WVI VIETNAM COVID RECOVERY ASSESSMENT REPORT

AUGUST 2020

World Vision
VIET NAM

Acknowledgements

This report would not have been possible without teamwork and dedication from several resource persons who contributed invaluable time, ideas, and wealth of experiences.

On behalf of the assessment team, we would like to express sincere thanks to all those who participated in the field work for this assessment, and in particular to the girls, boys, men and women in the 35 participating districts who willingly participated as survey respondents and key informants.

Most importantly, we would like to acknowledge the invaluable assistance and support received from the local authorities, especially the Provincial People's Committee, District and Commune Program Management Boards (PMB) of the 35 districts who made a significant contribution during the entire data collection period.

Special thanks go to the enumerators who conducted the survey and field interviews especially from the district, commune and hamlet partners and World Vision staff from various Technical Programs, Area Programs, Units, Zones and Departments. Sincere appreciation is also owed to World Vision Vietnam Zonal and Area Program Managers, the Operations Director-Dr Than Thi Ha, the Program Quality and Resource Development Director-Mr. Dan Mtonga, the National Director-Mrs. Tran Thu Huyen and all Support Offices for their leadership and support during the course of the recovery assessment preparation, execution and ongoing utilization of the assessment results.

This assessment was conducted to generate information that will be used to guide the planning, adaptation and performance management of the ongoing interventions in response to COVID-19, strategic decision making, fundraising and supporting policy level discussions with partners.

The assessment was conducted by World Vision and partners comprising the People's Committee of District/ Ward/ Commune and various departments, Women's Union, Youth's Union, Farmer Groups, Department of Labour, invalids and Social Affairs, Child Protection Committee, and community members including children across 35 Area Programs.

On behalf of the Assessment Team,
Nguyen Van Hoa and Vu Thi Thanh Chung-Program Effectiveness Unit, August 2020

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ACRONYMS

AP	Area Program
BCC	Behavior Change Communication
CLTS	Community led Total Sanitation
CPMB	Commune Project Management Board
CS	Child Survey
CSO	Community Social Organization
CWD	Children with disability
DOLISA	Department of Labor, Invalids and Social Affairs
DPMB	District Project Management Board
DRR	Disaster Risk Reduction
GC	Global center
HEA	Humanitarian and Emergency Affairs
HHS	Household Survey
HWTS	Household Water Treatment and Safe Storage
KII	Key Informant Interview
LLA	Local level advocacy
LQAS	Lot Quality Assurance Sampling
MFI	Microfinance Institutions
MFU	Micro Finance Unit
MVC	Most vulnerable children
ODK	Open Data Kit
NO	National Office
PEO	Program Effectiveness Officer
PES	Program Effectiveness Specialist
PEU	Program Effectiveness Unit
PWD	People with disability
RC	Registered children
TP	Technical Program
TPO	Technical Program Officer
ttC	Timed and Targeted Counseling
VRVC	Vietnam Association for Protection of Children's Rights
WASH	Water, Sanitation and Hygiene
WVV	World Vision international in Vietnam

EXECUTIVE SUMMARY

COVID-19 has affected almost all economic sectors in Vietnam. The unemployment rate in Vietnam is the highest it has been for the last 10 years and has especially affected workers with few professional qualifications. According to the Vietnam General Statistics Office, as of June 2020, 30.8 million people aged 15 and over had been negatively affected by the epidemic, including those who had lost their jobs, had been forced to take leave, reduce their working hours or accept a reduction in their incomes.

The Vietnamese government implemented measures to contain the spread of the virus. A National Steering Committee for Prevention and Response to COVID-19 was set up to lead an inter-ministerial, inter-provincial response. The response interventions included strict travel restrictions, setting up quarantine areas, temporary closure of public services and non-essential businesses, and providing free health treatment for confirmed cases. On April 9, the national government also launched an emergency financial support program worth an estimated VND 62,000 billion (equivalent to USD 2.6 billion) to provide immediate support to people impacted by the virus, especially the employees who lost their jobs from 1st April to 30th June 2020.

Significant findings

Livelihoods

According to the Vietnam General Statistics Office, as of June 2020 the nationwide 30.8 million people aged 15 and over had been negatively affected by the COVID-19 epidemic, including those who had lost their jobs, been forced to take leave, had reduced working hours or reduced incomes. Among them, approximately 17.6 million people suffered from reduced income due to the disease, accounting for 57.3% of the total number of affected people. This category does not include people who lost their jobs or had their hours reduced. The service sector has been the most heavily affected, with 72% of workers affected, followed by the construction industry with 67.8% of workers affected, and agriculture, forestry and fisheries with 25.1% of workers affected.

The survey results also showed the emergence of new group of poor and vulnerable people: casual workers, such as porters and builders labourers and domestic migrant workers. Many workers in these categories lost their jobs as the companies or factories closed due to social distancing regulations. Sole traders and micro-businesses were also affected by COVID-19 due to isolation and restrictions on their businesses.

66.2% of surveyed households identified livelihoods and 51.4% identified food security among their three most significant problems caused by COVID-19. By comparison, only 27.8% recorded medicine & health care among their three most important concerns. 48.6% of respondents reported that a household member had lost work or had their salary reduced due to COVID-19. There was a significant difference in the responses between genders and between respondents living in urban and rural areas.

Water, Sanitation and Hygiene

19.7% of respondents reported not having adequate access to safe water for drinking and cooking and 22.7% stated that their households did not have a toilet that fully met their needs. 42.4% do not have full access to water for irrigation or livestock. Inadequate access to clean drinking and cooking water for daily use increases the risk of waterborne diseases in the community. Lack of access to clean water poor personal hygiene and sanitation also contributes to malnutrition among children, especially children under 5 years old.

While 84.1% of respondents said that soap and detergent are always available in the market, 46.8% found that they could not fully afford these items. In addition, 24.2% did not have access to clean water for cleaning and washing.

Nutrition and Health

Approximately 39% of respondents recorded not having any food reserves at all, 30% had less than one month of food in reserve and 31% had enough food for over a month. Five percent of respondents noted they had to sell productive assets to pay for household consumption during the pandemic.

16.2% of adults and 7.7% of children ate less than three meals per day at the time of the field survey. Apart from skipping meals, in order to cope with the food shortage, 49.5% of households reduced quantity and quality of their meals. 28.6% had a diet which did not include protein rich food and 25% ate meals which did not contain energy dense foods, such as oil, nuts and sugar.

16.3% (CI: 15.00-17.5) of respondents stated that they or their family member had experienced physical illness since COVID-19 and satisfaction with basic health services had decreased slightly compared to before the virus. 30.6% (CI: 29.1-32.1) had limited access to essential medicines. Access to hospital services decreased by 5.1% (from 80.7% decreased to 75.6%) and access to community health centers decreased by 2.7% (from 83.4% decreased to 80.7%) compared to pre-Covid.

Child Protection and Education

39.2% parents or caregivers have difficulty coping with or believe they cannot at all cope with their children's behavior, many parents reacted negatively when their children misbehaved, including shouting and threatening (20.6% of children and 30.1% of parents reported those behaviors) or physical punishment (reported by 33.3% of parents).

During several months of social distancing to prevent COVID-19, schools closed and students were required to stay home. Outdoor activities and play between children of different families were also restricted. Many children felt stressed, bored or worried about themselves and their families getting sick. 29.3% of surveyed children stated that they felt stressed and 63.6% were worried about themselves or their family. There was no prior COVID-19 data for comparison. In some remote areas, some interviewed teachers said that due to long-term absence from school, some students forgot what they had learnt at school, and some did not want to return to school or even wanted to drop out of school completely.

> "The long absence made some ethnic minority children drop out. Teachers had to go to their families to encourage their children to go back to school after COVID-19. Children missed school for a long time so they forgot a lot and it created pressure for the teachers".
>
> *(KII, Women's Union Representative, North 2)*

Access to information

Both the household and child surveys show that almost everyone has received updated information about COVID-19, regardless of whether they are at home, work or school. The main information channel is broadcast media (94.4%) and updates from relatives and friends (90%).

