Adolescent and Youth Reproductive Health in

Vietnam

Status, Issues, Policies, and Programs

POLICY

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ADOLESCENT REPRODUCTIVE HEALTH IN VIETNAM

Status, Policies, Programs, and Issues

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POLICY Project

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
CEDPA	Centre for Development and Population Activities
DHS	Demographic and Health Survey
FP	Family planning
GSO	General Statistics Office
HIV	Human immuno-deficiency virus
IEC	Information, education, and communication
INGO	International nongovernmental organization
IUD	Intrauterine device
MOET	Ministry of Education and Training
MOH	Ministry of Health
MR	Menstrual regulations
NCPFP	National Committee for Population and Family Planning
NGO	Nongovernmental organization
NIES	National Institute for Education Sciences
NSAB	National Standing AIDS Bureau
NSRH	National Strategy on Reproductive Health
PDI	Population Development International
RH	Reproductive health
RTI	Reproductive tract infection
RTI	Research Triangle Institute
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VYU	Vietnam Youth Union
WHO	World Health Organization

1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Vietnam is part of a series of assessments in 13 countries in Asia and the Near East.[1] The purpose of the assessments is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls. The report begins with the social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Vietnam.

Vietnam is a tropical country in Southeast Asia that covers 330,000 square kilometers. Vietnam shares boundaries with China to the north, Laos and Cambodia to the west, and 3,260 kilometers of Pacific Ocean coastline to the south and east. About 80 percent of Vietnam consists of mountains, high plateaus, and jungles. These areas have low agricultural productivity. The rice-producing deltas provide the majority of food for the population. The climate in the southern part of the country is tropical, with rainy and dry seasons; in the northern part it is subtropical, with cool and dry winters and hot and humid summers.

Vietnam is divided into 61 major administrative units: 58 provinces and three municipalities. The province level units are further divided into approximately 600 districts, and they in turn are subdivided into nearly 10,000 communes. Hanoi, the capital of Vietnam, is an economic and political center in the north. Ho Chi Minh City is the biggest city in the country and an economic center in the south of Vietnam.

Vietnam is a multi-ethnic nation. The main ethnic group—Viet (or Kinh)—represents 84.4 percent of the population. The remaining 15.6 percent of the population includes 60 different ethnic minority groups that are thinly spread in the mountainous areas.

Vietnam has been and continues to be a predominantly rural society. Almost 80 percent of the population lives in rural areas and is involved in agriculture. The proportion of the urban population is still low—barely over 20 percent. With economic development, increased urbanization is a likely trend in the coming years.

In 1986, the government of Vietnam launched the *Doi moi* (controlled transition toward a market economy). The ongoing reforms have produced a positive impact on the development of the country: the gross national product per capita is increasing and reached US$375 in 2000,[2] the annual GNP growth was one of the strongest in the world in the mid-1990s (around 9.5 percent in 1996), and inflation has steadily slowed down.

Like most countries in the region, Vietnam is benefiting from a high economic growth rate but is also suffering from negative social side effects, despite the continuous efforts deployed by the government. Poverty alleviation remains a priority in a country where 22 percent of the population lives below the poverty line.[3] With the removal of the subsidy system in education, health care, and other social services in addition to the increasing cost of education and services, Vietnam's impressive gains in these spheres over the past 30 years are seriously threatened.

[1] The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.
[2] GSO, 2000a.
[3] UNICEF, 1998.

Most of these changes greatly impact the lives of adolescents and youth in general and their reproductive health in particular. The following sections describe and analyze the reproductive health situation among Vietnamese adolescents and youth.

With a total population of 76.33 million, Vietnam is the second largest country in Southeast Asia and the 13th most populous country in the world. The population growth is 1.7 percent per annum. Almost 16 million or 21 percent of Vietnam's population are adolescents (ages 15–24) (Figure 1). Vietnam has a young population—51.3 percent of population is under 25 years of age.[4] Therefore, young people will continue to occupy a significant proportion of the nation's population for successive generations. Educational attainment is high in Vietnam, and there is very little disparity between educational attainment for boys and girls. Less than 5 percent of boys and girls have no education. While slightly more girls have completed primary education than boys, fewer girls have secondary education than boys (Figure 2). Less than half of all pregnancies among youth result in births. In 2000, an estimated 37 percent of pregnancies resulted in abortion, and 48 percent in births; the remaining resulted in miscarriage (Figure 3). Pregnancies and births are assumed to peak in 2010 at almost 2 million and 1 million, respectively. By 2020, an estimated 863,000 births will occur to adolescents (Figure 3). Unmet need is very low in Vietnam, at 9.7 percent among 15–19 year olds, and 13.3 percent among 20–24 year olds (Figure 4). Vietnam is experiencing a rapid decline in fertility; the total fertility rate declined from 3.8 births per woman in 1985 to 2.3 in 1999.[5]

