in the poorest household group. Specifically, the percentage of parents/caregivers who believe in any violent discipline method decreased by 20.7 percentage point, from 77.5% in the baseline to 56.8% in the endline survey, for the lowest Wealth Index Quintile group (Figure 48). This suggests that UNICEF's activities have reached out and helped reducing the knowledge gap for the poorest beneficiaries, who often have the most limited access to information and guidance on updated, progressive child rearing practices.

Figure 48. Percentage of parents/caregivers who believe in any violent discipline method (%), by Wealth Index Quintiles



Source: MDRI endline survey and evaluation, 2021

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In the past, the fathers [in this village] used to hit the children whenever they did something wrong, but now the fathers have more knowledge on child-rearing thanks to the programme. Nowadays the majority of parents do not hit their children with sticks/canes anymore.

[...] Nowadays when the kids do something wrong, we only try to explain to them what they have done wrong so they understand.

FGD with female caregivers, Dien Bien.

Indicator 19

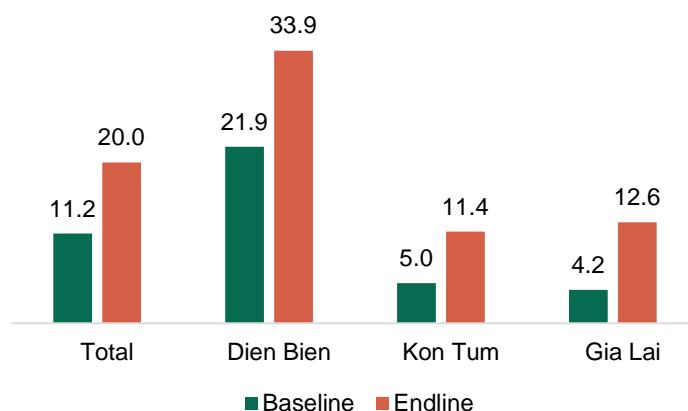
Percentage of parents/primary caregivers of children aged 0-8 years in project locations who practise non-violent discipline and responsive parenting

By raising parents' awareness and equipping them with knowledge on the importance and the methods of non-violent discipline and responsive parenting, the UNICEF's Nobody's Perfect Parenting programme aims to ultimately improve the parents/caregivers' practices in child rearing at their own homes.

Similar to the baseline, in the endline, the research team used a series of questions on the methods which adults in the households used to discipline a selected child during the past month to investigate information related to the practise of non-violence disciplinary with children. The surveyed discipline methods include both psychological aggression discipline (shout/yell/scream at the child; call them dumb, lazy or any similar names) and physical punishments (grab and shake the child; spank, hit or slap on the bottom; hit the child with some objects).

The results show that along with the improvement in knowledge about non-violent parenting, **the percentage of parents/caregivers who reported practising responsive parenting and non-violent discipline also increased by 8.8 percentage points in total in the three provinces**. Across the UNICEF-supported areas, Dien Bien again saw the highest percentage point in the proportion of parents/ primary caregivers who put non-violent and responsive parenting knowledge into practice. Particularly, Kon Tum and Gia Lai provinces observed a significant improvement in the practice of non-violent discipline, which demonstrated a double and triple in figure.

Figure 49. Percentage of parents/caregivers who practice responsive parenting and non-violent discipline (%)



Source: MDRI endline survey and evaluation, 2021

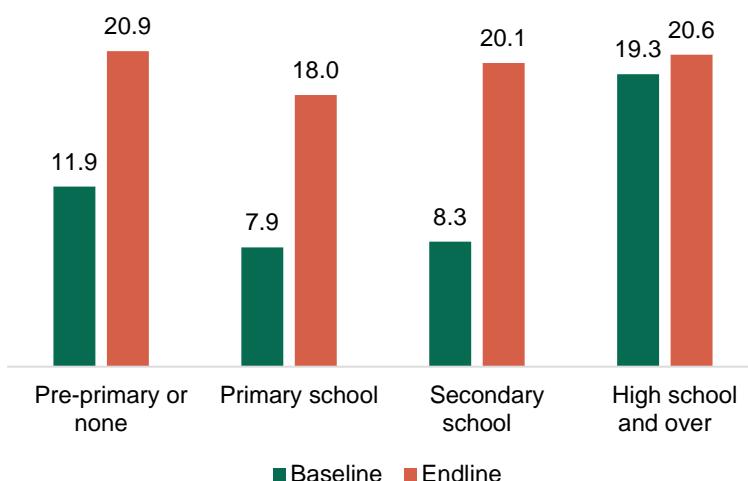
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Since I attended the training [Nobody's Perfect Parenting Programme], I learned to contain my anger from other mothers. When I feel too angry with my children, I leave the place for about 5-10 minutes and only return to talk to my children when I have calmed down. By then my children also have calmed down and can listen to me explaining what they did wrong. If I am wrong then I will admit it to them and change myself. I try to treat my children like I am their friend.

FGD with female caregivers, Gia Lai.

The improvement in parents/caregivers' discipline practices towards their children was found more significant in the parents/caregivers with lower educational levels than their counterparts (Figure 50). In the baseline, the percentage of parents/caregiver with high school and over education levels who practised non-violent discipline was the highest at 19.3%, leaving quite a gap with their counterparts who only finished secondary school or lower. However, at the endline, there was significant increase of the proportion of parents/caregivers practising non-violent discipline in the latter groups, specifically by 9, 10.1, and 11.8 percentage points for parents/caregivers with pre-primary or none, primary, and secondary school levels respectively. Thus, this shows that the gap in good child discipline practices amongst parents of different educational levels has reduced remarkably from the baseline to the endline of the programme.

Figure 50. Percentage of parents/caregivers who practice responsive parenting and non-violent discipline (%) by highest level of education of the primary caregiver



Source: MDRI endline survey and evaluation, 2021

4.8 Communication for Social and Behavioural Changes

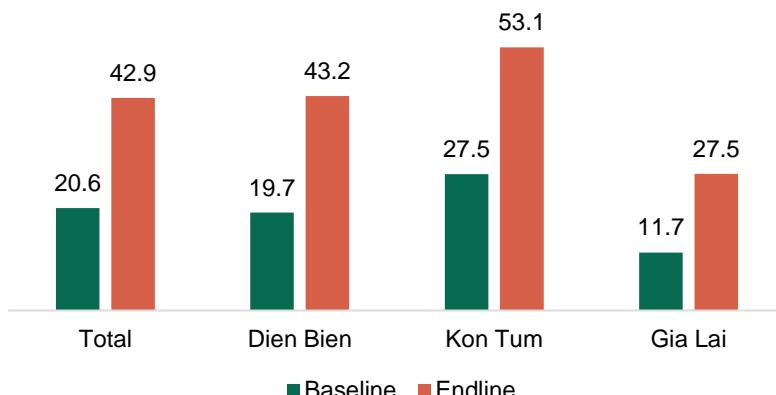
Indicator 28

Percentage of parents and caregivers of children aged 0-8 years in project locations receiving ECD related communication materials

Access to media materials can help parents and primary caregivers learn more information about ECD, as well as support for the care and feeding process. In this survey, the team investigated whether parents of children aged 0-8 in the project area received media materials or learned their own information about ECD. This information was collected to assess the primary care provider's access to early childhood development information.

Survey results show that **the percentage of parents and caregivers of children aged 0-8 years in project locations receiving ECD-related communication materials has doubled since baseline (42.9% compared to 20.6%)** (see **Error! Reference source not found.**). Particularly, among three project provinces, Kon Tum recorded the highest percentage of parents receiving ECD-related communication materials (53%), followed by Dien Bien and Gia Lai - at 43.2% and 27.5%, respectively.

Figure 51. Receipt of ECD related communication materials (%)

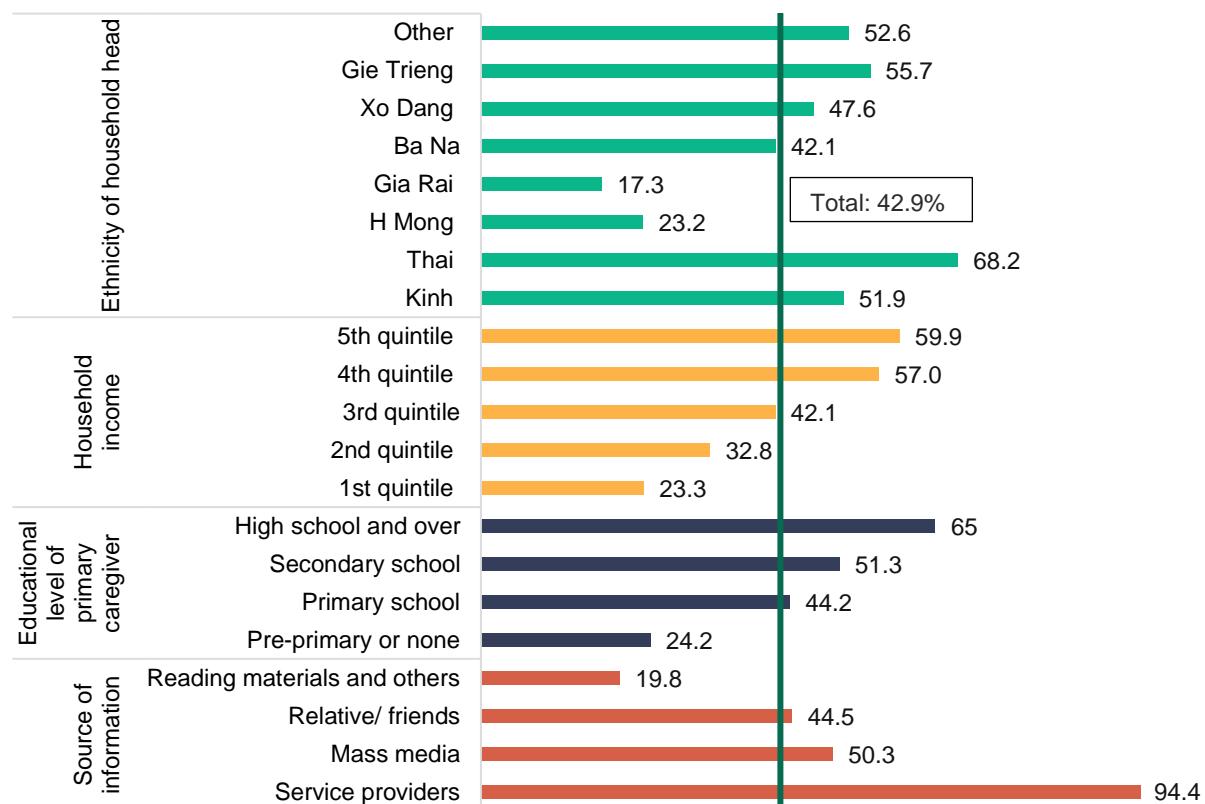


Source: MDRI endline survey and evaluation, 2021

By wealth index quintiles, despite some improvements compared to the baseline, there is a **noticeable gap between the poorest household group (23.3%) and the richest household group (59.9%)**, more than 30 percentage points in the endline (see Figure 52). This can be explained by the fact that richer households have more access to information than poorer households. Similarly, **the households, in which primary caregivers have a higher education level, tend to access more information**. Among ethnic groups, Thai (68.2%), Kinh (51.9%) and Gie Trieng (55.7%) households are more likely to be aware of ECD-related communication materials than other ethnic minority groups (under 50%). Besides, the research team also assessed “Other ethnic groups” as the sample size of this group is relatively small.

The ownership of items such as radio/cassette, computer, Internet, telephone, and access to ward loudspeaker could also affect households' access to information. The survey indicates that Kinh households owned more durable goods, including the above-mentioned items, more than other ethnic minority households. When it comes to information sources, **service providers were most likely to be approached by parents or primary caregivers** (94.4%). Specifically, service providers include doctors at health centers/hospitals, commune and village health staff, teachers in nursery/kindergarten/primary schools, and other communes/village staff. **The second most popular source of information is media** (50.3 %), followed by relatives or friends (44.5%) and reading materials (19.8%). The mass media includes Internet, television, radio, and ward loudspeaker systems.

Figure 52. Receipt of ECD related communication materials by sub-population groups (%)



Source: MDRI endline survey and evaluation, 2021

“ The contact with the staff is better. When there is a ticket dispenser, first come first serve. Three years ago, we did not have this machine... With the support and counseling center, fathers can participate in and understand better, which contributes to child development

FGD with male caregivers, Dien Bien.

“ My information source of childcare comes from our commune health center.

I attended the “No one is perfect” for parents and primary caregivers. At this class, (I learned) from commune officials and health workers about child care, Covid prevention.

Due to the COVID-19, I have not been able to attend the training. However, I can listen to it (propaganda on IECD contents) through the commune's loudspeaker.

FGD with male caregivers, Dien Bien.

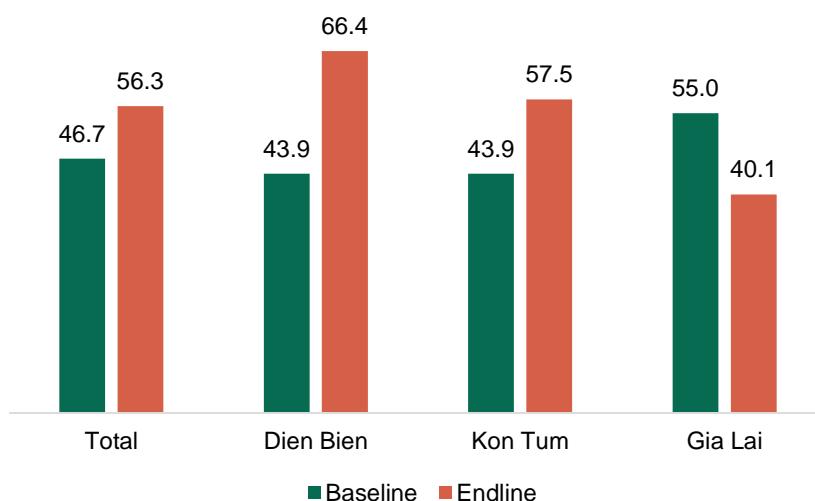
Indicator 29

Percentage of parents and caregivers of children aged 0-8 years who know and can list the benefits of all areas of IECD and know where to find supports

For this indicator, the research team evaluated whether parents or primary caregivers know the benefits of IECD and the place(s) to seek supports on IECD services. In particular, the IECD areas covered in this indicator at endline were (1) age-appropriate medical care for children and (2) integrated education about physical activities, communication, and social emotion. For each area, survey respondents (parents/ primary caregivers) were asked to list as many benefits as they could; and where they would go to receive assistance.

The endline results, illustrated in Figure 53, show that **56% of interviewed parents or caregivers of children aged 0-8 years understand the benefits of IECD aspects and know where to find supports, which rose by 9% since baseline (47%)**. If divided by project provinces, Dien Bien recorded the most significant improvement (66%), which was the result of a 1.5-time-increase compared to its baseline achievement. Standing at the second place, 57.5% of interviewed parents or caregivers in Kon Tum could list the benefits of IECD aspects and know where to find support. However, despite quite a good start at baseline, Gia Lai saw the lowest percentage (40.1%) among the three focus provinces.

Figure 53. Percentage of parents who can list the benefits of all IECD aspects and know where/ whom to find support for all IECD aspects (%)



Source: MDRI endline survey and evaluation, 2021

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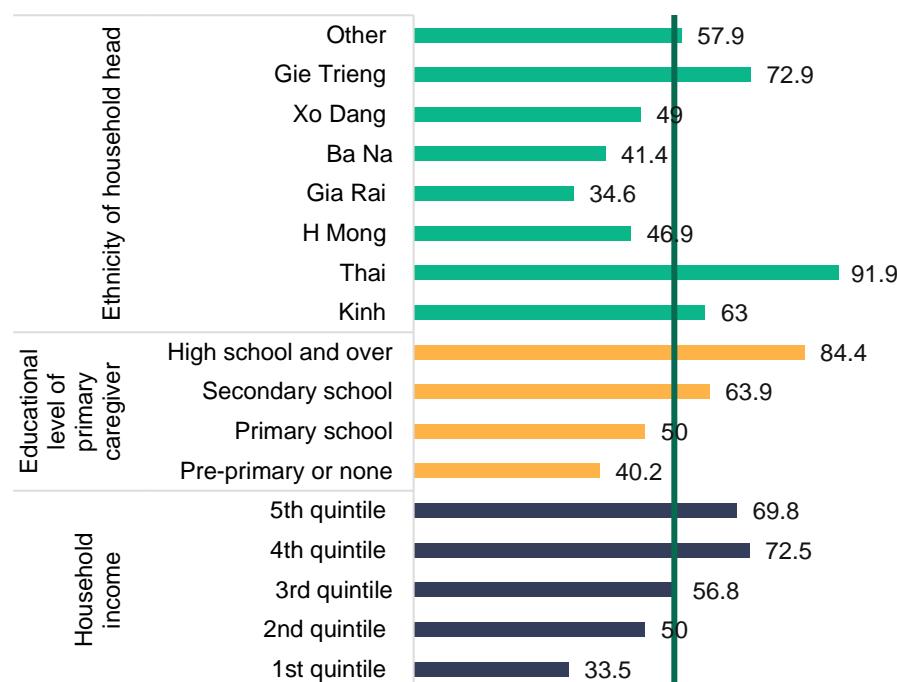
Since having a smartphone, I am always in frequent contact with the teachers. For example, when my kid is sick, I call the teacher to ask for leave permission. When my kid does not understand anything, I also ask the teacher for help or ask about my kid's school performance...

In the past, many children did not go to kindergarten. Even if they went, I did not know how to teach my child. He just came back from school and left his bag there.

FGD with female caregivers, Dien Bien.

Remarkably, a marked correlation is observed between primary caregivers' listing IECD benefits and other demographic characteristics (Figure 54). By wealth index quintiles, 33.5 percent of the poorest groups could list the benefits and find support, then it increased in other groups, up to around 70 percent in the second and richest groups. A similar pattern is also witnessed with primary caregivers' education level. Particularly, at primary education or lower, about 40-50 percent of parents or primary caregivers could list the benefits and find support, while at secondary education, high school, and higher, this rate reached 64 percent and 80 percent, respectively. When it comes to surveyed ethnic groups, a difference also exists. Thai, Gie Trieng and Kinh groups are among the top 3 groups recording over 60 percent. Meanwhile, Gia Rai and Ba Na groups got the lowest rate, under 45 percent. The gap among the above mentioned ethnic groups can be explained by the differences in households' wealth, education level and Vietnamese fluency.