Key recommendations

- Continue to provide direct support of food and prevent acute malnutrition
- Focus on livelihood activities which support casual workers to find alternative sources of income
- Consider support and/or advocacy on occupational health and safety for those involved in high risk work
- Partner with local government, MFIs and CSOs to develop financial counselling services
- Work with MFIs to develop debt consolidation services
- Facilitate discussion and planning on water management within communities and between government and communities.
- Prioritise water and hygiene facilities in health programs
- Prioritise positive parenting programs by developing ongoing support to compliment training and workshops. This could be initiated by training specialists among the teachers, health workers and Child Protection Committees (CPCs).

BACKGROUND

The COVID-19 pandemic caused by SARS-CoV-2 virus was first confirmed in Vietnam on January 23rd, 2020[1]. As of 31st Aug 2020, Vietnam had recorded 1040 cases and 32 deaths. 695 patients had recovered and 313 cases were being treated in hospital. In terms of the prevalence of COVID-19, on 31st Aug Vietnam was ranked 160th from 215 countries worldwide and 6th out of 11 countries in Southeast Asia[2].

Since the outbreak of the disease in January, the Vietnamese government has implemented measures to protect against the spread of the virus in Vietnam by implementing quarantine measures, tracking and restricting movement to and from virus hotspots, closing schools from January 20th through until early May and closing borders with China from 1st February, closing borders with other countries (Cambodia, Laos) from 1st April. Mass gatherings were prohibited nationwide and some localities implemented additional measures, such as measuring body temperature, providing disinfectant, distributing free masks in public places and tightening other forms of control. Domestic travel and trade was also limited.

The national government has also taken measures to support its population, including through reducing the cost of medical examinations and virus testing. However, like most countries around the world, Vietnam has suffered a significant social and economic impact. Social distancing, self-isolation and travel restrictions have led to job losses across all economic sectors. The need for most non-food commodities and manufactured products has decreased but, in contrast, the need for medical supplies has significantly increased. The food sector also faced an increased demand due to the stockpiling of food products.

Children and disadvantaged members of society are the ones most affected by the socioeconomic crisis caused by this disease. The closure of schools and other educational institutions for more than three months disrupted children's education and increased their risk of being neglected or subject to domestic violence and stress.

In that context, WVI-Vietnam is currently implementing recovery interventions in 35 of its Area Programs as the core of its COVID-19 response. The current response extends until the end of September so an assessment was undertaken in late June to reflect on the current recovery interventions and plan for the phase beyond September 2020. The assessment was led by WVI-Vietnam's Program Effectiveness Unit (PEU) and conducted across all 35 responding area programs (AP). Data collection was conducted from June 20 to 28. The assessment process was guided by WVV's Technical Program (TP) and Program effectiveness (PE) staff at national and zonal levels and carried out by AP staff and local partners as enumerators.

Specific Objectives:

- To assess the overall impact caused by COVID-19 in the programs in which WVI-Vietnam has been implementing a COVID-19 response;
- To assess the recovery capacity of the affected population;
- To identify the needs/gaps that require external intervention or resources.

1. Coleman, Justine (23rd Jan.. 2020). "Vietnam reports first coronavirus cases", https://thehill.com/policy/healthcare/public-global-health/479542-vietnam-reports-first-coronavirus-cases.
2. The official website of Vietnam Ministry of Health (5th July 2020). Updates on COVID-19 outbreak in the last 24 hours, https://ncov.moh.gov.vn/en/-/ban-tin-dich-covid-19-trong-24h-tuyet-oi-tranh-tam-ly-chu-quan-lo-la-mat-canh-giac-voi-dich-benh

METHODOLOGY

The assessment combined quantitative and qualitative methods of primary data collection, for which the three main sets of tools are available upon request: a household survey, child survey, and guiding questions for Key Informant Interviews. Smartphone based data collection using Open Data Kit (ODK) was the primary method for the quantitative surveys and phone or face to face interviews were used for qualitative data collection. Data collection took place in all the target communes of the 35 Area Programs. Secondary data was also used for the assessment, including reports published in the official websites of Vietnam Ministry of Health, Vietnam General Statistics Office and some online newspapers such as tuoitre.vn, thehill.com…

WVI-Vietnam combined the Lot Quality Assurance Sampling (LQAS) which also targeted some of the same respondents with this assessment to avoid going back to the same population several times. For the LQAS survey, 95 or 114 (depending on the program size: 95 Households for Area Programmes having 4 or 5 Supervision Areas and 114 Households for Area Programmes having 6 Supervision Areas) households with children per Area Program were randomly selected. Once a household was selected for LQAS, they were also invited to participate in the COVID Recovery Needs Assessment so at least 95 households per AP were randomly selected for interview in this assessment. No additional households were selected for the COVID Recovery Needs Assessment beyond those who had already been selected for the LQAS survey.

If adults who had any 12-17 year olds responded to the household survey, the children in those houselds were asked to respond to the child survey. As for LQAS, the sample size for the child survey was also at least 95 children per AP. If households did not have any 12 to 17 year-old children or if the child was absent during the survey then the enumerators selected a child from the nearest household in the COVID-19 Response beneficiaries list.

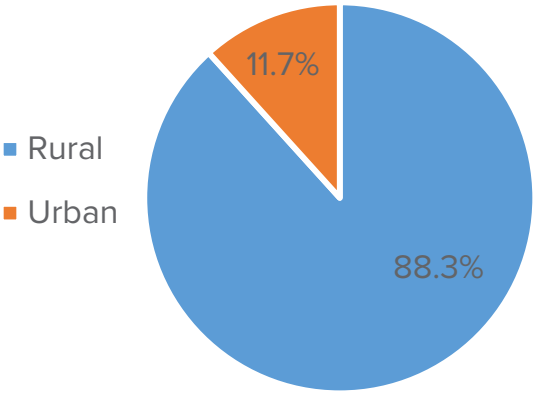
For qualitative data collection, at least five people per World Vision zone and at least one person per Area Program were selected from the list below for in-depth-interviews. Key Informant Interviews (KII) respondents included Commune and District Project Management Board (CPMB and DPMB) members, including Department of Labour, Invalids and Social Affairs (DOLISA) representatives, and community representatives from youth groups, Women's Union, Farmer's Union and the Commune Health Centre. A total of 33 KIIs were completed in the five zones by the zonal staff and Area Program Managers. Most KIIs were conducted by phone.

Table 1. List of KIIs' informants interviewed in the assessment

Key Informant	Quantity	Note
Commune leader	5	Representative from CPMB
Youth group representative	5	Children aged 12-17
District government representatives	4	Representative from DPMB
Commune women's union/rep	5	Women's union chairman
Commune Farmer's union/rep	5	Farmer's union chairman
Community Health Worker	5	Head of communal Health Center
Department of labor invalid and social affair representative	4	Head of District DOLISA
TOTAL	**33**	

Profile of surveyed households

A total of 6,856 participants provided information for the assessment: 3431 for the household survey and 3,425 for the Child Survey. 88.3% of surveyed households live in rural areas and 11.7% live in urban areas. A higher proportion of men than women responded to the household survey and a higher proportion of girls than boys responded to the child survey.

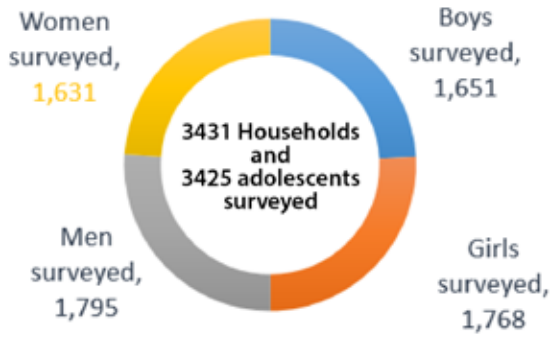


World Vision's current interventions focus on two main groups of children: children under five and children aged 12 to 17. Only children in the 12 to 17 age bracket were selected to take part in the survey. All children aged 12-17 in selected households were interviewed. In case there was a household with 2 or more children aged 12-17 at home, all of them were selected for interview. The age distribution of the surveyed children was evenly spread but the average age for the adults interviewed in the household survey is quite young, with 79% of adults aged between 25 and 50 years.