Traditionally, Vietnam, has not defined adolescence or young adulthood as a distinct development phase in the life of an individual.[6] Marriage occurred at an early age and was considered the rite of passage into adulthood. In Vietnam today, the concept of adolescence, or a "transition phase between childhood and adulthood," is taking root. Most Vietnamese people use the term *thanh thieu nien* to refer to young people 10–24 years old. The term *vi thanh nien* (adolescence) is used in legal documents to refer to individuals 10–15 years old.

[4] GSO, 2000b.
[5] GSO, 2000b.
[6] Le and Borden, 1998.

Figure 1. Total Adolescent Population
(Ages 15-24)

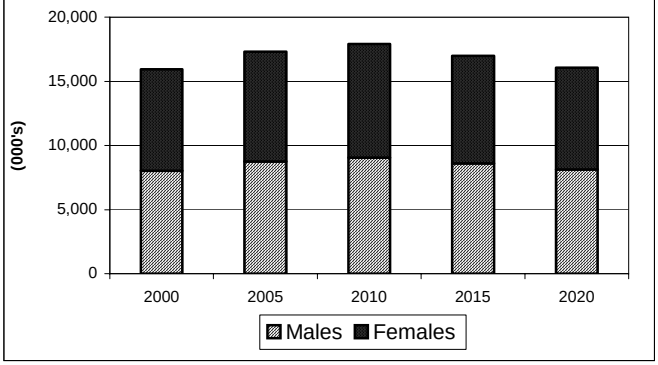


Figure 2. Years of Education Completed
(Ages 15-24)

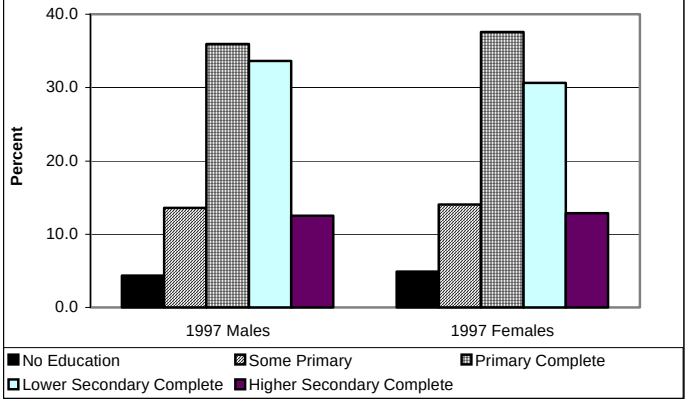


Figure 3. Annual Pregnancies and Outcomes
(Ages 15-24)

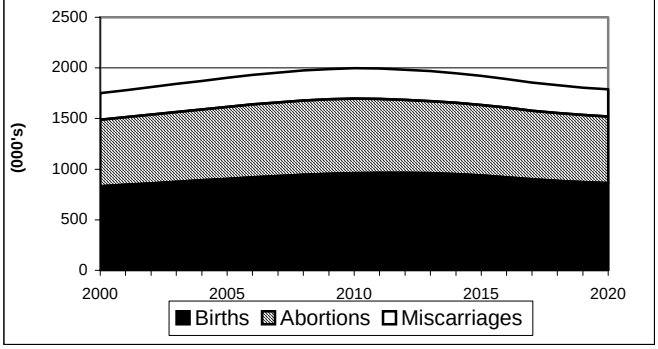
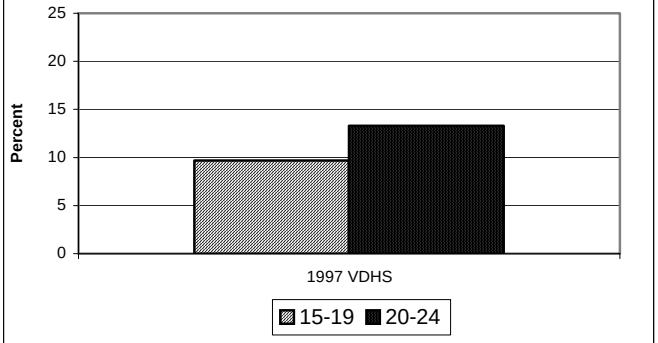