Figure 54. List the benefits of all areas in IECD and know where to find supports by population subgroups (%)



Source: MDRI endline survey and evaluation, 2021

4.9 IECD Perception

Indicator 30

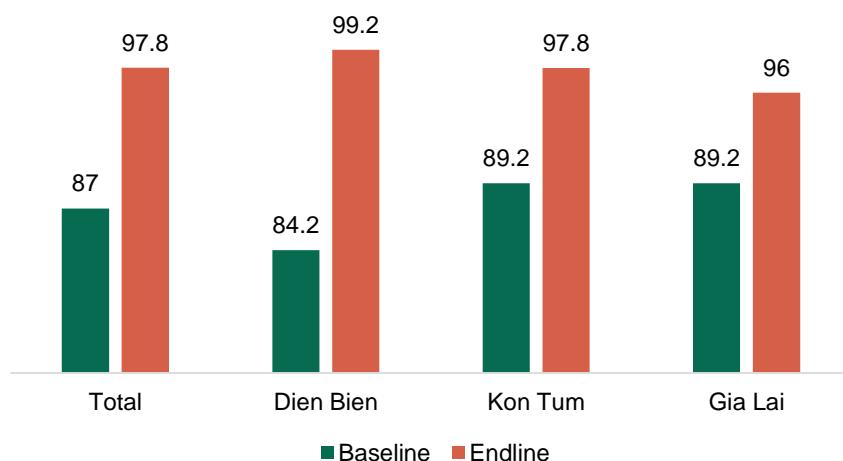
Percentage of parents/caregivers who believe that all children at the right age, regardless of background and abilities, should receive IECD services, equally

One of the key goals of the IECD programme is to ensure all children have equitable access to essential and quality child survival and development packages. Indicator 30 therefore serves the purposes of assessing if such goal can be nurtured from the grass-root level. The

quantitative endline survey aims to explore parents' and primary caregivers' beliefs by asking their actual practices such as giving children enough periodic health checks and vaccination according to age; providing children with enough meals and adequate nutrition per meal as guided by a doctor, health care worker or teacher; and registering (or plan to register) schooling for children at the right age. The rationale employed here is that if a child is fully involved in activities like periodic health checks, age-appropriate vaccination, in-time school enrolment, it reflects the parents/primary caregivers' belief in those IECD services. On the contrary, if a child is not offered with any of the listed benefits/activities by parents/primary caregivers, the evaluation team wants to know whether that comes from objective (availability/access to/quality of services) or subjective (perception-related) reasons.

Overall, **nearly all surveyed parents in the endline assessment (98%) supported equal rights of children to IECD services**, among whom 47% were capable of providing all three essential services to their children and 51% could not let their children enjoy IECD services even though they believe in them. Remarkably, by the time of the endline assessment, only 2% of respondents failed to offer IECD services to their children because of subjective reasons (disbelief), which reflects a considerable growth from baseline (13%). There is no major differences in IECD perception across three provinces at endline but Dien Bien recorded the most pronounced improvement compared to three years ago (Figure 55).

Figure 55. Belief about children's equal access to IECD services at the right age (%)



Source: MDRI endline survey and evaluation, 2021

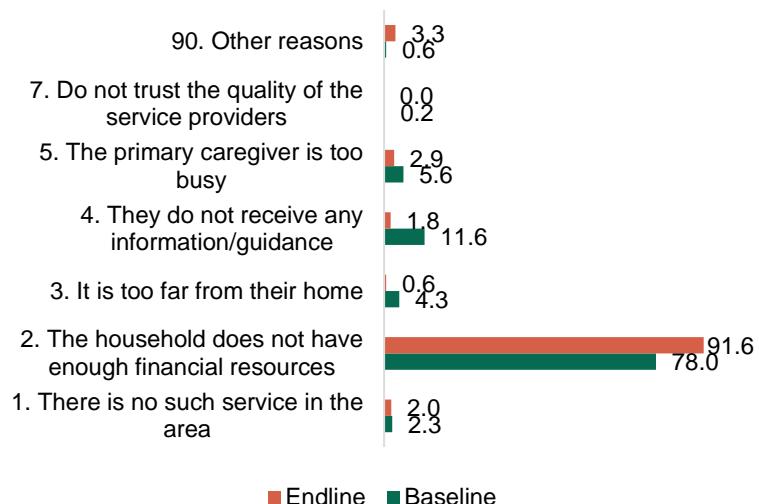
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The 24th of every month is called the vaccination day, never miss a child. Before it was not as often, some kids got the jab, some did not. But in the past 5 years, it have gotten better, every child gets the chance to be vaccinated. Specifically, ethnic minority people used to refuse child vaccination but recently, they have changed their mind after being convinced by the local government.

FGD with male caregivers, Gia Lai.

When disaggregated by IECD services, most parents/primary caregivers failed at “adequate nutrition instructed by health workers/teachers”. As can be seen from the below figure, financial resources remained the most prominent obstacle but it seemed to affect households in endline more severely than in baseline. However, since this reason is categorized as objective reasons (together with reason 1, 3, and 7), it symbolizes a challenge to equality rather than respondents’ belief in equitable IECD services for all children. On a positive note, subjective reasons (4 & 5), which strongly dictate one’s understanding of fair enjoyment of services, underwent a large decrease compared to baseline.

Figure 56. Reasons for not providing adequate nutrition as guided by health workers/teachers (%)



Source: MDRI endline survey and evaluation, 2021

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Some parents do not have the financial condition to buy milk for their children. So it really depends on the economic situation of that place. I know the knowledge in theory but in reality, we only follow what we could afford...

FGD with female caregivers, Kon Tum.

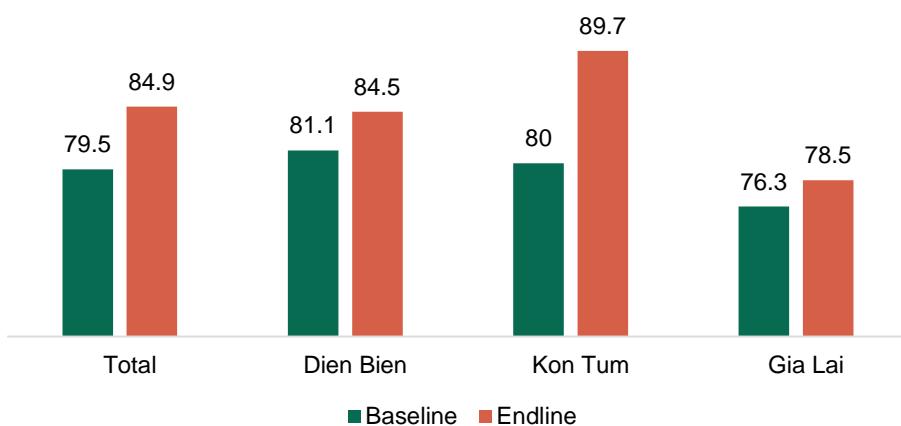
4.10 Peace Building and Social Cohesion

The IECD programme emphasizes the contribution of ECD services to horizontal and vertical social cohesion, specifically to strengthen interpersonal relations between individuals and intergroup relations in the community. The baseline assessment explored the collaboration of individuals and groups in the community in ECD, measured by their level of participation in ECD activities such as sharing useful information and giving advice about how to educate and take care of children.

To measure horizontal social cohesion, in the household survey, the endline assessment asked the primary caregivers if (i) they would share to community people useful information about how to educate and take care of children and (ii) they felt supported by community people in case of having difficulties in raising children. In term of vertical social cohesion which refers to the relationship between individuals and families with authorities, the endline assessment did ask primary caregivers if they regularly received information about how to raise children from ECD service providers including schools, health centers and other officers.

As shown in Figure 57, overall, there is a slight improvement in the endline proportion of primary caregivers who responded that they were willing to share useful information to people in the community about how to educate and take care of children (nearly 85 percent), compared to the baseline result (79.5 percent).

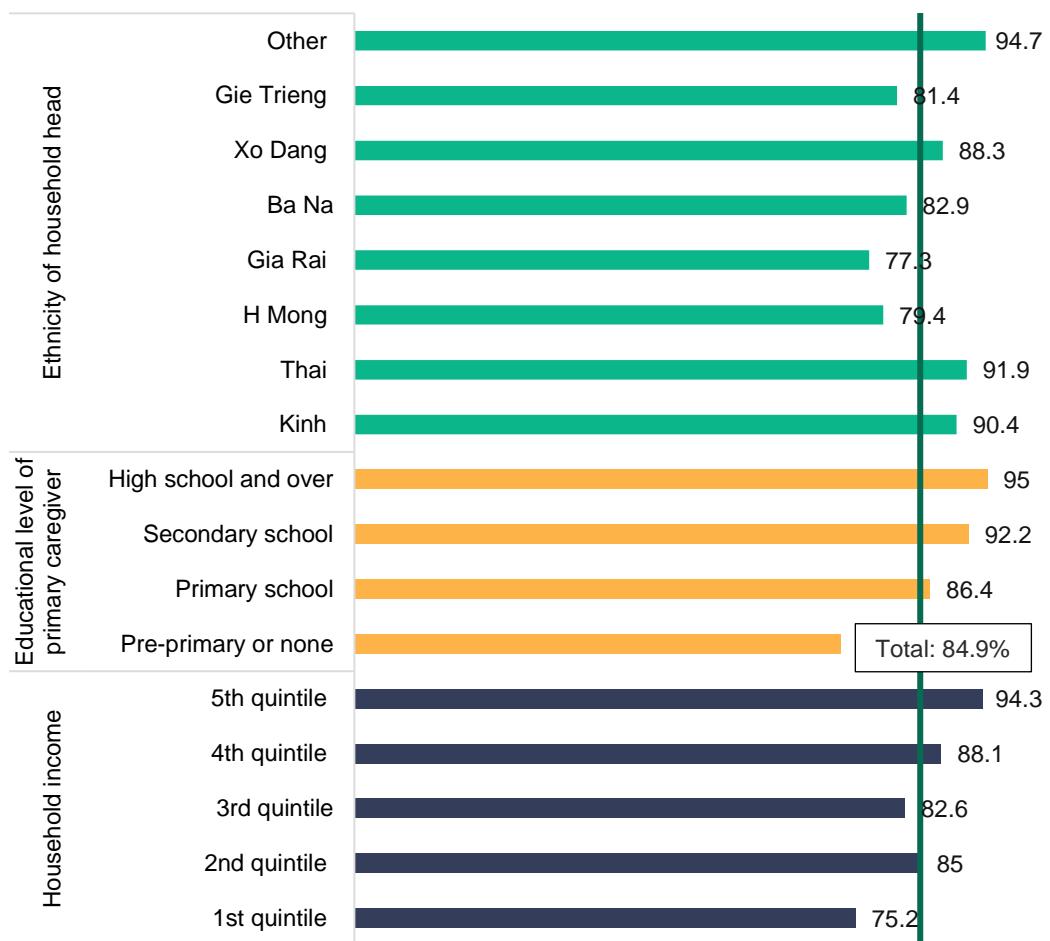
Figure 57. Percentage of primary caregivers who reported “actively sharing useful information about how to educate and take care of children” (%)



Source: MDRI endline survey and evaluation, 2021

Across three provinces, there are no major differences in primary caregivers' willingness and activeness to share information. Besides, the percentage does not vary much between different ethnic groups (Figure 58). However, the percentage increased as the educational level of primary caregivers and household wealth improved, implied that caregivers attaining higher education level and household prosperity were more open to the community and more willing to share useful childcare tips.

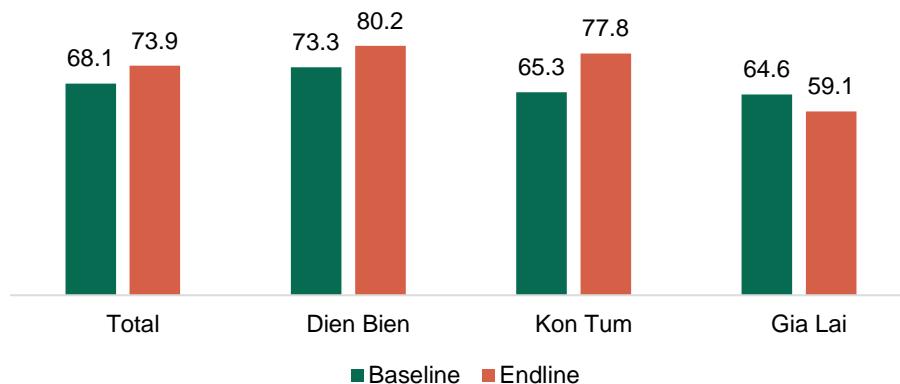
Figure 58. Percentage of primary caregivers who reported “actively sharing useful information about how to educate and take care of children” by population subgroups (%)



Source: MDRI endline survey and evaluation, 2021

Compared to the baseline, there is not much variation in the percentage of primary caregivers who responded “Yes” when being asked if they received support from community people when having difficulties in raising children. Among three provinces, Gia Lai recorded fewer primary caregivers who reported “receiving support from others in the community when having difficulties in raising children” than its baseline results (Figure 59).

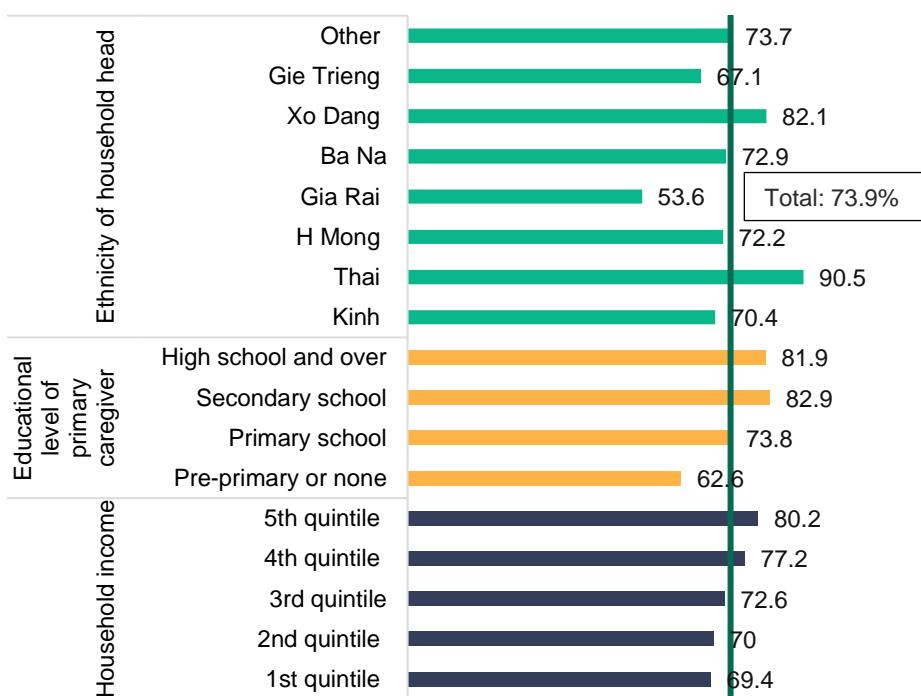
Figure 59. Percentage of primary caregivers who reported “receiving support from others in the community when having difficulties in raising children”



Source: MDRI endline survey and evaluation, 2021

Across different ethnic groups, Gia Rai caregivers remained the least likely to reported “receiving support from others in the community when having difficulties in raising children”. Similar to the abovementioned finding, the percentage increased as the educational level of primary caregivers and household wealth improved, implied that caregivers attaining higher education level and household prosperity were more likely to report that they received support from others in the community in raising children or in the other way, they more actively sought for support from the community (see Figure 60).

Figure 60. Percentage of primary caregivers who reported “receiving support from others in the community when having difficulties in raising children” by population subgroups (%)

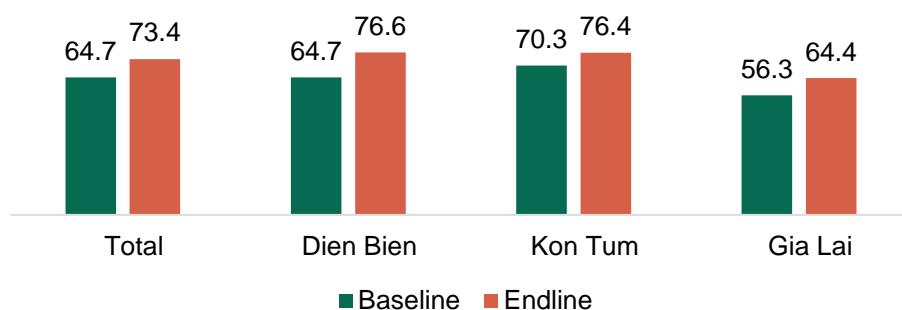


Source: MDRI endline survey and evaluation, 2021

In brief, results of horizontal social cohesion indicate that the interpersonal and inter-group relationships in the community were likely to depend on the educational level of primary caregivers and their household wealth.

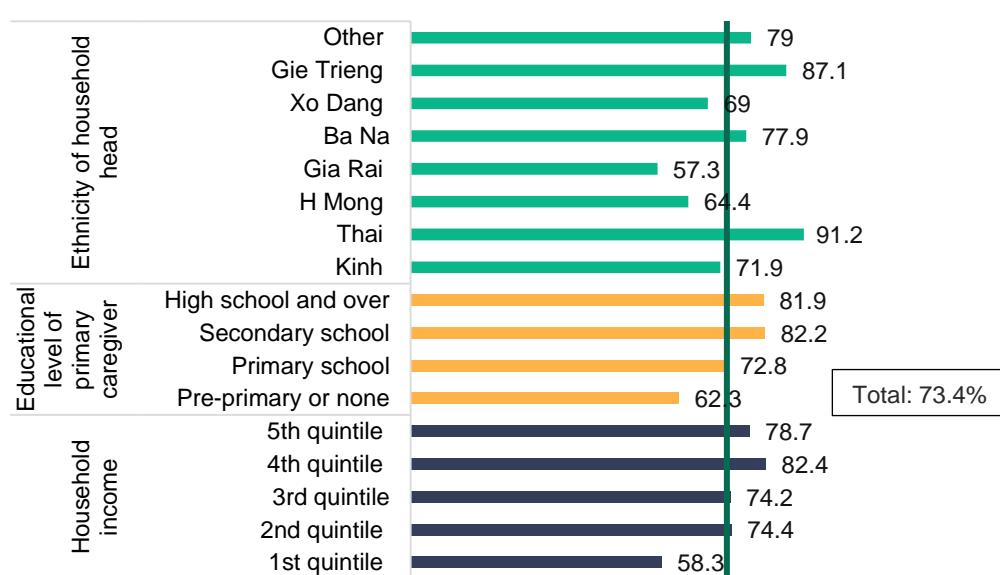
A modest improvement was witnessed in the proportion of primary caregivers who responded “Yes” when being asked if that they “regularly receive information about raising children from service providers” (Figure 61). Particularly, 73.4 percent of primary caregivers responded “Yes” in the endline, a rise of nearly 10 percentage points compared to the baseline. Among three provinces, Gia Lai recorded the lowest percentage. Comparing primary caregivers from different ethnic groups, Gia Rai, H’Mong and Xo Dang were least likely to report “regularly receive information about raising children from service providers” (Figure 62).