35 APs surveyed - Random Sampling
88.3% Rural and 11.7% urban

45.8% Registered Children (RC), 37.8% RC Family, 9.0% People with Disability (PWD) or chronically ill member

Among respondents were:
180 Micro Finance Unit (MFU) clients
307 PWD and Children with Disability (CWD)



There were 7,262 children of all ages (boys: 3,853; girls: 3,409) in the surveyed households. The majority of respondents were the head of the household (62.9%). Of the 3,431 adults surveyed, 9.7% were lactating women and 8.9% had disability or were chronically ill members.

Table 2. Distribution of respondents by vulnerable members and household's head

Pregnant woman		Lactating woman		Household members with disability or chronically ill members		Head of the household	
N	%	n	%	n	%	n	%
108	3.2	332	9.7	307	8.9	2,158	62.9

Among the 307 disabled or chronically ill participants in the household survey, 23.5% each were the husband and son in the family, 11.7 were the wife and 17.6% were the daughter.

Table 3. Distribution of respondents by disabled or chronically ill members

Disabled or chronically ill member in surveyed household	n	%
Husband	72	23.5
Wife	36	11.7
Son	72	23.5
Daughter	54	17.6
Other blood relations	73	23.8
Total	307	100.0

Limitations

The national aggregated findings were not weighted to the population of the Area Programs (AP). Sample size was the same across all APs while the population size of APs differ from each other, especially urban APs. It would have been better to analyze the data by assigning weights based on the population size because that would show better representation. However, only 4 out of 35 Area Programs that were surveyed are located in urban areas (Ngo Quyen, Son Tra, Binh Chanh & District 4), so there was no significant impact on the overall results.

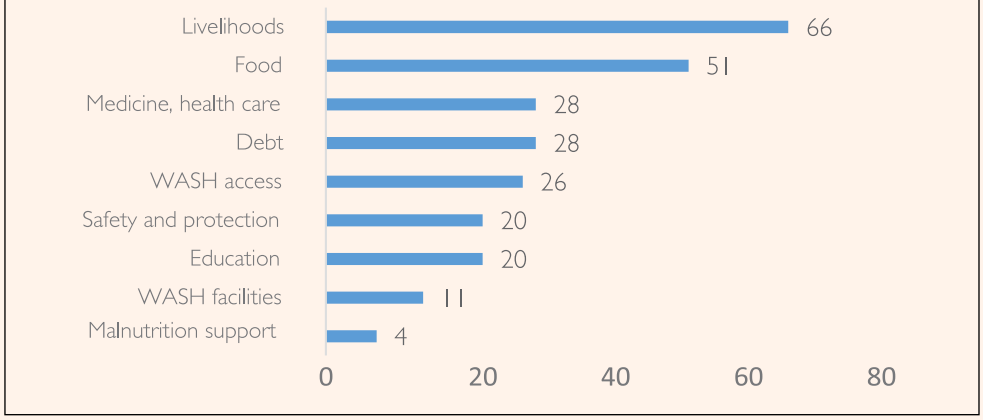
FINDINGS

Loss of Livelihood, Limited Access to Food and Essential Services, and Increase in Physical and Emotional Abuse of children

Findings

Among the 10 surveyed fields presented in the figure below, the largest proportion of respondents considered economic issues among their three most important problems. 66.2% of households identified livelihoods and 51.4% identified food security among the top three problems. Far fewer people, only 27.8%, considered medicine and health care to be a major problem. There was no significant difference in the response of male and female or rural and urban respondents for this question.

Figure 1. Overview of priorities by all respondents (%)



Livelihoods

COVID-19 has affected almost all economic sectors in Vietnam. The unemployment rate in Vietnam is the highest it has been in the last 10 years and is especially high among people with low professional qualifications[3]. According to the Vietnam General Statistics Office, as of June 2020 the nationwide 30.8 million people aged 15 and over had been negatively affected by the COVID-19 pandemic, including those who had lost their jobs, been forced to take leave, had reduced working hours or reduced incomes. Among them, 17.6 million people had a reduced income due to the pandemic, accounting for 57.3% of the total number of affected people. Services have been the most heavily affected sector, with 72% of workers affected, followed by the construction industry with 67.8%. Workers in agriculture, forestry and fishery sectors have had 25.1% of workers affected[4].

The survey results revealed casual labourers and workers who had migrated from their home village to be particularly vulnerable groups as they were most susceptible to losing their jobs as factories and work sites shut down due to social distancing regulations. Sole traders and micro-businesses were also heavily affected due to isolation and restrictions on their businesses caused by social distancing.

> "The majority of households here are poor or near-poor and from ethnic minority groups. Their economic life is inherently difficult. Before the outbreak, some of them sometimes worked part-time to earn more income, but during the time of social isolation they had to stay at home. Without any extra income, their life became even more difficult"
> *(KII, Commune Health Worker, Central Zone)*

3. Mrs Vu Thi Thu Thuy, Director of Department of Population and Labour Statistics, General Statistics Office, https://tuoitre.vn/hon-30-trieu-lao-dong-anh-huong-dich-COVID-19-that-nghiep-tang-20200710104857698.htm. 10th July 2020.
4. Bao Ngoc, "More than 30 million people affected by COVID-19, increased unemployment", Tuoitre.vn, 10th Jul, 2020, https://tuoitre.vn/hon-30-trieu-lao-dong-anh-huong-dich-covid-19-that-nghiep-tang-20200710104857698.htm

48.6% of respondents noted that COVID-19 caused them to lose jobs or suffer from reduced income during the social distancing period. Approximate two-fifths of respondents (41.6%) stated that their income did not change during the outbreak. There was a significant difference between male and female, and urban and rural responses to this question. The proportion of people who lose their jobs or reduce their personal income in women (54.6%) is higher than for men (43.1%) while urban respondents (75%) is much higher than rural respondents (45%).

Figure 2. Income change in the social distancing (%)

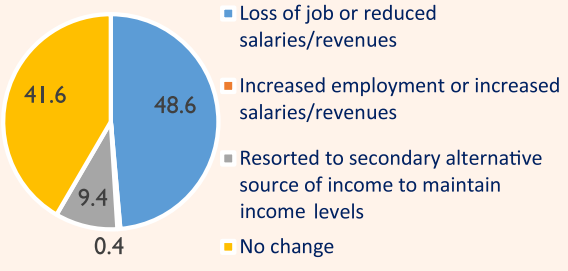
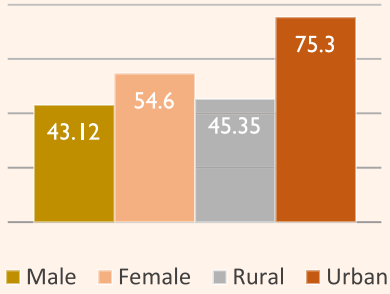


Figure 3. Loss of job or reduced income by gender/community type (%)