Figure 4. Total Unmet Need for FP
(Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 4

2 SOCIAL CONTEXT OF ARH

A number of issues need be addressed in a discussion about the social context of ARH. These include gender socialization, education, employment, and marriage.

Gender socialization

The large socioeconomic changes begun in the late 1980s have shaped the conflict between the modern and traditional models of gender relations.[7] While gender roles are in transition in Vietnam and the changes that have occurred over the last 50 years have led to a remarkable improvement in women's status during those years,[8] many stereotypes and gender values have changed little over centuries. Although what women do as part of their daily tasks has changed dramatically in recent years, the image of the ideal Vietnamese woman is still the traditional one of a housewife. Coping with multiple and sometimes contradictory expectations has created new stresses for the younger generations of Vietnamese women in both urban and rural areas. Women's modern workloads conflict with traditional roles and values; anguish and confusion is often the result for many women who try to live up to all expectations.[9]

A recent household study on adolescents in six provinces of Vietnam shows that girls are about on par with boys in terms of opportunities for education, but they are nevertheless expected to help parents more than boys are. Girls spend two times more time on housework and less time for recreational activity compared with boys. Adolescents in rural areas spend twice as much time helping their parents compared with their peers in urban areas.[10]

Similarly, while puberty occurs at an earlier age than in the past and young people are increasingly exposed to the more liberal western approach to sexuality through the media and the Internet,[11] sexuality remains taboo and sex education for young people is highly scrutinized due to the conservative nature of Vietnamese society.[12,13] While more young people engage in sexual activity at an earlier age, Vietnamese women are still expected to be virgins until marriage.[14] While young men are expected to be knowledgeable and active in terms of intimate relations, young women are expected to be "pure" and "innocent." The result of the traditional stereotypes—that girls show little knowledge of sexual matters—has hindered young women's negotiations for safe sex with their boyfriends.[15]

Education

Educational levels are remarkably high in Vietnam. Just over 91 percent of the population aged 10 years and older are literate (94.3 percent of males and 88.2 percent of females). The rate of males and females ages 15–19 currently attending school is 49.3 percent and 38.6 percent, respectively, and 5.4 percent and 3.9 percent, respectively, for those ages 20–29.[16] Within the five-year period from 1992–1993 to 1997–1998, school enrollment of 15–17 year olds (upper-secondary school) doubled from 27 percent to 54 percent.

[7] Johansson, 1996.
[8] UNDP, 2001.
[9] Franklin, 1999.
[10] Mensch and Dang, 2001.
[11] McMahon, 1996.
[12] Nguyen, 1998.
[13] NIES–MOH, 1997.
[14] Vu et al., 1996.
[15] Population Council, 2000.
[16] GSO, 2000b.

There is no difference in the enrollment of boys and girls of primary school age (ages 6–10), but a gender gap begins to appear in the lower-secondary school age group (ages 11–14). It then increases in the upper-secondary school level. The gender gap has declined, however, over the five-year period from 1992–1993 to 1997–1998 from 11 percent to 6 percent among those of lower-secondary school age and from 15 percent to 11 percent among those of upper-secondary school age.[17] There are also some gender disparities at higher education levels for the 15–24 year-old age group. According to the 1999 National Census, there are two times as many men as women with technical certificates. However, the number of women in college is almost 2.5 times higher than that of men and the number of women in universities is also slightly higher than that of men.[18]

The gender gap in education between urban and rural areas is substantial. In rural areas, within the 15–19 year-old age group, the percentage of those who are currently attending school is 45.5 percent for men and 32.8 percent for women, which are much lower than the rates of those in the same age group in urban areas, where the percentages are 62.1 percent and 58 percent, respectively. The disparity is much more noticeable at the university level, particularly in the 18–24 year-old age group. There are almost three times as many urban men than rural men in universities and almost five times as many urban women than rural women in university.[19] In rural areas, boys in the 18–24 year-old age group have better access to education and a broader array of career choices since families believe that boys can be more successful than girls in achieving social mobility; families thus support boys to a greater degree.[20] The majority of rural girls become a valuable part of the labor force for their families as they prepare to enter the marriage market instead of continuing their education.