Figure 61. Percentage of primary caregivers who reported “regularly receive information about raising children from service providers”



Source: MDRI endline survey and evaluation, 2021

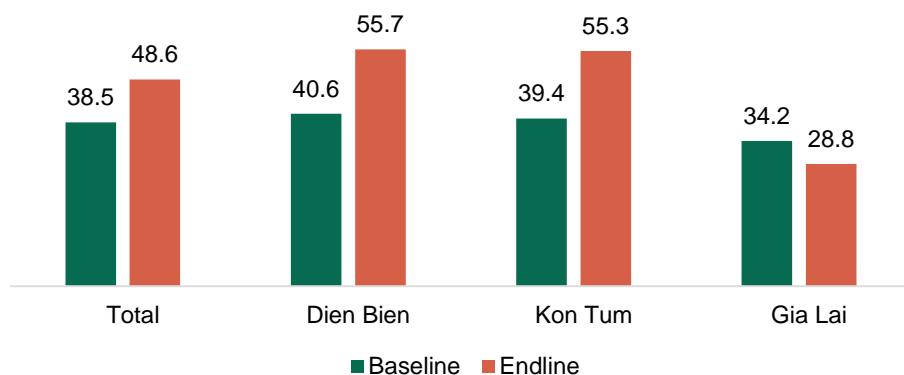
Figure 62. Percentage of primary caregivers who reported “regularly receive information about raising children from service providers” by by population subgroups



Source: MDRI endline survey and evaluation, 2021

Obviously, primary caregivers are more likely to ask questions or make suggestions on childcare and education than they did in the baseline (see Figure 63). It is remarked that Gia Lai saw a slight drop in the percentage of primary caregivers asking or suggesting, compared to the baseline. This province also recorded the lowest proportion (34.2 per cent), across three provinces. When categorised by population subgroups, the result shows that better educated and wealthier caregivers more often asked questions or made suggestions regarding child care and child education to community people and service providers.

Figure 63. Percentage of primary caregivers who ask question(s)/make suggestions regarding children care and education to community and service providers in the last 12 months



Source: MDRI endline survey and evaluation, 2021

“ [...] I occasionally participate in meetings organized by the commune. Sometimes, we give our opinions and receive others' advice on raising children. For instance, we agree to let the children go out, sleep on time and interact with them more.
I learned how to do parenting and raise my children from other families' experience.

FGD with male caregivers in Kon Tum province.

In lieu, the research team came up with a similar finding to questions about horizontal social cohesion. Accordingly, vertical social cohesion also indicates that better educated and wealthier caregivers were more likely to respond “Yes”.

4.11 Access to and use of IECD services

Indicator 5 Number of communes having functioning IECD services

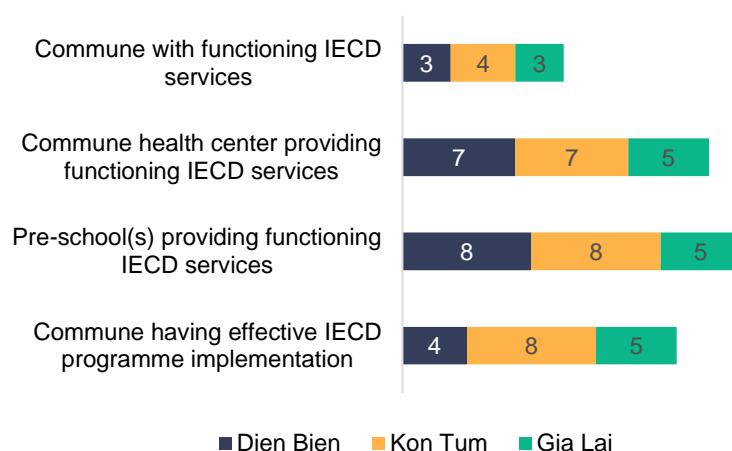
A commune is qualified as having functioning IECD services if it meets all of the following criteria:

- Effective IECD programme implementation: having an IECD programme steering committee; having an IECD club with weekly activity; having a network of IECD core staff at village level; having a child protection committee.

- Effective provision of healthcare, nutrition & WASH services in commune health centres: post-natal care within the first month of delivery for both mother and baby; new-born care at home by skilled birth attendants; exclusive breast feeding, IYCF and micronutrient supplementation, community-led total sanitation, hygiene promotion.
- Effective provision of early education services & WASH services in pre-schools: WASH in schools focusing on handwashing; having early learning centres both formal and community based.

At the baseline, no surveyed commune was found to be qualified for having functioning IECD services according to the above criteria, mostly because of the lack of effective IECD programme implementation. By the time of the endline, there were a total of two communes qualified as having functioning IECD services. However, the research team observed that to meet the first criterion, i.e. having effective IECD programme implementation, the original conditions required the commune to have an IECD club that held at least 4 meetings in the last month at the time of the endline survey (i.e. in the commune questionnaire, answer to IECD.5b $>=4$). Since the Covid situation in Vietnam has been critical since July 2021 with restrictions being placed in different locations including the project areas, gathering of more than 10 people was not allowed in some locations, making it difficult for communes to meet this condition. Thus, the research team decided to revise this condition, which only requires communes' IECD clubs to have held at least one meeting since establishment (IECD.5a $>=1$). With the revised condition, 15 communes were found to meet the first criterion of effective IECD programme implementation, making a total of **10 communes satisfied the criteria for having functioning IECD services** (Figure 64). Those communes are: Na Tong (Tuan Giao, Dien Bien), Dak Glei town, Dak Choong (Dak Glei, Kon Tum), Dak To Re (Kon Ray, Kon Tum), Dak Ro Ong (Tu Mo Rong, Kon Tum), Kong Chieng, Dak Troi (Mang Yang, Gia Lai), Chu Drang (Krong Pa, Gia Lai).

**Figure 64. Number of communes having functioning IECD services at the endline
(Using revised criteria)**



Source: MDRI endline survey and evaluation, 2021

Image 4. Children playing in a pre-school playground, Dien Bien



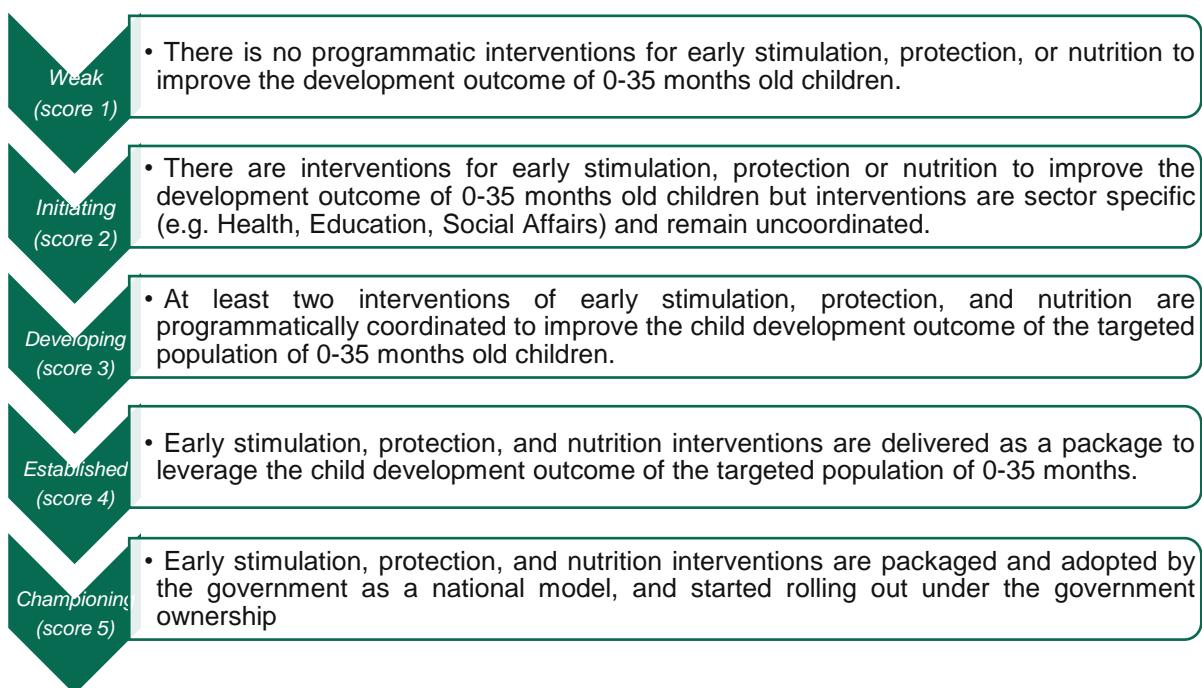
Source: MDRI Research Team

Indicator 9

Existence of integrated early stimulation, protection and nutrition intervention package targeting 0 to 35 month-old children

Being one of UNICEF's Results Assessment Module (RAM) standard indicators relevant for ECD, this indicator aims to capture the progress in a country towards establishing an integrated ECD approach to address the critical first three years of life through a packaged intervention of early stimulation, protection and nutrition. Accordingly countries are classified into one of the five (5) categories.

Figure 65. Five categories of integrated early stimulation, protection and nutrition intervention package targeting 0 to 35 months old children



As the baseline results showed, in the project locations all interventions aimed at young children aged 0-3 were primarily delivered through the health system, in particular by the commune health centre. As a consequence of the sole involvement of the health system in providing the package, the interventions were mostly childcare-related, including stimulation and nutrition. The protection component was delivered separately by the commune's Child Protection officials and targeted the older age-groups, from 3 years old and above. In addition, the Vietnam government has not yet adopted the ECD package as a nation-wide model. For those reasons, by the time of the endline, no project communes were qualified for Score 4 (Established) or 5 (Championing) yet.

To meet the criteria for Score 3 (Developing), the communes have to have health centers providing both stimulation and nutrition services, and have an established ECD coordinating committee to implement these services in a programmatic way. Accordingly, **at the endline, 20 out of 24 surveyed project communes (excluding 3 communes in Gia Lai) were found to meet Score 3 - having at least two interventions of early stimulation, protection, and nutrition programmatically coordinated to improve the child development outcome of the targeted population of 0-35 months old children.** The remaining four communes, namely Ta Phin, Chieng So (Dien Bien), Dak Rve and Tan Lap (Kon Tum), met Score 2 (Initiating) since in those communes, although the ECD coordinating committees were in place, the health centers were only providing either stimulation or nutrition intervention.

Indicator 12

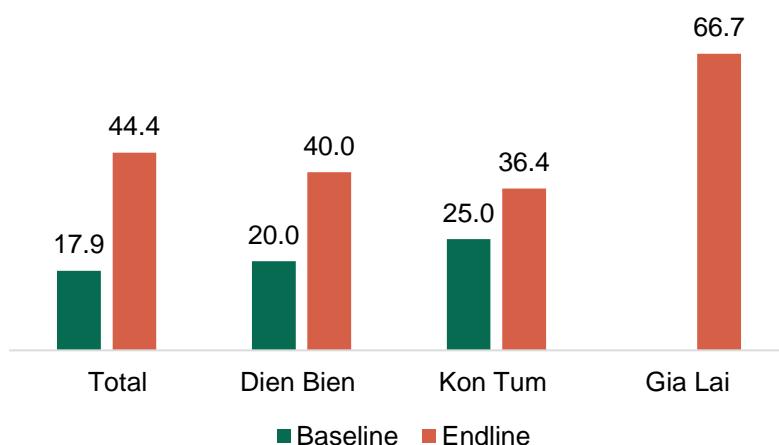
Proportion of ECD centers that provide integrated ECD services based on national standards

ECD centres, namely preschools, play an important role in providing a foundation for the physical and cognitive development of children aged 0-6. This indicator demonstrates the proportion of surveyed preschools in the project areas which have achieved National Standard

level 1 or 2 recognition during the last 5 years. National Standard level 1 specifies that preschools have childcare and education activities, which ensure comprehensive quality education in compliance with the goals of preschool education. Level 2 requires some other criteria in addition to level 1's, such as school attendance, school lunch provision, proportion of children with normal growth in weight and height by age.

The survey results showed that **the proportion of ECD centres that provide integrated ECD services meeting national standards level 1 or 2 increased considerably from 17.9% in the baseline to 44.4% at the time of the endline in the project provinces** (Figure 66). Gia Lai is the province which witnessed the most significant improvement, from having none of the six surveyed preschools meeting national standards three years ago to having four (accounting for 66.7%) in 2021. Dien Bien and Kon Tum each achieved an increase of two and one preschools meeting national standards respectively.

Figure 66. Proportion of ECD centers that provide integrated ECD services based on national standards



Source: MDRI endline survey and evaluation, 2021

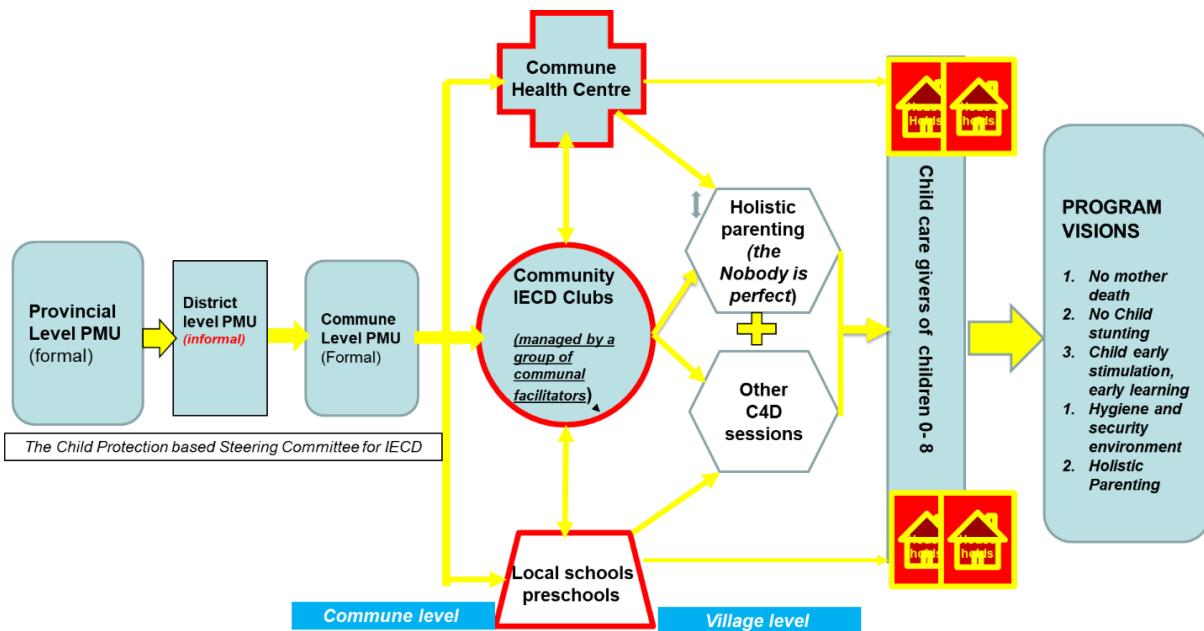
4.12 Effective implementation of the IECD Programme

Indicator 33

Availability of co-ordination committee and mechanism on IECD at provincial, project districts and communes

At the time of baseline evaluation, **the IECD Project Management Unit (PMU) Committee was established from provincial and district level to commune level in all three provinces at different times in 2018**. In order to effectively facilitate the project activities, a multi-sectoral mechanism of operationalization model at all levels has been built during the implementation period.

Figure 67. The structure of the operationalisation model at all levels



Source: Operationalisation model for implementing IECD activities at subnational level, UNICEF

Mechanism for multi-sectoral collaboration represented by:

- i) An effective programme management unit (PMU) maintains statutory governance and programme oversight on integrated early childhood development (IECD) implementation in each province and project communes;
- ii) A model commune operationalization guideline is in place that guides the work of different groups involved, and facilitates effective linkages between the different service components of IECD involved;
- iii) Regular micro planning/coordination meetings are conducted monthly in all project communes, ensuring cross-sector collaboration for delivery of IECD essential services to targeted women and children at grassroots level;
- iv) A cross sector joint monitoring field trip that helps ensure undesired practices of sectoral interventions and services are identified and corrected in a timely manner.

In each provincial PMU, there has been the representation of members from key sectoral departments and agencies, including Department of Health (DOH), Department of Education and Training (DOET), Department of Labour, Invalids and Social Affairs (DOLISA), and other relevant stakeholders, which contributed to the greater coordination among project components. The main responsibility of a provincial PMU is to facilitate, oversee, expedite, monitor and evaluate the implementation process and to report on project activities. Besides, a District programme team was formed for each of the project districts under the guidance of the provincial PMU as a focal point to enhance the coordination between PMU at province and communes.

At commune level, a Project Management Group (PMG) was established under the guidance of a leader from Commune People's Committee. The group's composition involves multi-sectoral participation of technical staffs in child protection, healthcare, education sectors and for the Women's Union. The communal PMG plays a central role in implementing IECD activities taking place at commune level in a connected and integrated manner. There was

also the IECD team established in all project villages, constituting a network of core staff at grassroots level (ex. village heads, village health worker, child protection collaborators, local teachers, etc.). Their duties were mainly to implement the communication activities, deliver consultation services, provide care and support, initiate changes in holistic ECD perception and skills, and to spread IECD in the community and households. Results taken from the commune survey indicated that 2 communes Chu Gu (Gia Lai) and Hang Lia (Dien Bien) have not set up a network of core staffs at village level yet. Among communes having village staffs, only 2 communes have recorded the network expanded while around 32 per cent of these communes observed the reduction in the number of staffs since September 2018. It seemed that the operationalization of the communal and village team was not effective as expected due to the insufficiency of consistent system and supporting funds for worker-in-charge.

“

[...] In the program's operationalization structure, only PMU at provincial level has a well-constructed model, while in districts, communes and villages, the leaders are appointed to be the focal point. The lack of a consistent and integrated system really became major hindrance during the implementation process. In addition, without the receipt of monthly allowance within the project, the person-in-charge at communal and village level would work under low efficiency and drop out of their jobs.

KII with Vice Director of Department of Health, Dien Bien.

As of November 2021, 19 out of 24 surveyed communes have still maintained the activities within IECD clubs. Among 5 communes reported to cease organizing these clubs, there are up to 4 communes in Dien Bien province, namely Ta Phin, Xin Chai, Ta Sin Thang (Tua Chua district) and Pu Nhi commune (Dien Bien Dong district). Even though all three provinces have not been significantly impacted during the Covid-19 pandemic in comparison with other provinces nationwide, the restriction on public gathering in 2020 has disrupted the clubs' activities as well as the fieldwork of UNICEF experts. For the adaptation in the context of Covid-19, the means of multi-stakeholder communication and coordination has already switched to online platforms (ex. Zalo, Facebook). Despite their great efforts to overcome these challenges, communal staffs still face many difficulties in supporting service provision and communication with beneficiaries, particularly those in remote areas.

“

[... in the context of Covid-19 outbreak] The communication to the beneficiary caregivers became limited since not all of them own a smart phone.

KII with the representative of DOLISA, Dien Bien

Indicator 34

Availability of Provincial IECD Action Plan 2018-2021 with budget allocation for implementation

According to the baseline evaluation report, **all three provinces Dien Bien, Kon Tum and Gia Lai have mapped out the Action Plan for the whole programme period of 2018-2021** which set out the annual roadmap with budget allocation to each executing partner in response to the provincial project's immediate objectives. In the early of 2020, the two-year 2020 and 2021 provincial's Annual Work Plan for IECD was developed and adopted in a participatory manner by UNICEF and the provincial governments. This document synthesized the achieved outcomes from the previous implementing period and plan for 2020-2021 period, specifically:

In 2017, the project focused on the project preparation and approval procedures.