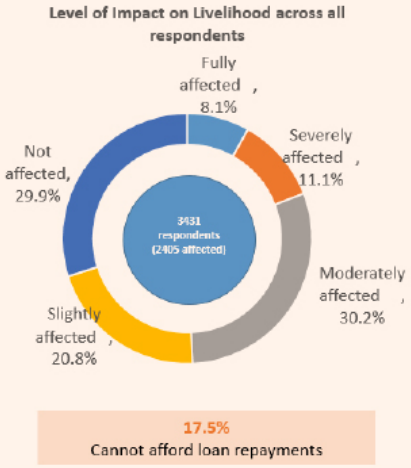


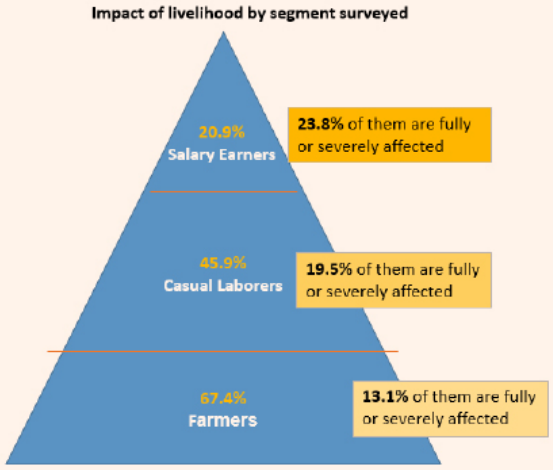
Before the COVID-19 outbreak, agriculture/ livestock (67.4% of respondents), casual labour (45.9%) and salaried workers with regular incomes (20.9%) had been the main sources of income for the surveyed households. When it broke out, 70.1% of households were affected to varying degrees: slightly - 20.78%, moderately - 30.17%, severely - 11.05% or fully affected - 8.1%. Since the majority of the people surveyed were farmers living in rural and remote areas and farming work is often seasonal, the disease's impact on their farming activities was not really significant. Only 13% of farmers were fully or severely affected. The social distancing period from February to April occurred during the time of the year when rice farmers had finished planting and had not yet started the summer-autumn harvest. Some of them stayed home due to the virus when otherwise they would have looked for casual work but by the time of the survey most of their livelihood activities had returned to normal.

> Tho Thanh is a purely agricultural commune and many people work away from home to earn extra money. Due to COVID-19, they lost their jobs and returned to live with their families. Usually 255 people from our commune work away from home but 155 of them were unemployed during the social distancing period. However, it did not affect their quality of life very much because the remaining family members continued farming and the casual workers rarely sent money back every month anyway. They often only sent money back for the Tet holidays. The purely agricultural households were less affected." *(KII, Head of Tho Thanh Child Protection Committee)*
>
> "Cultivation and animal husbandry activities have returned to normal." *(KII, Commune Leader, North 1 region)*
>
> "Work as farm labourers has returned to how it was before but there is now less casual work available in other industries." *(KII, youth group representative, North1)*

The people most affected are casual workers and wage earners in the private sector. Loss of work has naturally affected their incomes. Nearly 20% of casual labourers and 23.8% of private sector wage earners responded that their livelihoods had been fully or severely affected by the disease. A higher percentage of urban respondents were affected - 33%.

> Employees in state-owned enterprises are less affected, but workers in private establishments are affected. Businesses were affected a lot because their production was delayed and there were no customers." *(KII, District PC's representative, North2)*
>
> "Local officials and teachers were unaffected but some people who worked in private companies or casual workers in cities lost their jobs during the COVID period and returned home." *(KII, Lang Chanh district PC's representative)*
>
> "During social distancing, only pharmacies and other stores selling essential items were allowed to operate. Other business activities were temporarily closed so some people working as casuals outside the locality lost their jobs and had to return home." *(KII, District Representative, Lang Chanh AP)*

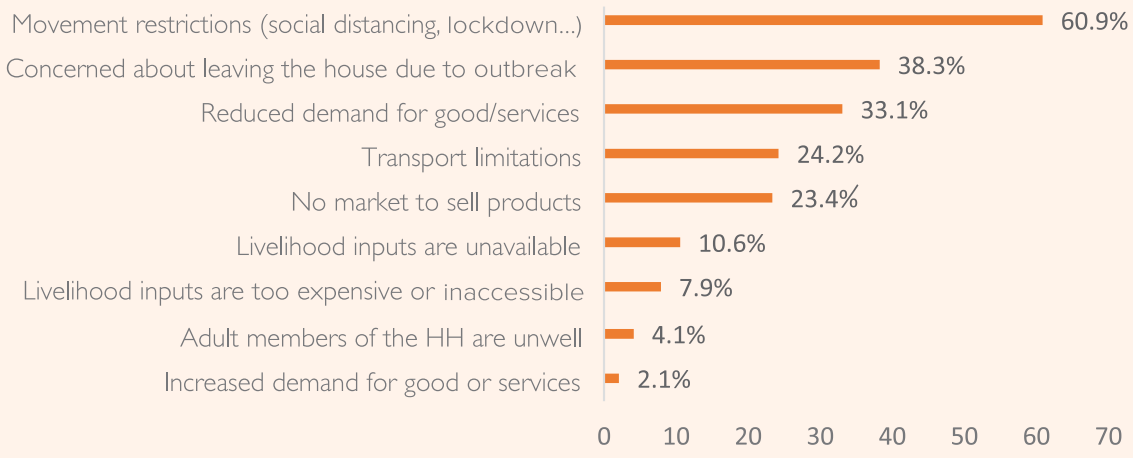




The assessment results also showed that 30.6% of respondents could not afford to pay their rent (rural: 31%, urban: 25%; male: 34%, female: 27%) and 17.5% could not afford to pay their loans on time. In addition, 61.3% of surveyed households had not been able to fully cover food costs and 53.5% had not been able to fully cover cooking costs. However, there is no evidence that COVID-19 was the main cause of these results because most surveyed households were already poor or near-poor households before the pandemic began so it is usual for them to be unable to afford these basic expenses regardless of the virus.

Government regulations on social distancing, including movement restrictions, had the largest impact on livelihoods. Nearly 61% of respondents said that restrictions on movement, such as lockdown or social distancing, were the principal causes of household livelihood distress. Concerns about leaving home due to the outbreak (38.3%), a reduced demand for goods and services (33.1%), no market to sell products (23.4%) and transport limitations (24.2%) also caused some disruption to livelihood activities.

Figure 4. Reasons for disruption of livelihood activities



Among 2405 impacted households as mentioned above (70.1%), 1667 respondents noted that they lost job or reduced salaries/ revenues. To cope with the loss of livelihoods, approximately 33.95% (566/1667) of impacted households could use their savings to cover family consumption, although 70% of this group had less than one month of savings. 41.2% of the affected households borrowed money informally from neighbors, friends or relatives and 40.6% reduced their food intake. This finding shows the importance of saving for poor households. Households without savings were forced to find other ways of coping. 19.1% of respondents whose livelihoods had been affected to the household survey (urban households: 5.8%)) sent their children to work and 11.9% (urban respondents: 3.9%) engaged in high-risk jobs.

Figure 5. Coping with loss of livelihoods

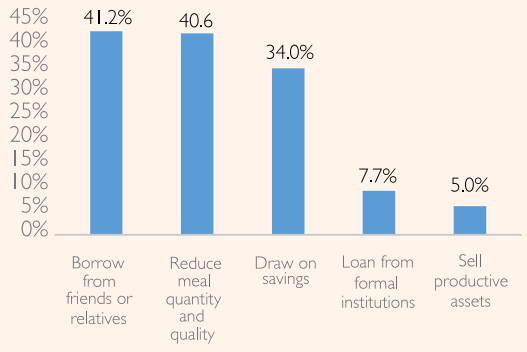
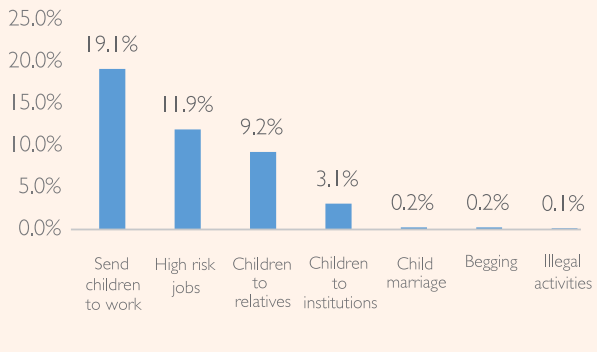


Figure 6. Coping with reduced income



The results show the diversity of coping mechanisms used in response to a loss of livelihoods, some of which increase the risk of child labour and malnutrition.