Employment

In Vietnam, the legal age for employment is 15 years. Women account for 49.5 percent of all employed 15–29 year olds. The proportion of women aged 15–29 working in the state sector and in collective (socialist) enterprises is, at 10 percent, higher than that of men. Unemployment among youth is the highest of all age groups in the country. For Vietnam, as a whole, the unemployment rate is 4 percent but for the youngest age group, 15–19 years, the rate is as high as 11 percent. The 20–24 year-old age group ranks the second highest with an unemployment rate of 6.6 percent.[21] In 1999, over a quarter (25.6 %) of all young people in the 15–24 year-old age group were employed—five percent less than in 1989. In rural areas, the rate of unemployed young people is much lower than that in urban areas and the rate of unemployment decreases with increasing age. However, the numbers depend on the employment status of those involved in the agricultural sector (i.e., those seasonally unemployed or "between crops" unemployed). Factoring in the young unemployed in the agricultural sector substantially increases the number of unemployed youth.

Marriage

The legal age for marriage is 18 years for women and 20 years for men. According to the 1999 National Census, the average age at first marriage is 25.5 years for men and 24 years for women. Ever-married young people ages 15–24 account for 22.9 percent of the married population. In the subgroup of those aged 15–19 years, this proportion is about 6 percent, and in the subgroup 20–24 years, it reaches 44 percent. The percentage of married people in both subgroups in rural areas is about double than that of urban areas (6.5% versus 3.2%, and 49.6% vs. 27%).

There are 1.6 percent of men younger than 20 years of age and 1.9 percent of women younger than 18 years of age who get married before they are of legal age. Most of these people live in rural areas and

[17] Desai, 2000.
[18] GSO, 2000b.
[19] GSO, 2000b.
[20] NCPFP, 2000.
[21] GSO, 2000b.

are ethnic minorities.[22] Many of them get married as young as 13 years of age. Marrying at a very young age doubles young women's health risks in remote and mountainous areas because of their age and because they have poorer access to health services compared with women in other regions of the country.[23] Studies in northern rural areas show that many young men get married at ages 19–20 and many young women at ages 17–18.[24]

Since Vietnam changed to a market economy, education is no longer subsidized and has become more costly. In addition, the government economic sector has been reduced, forcing many rural girls to discontinue their studies at a very young age to work for their family. While there are more job opportunities in urban areas overall, families prefer for young men rather than young women to go to work in the cities. Because of the increase in migration of young men, female teenagers now make up a higher percentage of the total rural youth population and now, therefore, encounter difficulties finding potential companions.[25] Nevertheless, social pressure in many rural areas for girls to marry at a young age is strong and girls who are 20 years old and without "visitors" are considered "on the shelf" or "with problems." Many of these girls and their families are greatly worried when they have not yet seen young male visitors. In most cases, girls and their families accept the first marriage proposal, worrying that once they refuse they may have no other chances for marriage. Seemingly, there are few choices for young women in this age group other than getting married.[26]

[22] GSO, 2000b.
[23] NCPFP, 1999.
[24] Khuat, 1994.
[25] Dang, 1994.
[26] Khuat, 1994.

3 ARH ISSUES

There are several issues that should be considered in a discussion of ARH in Vietnam. Of particular note are early high-risk pregnancy and birth; unwanted pregnancy and abortion; and HIV/AIDS and sexually transmitted infections (STIs). These are discussed below. No data were available on age at first sex and contraceptive use among adolescents.

Early, high-risk pregnancy and birth

Early pregnancy and birth are not widespread in Vietnam. Nationally, 5.7 percent of young women in the 15–19 year group have been pregnant or have given birth to their first child. Almost two percent of women first gave birth before age 18. Among married women ages 20–24, about one-fifth (18.9%) gave birth to their first child between ages 15 and 19. About 4 percent experienced their first birth between ages 15 to 17.[27]

According to the 1997 Vietnam Demographic and Health Survey (DHS), more than one-third (35.3%) of pregnant women younger than 20 years old have never had a prenatal examination. Almost half (46.9%) of the women who gave birth before age 20 delivered at home. The majority of these women are ethnic minorities from remote and mountainous areas.