In 2018, the project officially kicked off and implemented activities, emphasizing on the establishment of an IECD governance and coordination system in districts, communes and villages, capacity building for IECD service providers, IECD awareness-raising in communities and application of mobile technology (m-IECD) to track the implementation progress in project locations.

In 2019, the project focused on building capacity for IECD service providers and raising awareness and practice of IECD in communities through effective IECD services and models.

In 2020-2021 period, the project continued to provide services and equipment with the application of m-IECD, digital technology, indicators to track and evaluate the implementation process, create favourable environment and conditions to deploy the intervention of IECD in districts and communes to achieve the set targets.

At the time of interview, all three provinces have been in the progress of evaluating the end-of-programme achievements of outcomes.

Indicator 35

Existence of a monitoring system for tracking the progress of the IECD models implementation

From the initial design, the IECD programme adopted the result-based management approach in combination with a number of M&E tools (sectoral and government surveys, case studies, situation analysis, period review and field visit and independent assessment). **At the time of endline evaluation, all three provinces have finished the implementation of a monitoring system.** For tracking the implementation progress, a quarterly reporting activity was created and applied in all 27 programme communes. The report covers key and simple indicators that allow the programme to track implementation status in communes, especially tracking key results achieved by the community, such as number of group communication sessions conducted, number of parent/child caregivers participating in the ECD sessions, or essential ECD services coverages among targeted beneficiaries.

To be specific, relevant departments at provincial level being in charge of each IECD component held monthly or quarterly briefings to strengthen the coordination and discussion of work related to children. It was also reported that each department organized inter-sectoral supervision of its specific responsibilities mentioned in relevant provincial decisions. Moreover, DOLISA Dien Bien has developed a database system of children, which has been regularly and promptly updated in the Children Monitoring Book. The province aimed to update children's information into the Children Management software according to the regulations of

the MOLISA. Additionally, provincial PMU representatives reported to receive UNICEF's support in the form of technical training and periodic supervision through field visits for the programme's evaluation.

At the grassroots level, the internal meetings were frequently conducted with the participation of members in provincial and district PMU Board, which is not only to monitor the implementation of project activities but also to provide support for the communal officials in work plan development. Besides, the commune questionnaire explores the current status of IECD programme steering committee's meetings in terms of frequency and format. The final results showed that most of these meetings had been conducted monthly, but some communes in Dien Bien organized the meeting quarterly or had to switch to quarterly due to the Covid-19's impacts. The meetings have mainly taken place directly and only Chieng So commune (Dien Bien) and Dak Rve Town (Kon Tum) have recently changed the meetings via online platforms. The most significant improvement in the monitoring system should refer to the fact that all communes have reported the programme progress periodically. The achievement of result was consolidated and submitted in document, generally on a monthly or quarterly basis.

“

[...] The main purpose of briefing meeting in the commune is to oversee the progress in case management and how the case managers provide supporting interventions for the children in need. In addition, we are also willing to support the child protection workers in developing the annual, quarterly and even monthly workplan, and other relevant tasks such as intervention plan for children being abuse or neglect.

FGD with PMU Mang Yang, Gia Lai



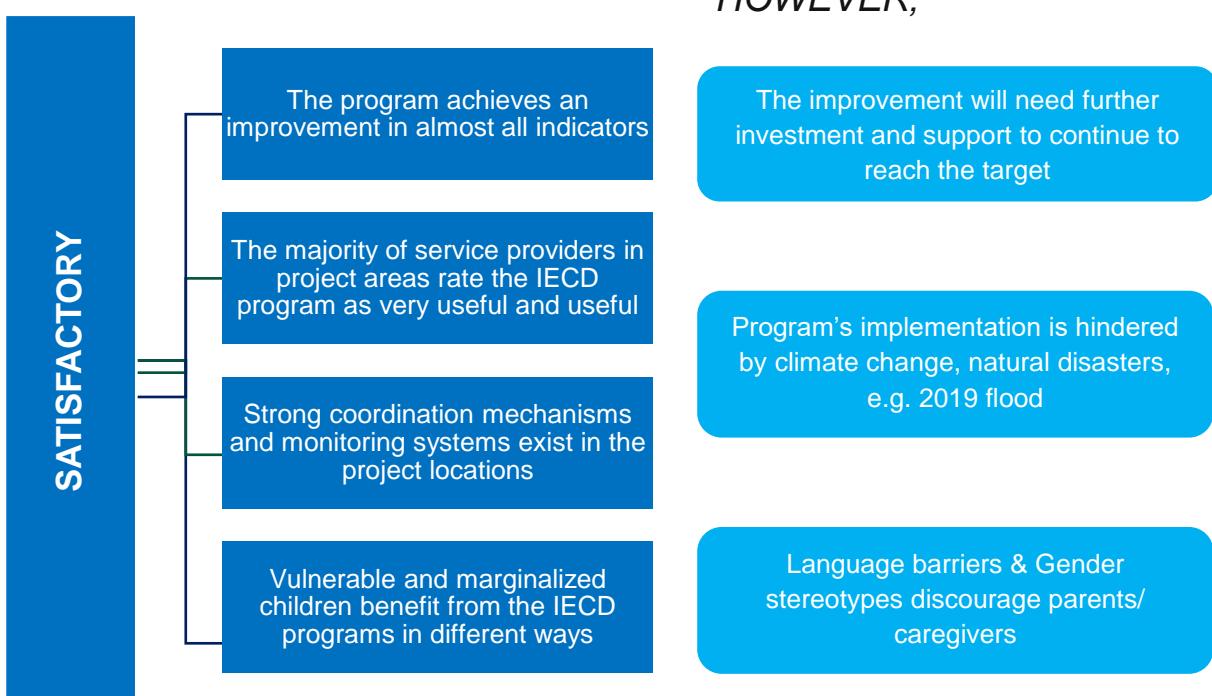
VOLUME II:
PROGRAMME EVALUATION

PROGRAM EVALUATION



5.1 Effectiveness

Overall findings



Findings on the key evaluation questions

The effectiveness of the IECD programme is evaluated based on the extent to which the program has achieved targets and results set out in the programme design. More explicitly, questions of effectiveness include:

- Has the Programme achieved the targets and results set out in the programme design at the outset?
- What is the governance structure of the programme and how effective this structure was for service delivering, coordination, and collaboration?
- How did COVID-19 pandemic affect the programme implementation, progress and achievement of results?

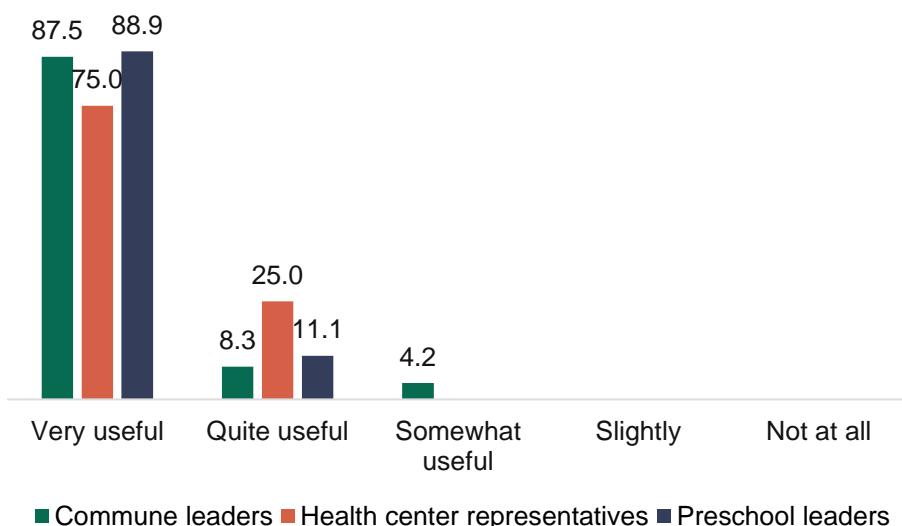
Overall, the research team assess the programme's effectiveness as "Satisfactory" with reasons explained below:

1. Has the Programme achieved the targets and results set out in the programme design at the outset?

Summary response: Yes. In six areas of focus, namely Child health, Education, Child protection, Peace building and social cohesion, Access to and use of IECD services and Implementation of IECD programme, **the programme achieves an improvement in 31 out of 33 indicators**, except for the decline in the percentage of local health workers able to perform IYCF counselling and the decline in the percentage of boys and girls aged 6-8 years who know where to report violent incidents involving themselves and other children. The decrease in the percentage of IYCF counselling-capable health workers is attributed to the reduced training rate, which comes from the fact that (1) not every health worker in the center received IYCF training; and (2) in the year 2021, under the COVID-19's pandemic impact, no IYCF training has been conducted.

When asked to self-evaluate the usefulness of the programme to the communes, **the majority of respondents in the service provider survey rate as quite useful and very useful**. This confirms the effectiveness of the IECD model delivered in the project locations.

Figure 68. Usefulness assessment, divided by service provider (%)



Source: MDRI endline survey and evaluation, 2021

There has been improvement in both quantity and quality of ECD centres/ programmes for children. 100 per cent of ECE centres, including family-based childcare groups in the three project provinces are found to have minimum IECD equipment. 81.5 per cent of ECE centres provide all four early learning/ stimulation services, namely parent counselling, early stimulation, social and emotional learning and positive discipline.

Vulnerable and marginalized children benefit from the IECD programme in different ways. For example, in Dien Bien province, 9 models managing disadvantaged children are established in project communes. In the whole province, a total number of 2,760 disadvantaged children (including orphans, marginalized children and COVID-19-impacted children) are entitled to social assistance. More than 3,000 children in SOS villages and social assistance centres are subject to case management and receive skills development.

There has been improvement in parents/ caregivers' attitudes and practices of positive discipline in households. Percentage of parents/ caregivers who engaged with their children aged 0-4 years (under 5) in activities to promote responsive care including early stimulation increases from 56.8 per cent to 59.8 per cent. 100 per cent of project districts and project communes are committed to protecting children from violence, abuse and neglect and already established child protection committees at the district and commune level.

However, even though there has been improvement in some indicators' performance, **the improvement is not sufficient to reach the target.** The percentage of people in humanitarian situations who access safe drinking water increases from 30.1 per cent to 49.4 per cent, but the target rate for the whole programme area is 100 per cent. Also, the proportion of population having an improved sanitation facility grows from 26.2 per cent to 46 per cent, against the target rate of 100 per cent for the whole programme area. Also, the percentage of parents/caregivers who practice responsive parenting and non-violent discipline is 11.4 per cent, against the target rate of 50 per cent.

Also, **climate change and natural disasters are a hindrance to the programme's implementation.** In 2019, there was a devastating flood that affected a wide area, including Gia Lai and Kon Tum province. Climate change and natural disasters put people's lives in jeopardy, thus slowing down the programme's progress.

Language barriers and gender stereotypes are a hindrance to the programme's achievement of results. Language barriers and the lack of communication materials in ethnic languages make it hard for parents/ caregivers to comprehend the training content. Even though fathers are more literate than mothers, the perception that childcare is mothers' duties discourage fathers from participating in the training and club meetings. In such meetings, the majority of participants are mothers.

2. What is the governance structure of the programme and how effective this structure was for service delivering, coordination, and collaboration?

Summary response: Yes, effective. At the central level, the IECD programme has created a clear working structure and well-shaped coordination mechanism. Previously, there was no central-level agency assigned to be in charge of IECD. In October 2018 MOLISA was assigned to develop the IECD programme with the participation of MOH and MOET, under Decision no.1437. The decision is a legal and strategic document that serves as basis for ministries and agencies to work together in programme implementation.

Technically, the Government has adopted a mandatory inter-ministerial circular on inter-sectoral cooperation on IECD. The collaboration in technical assistance is good because all the techniques introduced to the local areas have the central government's imprint. Compared with the baseline, the linkages between stakeholders are strong in the sense that the central government provides technical support to the local government and the local government, in return, reviews and provides the central government with evidence of the interventions' effectiveness.

At the local level, in the 2017-2021 period, interdisciplinary cooperation has been professional and intensive on the principle of optimizing children's development. The coordination is shown in the development of the draft programme, implementation of action plans and annual plans

as well as monitoring and supervision. For example, a monitoring activity can be joined by more than one sector. The donor's field visits are attended by representatives of all sectors.

In all project districts and project communes, coordination committee and mechanism on IECD are available. In 20 out of 24 communes, at least two interventions of early stimulation, protection and nutrition are programmatically coordinated to improve the child development outcome of the targeted population of 0-35 month olds. There is cross-sectoral collaboration in progress tracking of IECD models in each province.

There has also been an increase in counterpart funding and its share in total approved budget. Counterpart funding of three provinces increases from USD 151,124 (2018) to USD 200,090 (2020-2021). The share of counterpart funding in total approved budget (of three provinces) increases from 6.3 per cent to 11.5 per cent.

3. How did COVID-19 pandemic affect the programme implementation, progress and achievement of results?

Summary response: COVID-19 pandemic seriously impacts programme implementation and achievement of results.

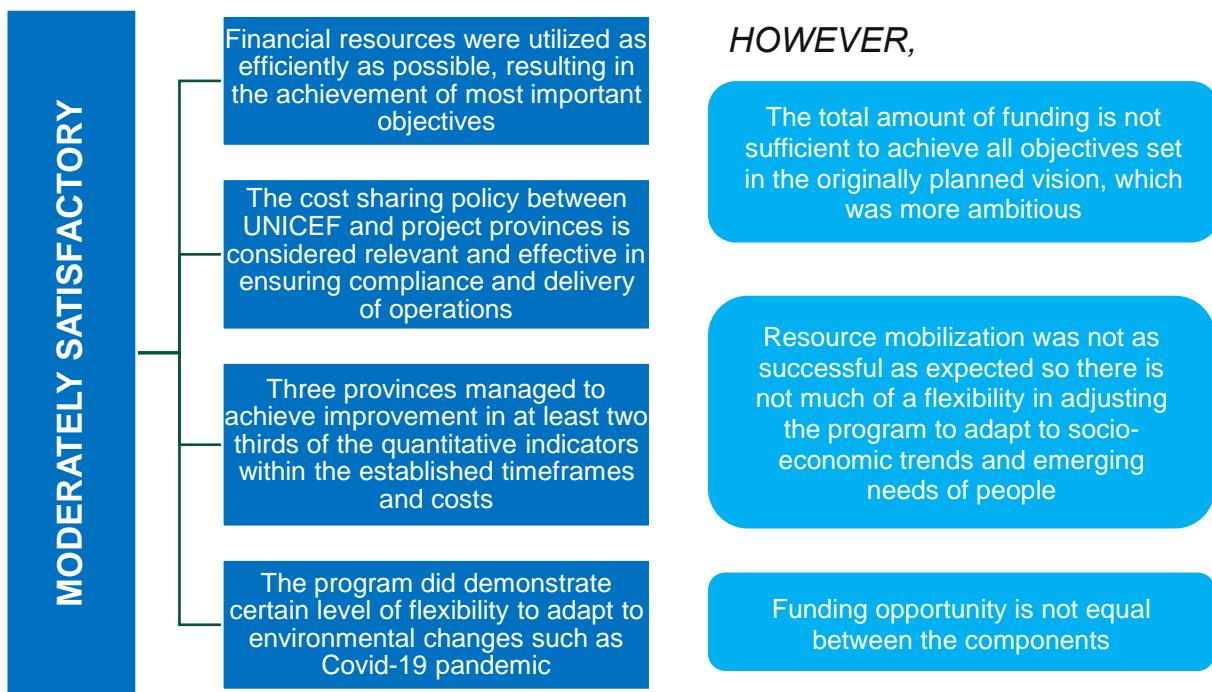
The pandemic increases the programme staff's workload, hence their dedication to IECD programme is affected. Particularly in the Healthcare sector, the focus was on pandemic control and prevention and healthcare staff did the extra tasks of testing and tracing COVID-19 patients. Also, the pandemic has switched the provincial budget for communication from IECD programme to pandemic prevention. As a result, the provincial budget for IECD programme has been reduced.

Due to social distancing order, almost all programme activities have been switched from offline to online. For communication, indirect communication through loudspeakers and written materials is not as effective as home visits and direct communication. Furthermore, in Muong Mun commune (Dien Bien province) where 2 out of 12 villages do not have electricity, communication through loudspeakers does not work.

The pandemic makes people more cautious when accessing healthcare services for fear of infection. Therefore, the healthcare staff has to make home visits to distribute multi-micronutrient packages. Activities such as prenatal check-ups and providing iron pills for pregnant women are interrupted. Home counseling for the most vulnerable groups of children are also very limited.

5.2 Efficiency

Overall findings



Findings on the evaluation questions

The efficiency of the IECD programme is defined as the extent to which the programme has optimized its resources and input throughout the programme cycle. More explicitly, questions of efficiency include:

- How economically resources or inputs (such as budget, expertise and time) are converted to results?
- Did the programme manage to achieve all or some of its objectives within established timeframes and costs?
- Did the programme demonstrate some flexibility in adapting to any change in environment in terms of political, legal or socio-economic aspects?

Overall, the programme's efficiency is ranked as "Moderately Satisfactory" by the research team for the following reasons:

- 1. How economically resources or inputs (such as budget, expertise and time) are converted to results?**

Summary response: Project implementation is as cost-effective as originally proposed. There was a timely and stable release of counterpart funds as committed by project provinces, which is very instrumental for local actors to run the desired activities. Three provinces also managed to achieve improvement in at least two thirds of the quantitative indicators.

- The cost-sharing policy between the donor (UNICEF) and the recipients (project provinces) is considered relevant and effective in ensuring compliance and delivery of operations, as mutually agreed by stakeholders. The counterpart fund was mainly used for regular expenses during operations of PMU and local collaborators (staff remuneration, meeting location, means of transportation for officers on duty, other working conditions, ...).

According to the opinions of provincial governments, the cost-sharing is vitally important as it demonstrates mutual trust between the two parties (donor – recipient) and reflect the commitment of the local authority during programme implementation.

- Generally, all three provinces **achieve a high disbursement rate**, at higher than 90 per cent, which implies that almost all project activities are delivered, and associated expenses are disbursed according to the plan.
- **Three provinces manage to achieve improvement in at least two thirds of the quantitative indicators within the established timeframes and costs.** The key costs, however, vary across provinces.

Table 15. Key efficiency measures, by provinces

| | Dien Bien province | Kon Tum province | Gia Lai province |
|---|--|---|---|
| Approved UNICEF fund (VND) | 37,658,496,236 | 30,614,990,680 | 39,721,740,817 |
| Disbursed UNICEF fund (VND) | 36,238,637,416 | 28,931,882,576 | 38,407,541,021 |
| Number of beneficiary children ¹⁸ | 6,743 | 7,418 | 5,263 |
| Disbursement rate | 96.2% | 94.5% | 96.7% |
| Cost per beneficiary child (VND) | 5,584,828 | 4,127,122 | 7,547,357 |
| Number of quantitative indicators with improvement | 20 (74.1%)¹⁹ | 23 (85.2%)²⁰ | 20 (74.1%)²¹ |
| Key costs | <ul style="list-style-type: none"> - Healthcare (45.5%) - Child protection (26.3%) - Education (22.7%) - Management board (5%) - Planning & Investment (0.4%) | <ul style="list-style-type: none"> - Child protection (40.9%) - Healthcare (34%) - Education (18.6%) - Policy & Management (6.5%) | <ul style="list-style-type: none"> - Healthcare (67.6%) - Policy & Management (20.2%) - Child protection (12.2%) |

Source: MDRI endline survey and evaluation, 2021

2. Did the programme manage to achieve all or some of its objectives within established timeframes and costs?

Summary response: Partially yes. The financial resource is not sufficient to achieve all objectives set in the originally planned vision, which was more ambitious. However, despite

¹⁸ Number of beneficiary children is taken from the number of children aged 0-8 in project locations, according to data from Department of Child Affairs (MOLISA), as of December 2020.