Most households currently have easy access to local markets to buy food and essential items. 10.6% of respondents said that some medicines were not available but there were no problems with other basic items, such as hand soap. Poor households had difficulty buying masks during the peak of the pandemic due to their high price but the price had returned to normal by the time of the survey.

Figure 7. Availability of essential items in local market (%)

The domestic food supply chain had almost returned to normal by the time of the survey and the ability to meet basic food needs in the domestic market is now quite good. However, the import-export sector is still facing many obstacles due to the effects of the pandemic in many other countries. Since farming is the main source of income for most of the surveyed households, they are largely self-sufficient in rice, vegetables, eggs and meat. Households whose main income earner lost work or had their income reduced due to COVID-19 received cash support of VND 1 million to VND 1.8 million per month from the government for the three months from April to June. On April 9, the national government also launched an emergency financial support program worth an estimated VND 62000 billion (equivalent to USD 2.6 billion) to provide immediate support to the people impacted by COVID-19,

especially the employees who lost their jobs due to COVID-19 from 1st April to 30th June 2020. Accordingly, employees who must agree to suspend labour contract, leave unpaid work for 1 month or more because businesses were facing difficulties due to COVID-19 pandemic were supported with VND 1.8 million per person per month. The employee had the labour or working contract terminated but was ineligible for unemployment benefit and employees without labour contracts lost their jobs were supported VND 1 million per person per month. Poor households and near-poor households according to the national poverty line on the list as of December 31, 2019 were supported with being paid once VND 250,000 per person per month for 3 months, from April to June 2020[5]. By the end of July 2020, localities had approved a list of nearly 16 million people eligible to receive government support with a total budget of over 17,500 billion VND[6]. In addition, the government's response interventions also included providing free health treatment for the Vietnamese confirmed cases.

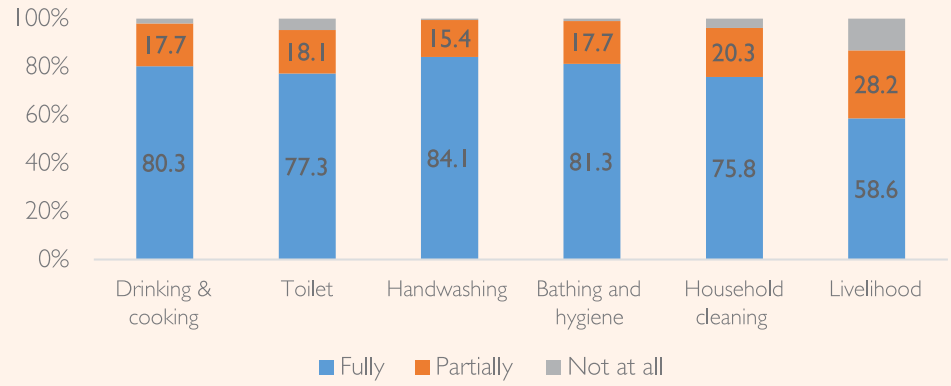
> The market is now easily accessible in the community, not closed for trade and transportation. Necessities including soap and fuel are always available at the grocery store in the commune." *(KII, Commune Leader, North1)*
>
> "There was no change in the local price of commodities. The operation has reopened normally". *(KII, district leader, North1)*
>
> "Currently, the disease is contained thanks to good control measures undertaken by the government. Access to the domestic market is not affected but access to foreign markets is still difficult because of the ongoing impact of the pandemic in many countries around the world." *(KII, Communal Women's Union Representative, Central zone)*
>
> "People here have easy and complete access to food. There is no hunger from a lack of access to food caused by Covid" *(KII, District Leader, Lang Chanh Area Programme)*
>
> There is no significant difference in average household spending on food between the time of survey and one week before the COVID-19 outbreak.

5. Resolution on measures to support people facing difficulties caused by COVID-19 pandemic, Information portal of the Ministry of Health on April 10th 2020, https://moh.gov.vn/hoat-dong-cua-lanh-dao-bo/-/asset_publisher/TW6LTp1ZtwaN/content/chinh-phu-ban-hanh-nghi-quyet-ho-tro-truc-tiep-cho-nguoi-dan-gap-kho-khan-do-covid-19
6. Duc Binh, tuoitre.vn. Proposal for the second support package: 18,600 billion for employees and businesses affected by COVID-19 on Aug 21st 2020, https://tuoitre.vn/de-xuat-goi-ho-tro-lan-2-18-600-ti-cho-nguoi-lao-dong-doanh-nghiep-bi-anh-huong-vi-covid-19-20200821165007435.htm

Water, Sanitation and Hygiene (WASH)

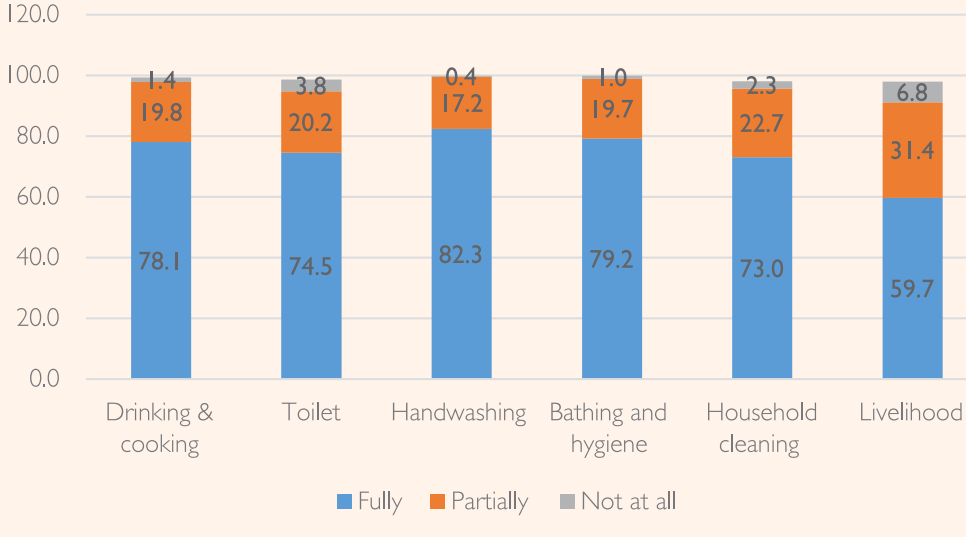
19.7% (male: 22%, female: 17%) of respondents did not have adequate access to clean or safe water for drinking and cooking. 22.7% (male: 25.7%, female: 19.4%) stated that their households did not have a toilet that fully met their needs. 42.4% did not have full access to water for irrigation and livestock. Inadequate access to clean drinking and cooking water increases the risk of waterborne disease. Poor hygiene and sanitation, and a lack of access to clean water also contributes to significant challenges with malnutrition among children, especially children under 5 years old.

Figure 8. Access to clean and safe water by all respondents (%)



There is a significant difference between urban and rural households in terms of access to clean water for basic household needs. Accessibility to clean water in urban areas is much higher than in rural areas for key daily activities. Over 95% of urban households had access to clean water for all their household needs: drinking, cooking, toilet, handwashing, bathing and cleaning.