A 1997 Ministry of Health (MOH) study on maternal mortality in three provinces found 321 maternal deaths among the 2,822 deaths of women ages 15–49 that were reported in 1994–1995. Maternal mortality among 15–24 year-olds was 21.5 percent of the total maternal mortality rate. This study also found that the maternal mortality rate of ethnic minority women was much higher than that of Kinh women.[28]

Unwanted pregnancy and abortion

The abortion rate in Vietnam appears to have doubled during the last decade. Records show that the number of abortions per year has jumped from 700,000 to 800,000 in the 1980s to 1.5 million in the 1990s.[29] The rising demand for abortion services in both urban and rural areas has led to the hypothesis that more young, unmarried people are becoming sexually active, leading to an increase of unwanted pregnancies.[30] In spite of scarce statistical evidence, ad hoc estimates suggest that young, unmarried women who are terminating pregnancies are contributing to the currently high abortion rate in Vietnam, at least in major urban areas.[31] Studies in Hanoi and Ho Chi Minh City have estimated that at least 10–20 percent of abortions in the city there are performed for single women.[32,33] Nationwide, about one-third of all procedures performed for regulating menstrual cycles (menstrual regulations, or MRs) and abortions occur among young, unmarried women. That percentage would translate to at least 300,000 MRs and abortions per year (833 per day, or one every two minutes).[34]

Repeat abortions are common among unmarried women using abortion services. According to Belanger and Khuat's 1996 study in Hanoi,[35] and the Population Council's 1998 study in Ho Chi

[27] NCPFP, 1999.
[28] MOH, 1997.
[29] MOH, 2001.
[30] Goodkind, 1994.
[31] MOH, 1998.
[32] Nguyen, 2001.
[33] Population Council, 2000.
[34] VYU, 1998.
[35] Belanger and Khuat, 1998.

Minh City,[36] 10–20 percent of unmarried women have had more than one abortion. In-depth interviews conducted through the Population Council study showed that out of the 19 women interviewed, 11 women have had two or three abortions.

Due to the social stigma associated with pregnancy among unmarried youth and the frequent lack of understanding of the physiology of pregnancy, which results in delayed recognition of pregnancy, many young women often delay seeking abortions until after the first trimester of pregnancy. Second trimester or late abortions are reported to be common among unmarried youth.[37,38]

No data are available on abortion services in the growing private health sector. However, it is believed that many unmarried women prefer to use private clinics for abortion because these facilities have more flexible working hours and most remain open until well after dark, giving women a better chance of preserving their anonymity.

The above-cited studies point out several barriers to contraceptive use among young men and women who use abortion services. The generally weak and often incorrect knowledge about contraceptives stands as the most important barrier to contraceptive use. A common misconception is that only married women should use contraceptive methods and that they can harm single women. The second barrier results from the relationship between the woman and her boyfriend. Women expect men to take the initiative to use contraception. Women are afraid to show their boyfriends that they have contraceptive knowledge and skills. They prefer to give the impression that they have no experience (i.e., that they are pure or innocent) and they thus risk unwanted pregnancy. Men are often the decision makers for which method to use, although few appear to care. If they do take responsibility for choosing the method, they often practice contraception irregularly. Finally, social pressure to hide sexuality limits the possibilities for single youth using contraceptives. Single women and men are afraid that their parents will discover that they are having sexual relations if they bring condoms or oral contraceptives home (since many youth live in a household where they do not have private space, it would be very difficult to hide a contraceptive device).