¹⁹ List of improved quantitative indicators in Dien Bien province: 1-3-5-6-8-10-12-17-19-20-21-23-24-25-27-28-29-30-31-32

²⁰ List of improved quantitative indicators in Kon Tum province: 1-2-3-5-6-7-8-10-12-15-17-19-20-21-22-23-24-25-26-28-29-30-31

²¹ List of improved quantitative indicators in Gia Lai province: 1-2-3-5-6-8-10-11-12-17-18-19-22-24-26-27-28-30-31-32

funding constraints, financial resources were utilized as efficiently as possible, resulting in the achievement of **most important** objectives.

“ According to the approved plan, UNICEF's total resources are more than 3 million USD (both readily available sources and mobilized sources). However, in reality, the program only received more than 26 billion VND (roughly 1.1 million USD), which is 52% of the planned budget. Despite that, the program still managed to reach more than 80% of its objectives. The counterpart funds for operational management were also guaranteed 100% as initial commitment.

KII with PMU Gia Lai

- The funding constraints lead to modifications of some activities and add complexity to the implementation process.

“ Financial resources from the local government did increase compared to previous years but still not adequate to achieve all targets.

KII with DOLISA Dien Bien

3. Did the programme demonstrate some flexibility in adapting to any change in environment in terms of political, legal or socio-economic aspects?

Summary response: Yes, the programme did demonstrate certain level of flexibility to adapt to environmental changes such as Covid-19 pandemic. However, resource mobilization was not as successful as expected so there is not much of flexibility in adjusting the programme to adapt to socio-economic trends and emerging needs of people.

“ The only disadvantage is the lack of funds in reality compared to the design. We had to cut down on some activities related to communication materials for dissemination of project results (developing booklets, documents, handbook for public release) in order to prioritize other important activities

KII with PMU Kon Tum.

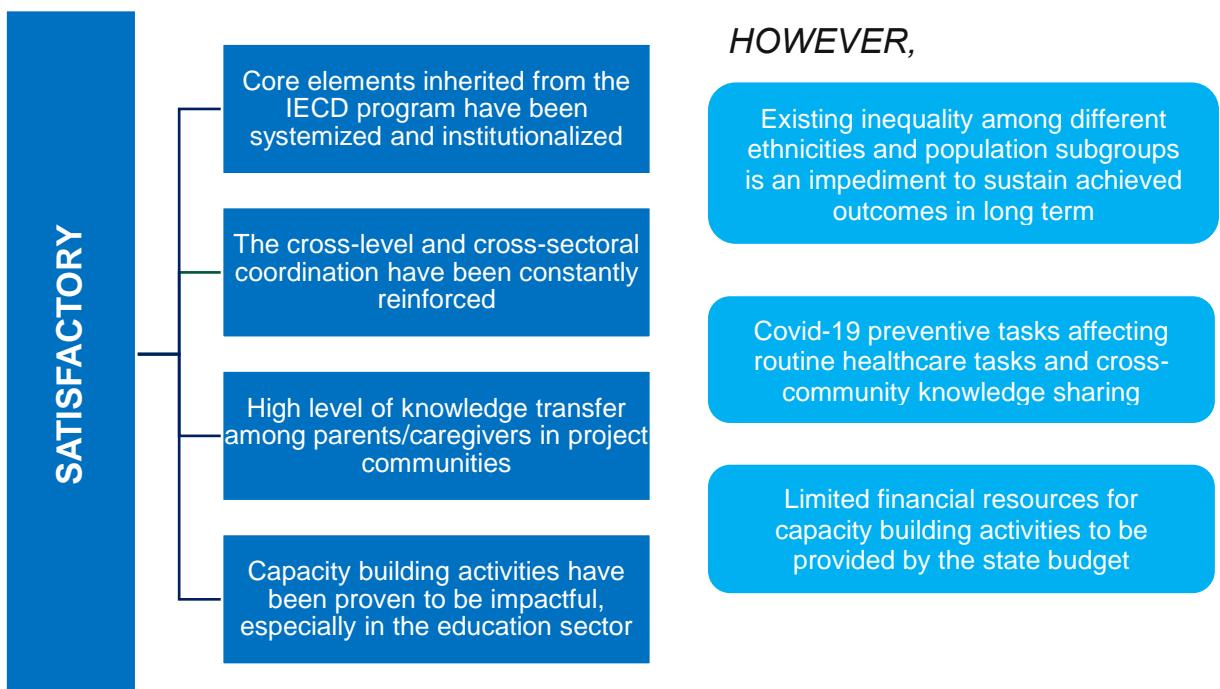
- During the social distancing period due to Covid-19, the delivery of key programme messages changed from club activities to using local loud speaker system in all 27 project communes. The radio messages were designed in Vietnamese and the local languages.

At the outbreak of the fourth Covid wave, UNICEF responded quickly and invested in digital equipment for PMU and provincial partners to conduct online meetings/training so that the frequent operational activities were not interrupted abruptly.

- However, budget planning was strictly followed with limited space for incurred costs. Resource mobilization was not as successful as expected so there is not much of a flexibility in adjusting the programme to adapt to socio-economic trends and emerging needs of people.
For example, despite attempts to take a high-tech approach in reaching the most vulnerable children in remote areas, UNICEF could not deploy the mobile technology tracking system called Mobile Integrated Early Childhood Development (MIECD)²² in 27 project communes due to the substantial amount of additional budget required.
- Funding opportunities are not equal between components. Some have generous funding (EENC, Holistic parenting) but the budget belonging to this component could not be allocated for the other component where funds are in thirsty.

5.3 Sustainability

Overall findings



Finding on evaluation questions

²² MIECD is an artificial intelligence-driven analytic system that provides complete decision support for appropriate and timely actions at critical points of care to save mothers and children's lives through data warehousing, predicting, data mining and advanced analysis

The sustainability of the IECD programme is evaluated based on the extent to which the achieved results and benefits brought about by programme-related interventions are maintained for an extended period of time after the end of the programme cycle. More explicitly, the questions of sustainability include:

- Are there prospects for further development of related interventions after project's completion?
- Are local governments in project locations committed and simultaneously capable of maintaining the IECD operationalization model by the end of the programme cycle?
- Do capacity-building activities within the IECD programme positively affect sustainability?

Overall, the research team assessed the programme's sustainability as "Satisfactory" with reasons explained below:

1. Are there prospects for further development of related interventions after project's completion?

Summary response: Yes, very likely. Given that the programme was deliberately built upon local needs and capacities, **several core elements inherited from the IECD programme have been systemized and institutionalized for continuous implementation.**

- The nutrition component successfully modelled in three project provinces was officially formulated as a key Nutrition Benefit Package at MOH and being used to feed advocacy programme agenda to the National Assembly so as to make that benefit package to be covered by the National Health Insurance Scheme. The policy advocacy work is ongoing with promising results and will bring a major sustainable opportunity for this component's interventions. In that sense, the provision of micro-nutrient supplementation for pregnant women and micro-nutrient powder for children aged 6-23 months old as well as the treatment costs for severely malnourished children will be sustained in long term, potentially narrowing the health gaps across regions.
- Impacts of the education sector (the Social Emotional Learning (SEL) curriculum, GGA and ECDS tools) are also very likely to persist as having been nationally adapted by MOET. Another key factor contributing to increase programme's sustainability in the education sector is the fact that a great amount of interventions focuses on capacity building for teaching staff at both national and subnational levels. .

“ [...] For education sector, it is more convenient to prolong as well as replicating the program's benefits because we have an advantage that teachers can easily access online information using technology. After the training, the materials will be shared immediately through the internal website system or emails so that many schools can apply altogether.

FGD with PMU Dien Bien.

[...] An example of program's sustainability is our network of education core staff at provincial level. All of them went through capacity training provided in the IECD program. They all have good communication skills, curriculum design skills, presentation skills, and organizing skills. Their knowledge and skills will be sustainable and lasting

FGD with PMU Gia Lai.

- The child protection system at subnational level has been built and strengthened. The component's interventions hosted by DOLISA (the Nobody's Perfect model, case management for children in special circumstances, ...) have been formalized into national and provincial action plans to be maintained regardless of UNICEF's support.

For example, as shared by an official from DOLISA Dien Bien in the qualitative interview, the department has successfully defended the budget for child protection component (300 million VND) and managed to allocate an addition of 200 million VND for maintaining and expanding current models in the next phase. Gia Lai and Kon Tum's representatives also affirmed with great confidence that the child protection mechanisms, fortified during the IECD programme, will be able to operate independent of UNICEF's involvement.

2. Are local governments in project locations committed and simultaneously capable of maintaining the IECD operationalization model by the end of the programme cycle?

Summary response: Yes, a high degree of ownership can be observed in three aspects. First, **the cross-level and cross-sectoral coordination mechanisms** are considered a distinguished element of the IECD programme and have been constantly reinforced throughout the implementing period²³. Second, **child related indicators** linked to IECD have been successfully incorporated into provincial SEDP. Last but not least, there exists **a genuine willingness and a continuing commitment of beneficiaries**, local governments and service providers to sustain IECD results in the coming phases.

²³ During the UNICEF pilot program, UNICEF IECD mechanism for cross-sectoral collaboration was reviewed and borrowed by MOLISA to institutionalize that cross collaboration in implementation of the IECD program. MOLISA and other line ministries formulated an Inter-ministry Circular on cross-sector collaboration in delivery of IECD service at households and communities. This formulation exercise completed in 2021 and approved in Feb 2022 by joint MOLISA/MOH/MOET/MOICS which provided a fundamental for program sustainability.

- UNICEF has helped facilitated smooth vertical cooperation between provincial, district, communal and village stakeholders specifically in terms of establishing action plans in alignment with targeted objectives; carrying out capacity building for service providers; monitoring and documenting achieved results through field visits, periodic meetings, and progress reports. Furthermore, for the sake of timely and comprehensive services for all children, the multi-sectoral collaboration in each level of subnational government is also maximized, reflected by the representation of different technical fields (health, education, child protection, ...) in both IECD management boards and in IECD activities (training, communication sessions, ...).

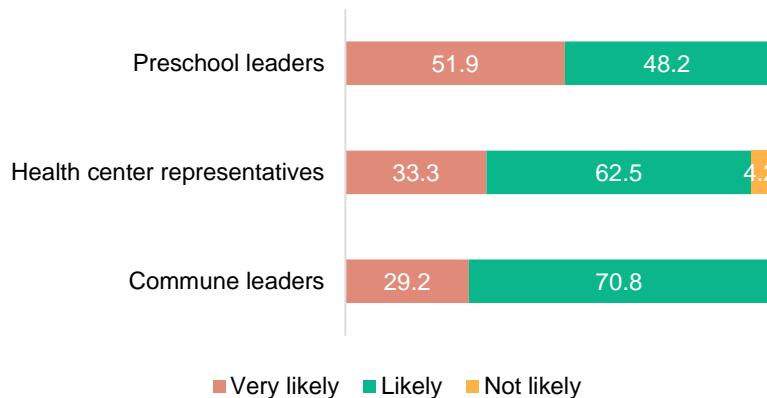
The significance of this coherent coordination mechanism not only lies in the effective delivery of interventions but more importantly in the improved system that goes beyond the programme cycle. Given the availability of such coordination mechanism, communication flows are easily encouraged and strengthened in many directions (top-down, bottom-up, lateral, and diagonal). While the IECD steering committees at provincial, district, and commune levels may disband at the end of the programme, the established communication system and network, which in this case is closely-connected and well-functioning, will continue to be utilized for further activities.

- A number of IECD related indicators on health, education, and child protection have been integrated into the final approved SEDPs of Dien Bien, Kon Tum, and Gia Lai for the 2021 - 2025. Not only does this mean the impacts will continue to be closely monitored but it is also indicative of the local governments' growing awareness and commitment towards child-sensitive planning.

For example, thanks to UNICEF's advocacy efforts since 2018, such indicators as "percentage of children under 5 who are stunted", "number of vulnerable children receiving social assistance at community", and so on now become annually tracked indicators by the local budget in 2021 and the following years in the three focus provinces. Dien Bien stands as the most proactive in retaining the comprehensive list of child related indicators on health, education and child protection/social assistance into their new SEDP. While Kon Tum also expressed strong eagerness to prioritize IECD in their SEDP during the next period, Gia Lai decided to take a prudent approach in selecting child related indicators to be included in the 5-year plan.

- From the service provider's point of view, when asked about self-assessment of the ability to maintain achieved results even after the IECD programme has ended, a majority of respondents in MDRI quantitative survey looked forward with optimism, except for a health center representative in Gia Lai province (**Error! Reference source not found.**).

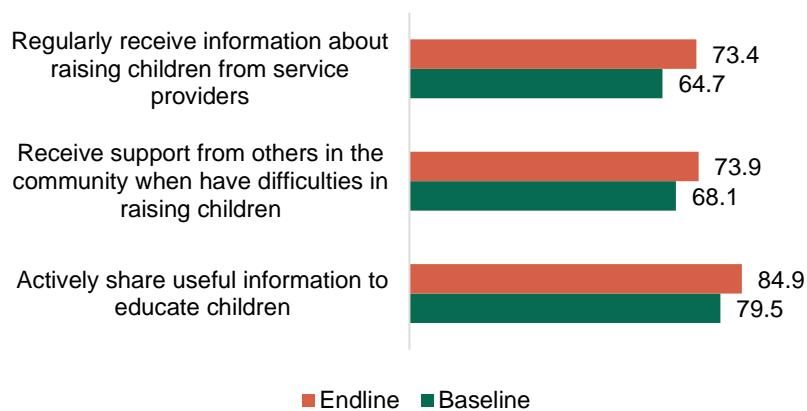
Figure 69. Sustainability assessment, divided by service providers (%)



Source: MDRI endline survey and evaluation, 2021

- From the beneficiary perspectives, as illustrated in **Error! Reference source not found.**, an enhanced level of knowledge transfer has been identified, signalling a high potential that lesson learnt and skills equipped by programme interventions will be passed on in mid to long term at community level.

Figure 70. Percentage of parents/caregivers who involved in community sharing of child rearing



Source: MDRI endline survey and evaluation, 2021

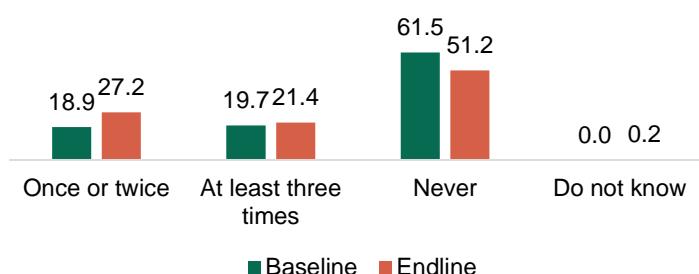
“

[...] Speaking of the local people, they are constantly reminded during training that they are not only listening for themselves but also for their relatives, their surrounding people. We do worry that people may forget what they are taught very soon because they are too mindful of other businesses (agricultural production). Therefore, we gave them leaflets, books, written materials so they can read or give to their husbands (if they don't understand the language). If they attend the training themselves and directly participate in interactive games during training, I believe they can easily remember the knowledge.

KII with commune health center in Dien Bien.

However, a certain part of the intervened population still find it hard to interact with IECD service providers or engage in community knowledge transfer and exchange as more than 50% of surveyed respondents **never** asked question(s) or made recommendations about IECD-related topics in the past year (even though the figure witnessed a 10% decrease from baseline) (**Error! Reference source not found.**).

Figure 71. Percentage of parents/ caregivers who ask question(s)/make suggestions regarding children care and education to community and service providers in the last 12 months (%)



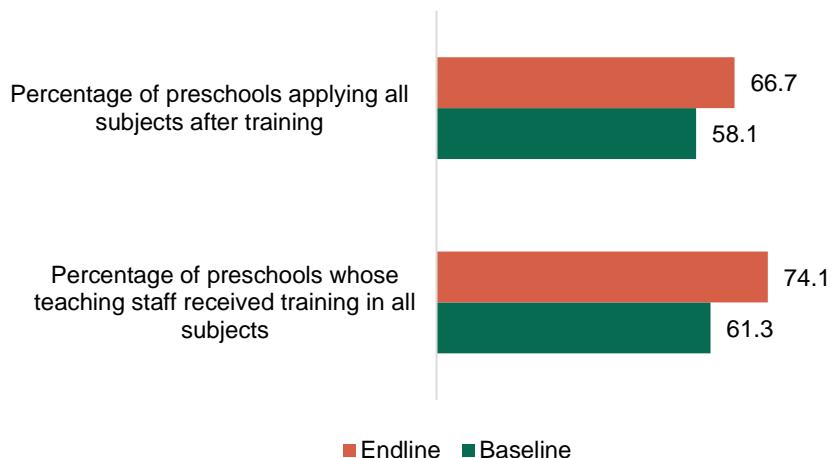
Source: MDRI endline survey and evaluation, 2021

3. Do capacity-building activities within the IECD programme positively affect sustainability?

Summary response: Yes, to a certain extent. Capacity-building activities were very much appreciated and valued by the central government, the local governments and IECD service providers. However, limited financial resources to organize repetitive training (or follow-up activities after training) as well as personnel transfers are among the key issues to be taken into accounts.

- **Capacity-building for teaching staff has been proven to be impactful, which further highlights the potential sustainability of ECE interventions.** During the IECD implementation period, technical training was offered in four subjects namely (i) Supporting children during transfer from preschool to primary school; (ii) Parenting programmes; (iii) Social and emotional learning for children; and (iv) Early learning/ early stimulation, including positive and responsive care. **Error! Reference source not found.** displayed the percentage of surveyed preschools having core personnel(s) trained in all four subjects and the associated application rate after training. Higher endline values in both training rate and application rate (compared to baseline) equals to higher likelihood that preschools in project areas are able to provide services independently and intuitively without direct intervention from UNICEF.