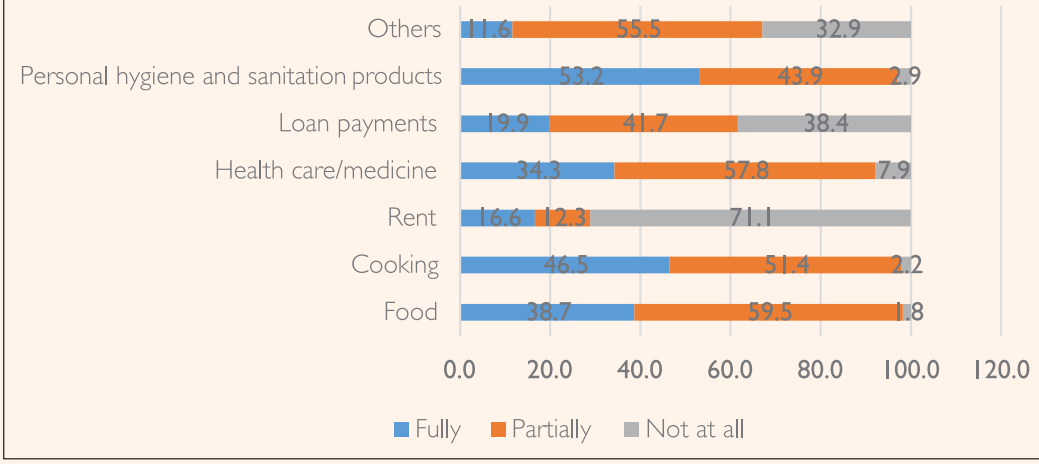
Figure 9. Access to clean and safe water by rural respondents (%)



In the context of a pandemic, the availability of sanitary and hygiene products as well as access to clean water is extremely important and helps reduce the spread of the disease. Although 84.1% of respondents said that soap and detergent are always available (see more details in figure 8), 46.8% reported that that they could not fully afford these items and 24.2% did not have access to clean water for their cleaning and hygiene needs.

> Currently we find it easy to access hygiene items such as masks or hand gels. At the peak of the COVID-19 pandemic, buying face masks and handwashing gel was difficult and their prices were very high, but at this time it was no longer a problem, masks were cheaper and easier to buy"
> *(KII, Commune Leader, South zone)*

Figure 10. Affordability of essential needs by all respondents (%)



Nutrition and Health

Approximately 39% of the households surveyed did not have any food in reserve, approximately 30% had less than one month of food in research and 30.8% had one month or more of food stored. In addition, 5% of respondents noted that they had to sell productive assets to pay for family consumption during the pandemic.

The results show that 16.2% of adults and 6.06% of children ate less than three meals per day at the time of the field survey. Apart from reducing meals, in order to cope with food shortages 49.5% of households reduced their meal quantity and quality (40.6% among urban respondents). At the time of the survey, 28.6% did not have protein rich food in their family's meals and 25% did not have energy dense food, such as oil, nuts and sugar.

Figure 11. Coping with shortage (%)

At the time of data collection, there had been no confirmed Covid cases in the survey areas but 16.3% (CI: 15.00 – 17.5) of respondents noted that they or their family member had experienced physical illness since the outbreak began. 15.9% had limited access to hygiene items like soap and detergent, and 30.6% (CI: 29.1 – 32.1) had limited access to essential medicines. Access to hospital services had decreased by 5.1% (see figure 12) and access to community health centers had decreased by 2.7% (see figure 12) compared to before the pandemic. As for access to maternal support centers, outreach services and traditional medicines, the response rates remained almost the same as before the pandemic began.

Figure 12. Changes in access to basic healthcare services - all respondents

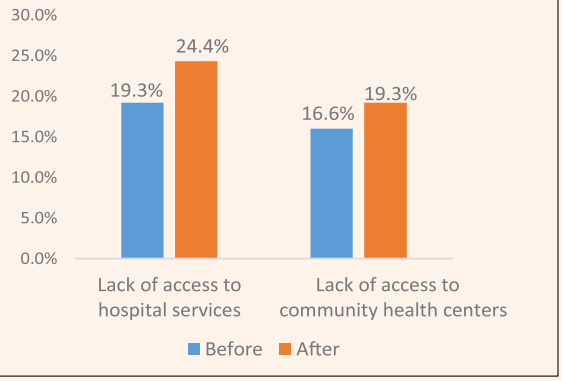
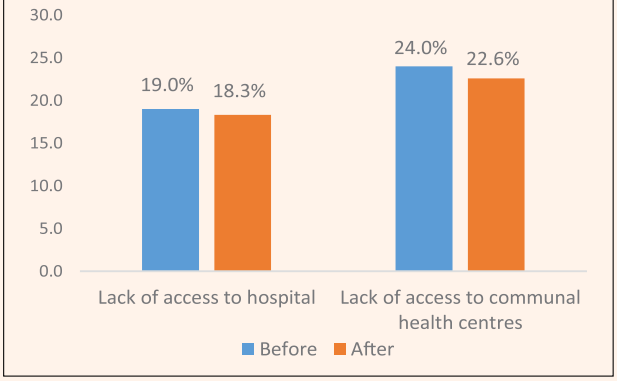


Figure 13. Changes in access to basic healthcare services - urban respondents



While 69.4% of respondents said health care and medicinal products were always available in the market, 65.7% of households indicated that they were struggling to afford the cost of health care and medicine.

Vietnam's health care system operates down to a village level. There is at least one health worker per village who is responsible for providing medical support and information. At the commune level, a health centre is available or accessible 24 hours a day. Controlling people's movement to or from an epidemic area as well as monitoring home isolation are carefully conducted by village and communal health workers and this was shown to be effective during the outbreak of the disease.

> In the locality, there is one health centre, 2 regional clinics and 12 commune health stations. People can fully access these facilities" *(KII, District People Committee's representative, North 1)*
>
> "The health station has been open every day during COVID-19 but even though sometimes I felt ill, I was afraid to go there because I have no money". *(KII, youth representative, North1)*
>
> "Social distancing has been relaxed since April 16th so now people come to clinics and hospitals as normal. Currently the commune is organizing eye exams for local people". *(KII, Communal Health Center Representative, Ba Thuoc Area Programme)*
>
> "Access to commune health stations, district health centres and hospitals is normal. It's unaffected. The Commune Health Center is open 24 hours." *(KII, Youth Representative, Central Zone).*

Child Protection and Education

Children have been among society's most vulnerable groups, both during and after the COVID-19 crisis. They had to stay home for over 3 months during the social distancing period (closing schools from January 20th until early May). Instead of studying in class, children had to learn online. The disturbance in daily activities also entailed many threats to children's safety and lifestyle. The Child Survey results showed that 63.6% of adolescents worried about themselves or their family and 29.3% felt isolated or stressed about the pandemic.

76% of adolescents stayed home from school due to COVID-19. Of those who stayed home, 21.7% were completely or always happy but 32.8% were rarely or never happy. Almost all the youths surveyed understood the reason for having to stay home.

During the three months of social distancing, schools closed and students were required to stay home. Playing activities or outdoor activities between children of different families were also restricted. Many children felt stressed or bored and worried about themselves and their families getting sick. These emotions affected their behavior, making them more likely to have negative behavior. 12.2% of children reported that their siblings and friends showed a negative change in behavior during the COVID social distancing period.

In addition, in some remote areas some students reported forgotting their school work after a lengthy period away from school, which led some of them to not go back to school or even want to leave school.

Figure 14. Extent to which adolescents were happy at home

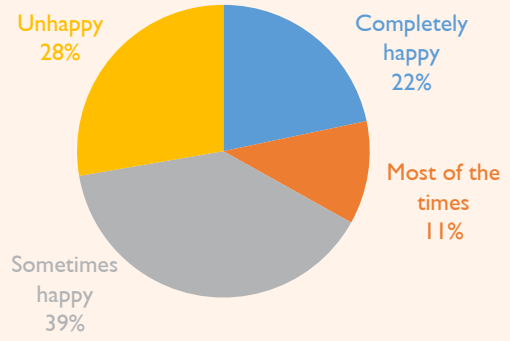
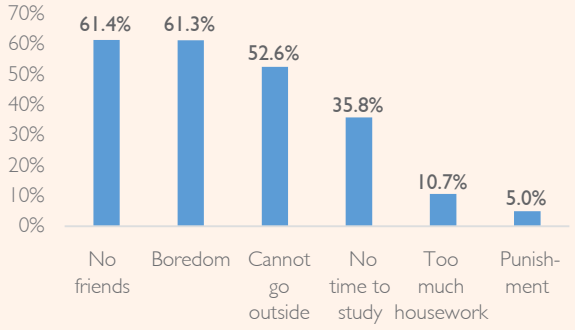


Figure 15. Reasons not happy at home



39.2% of parents or caregivers could not cope with or could only partially cope with their children's behavior. When children misbehaved, parents used negative ways to deal with them, including shouting, yelling, name-calling or threatening (20.6% children and 41.8% parents reported on that behavior) and physical punishment like hitting, beating, slapping or spanking (33.3% parents and 4.97% children reported on these behaviors). This may affect the physical and psychological development of the children. There is a significant difference between the reaction of mothers and fathers towards their children's behavior. The proportion of mothers who reported shouting, or spanking/hitting their children is higher than fathers. On the other hand, there were also some positive outcomes from the pandemic because 73.8% of children said that they felt happy to be able to spend more time with their family.