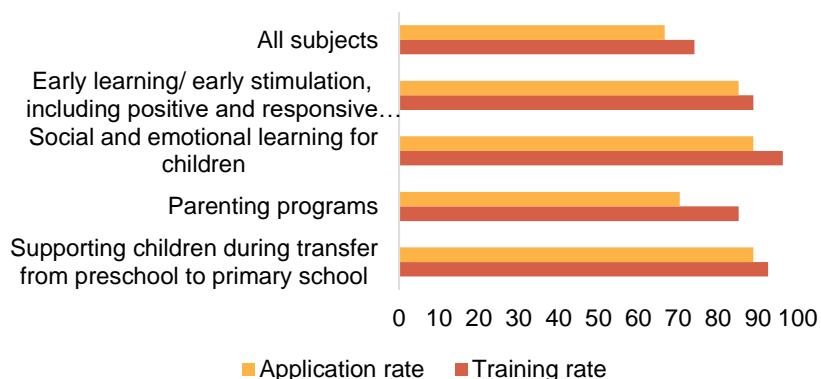
Figure 72. Pre-school training



Source: MDRI endline survey and evaluation, 2021

Notably, if divided by individual subject, the number of schools whose teachers received training as well as implementing a single introduced subject is also impressively high (>80%), especially with regards to social and emotional learning and school transfer (**Error! Reference source not found.**).

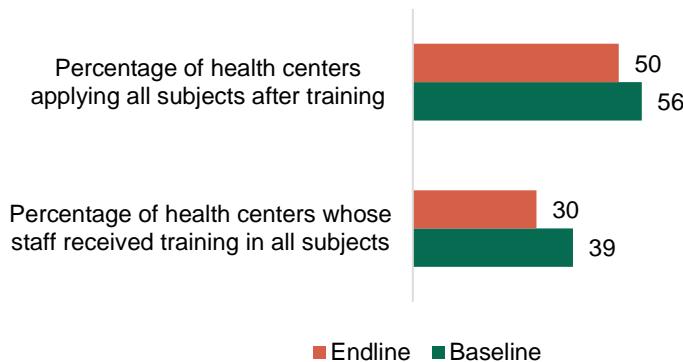
Figure 73. Pre-school training at endline, divided by subjects (%)



Source: MDRI endline survey and evaluation, 2021

- When compared to the education sector, capacity building training for healthcare service providers seemed to have more minimal effects. Despite an observable spill-over effect (the application rate is higher than the training rate), a very small number of respondents in the quantitative survey did attend technical training in all three IYCF key topics: (i) Early breastfeeding; (ii) Supplementary feeding (weaning) using diverse nutrient-rich foods, and (iii) Frequency of feeding by age (see **Error! Reference source not found.**). The decrease comes from the fact that IYCF training was only provided for a limited number of healthcare workers whereas in the year 2021, under the Covid-19's situation, neither training is allowed nor healthcare staff have time for participation.

Figure 74. IYCF training at commune health centers



Source: MDRI endline survey and evaluation, 2021

“

[...] To be honest, the program is about to end but we have no time for many activities that we would have otherwise done very well. First, we can't gather in large groups. Second, some children are living in quarantined areas so we can't access them. Third, the healthcare staff have to do a lot of Covid related tasks – vaccination, F0 treatment,... I myself just came back from a 1.5 month duty in quarantine camp... A lot of pressures...

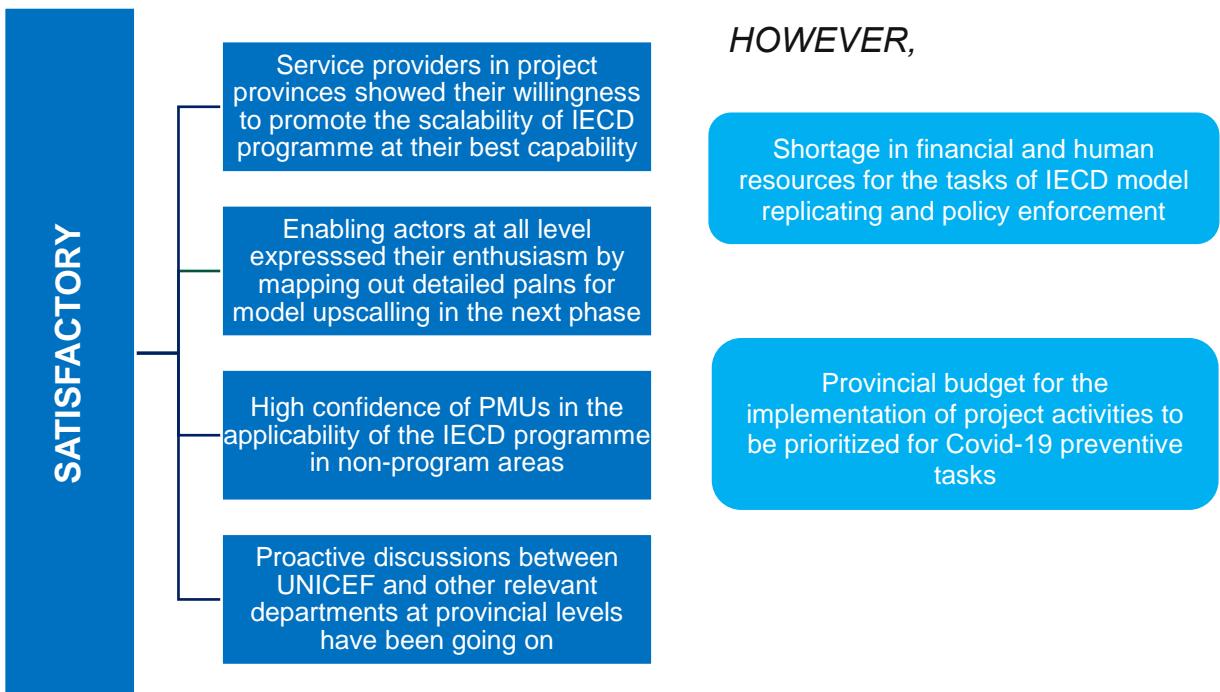
FGD with PMU in Mang Yang district, Gia Lai province.

Overall, there are several factors negatively affecting the programme's sustainability to be summarized below:

- Inequality remains an overarching challenge to always be redressed in parallel with any kind of interventions, especially when considering that the three project provinces are accommodating heterogeneous population in cultural backgrounds, socio-economic statuses and living conditions.
- The Covid-19 pandemic is presenting many difficulties for sustainability, specifically for the health sector as all available resources, both financial and human, are prioritizing disease prevention. On the other hand, Covid-19 restrictions and preventive measures, if prolonged, will also hinder beneficiaries' access to IECD services and interfere with the process of cross-community exchange of knowledge and lesson learnt from the model
- Limited local budget for capacity-building activities and knowledge loss due to staff offboarding/transfer are also worth considering for better preparedness and stronger programme sustainability.

5.4 Scalability

Overall findings



Findings on evaluation questions

In the endline evaluation, the scalability of the programme is determined as the extent to which the programme demonstrates its potential for future upgrade and expansion to other provinces nationwide. To explore the likelihood of program's scalability, some key questions of scalability will be further explained, including:

- Are there prospects for further development of related interventions after the end of the programme cycle in other provinces?
- Are local governments in project locations committed and simultaneously capable of upscaling the IECD operationalization model after the programme's completion?

In general, the scalability of the IECD programme is “Satisfactory” with the following justification:

1. **Are there prospects for further development of related interventions after the end of programme cycle in other districts/provinces?**

Summary response: Yes, there is a high likelihood of upscaling the programme's interventions in other districts within UNICEF-supported provinces and even in other provinces across the country. To be specific:

- ***Substantial evidence for the replicability and applicability of the IECD model consistently exists in all three project regions.*** For the scalability at the national scale, most of the respondents in the qualitative study shared that they have high confidence in the broad applicability of the IECD model but with some modifications in each locality.

Box 1. Evidence for IECD model replicability in Dien Bien, Kon Tum and Gia Lai

Dien Bien, by the attempt of designing UNICEF-supported activities in alignment with the Provincial Action Programme for Children, has left a distinct mark within the scope of the child protection component. During the four-year period of implementation, Dien Bien has formed a well-trained core team of child protection staff who would greatly contribute as the “seed of replicability”. In fact, there is evidence that the child protection model did scale up in other communes and districts. According to the representative of DOLISA Dien Bien, the Blue Dragon Children’s Foundation and World Vision have adopted a similar model of tracking, monitoring and supervision into child protection and case management systems in their project communes/districts. They invited the core team of child protection in UNICEF-supported regions to join workshops/training courses to disseminate their skills and knowledge in case management and model operation. Although the number of communes having the IECD model replicated is still modest, this somewhat proves the effectiveness of the pilot model in child supporting work in Dien Bien.

The FGD with provincial PMU representatives in Kon Tum revealed that 42 out of 102 communes (including 9 project communes) had deployed a similar community-based child protection system. Among the out-of-project communes, some have maintained the system developed by UNICEF in the previous period 2011-2016 with the province budget, while others adopted the same one from the Plan International’s activities. Not only community-based child protection but a IECD system has also been well developed in these communes, which incorporated the child education and healthcare sector. In the synthesis report of overall IECD programme in 2017-2021 period, key departments in PMU Kon Tum proposed some outstanding models to be replicated in the coming time, specifically:

For the Department of Education and Training: (i) Socio-Emotional Development for preschool students; and (ii) Community-based Library.

For the Department of Labour, Invalids and Social Affairs: (i) “Nobody is Perfect” Communication Programme and (ii) Case management system for marginalized children.

For the Department of Health: (i) IECD clubs and (ii) Community-based management for stunting children under 5 years old.

Gia Lai initiated the upscaling of the community-based library model in other communes. According to the synthesis report provided by PMU Gia Lai, in 2020, all 257 schools in 17 non-program districts established this model, of which there are 34 pre-schools. During the academic year of 2020-2021, it was reported that 193/257 schools (equivalent to 75 per cent) have successfully implemented and officially put the model into operation. Leaders of pilot communes/districts in Gia Lai arranged a field trip for other communes/districts for exchanging and discussing the model’s structure. In addition, a plan for the system upscaling across Gia Lai has been set out by the provincial DOET with the highlight of training sessions and end-of-programme results introduction. Among non-program districts, Pleiku City has taken the primary steps in the development of the replicability and applicability plan of the model in locality. Noticeably, in 2020, MOLISA organized an exchange workshop for provinces nationwide; thereby, opening up opportunities for consulting the way of IECD Programme implementation. On this occasion, nearly 30 other districts did express their desire and practical needs for the model enhancement. This would imply the library’s potential for further scalability in Gia Lai.

- ***Enabling actors at national level have actively engaged in the programme’s expansion nationwide.*** There is a strong possibility for further upscaling the IECD model at national scale, evidenced by the fact that the People’s Committee in all 63 provinces have ratified the Provincial Scheme on Early Childhood Development under the approval

of the National ECD Scheme in 2019. Particularly, from our discussion with representatives of MOET and MOLISA, the national plan for further IECD model replication has integrated all the UNICEF-supported activities and objectives into the annual governance plan. Even UNICEF has put great effort in proposing and back-and-forth discussing with relevant departments for IECD implementation at national scale over time.

- On the side of project provinces, **official staffs at all levels have demonstrated their willingness for the model upscaling to other districts and communes** due to the impressive changes that the programme has delivered. All three provinces have currently progressed towards the summary of end-of-programme achievements and lessons learnt drawn from the pilot model. This synthesis report is expected to serve as a practical cornerstone for the development of Provincial Replication Plan and further revision of the National ECD Scheme by MOLISA. However, the shortage in both financial and human resources could become a major barrier to the IECD-related policy enforcement in the next stage.
- However, ***the Covid-19 pandemic is believed to be a possible impediment to the upscaling process of the IECD programme to some extent***. Since the early of 2020 with the emergence of Covid-19 in Vietnam, many strict and restrictive measures have been implemented by the (social distancing, lockdown, barricades, etc.). According to some key members of PMUs at central and provincial level, Covid-19 will greatly affect the implementation of programme activities when replicating the model on a large scale. For example, the community meetings for parents/caregivers would be postponed in the regions subjected to lockdown or public gathering restriction. In addition, the provincial budget for project activities would be distributed to other epidemic preventive tasks. However, from the PMU's evaluation, Covid-19 pandemic, in fact, may not have a heavy impact on the programme's sustainability as well as the model replication plans at all levels. In the future, the design of the programme's activities is projected to be flexible to adapt with the current context.

2. Are local governments in project locations committed and simultaneously capable of upscaling the IECD operationalization model in other districts?

Summary response: Yes, to a certain extent. Evidence from both qualitative discussion and quantitative survey has implicated strong commitment to replicating IECD operationalization model in other districts across three project provinces.

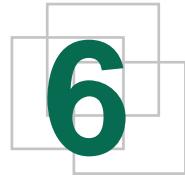
- ***Beneficiaries and official staffs expressed their genuine willingness for participation in terms of the programme's scaling up***. According to the qualitative interview and discussion, the project participants well recognised the benefits that the programme has brought about with regards to ECD related awareness-raising and practices. From the perspectives of project staff in provinces and communes, they showed their strong commitment for upscaling the programme' achievements in the future.

However, in the context of Covid-19 outbreak, most of the local resources would be used with the priority of dealing with Covid-19 rather than for replicating activities.

“ [...] It is our “regular duty” to scale up the program’s achievements so there is no reason for the unreadiness.

KII with the Vice Director of PMU, Kon Tum.

- ***There is firm recommendation from the service providers (leaders of communal PMU, health centres and pre-school) to expand the implementation of IECD model in other localities.*** The endline questionnaire designed for service providers in project provinces asked if they would recommend a similar model in other provinces. Remarkably, 100 percent of the respondents in all three provinces confirmed that they definitely would promote the programme’s scalability at their best capability.



ETHICAL CONSIDERATIONS, GENDER EQUALITY, HUMAN RIGHTS AND EQUITY ISSUES

6.1 Ethical Consideration

In an effort to follow the ethical guidelines and standards set by the UN and UNICEF as mentioned in TOR, the research team has sought to obtain the ethical approval for research involving human participation. The decision for undertaking the study was granted by the Ethical Review Board (ERB) of Hanoi University of Public Health (please see Appendix 3 for further details). The set of documents for ERB submission included: (i) Research proposal that details the overall objectives and methodologies applied in the studies, (ii) CVs of the study's researchers, (iii) general information of the study provided for participants and (iv) consent form. There are some crucial factors that the research team has taken into consideration during the study implementation, including: participants' benefits and harms, consent, barrier of language, personal privacy and compensation. The procedure for applying ethical consideration will be demonstrated in detail as below.

Informed consent

The research team encouraged the respondents' decision to involve in the study on a voluntary basis. There is no explicit or implicit risk so that the potential respondents can be fully informed of their roles. Prior to the interview, enumerators will inform potential participants to read and sign a consent form, which provides the information about (i) evaluation's objectives, (ii) implementing agent, (iii) duration of the study, (iv) participants' roles, (v) potential benefits and risks arising from their involvement in the study, (vi) personal information privacy and (vii) emergency contact information. In addition, the respondents will be also informed and ensured about the confidentiality of data information and all information and allow them to withdraw from answering the question whenever they feel uncomfortable to respond. In some cases where the interviewees cannot speak Vietnamese fluently, the enumerator asked a local person to interpret. To ensure personal privacy, local interpreters were required to commit to confidential agreement as regulated by MDRI. Particularly, in case of interviewing children, the permission will be sought from both the primary caregiver as well children themselves. It will be operationalized by the provision of a written consent form to be signed by representatives or heads of households or primary caregivers.

Anonymity

The anonymity of the participants maintains the safeguard in both quantitative (household and service provider survey) and qualitative study (KIs and FGDs). Prior to the interviews, they will be informed that their answers are for research purposes without revealing their identities to external parties. The research team will be responsible for the confidentiality of participants' information sharing during the interview. The interview data then will be saved on password-protected computers and be encrypted for confidential protection during the process of data clearance and processing. This means that the names and other identifying information of study participants will not be stored securely and safely from unauthorized access.

Privacy

The research team took the responsibility to preserve the privacy of participants during the data collection process. We also took necessary measures with an attempt to ensure that the participants were not vulnerable or controlled by other individuals, particularly in sensitive contexts. For the FGD, the discussion will be implemented without the presence of their superiors or leaders in the village or commune. This could encourage an open and comfortable environment for participants in opinion-sharing and avoid the reluctance in their response to the evaluation questions related to the IECD programme. In addition, the FGDs will be held separately for each gender group, in order to avoid the dominance of males to females in ethnic minority culture. Other pictures and audio materials throughout the data collection process were taken upon the participants' agreement and will be disclosed to external parties.

Respect for participants

The research team always demonstrated our respect to the participants and their answers given during the interview without any judgement or opinion expression. All their perspectives were well-recorded and taken into consideration in the evaluation process. Besides, we also took cultural sensitivity as a crucial dimension to be concerned when implementing the research with EM people. Specifically, when conducting the interview, the research team attempted to build an inclusive environment for all to equally share their opinions, in order to diminish the inferiority and avoid the domination arising during the discussion. Being aware of the different identity of each ethnic minority group, the research team respected all the distinctions in their belief, customs and practices.

Harms and/or benefits realized

The study has minimal risks, which may be from the stress generated by the tension throughout the interview. In order to minimize participants' pressure from answering the questions (related to IECD/ECD programmes, their usual practice of parenting, caring children, service providers of education and health in the community), they were advised to answer as best as they can and if they do not want to answer one or more of the questions, they can choose not to answer them. Moreover, the research team paid as much effort as possible to mitigate any potential risk and to ensure none of researchers or enumerators in the fieldwork are exposed to unacceptable lives of risk. Prior to the fieldwork, the research team prepared the insurance for all staff and enumerators to deal with the potential risks associated with travel and work in the fieldwork, particularly with the emergence of Covid-19 in project areas.

Regarding the benefits, there are no direct benefits to the respondents as a research subject other than compensation for their time. However, the results obtained from this study may be useful for UNICEF Viet Nam in understanding the context of project provinces as well as prepare for their advocacy of the IECD model at national level.

Compensation

The respondents will receive a reasonable compensation for their time to participate in the study, based on the research team's previous experience from baseline assessment and local consultation about payment. Additionally, the research team's compensation will not distort potential participants' decision to take part in the study or their responses given. Due to the fact that, the compensation will be provided after the interview or FGD is completed.

6.2 Human rights, child rights, gender and equity

6.2.1. Human rights and child rights-based approaches

The design of the IECD programme is coherent with Human Rights Based Approaches (HRBA) to programming. The programme is designed to enable concerned duty bearers and right holders to fulfil rights to survival and development of the child, employing an integration approach as the success strategy to help children have better a start and reach their full potential.

To be specific, IECD interventions in three thematic areas are considered to fulfil some basic human rights that have been recognised by law, including the rights to healthcare, the rights to have access to basic social services, and the rights to education.

The Programme is also one of the vehicles that UNICEF Viet Nam and the Government of Viet Nam utilised to promote children's rights, i.e. children's access to basic services in a holistic manner and opportunities to reach their full potential. This approach is appropriate since Viet Nam was the first country in Asia and the second country in the world ratifying the United Nations Convention on the Rights of the Child. In addition, Viet Nam has also actively implemented the Declaration issued by the World Summit for "Child Survival, Protection and Development" and the Declaration adopted by the UN General Assembly, "A World Fit For Children".

Last but not least, a facet that demonstrates the Programme's alignment with HRBA is through the addressment of the needs of duty-bearers when it comes to capacities. The duty bearers at national and local level have been properly trained and empowered to educate and sensitise their communities (including the right holders) of their responsibilities and entitlements.

6.2.2 Equity

The IECD programme's coherence with equity principles is highlighted in various aspects. One of them is the priority in the selection of specially disadvantaged communes. Three selected provinces represents the lowest levels of development across spectrum development indicators related to children such as nutrition, access to safe water and hygienic latrines.

The programme interventions such as improving parents' knowledge, skills and practices in childcare or health care for pregnant women have brought benefits to its target population, regardless of their gender, ethnicity and background. Ethnic minorities were greatly involved in programme implementation to ensure their participation and voice. For example, in many communication sessions, information was explained in ethnic languages by the local collaborators.

6.2.3. Gender issues

In the baseline report, we applied the Women's Empowerment Framework by Longwe to look at gender issues in the IECD programme. This framework identifies what women's equality and empowerment would mean in practice, hence is useful in determining to what extent a development intervention supports greater empowerment, based on the concept of five levels of equality as shown in [Figure 75](#). Our analysis showed that the emphasis of the programme was at three levels, from Access to Participation: increasing women's access to healthcare services, their self-confidence and capacity in childcare, along with their participation in

decision-making processes. In the endline, we examined gender issues again through these aspects to understand how the programme's emphasis on gender had worked out.

Figure 75. The Women's Empowerment (Longwe) Framework



Source: Gender Toolkit, UNICEF Office of South Asia

Access

As indicated previously in the endline assessment's findings, the IECD Programme contributed to the improvement in female beneficiaries' welfare, specifically their access to maternal healthcare services. Firstly, the ICED programme was found to generate a number of positive impacts on the antenatal care coverage in general in the project areas. The endline results indicate a 17 percentage point increase in the percentage of pregnant women receiving supplementation, compared to baseline (Indicator 6). In terms maternal health check-up, notably, in Dien Bien and Kon Tum province, the endline rates of women aged 15-49 with a live birth in the last 2 years who were attended at least four times by health care providers grew larger by 9% and 11% respectively (Indicator 24). The proportion of women who attended at least one antenatal visit also increased from 80% to 84% after three years of the programme. There has also been a decrease in the percentage of women with no prenatal check-up throughout the last pregnancy from 20% at baseline to 16% at endline. Secondly, in terms of birth delivery, the proportion of women giving birth at a health facility has increased by 7,3 percentage points after the programme's interventions (Indicator 25). In addition, the percentage of women who were attended by skilled health personnel during labour increased from 55.2% to 61.3%, while only 1% went through a delivery without any assistance. These indicators clearly manifested the programme's efforts in tackling the gender issue of women's access to maternal healthcare services in rural areas.

Conscientisation

At the conscientisation level, we look at the programme's focus and impacts on the awareness of rights, gendered roles, and divisions of labour, equality. As pointed out in the baseline report, the IECD Programme focuses on the engagement of both parents into child care and development to raise the beneficiaries' awareness of gendered roles. The programme's

interventions encouraged the participation of not only mothers but also fathers in antenatal care, and in child-rearing through the parenting classes.

However, as evident from the informants' sharing during the programme evaluation, the participation of fathers in the parenting classes was still much lower than mothers, which reinforced the gendered roles of women as the sole responsible person in taking care of children aged 0-8, including feeding, protecting, and educating them. Two main reasons were found to be the cause of fathers' low participation in the programme's training activities. Firstly, gendered roles and the divisions of labour, which assigned women with child-rearing and men with income-earning roles, were still deeply ingrained in the mind-sets of the local people. A commune leader in Muong Mun, Dien Bien shared that in their commune, the proportion of mothers in IECD training sessions was normally about 70%, and the main reason for this gender imbalance was that the fathers would shy from these activities because they saw this as the mothers' business, not theirs. This perception regarding gendered roles was also found in Kon Tum, where fathers participating in a FGD admitted that it was mostly the mothers who attended the IECD clubs. Even when the mothers shared what they learnt from the training, the fathers would not pay too much attention since they perceived child-rearing to be mostly the mothers' responsibilities. This suggested changing the deep-rooted mindset of the local people on the exclusive role of women in child-rearing is a difficult task that could take a long time to have an impact. Thus, it would require more focused interventions to target this issue.

Secondly, the fact that the training classes for parents were organised during daytime in some localities also discouraged fathers' participation. Some KIIs and FGDs in Dien Bien and Kon Tum revealed that since the fathers often had to go to work during daytime, they could not attend the parenting club even if they wanted to. Thus, it was recommended by the informants that these sessions should be organised in the evening so that fathers could also attend.

Participation

As analysed in the baseline report, the IECD programme's attention to increasing women's participation was evident in its engagement of the Women Unions in the implementation of the programme's activities from the beginning. Specifically, the Women Unions was a member of the project management group, managed the parenting club activities, and coordinated with other focal points. The Women Unions' active participation provided a chance for local women to share their daily issues about family planning or reproductive health.

However, although the women's participation in the IECD programme was a commendable achievement and could encourage women to participate in other community issues, in some surveyed localities, women's participation in the local affairs was still low. As shared in an FGD with mothers in Kon Tum, the women rarely took part in the village's meeting, except for when the discussion concerned childcare. This again highlighted the perception of women as the sole responsible person for childcare, as well as undermined the women's role in the community.

“ *We have monthly meetings organised by the village head, where he invites community members to come to talk. If it is related to childcare, then the mothers would go, if not then the husbands would go.*

FGD with female caregivers in Kon Tum.



IMPACTS OF COVID-19 ON THE PROGRAMME IMPLEMENTATION

7.1. Impacts on the achievement of results in key programme components

Healthcare component (Child health and Maternal health)

The emergence of Covid-19 pandemic has put intense pressure on the healthcare service providers' workloads. Handling with tasks of Covid-19 control and preventive measures has become the centre of attention within the provincial healthcare system, taking most of the staffs' working time. This, therefore, induced an interruption in the periodic medical check-ups for children and pregnant women. The group discussion with Gia Lai PMUs recognised current situation that the outburst of Covid-19 across local areas hindered the undertaking of acute malnutrition management as planned. More specially, under the normal context, a core team of communal healthcare staffs used to take charge of measuring children's heights and weights for further assessment of their stunting rate, by which the staffs would give advice to caregivers on nutritional supplements to children. Moreover, according to communal staffs, cases of local parents having been in quarantine camp for 2 weeks would also be a contributing factor to the malnutrition percentage in 3 provinces since they could not take care of their children during this period. To investigate how the pandemic affects the socio-economic conditions among households, the endline survey asked if the household's earnings changed and if they worried about not having enough food to eat amid the Covid-19 outbreak. The results showed that half of surveyed households have suffered from the reduction in their total income, with almost none of households claimed to have their earnings increased ever since the pandemic arrival in Vietnam. Food security is currently of major concern to majority of households in surveyed areas, recorded by 73.67 per cent of those expressed their anxiety about food insufficiency in the future. Another impact of Covid-19 pandemic on the healthcare component in project areas should refer to the fact that no expanded IYCF training has been conducted for health workers at the village level, leading to the decrease in the number of IYCF counselling-qualified health workers (as mentioned in Indicator 11).

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[...] Covid-19 has lots of effects on not only communications campaign but also the beneficiaries' economic situation. The price of foodstuffs has been rising, while parents has turned to be unemployed for a long time, having not enough money to buy food to maintain dietary portion for their children as guidance.

FGD with PMU representatives in Tuan Giao district, Dien Bien.

“ Since 2019, the Covid-19 pandemic put severe impact on our household's economic situation and mental health. Our total earning, in general, has limited in value, while our mental state has been deteriorated from every aspect.

FGD with male caregivers in Dien Bien.

Even though most of the indicators reflecting the healthcare services for mothers achieved positive improvement in terms of nutritional supplementation for pregnant women, child delivery and prenatal care check-ups, the pandemic still has posed some potential challenges to maternal health development in project areas. From the observations of communal health centre leader, the percentage of local women giving birth or having prenatal examination at health facility had a tendency to decrease in the year 2021 due to their fear of infection, thus making them feel more reluctant when getting access to healthcare system.

“ When the pandemic happened, people seemed to be reluctant to take prenatal check-ups or give birth at health facility. They only came to health centre when things became really urgent.

FGD with PMU representatives in Dien Bien.

Education component

Among the key components within the scope of IECD Programme, the development of some indicators in education sector faced up with significant challenges presented by the outbreak of Covid-19. At the time of conducting qualitative interview with PMUs at all levels (from provincial to communal level), it was reported that only students from primary schools and above could have a chance to study in face-to-face mode, while those attending kindergarten or nurseries had to stay at home with their caregivers. This could be primary explanation for the lower rate of literacy-numeracy learning than other domains among children aged 36-59 months, considering the school closure and limited school attendance during Covid-19 period (refer to Indicator 20). In addition, staying only at home in a long time would cause some potential mental and communication-related issues to children under 6 years old, according to most of representatives working in education sector. For example, without playing with their peers, children may be less likely to open their hearts or feel confident to express their thoughts or feelings. Their study in a short term could be distracted due to the lack of strict supervision from their teachers or unstable network connection. On the side of the caregivers, it seems that they merely do not spend much time playing or teaching their children, partly because they are busy working in the field all daytime.

“ *In the normal context, when attending schools, children have a chance to participate in many activities including sports event, school clubs, etc, but all these activities have been cancelled under the impact of Covid-19 across the province.*

FGD with PMU representatives in Dien Bien.

However, the Department of Education in all three UNICEF-supported provinces has taken great efforts to propose teaching plans to adapt with the “new normal” situation, applying in different ways based on the pandemic level. A specific teaching plan was mentioned by the principal of kindergarten in Kon Tum that:

- At the first-level pandemic: Conduct face-to-face learning mode
- At the second-level pandemic: For children aged 5 years old, divide class into small groups of students and no lunch will be conducted at school. For those below 5, the teachers will design syllabus as guidance for parents to teach their children at home
- At the third or fourth-level pandemic: Conduct self-study at home for children with support from teachers via video call

Despite of all the efforts to prepare for adaptation plan, the infrastructure and household socio-economic level still cannot meet the requirements for remote learning, presenting huge challenges to the educational quality. Given that the programme has undertaken in one of the most extremely difficult regions, a large amount of local people cannot have access to mobile phone or internet, so that online learning is quite unfamiliar with households in these provinces. The application of teaching method and even extracurricular activities via online platform seems to be far from practical scenario.

“ *Covid-19 pandemic put negative influence on the quality in education sector. Dien Bien is a mountainous region and the infrastructure here still cannot meet the requirement for online learning. Statistically, up to 75% of the student in Dien Bien reported to be unable to join online learning due to not only the under-qualified infrastructure system but also the shortage of necessary devices. Besides, their study would be severely affected by the unstable internet connection or external distractions.*

FGD with PMU representatives in Dien Bien.

Child protection component

When looking at the performance of child protection component in project regions, the occurrence of Covid-19 since 2020 appears not to bring up any serious matters to its improvement, but difficulties to providing beneficiaries with child protection services have been fully aware by the staffs at all levels. The restrictive measures, including the ban of public gathering, would constitute impediment to organising communications activities or trainings for

beneficiary caregivers. The process of approaching and making lists of vulnerable children such as those suffering from violence, abuse or neglect amid Covid-19 pandemic could not be provided timely as a result of limited opportunity to visit household in person, which is considered to be necessary when providing children-related interventions, particularly in the disadvantaged regions. This helps gather the information of disadvantaged children from various sources (e.g. parents/ caregivers, relatives or neighbours), directly storing data in the form of media or photos for the completion of case management profiles. The widespread of Covid-19 pandemic since 2020, in fact, restricted case managers from visiting beneficiary households, and also became the primary reason behind the local residents' hesitancy to report the case-in-need promptly.

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The programme has only five years of implementation, but it takes two years of operation under the Covid-19's impact. This put a negative impact on the provision of child protection service for children, which requires meeting children in person for information collection. Currently we only get information through indirect sources, but most of the time this method would bring up only imprecise information. From my own experiences, this limitation could lead to the decrease of approximately 60 to 70 per cent in the quality of case management.

FGD with PMU representatives in Mang Yang district, Gia Lai.

From the initial design of qualitative tool, the research team desired to explore if there are any unexpected consequences arising from Covid-19's impacts to the rate of children suffering from violence, abuse or neglect. Nearly none of participating communes and districts in qualitative study recorded any significant changes in this figure, except for the case confirmed by child protection staff in Mang Yang district (Gia Lai). The staff highlighted the fact that during 5 years of working, no case of child abuse has been reported from communal level but the case of two children as victims of domestic violence occurred in 2021. In this case, the act of violent was perpetrated by their drunk fathers, who recently became unemployed as a result of Covid-19 pandemic.

7.2. Impacts on the programme implementation

Since the early of 2020, Vietnam has witnessed the widespread of Covid-19 pandemic at national scale in an unpredictable way. A package of containment measures has been implemented to mitigate the adverse impacts of Covid-19, one of which includes the restriction of travel and public gatherings. This situation did bring about many challenges in the implementation of the IECD programme, especially communication activities that require a large group of about 20-30 caregivers to participate. With the social distancing order being imposed, the organisation of group communication activities has been cancelled. Home visit to provide multi-micronutrient package or vulnerable children counselling and prenatal check-ups has experienced the interruption in frequency due to the concern about health safety of local residents. Furthermore, the UNICEF staffs seem to have struggle arranging monitoring and fieldtrip to project locations.

Above all, the programme did manage to make some necessary adjustments during the implementation period as an adaptation plan in the context of Covid-19 pandemic. To be specific, instead of organising communication activities in large groups of nearly 30 people, some project communes came up with the idea of subdividing into smaller groups of 5-7 participants and integrating the parenting knowledge for caregivers when they brought their children to health centres for periodic immunisation. Meanwhile, other communes switched to indirect communication through loudspeakers and written materials or provided telephone counselling for children-in-need. Besides, a core team of local collaborators in child protection and key staffs in healthcare and education based in village was established to take the supporting role even in case of lockdowns. Although all the adjustments above demonstrated a certain level of flexibility to adapt with the contextual changes, the effectiveness of communication activities still did not satisfy the programme's expectation as under normal condition due to the uncontrollability in the number of people reached and insufficiency of key messages delivered.

With great effort to implement remote monitoring, most of the monitoring and coordination activities have been switched from offline to online. In response with the environmental changes, UNICEF invested in digital equipment for PMU and provincial partners to conduct online meetings/training so that the frequent operational activities were not interrupted abruptly. In fact, according to PMUs in three provinces, the means of communication and coordination between stakeholders at different levels have currently been taken via common only platforms, such as Zalo, Facebook or Zoom Meeting. At the time of endline survey, almost all communes conducted brief meetings on regular basis and others reported to change their mode of meeting to online recently. However, communal staffs claimed that they still have to confront with many difficulties in supporting service provision and staying in contact with beneficiaries, particularly in remote areas without the cell phone coverage.

8

LIMITATIONS

Almost every challenge previously faced in the baseline assessment has been well avoided by the research team thanks to thorough fieldwork preparation. However, the COVID-19 pandemic affected how the quantitative and qualitative fieldwork took place. This section outlines the challenges posed by the pandemic and how the research team tackled them.

8.1 Quantitative Study

Enumerator training

In following the national regulations on Covid-19 prevention and for the safety of the research team and survey team, there were two major challenges faced by MDRI with regards to enumerator recruitment and enumerator training. First, due to the tightened traveling restrictions imposed on external people, **100% of enumerators employed in the endline survey were local residents** of the three project provinces. Therefore, the data collector team includes both experienced enumerators selected from MDRI's network in tandem with beginners who had never conducted household surveys first-hand. To equip these newcomers with adequate interviewing skills and attitudes, our research team managed to group them with highly competent enumerators who either participated in the baseline survey or possessed similar experiences.

Second, also due to social distancing rules, **the training mode was forced to switch to online** (through Zoom), which caused both the trainers and the trainees many difficulties. Besides the arising technical issues related to unstable Internet connections during training, the lack of face-to-face interactions when practicing/lecturing was truly a major shortcoming that disrupted participants' concentration and comprehension. In order to mitigate the anticipated limitations of virtual training, MDRI recorded every training session and uploaded all materials used in class (presentation slides, documents, exercises, videos, etc.) in a shared folder immediately after each day. We also created a Q&A thread (through GG sheet) so everyone could pose their questions pre-, during, and after the sessions. Last but not least, in-class practices, homework and tests were made the most use to track trainees' understanding of delivered contents. However, despite the mentioned efforts, it is important to acknowledge that the quality of online training could not be compared with an interactive, face-to-face one; putting heavier load on the role of monitoring and supervising enumerators' survey performance.

Fieldwork survey area

Shortly before the beginning of the quantitative fieldwork, there were newly emerged Covid cases in K'Bang district of Gia Lai province. This leads to the local authority's decision to suspend the entire evaluation activities in the locality. Upon multiple discussions with all stakeholders, it was mutually agreed that the situation is beyond UNICEF and MDRI control, and therefore K'Bang district was excluded from the endline assessment, which resulted in the cut down of the sample size from 27 communes (1080 households) to 24 communes (960 households)

Statistically, this omission did not have a major impact on the overall evaluation, but may have some adverse impacts on the performance of Gia Lai province in some specific indicators that are linked to characteristics of K'Bang area.

Fieldwork supervision

Due to Covid-19 preventive measures, the research team was deprived of travelling to the survey area for fieldwork supervision. Therefore, it is a necessity that research team strengthen other methods of quality control, specifically audio supervision and phone back-checking. In sum, **the research team listened to 10% of the total number of household responses (97/960) through audio supervision and called back 30 survey respondents** for the sake of data quality control.

8.2 Qualitative Study

The pandemic also made the research team conduct 27 KIIs and 12 FGDs virtually. **The team understood that online KIIs and FGDs have certain disadvantages, especially when involving grass-root levels (parents/primary caregivers).** For example, some participants may feel camera-shy, thus not being as much comfortable and present as in a person-to-person situation. Also, because person-to-person interactions such as eye contact or body language or the use of visual aids is limited, some activities for FGDs with lay people were omitted – resource map, flow diagram, transect walk. The research team's not being able to conduct qualitative fieldwork also hinders our opportunity to gain practical observations and insightful look into the life of beneficiaries, partially affecting the comprehensiveness of this assessment. Last but not least, due to the physical and technical constraints of online FGD, the number of participants in each FGD was limited at 3-5 (instead of 6-8 people).

Despite those obstacles, the team still tried our best to successfully finish the qualitative study both in terms of quantity and quality, with special thanks to the cooperation and coordination of programme personnel at all levels (province, district, commune, and village).





9

CONCLUSION, LESSONS LEARNT AND RECOMMENDATIONS

The evaluation adduced conclusive and convincing evidence that the IECD programme implemented in Dien Bien, Kon Tum, and Gia Lai has been a successful project in terms of both achieved results and worthwhile lessons for national scale up.