Figure 16. Means of disciplining children (%)

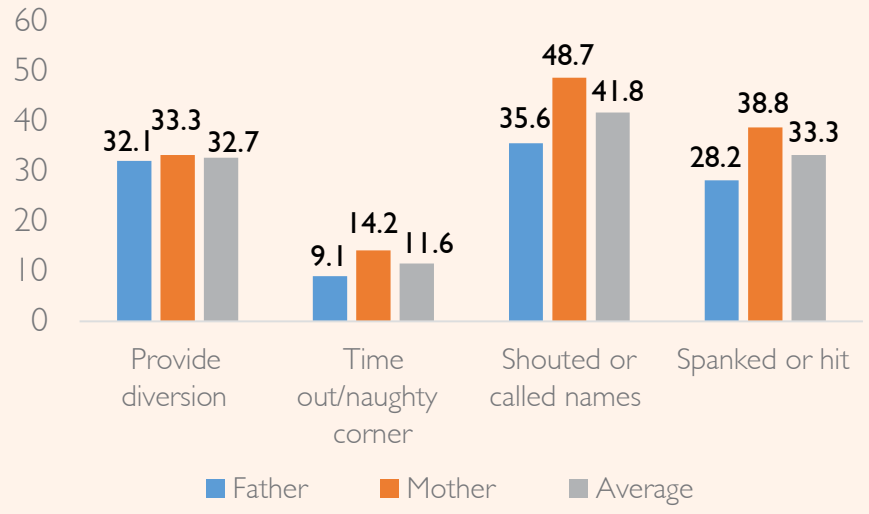
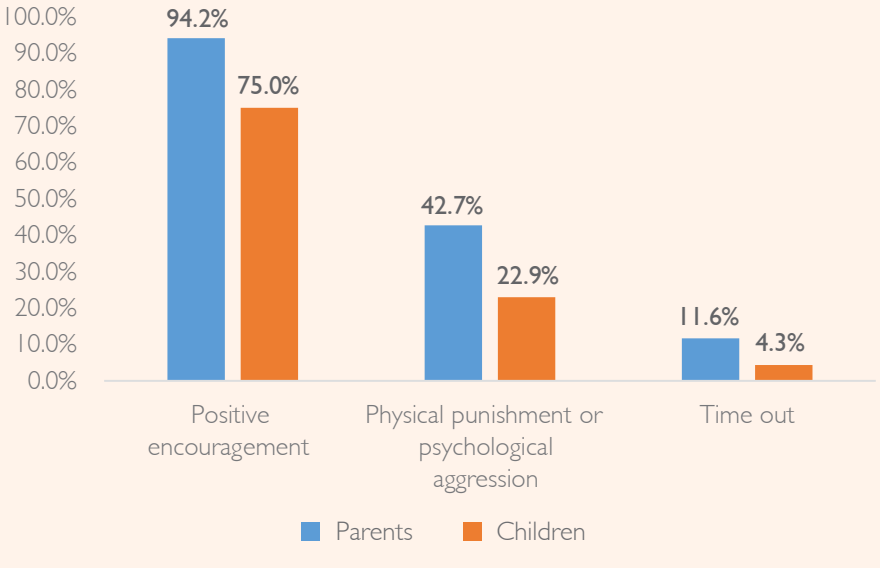


Figure 17. Some differences in responses by age

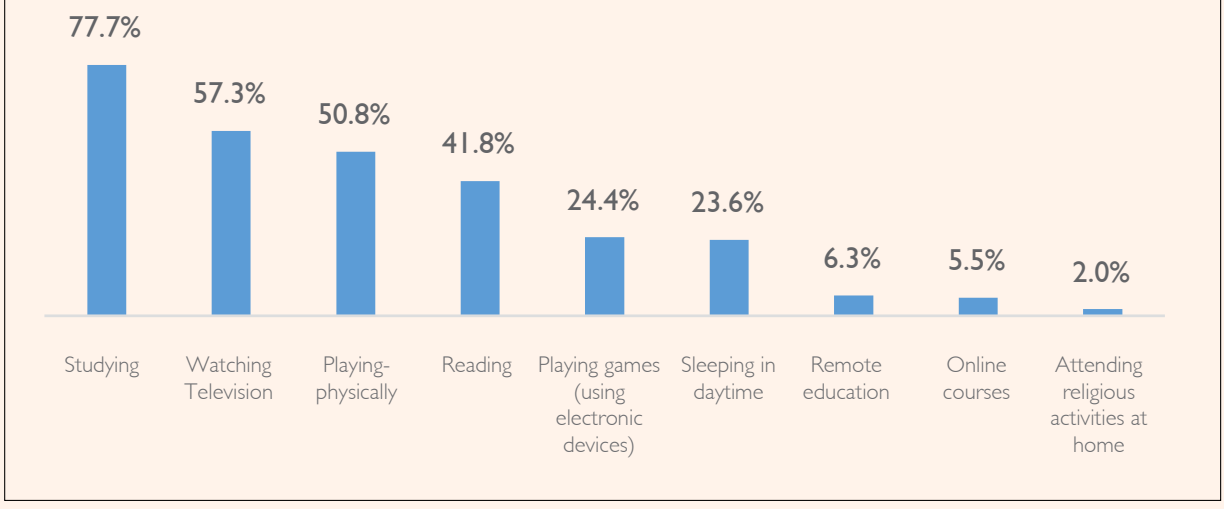


94.2% of household respondents indicated that they provided positive encouragement or had a rational and calm discussion with children when their children misbehaved. This result was similar for mothers and fathers but was significantly lower from the children's perspective (75%). There were some significant differences in the responses of parents and children on disciplinary methods (more details in figure 16) but mostly no statistical difference in responses by gender.

> The closure of schools affected the care and education of children. During this closure, the local authorities sent teachers to some villages to distribute homework to students. Students who lived in town areas or in well-off families could access online learning but poor households don't have a television, smartphone or internet connection so they couldn't take part in online learning courses." *(KII, District People Committee representative, North 1)*
>
> "The 3-month absence from schools caused students to forget about studying, and neglect their studies and homework assigned by teachers through class groups in Zalo or Zoom. Parents still went to work while their children had to stay home so they did not monitor their children. Children who stayed home alone were at a high risk of being drawn into early labor, dropping out of school or becoming addicted to electronic games and watching television." *(KII, Farmer's Union Representative, North 1)*
>
> "The long absence made some ethnic minority children drop out. Teachers had to go to their families to encourage their children to go back to school after Covid-19. Children missed school for a long time so they forgot a lot and it created pressure for the teachers." *(KII, Women's Union Representative, North 2)*

Regarding spending time yesterday, 77.7% of youth respondents had studied the day before the survey, 41.8% had spent time reading and 50.8% had played outside. 57.3% had watched television and 24.4% had played electronic games.

Figure 18. Time spent yesterday



Access to information

Both the household and child surveys show that almost everyone (adults: 92.2%, children: 100%) had received updated information about COVID-19 regardless of whether they were at home, the office or at school. The main information channel was broadcast media (94.4%) and updates from relatives and friends (90%).