Achievement of results

Quantitatively, the Programme has been effective: most indicators at endline showed progressive improvement compared to its benchmark values in all thematic areas. First and foremost, both maternal health and child health have greatly improved in its status, with the former witnessing a high level of increase in its related indicators and the latter seeing a considerable reduction in stunting rate in combination with an improvement in age-appropriate nutrition. Second, with regards to education, capacity-building for educators at both national and provincial levels resulted in the broad adoption of tools and teaching methods that foster responsive care and social – emotional learning for children, raising the overall awareness of the significance of the early years to one's lifelong development. Besides, some good models like Growing with music and Community based child friendly libraries have been documented and endorsed for provincial widespread implementation. Third, in the area of child protection, the system has been enhanced and fortified in comparison to prior years, comprising of staff who have been professionally trained and can perform case management. Moreover, both awareness and practice of non-violent child discipline has experienced an increase from baseline, indicating a gradual shift toward responsive parenting. On the other hand, there were some areas that did not show as impressive performance as the others at the time of the endline evaluation, namely IYCF or early stimulation. The total time of interventions affected by Covid-19 could be a factor to consider in this case. During 39 months of programme implementation, only 27 months happened under normal conditions. For example, in the year 2021 alone, no expanded IYCF training was conducted for village health workers as planned, due to the impact of the Covid-19 pandemic.

Speaking specifically of province partners, apart from the indicators that increased from baseline in all three provinces and/or did not have a major gap across provinces (ie: WASH, child awareness, child development), **it is interesting yet also surprising at the same time to see that each province demonstrated its own strength in some particular areas.** For instance, Dien Bien, even though lagging behind in most indicators, still rose high and surpassed the other two provinces in a number of key indicators including non-violent child discipline practices and IECD perception. Kon Tum had quite a steady performance overall, yet most notably in maternal health, early stimulation and responsive care. Gia Lai's case is rather unpredictable in the sense that this province did not follow the same upward/downward trend as the other two in many areas. For example, although there has been a decrease in the number of healthcare workers who are able to perform IYCF (Indicator 11) or in the number of children receiving age-appropriate nutrition and early stimulation/learning from parents

(Indicator 18) in both Dien Bien and Kon Tum, the reverse happened in Gia Lai. This observation should indicate that it is important to understand and study the potential of each province so that we could share not just the mere result numbers but also the unique experience and lessons learnt from each other.

Enabling environment

The IECD programme has played a valuable role in capacity building for the local actors as well as fostering cross-sectoral coordination mechanism, which clearly reflects a betterment in the provision of comprehensive childcare and child development services. For example, child protection officers who can perform all the steps in case management have doubled in number after three years in the three supported provinces. 22 out of 27 preschools in the three projects provinces (equivalent to more than 80%) are capable of providing all four early learning/stimulation services. Interdisciplinary engagement is present in the programme management board and in many activities – group communication, consultative meetings, holistic parenting clubs, and so on. More importantly, participants in the qualitative KIIs and FGDs including government representatives, service providers, and parents/primary caregivers exhibited a great level of support towards early childhood development and improving early-years nurturing care system for children.

There has been continuing improvement in the access and quality of IECD services thanks to the strong political will and determination of the local governments, service providers, and programme collaborators in all three project provinces. To be more specific, the number of communes having functioning IECD services and the proportion of ECD centres providing integrated ECD services has clearly increased since the baseline. The child protection systems from provincial to grass-root level have also been established and reinforced in accordance with the national standards.

In addition, **although signs of inequality in ethnicity, educational attainment, and living standards still persist across almost all indicators, the “integrated” system of early childhood development initiated and strengthened throughout the past four years does help gradually narrow the gaps between the privileged and the underprivileged**, evidenced by the outperforming of disadvantaged groups in indicators related to child development (Indicator 20), early breastfeeding (Indicator 21), skilled birth attendance (Indicator 23), among others.

On efficiency

From the project implementation perspective, financial resources were utilized efficiently, resulting in the achievement of most important objectives. In details, three provinces managed to achieve improvement in at least two thirds of the quantitative indicators within the established timeframes and costs.

On sustainability & scalability

Moving forward, it is highly likely that the results and benefits brought about by programme-related interventions are maintained for an extended period of time after the end of the programme's cycle. A number of IECD-related indicators on health, education, and child protection have been integrated into the final approved SEDPs of Dien Bien, Kon Tum, and Gia Lai for the 2021 – 2025 period. Another key factor contributing to programme's sustainability is the fact that a great amount of interventions focuses on capacity building at

both national and subnational levels, which creates a high degree of community ownership and participation. There is also concrete evidence that certain core elements of the IECD programme have been replicated and scaled up in non-programme areas. Examples include the replication of case management systems for child protection in Dien Bien or the widespread development of the community-based library friendly to children in Gia Lai, among others.

Lessons learnt

Following the key success and the positive results, unresolved challenges and critical lessons learnt deserve special attention.

First, despite the improvement in many indicators, it was not enough to reach the endline target, many of which were set at 100%. Therefore, when up-scaled nationwide, the objectives must be set to be extremely sharp, focus, and highly practical. The design of action plans needs to carefully consider financial factors. Clear communication about budget/costing should be made early to avoid modifications of the targets for being overly ambitious as well as to make sure all parties are stayed on track.

Second, human resources must be further leveraged. Despite a strengthened system of child protection compared to baseline, the popularity of child protection officers among children themselves does not seem to have improved much. Furthermore, the matter of how to sustain the knowledge and skills acquired in UNICEF-supported training courses irrespective of changes in the personnel apparatus also needs to be well thought out.

Last but not least, the importance of the local languages cannot be overemphasized. Even though the percentage of people who can speak/read Vietnamese is high in most communes, it does not mean the level of comprehension can be as high. Many ethnic minorities can only understand a few simple words in Vietnamese if spoken slowly, thus their ability to absorb information in their non-native language is very limited.

Recommendations

The evaluation team has compiled the following recommendations based on evaluation findings and conclusions. The recommendations are presented separately for each type of stakeholders, considering their roles, interests and capacity to strengthen systems for improved governance. However, the shared objectives between all parties involved are to deepen the partnership, expand funding and other support, where possible, and otherwise protect the resources provided.

| # | Duty bearers | Recommendations | Priority |
|------------------------|-----------------|--|--|
| By stakeholders | | | |
| 1 | UNICEF Viet Nam | Organize multistakeholder conferences to use the programme evaluation results to inform policy and suggest future adjustments from the strengths and weaknesses of the pilot model; This includes working with the three provinces to identify successful lessons and discuss ways to turn plans to maintain and replicate programme's outcomes into concrete actions; | Immediate (3 to 6 months) to medium- term (7 to 24 months) Short- to medium-term (7 to 24 months) |
| | | Continue to invest in capacity building activities for relevant stakeholders when possible, especially in the area of health and nutrition; | Short- to medium-term (7 to 24 months) |
| | | Technology can be further leveraged in order to generate more widespread impacts. It would be strategic to make good use of technology in order to eliminate geographical barriers to people living in remote and isolated areas, such as various local social media channels (zalo, viber, facebook etc.) and other social media devices could be used for disseminating IECD messages. | Long-term (2 to 3 years) |
| | | The design of any future programme should take into accounts cross-cutting issues like climate change, economic shocks, and gender equality. | Long-term (2 to 3 years) |

| # | Duty bearers | Recommendations | Priority |
|---|---------------------------|--|--------------------------|
| | | In order to establish highly practical and not overly ambitious objectives, it is important to carefully consider financial factors and pay greater efforts in doing costing for each intervention package. | Long-term (2 to 3 years) |
| 2 | The Vietnamese government | Continue to foster coordination between sectors and across levels in order to optimize resources and highlight the role of a holistic approach in IECD; This could be done through Government's enforcement of the implementation of the inter-ministerial circular on cross-sectoral collaboration of IECD which has been signed among concerned ministries. | Long-term (2 to 3 years) |
| | | At national level, ministries and agencies should prioritize the needs of the underprivileged in disadvantaged areas in order to reduce regional disparity, when developing policies and allocating resources to provinces. Thereby realizing development goals in a more focused manner. Support for vulnerable populations can be more resource intensive and diverse in methods. Resources should be distributed based on the local context, in regard of the level of people's socioeconomic backgrounds and status; | Long-term (2 to 3 years) |
| | | Simplify project administrative and financial procedures and cut down on cumbersome regulations required during programme implementation to reduce unnecessary burdens created by bureaucracy and paperwork; | Long-term (2 to 3 years) |
| | | Work closely with UNICEF to provide technical guidance to 63 provinces during the implementation of Decision 1437/QD-TTg regarding early childhood development scheme | Long-term (2 to 3 years) |

| # | Duty bearers | Recommendations | Priority |
|---|---------------------|--|--|
| 3 | Provincial partners | Continue to develop concrete action plan to sustain achieved results as well as to replicate IECD models in non-program areas. <ul style="list-style-type: none"> Promote the exchange of knowledge and experience between intervened and non-intervened communes; Interact with the central government and relevant stakeholders for IECD-related policy feedback | Immediate (3 to 6 months) to medium- term (7 to 24 months) |
| | | Maintain and nourish the enabling environment for IECD at provincial, district, commune and grass-roots level; <ul style="list-style-type: none"> Mobilize financial resources from diverse sources to allocate adequate funds for committed plans; | Long-term (2 to 3 years) |
| | | Encourage and support the use of ethnic languages in all communication materials targeting the ethnic minorities who have limited cross-cultural interactive opportunities. | Long-term (2 to 3 years) |

By programme components (Government of Viet Nam)

| | | | |
|---|---------------------------|--|--|
| 4 | Nutrition & Health sector | Internally review the effectiveness of IYCF training and mobilize more funds to organise IYCF training for healthcare workers at village levels in future programme | Medium (7 to 24 months) to Long-term (2-3 years) |
| | | Diversify communication materials and channels (ie. visualised infographics) to reach more people in remoted areas | Medium (7 to 24 months) to Long-term (2-3 years) |
| | | Provide technical guidance for the central government and provincial partners to design nutrition strategy and healthcare programme including costing and financing, in alignment with international standards | Medium (7 to 24 months) to Long-term (2-3 years) |
| 5 | Education sector | Gather feedback from relevant stakeholders during the application of GGA tools/ECDS for further improvement | Immediate (3 to 6 months) to medium- term (7 to 24 months) |

| # | Duty bearers | Recommendations | Priority |
|---|-------------------------|--|--|
| | | Conduct communication campaigns to raise public awareness about the importance of socio-emotional learning as well as other development domains in early childhood education | Medium (7 to 24 months) to Long-term (2-3 years) |
| | | Organise sharing sessions (online – offline) between national and foreign experts to learn from each other's experience | Long-term (2-3 years) |
| 6 | Child protection sector | Develop specific strategies and action plans to popularise the role of child protection officers, particularly at local levels | Immediate (3 to 6 months) to medium- term (7 to 24 months) |
| | | Increase the number of functioning Social Work Service Centres applying national standards | Long-term (2-3 years) |
| | | Continue to promote gender-responsive parenting programme including non-violent child discipline through multiple media channels and other effective education platforms | Medium (7 to 24 months) to Long-term (2-3 years) |



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APPENDIX

Appendix 1: Term of Reference

Terms of References

An Institutional Contract

Survey and Formative Evaluation of the Integrated Early Childhood Development Programme

| | |
|---------------------|--|
| Title | Survey and Formative Evaluation of the Integrated Early Childhood Development (IECD) Programme |
| Purpose | To (i) collect data on the IECD 'programme's situation in a qualitative and quantitative manner based on of the benchmark indicators and to (ii) evaluate the' programme's effectiveness, efficiency, scalability, and sustainability. |
| Location | Three project provinces of Dien Bien, Gia Lai and Kon Tum, Viet Nam |
| Duration | December 2020 – Oct 2021 |
| Start Date | December 2020 |
| Reporting to | Mr. Nguyen Huy Du , Acting Chief of CSD, and Ms. Ngo Thi Quynh Hoa , Chief of PME, UNICEF Viet Nam |

Background: Integrated Early Childhood Development (IECD) Programme

Early childhood, from conception to the first eight years, is the period when the brain develops most rapidly and most dependently on both enriching and adverse environments. Early years of childhood form the basis of intelligence, personality, social behavior, and capacity to learn and nurture oneself as an adult. Many children do not reach their full human potential because of their 'families' income status, geographic location, ethnicity, disability, religion, or sexual orientation. They do not receive adequate nutrition, care, and opportunities to learn. These children and their families can be helped. It is their right to develop as well as to survive.

UNICEF globally calls for greater integration and synergy across sectors to support integrated programming for children at different stages of the life cycle. The current UNICEF Strategic Plan recognizes specifically the critical importance of the early years on the basis of the latest evidence on the science of brain development: "*New scientific research on brain development has brought fresh evidence of the critical importance of early childhood development for future learning achievements, health outcomes and productivity, and the cumulative nature of deficits*"¹. An integrated approach to early childhood development (IECD) is not only a global but a national priority in Viet Nam as set forth in the Law on Children 2016. IECD will help the country to achieve a high quality of human capital from the early years of human life, a pre-requisite for sustainable development. The newly endorsed Law on Children 2016 introduces a number of improvements as compared to the Law on Protection, Care and Education of Children, 2004. Holistic childhood development is articulated in almost key chapters on specific child rights and state duties. However, holistic early childhood development and rights to early childhood development are not adequately stipulated with legally binding duties and measures for enforcement. The Ministry of Labour, Invalids, and Social Affairs is responsible for coordinating sectoral policies and programmes among concerned ministries and agencies on childhood care and development, which implicitly includes holistic early childhood development. However, there is no coherent, comprehensive Early Childhood Development policy nor an effective coordination mechanism on ECD¹ while it is recognized as an on-going policy initiative about the establishment of Viet Nam Committee on Children with political support from the highest level in the Government. Recent economic progress has improved the well-being of millions of Vietnamese children, but not all have benefited equally from such prosperity. There is equity in access to preschool by gender and ethnicity, but it does not necessarily translate into improved learning outcomes for all children. According to the data published by the General Statistics Office (GSO) and UNICEF in 2014, 96.8 % of children in Grade 1 of the primary

¹ Asian Development Bank (2006). Recommendations for Early Childhood Development in Viet Nam. Period 2006-2010 and the vision toward 2020.

Appendix 2: List of people interviewed in qualitative study

| Location | Organization | Department / Position |
|---------------------------|---|--|
| National level (Hanoi) | Ministry of Labour, Invalids and Social Affairs | Department of Children Affairs |
| | Ministry of Education and Training | Department of Early Childhood Education |
| | Ministry of Health | Department of Maternal Health and Children |
| | UNICEF Vietnam | Managers of Integrated Early Childhood Development Programme |
| | World Vision Vietnam | Zonal Program Manager North 1 |
| | Save the Children Vietnam | Education Program Manager |
| | Child Fund Vietnam | Education Specialist |
| Dien Bien Province | Key Informant Interview | |
| | Provincial IECD PMU | Vice director of Dien Bien provincial PMU |
| | DOLISA | Programme officer of DOLISA Dien Bien |
| | Commune-level IECD PMU | Vice president of Muong Mun commune |
| | Commune-level Child Protection | Child protection officer in Muong Mun commune |
| | Commune-level Pre-School | Pre-school principal in Muong Mun commune |
| | Commune-level Health Centre | Leader of health centre in Muong Mun commune |
| | Focus Group Discussion | |
| | Representatives of province-level PMU | Representatives of PMU in Dien Bien province (DOLISA, DOET and DOH) |
| | Representatives of district-level PMU | Representatives of PMU in Tuan Giao district (DOLISA, DOET and district-level health center) |
| Kon Tum Province | Male caregivers' focus group | Male caregivers in Muong Mun commune (Tuan Giao district) |
| | Female caregivers' focus group | Female caregivers in Muong Mun commune (Tuan Giao district) |
| | Key Informant Interview | |
| | Provincial IECD PMU | Vice director of Kon Tum provincial PMU |
| | DOLISA | Vice director of DOLISA Kon Tum |
| | Commune-level IECD PMU | Vice president of Dak Glei town |

| Location | Organization | Department / Position | |
|------------------|---------------------------------------|--|--|
| Gia Lai Province | Commune-level Child Protection | Child protection officer in Dak Glei town | |
| | Commune-level Pre-School | Pre-school principal in Dak Glei town | |
| | Commune-level Health Centre | Leader of health centre in Dak Glei town | |
| | Focus Group Discussion | | |
| | Representatives of province-level PMU | Representatives of PMU in Kon Tum province (DOLISA, DOET and DOH) | |
| | Representatives of district-level PMU | Representatives of PMU in Dak Glei district (DOLISA, DOET and district-level health center) | |
| | Male caregivers' focus group | Male caregivers in Dak Choong commune (Dak Glei district) | |
| | Female caregivers' focus group | Female caregivers in Dak Choong commune (Dak Glei district) | |
| | Key Informant Interview | | |
| | Provincial IECD PMU | Programme officer of Gia Lai provincial PMU | |
| Kon Tum Province | DOLISA | Programme officer of DOLISA Gia Lai | |
| | Commune-level IECD PMU | President of Kon Chieng commune | |
| | Commune-level Child Protection | Child protection officer in Kon Chieng commune | |
| | Commune-level Pre-School | Pre-school principal in Kon Chieng commune | |
| | Commune-level Health Centre | Leader of health centre in Kon Chieng commune | |
| | Focus Group Discussion | | |
| | Representatives of province-level PMU | Representatives of PMU in Gia Lai province (DOLISA, DOET and DOH) | |
| | Representatives of district-level PMU | Representatives of PMU in Mang Yang district (DOLISA, DOET and district-level health center) | |
| | Male caregivers' focus group | Male caregivers in Ayun commune (Mang Yang district) | |
| | Female caregivers' focus group | Female caregivers in Ayun commune (Mang Yang district) | |

Appendix 3: Ethical approval obtained by the research team



SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness

Hanoi, October 22th, 2021

DECISION

On Ethical approval for research involving human subject participation

THE CHAIR OF THE ETHICAL REVIEW BOARD FOR BIOMEDICAL RESEARCH
HANOI UNIVERSITY OF PUBLIC HEALTH

- Based on decision No. 732/QĐ-DHYTCC by the Dean of Hanoi University of Public Health on the Issuing Regulation of the Institutional Ethical Review Board of Hanoi University of Public Health; October 18th, 2021;
- Based on Decision No. 560/QĐ-DHYTCC by the Dean of Hanoi University of Public Health on Establishment of The Institutional Ethical Review Board of Hanoi University of Public Health; June 01st, 2021;
- Based on the minutes of meeting to review ethics application No. 021-379/DD-YTCC dated October 22th, 2021

DECIDED:

Article 1. Grant ethical approval for ethnographic study project:

- Study Title: **Survey and Formative Evaluation of the Integrated Early Childhood Development (IECD) Programme**
- Principal Investigator: **Phung Duc Tung**, Mekong Development Research Institute (MDRI)
- Research site: Dien Bien province, Kon Tum province and Gia Lai province, Vietnam
- Project time: from 13/4/2021 to 31/12/2021
- Data collection time: from 01/11/2021 to 14/12/2021
- Review type: Full review

Article 2. This decision is effective from 22/10/2021 to 31/12/2021

Article 3. Principal Investigator must report to IRB (The Institutional Ethical Review Board) about any change and risk associated with closing the research implementation. Active research projects are subject to random inspection by the IRB of HUPH

CHAIR OF HUPH IRB
(Signature and full name)


Nguyen Thuy Quynh

SECRETARY
(Signature and full name)


Vu Thi Hau