Figure 19. Access to COVID-19 Information by household (%)

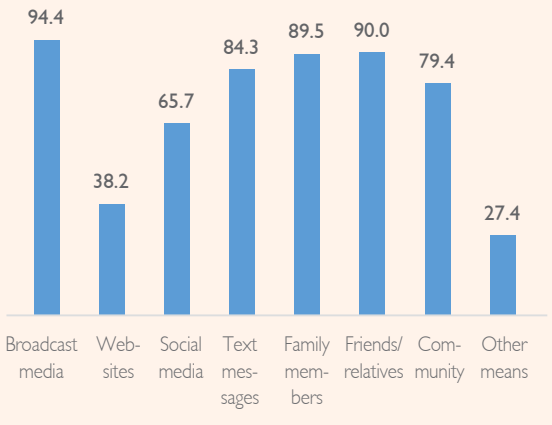
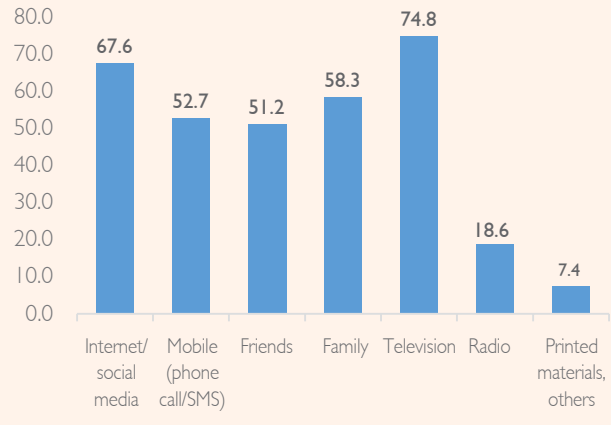


Figure 20. Access to COVID-19 Information by Children (%)



The children stated that they got their information related to COVID-19 through television - 74.5%, internet/social media - 67.6%, family members - 58.3%, friends - 51.2% or phone calls/SMS sent by official hotlines or the government steering committee for COVID prevention - 52.7%.

Cross cutting issues

The new poor and vulnerable groups that emerged due to COVID-19 are casual workers, construction labourers working away from home, and workers in companies, especially in urban areas who lost work because their company closed. These groups lost their jobs due to social distancing, which caused their companies to close or reduce the number of workers, and they had no savings to help them to overcome the sudden drop in income.

> The new poor and new vulnerable groups that emerged due to COVID-19 are unskilled labourers. The reason is that they lost their jobs or their incomes decreased during the social distancing period. Since that period, the government has only provided support to contracted workers and people benefitting from government's policies such as: poor households, invalids and martyr's families, people with disability and orphans, but other groups have not received any government support"
>
> *(Youth Association Representative, Central Region).*

Risks and Constraints

>> Operational constraints:

In the design of the WVI-Vietnam COVID-19 Response Plan, several operational constraints were anticipated and counter measures were applied as follows:

- Temporary suspension of response activities and Area Program office's closure due to compulsory isolation/ quarantine requirements. Social distancing was applied in Vietnam from the end of February and was eased in around early May. Some other social services continued to be restricted until June 9. During this period, a response was still undertaken through distant/virtual facilitation and monitoring by field staff in close coordination and collaboration with local partners and communities.
- Other disasters occurred in some Area Programs during the response period. One of these cases was the drought in Ham Thuan Bac Area Program. In these cases, Area Programs integrated their Covid-19 Response with the response to the local disaster.
- Fluctuation in the price of relief items and other commodities. To reduce the risk, the majority of health care-related relief items were procured centrally and distributed to the Area Programs. A few items were procured locally by the Area Programs based on existing framework contracts.

>> Natural disaster risks and climate change impact

No significant disasters occurred in Vietnam during the assessment period. However, Ham Thuan Bac Area Program suffered from a prolonged drought and areas in the Mekong Delta and South-central Vietnam suffered from saline intrusion. In addition, from the beginning of the year until the end of June, there were 186 whirlwinds, and severe storms were recorded in 40 provinces, 9 of which covered 21 provinces in northern and north-central Vietnam[7]. As a result of these events, 47 people were killed, 1 was missing and 130 were injured. 1,756 houses collapsed, 59,961 houses were unroofed or partly damaged, 108,458 hectares of rice and other crops were damaged and 7,955 livestock and poultry were killed. The total economic loss for that 6-month period is estimated at VND 3,380 billion (around 146 million USD).

In addition to the disasters above, since the beginning of June, a diphtheria outbreak has occurred in a number of provinces in the Central Highlands, where Dak R'lap Area Program is operational. The confirmed diphtheria cases have also been recorded in this district[8]. As of the beginning of July, diphtheria hotspots had been recorded in 4 Central Highland provinces, with 63 confirmed cases and 3 deaths.

7. Including provinces, where APs are operational such as Dien Bien, Yen Bai, Tuyen Quang, Hoa Binh, Thanh Hoa
8. Chan Hung, Occurrence of 9th cases of diphtheria in Dak Nong, July 19th 2020. https://nhandan.com.vn/tin-tuc-y-te/xuat-hien-o-dich-bach-hau-thu-9-tai-dak-nong-609225/

RECOMMENDATIONS

COVID-19 has impacted on all aspects of Vietnam's social and economic life. The most significant impact was on livelihoods, mainly due to job losses, especially among casual workers. The reduced income had negative consequences for nutrition and child care. In addition, long-term social distancing had a significant impact on education and child protection. We have drawn the following recommendations based on the findings described and analysed above.

Nutrition and health

>> Recommendations for COVER Response

- Continue direct support for food and acute malnutrition with a focus on livelihood activities that would support casual workers to find alternative sources of income and support households to ensure the quality and quantity of meals for adults and children.
- Prioritise support for household-level water and hygiene facilities. Currently, most Area Programs focus on setting up school water systems. Continue providing soap and detergent for poor households and families with malnourished children, Most Vulnerable Children (MVC) or Registered Children (RC).

>> Recommendations for Nutrition:

- Prioritise livelihood activities which improve nutrition in families with children under 5 by ensuring the long-term quality and quantity of meals and ensuring that households can afford the health care and medicine they need.
- Share these findings with local partners who provide training for Timed and Targeted Counseling (ttC) home visitors so they can carry out more effective ttC visits and include messages on supplementary feeding for children under five. Improve information and education activities through ttC home visits and Nutrition Club sessions.
- Facilitate discussion and planning on water management within communities and between government and communities beyond Area Program budget to resolve irrigation issues. Prior to the discussions, collect data and information to be used by community members and decision makers for planning and taking appropriate actions to address identified water management issues.
- Collected data and information should be used to advocate to government health agencies and local authorities to improve the availability of essential medicines at health facilities.
- Area Programs and local partners should prioritise water and hygiene facilities in nutrition interventions and invest more resources in helping community members to improve their knowledge and practices on water and sanitation, and building latrines and safe water system at home. Poor families with limited hygiene and cleaning facilities should actively participate in livelihood groups to enable them to earn income for building water and hygiene sanitation facilities.
- Provide support through advocating to relevant government authorities on occupational health and safety for those involved in high-risk work including distributing Personal Protective Equipment to health facilities.

Livelihoods

- Interventions should engage the poor as much as possible in new or existing Savings groups.
- Reinforce the establishment of family gardens and support short-term livestock rearing and cultivation in order to reduce the dependence of poor households on purchased food. Assets transfer should be considered for longer term support.
- Partner with local government, Micro Finance Institutions (MFIs) and Community Social Organisations (CSOs) to develop financial counselling services.
- Work with Micro Finance Institutions to develop debt consolidation services.

Child Protection and Education

- Prioritise positive parenting programs by developing ongoing support to compliment training and workshops that target teachers, health workers and Child Protection Committee members. Besides, Area Programs should promote the application of positive parenting and activities that encourage healthy family relationships.
- Raise awareness of the local government, parents and community on child protection. Continue communicating to parents on how to help children deal with stress.
- Advocate to local government to include solutions that address stress in their Covid response action plan or emergency preparedness plan.
- Area Programs should promote communication to children and parents through online communication channels. Printed materials for children should be reduced. Area Programs should also include online child protection issues in their programs, including advocating to local government to include online child protection on their agenda.

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