HIV/AIDS and STIs

As of July 2002, the cumulative number of HIV infections reported in Vietnam was 52,000.[39] However, in 2000, the MOH has estimated that 118,000 people were living with HIV/AIDS.[40] All 61 provinces have reported HIV/AIDS cases. Of the reported cases, almost 10 percent are young people under 20 years of age, and 50.4 percent are between the ages of 20 and 29. The majority of HIV infected cases (65%) are related to intravenous drug use. There are also indications of the increasing risk for heterosexual transmission. The number of HIV-positive women has steadily increased. The rate of HIV-positive pregnant women increased from 0.02 percent in 1994 to 0.2 percent in 2000. Sexual transmission of HIV also has increased among female sex workers; the prevalence increased from 0.59 percent in 1994 to 4.33 percent in 2000.[41] According to government estimations and projections, current HIV prevalence among adults is 0.22 percent and is expected to rise to 0.27 percent by 2005.[42]

A great concern about HIV/AIDS infection among youth is related to unsafe sexual behaviors of many young people. Results of many studies show the big gap between a high level of knowledge of HIV/AIDS and a low level of condom use. Studies also found that many young people have a number of mistaken ideas about condoms. A study on attitudes and knowledge about HIV/AIDS among

[36] Population Council, 2000.
[37] MOH, 1998.
[38] Le Nham., et al., 1996.
[39] NSAB, 2002.
[40] MOH, 2000.
[41] UNAIDS, 2001.
[42] UNAIDS, 2001.

young men aged 14–28 in Tay Ninh province found that 33 percent of interviewees reported having premarital sex and that they have a fairly good knowledge about HIV/AIDS. Nevertheless, few of them use condoms due to a number of incorrect beliefs. Young men play an important role in practicing safe sex since they often are the ones who decide whether or not a condom will be used. Young women have difficulties refusing the sexual advances of their boyfriends but are sometimes able to persuade them to use contraceptives.

There are other concerns. Studies also found that youth in rural areas, especially out-of-school youth, are more vulnerable to HIV/AIDS infection due to socioeconomic constraints and limited access to information.[43] Another area of concern regarding the vulnerability of youth to HIV/AIDS infection is related to the increase of the number of young women engaged in sex work. Studies in the late 1990s found that at least 11–15 percent of sex workers are younger than 18 years old.[44]

Reproductive tract infections (RTIs) are reportedly common among Vietnamese women and have received considerable attention from researchers and providers, particularly since IUDs are the most popular contraceptive method for married women. Statistics are still not often broken down into age groups, and therefore no data about RTI incidence among youth are available. A cross-sectional study of 609 married women aged 15–49 living in one commune in Thai Binh province found that 33 percent of the women were suffering from endogenous RTIs, especially candidasis.[45] In a population-based study in five communes, Nguyen Thi Hoai Duc found the rate of RTIs to be as high as of 66 percent in a sample size of 500 married women aged 15–55.[46] Little is known about RTIs among youth because many young women do not regularly use health services for gynecological check-ups and because young women feel shy about discussing "intimate issues."[47]

Information about STIs is as scarce and unreliable as that of the information on RTIs. The fact that STIs are heavily stigmatized in Vietnamese society partly explains the scarcity and unreliability of data on STIs. It is generally acknowledged that as few as 5–10 percent of STI patients use public sector health services for diagnosis and treatment. According to MOH statistics, the prevalence of STIs among the general population is low. In 2000, the rate of gonorrhea was 7.85 per 100,000 and the rate of syphilis was 3.31. There were 527 people younger than age 15 who were diagnosed with STIs, including HIV/AIDS, accounting for 0.46 percent of the 112,141 total cases.[48] However, given what is known about youth's sexual behavior and their failure to practice safe sex consistently, there is good reason to believe that STIs would be highly prevalent.[49]

[43] Population Council, 1997.
[44] Khuat et al, 1997.
[45] Tran et al., 1998.
[46] Nguyen, 1997.
[47] Le and Borden, 1998.
[48] MOH, 2000.
[49] MOH, 2000.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

Among the important legal and policy issues related to ARH in Vietnam are legal barriers, existing ARH policies, and existing ARH policy initiatives. These are explored below.

Legal barriers

In general, there are no substantial legal barriers for promoting ARH. Relevant legal documents such as the Laws of People's Health Protection, the Laws of Protection and Care for Children, the Labor Codes, and the Laws on Marriage and Family ensure the rights for the safety of and health care for all people. However, none specifically addresses ARH. This may explain why successful pilot activities and initiatives have not been developed into a national ARH program that could be consistently implemented throughout the country.

Existing ARH policies

For decades, little has been done for ARH.[50] Neither specific policies addressing ARH nor ARH national programming has been developed.[51] Adolescents, especially unmarried youths, are often neglected even in population and family planning policies. For example, the Vietnam Population and Family Planning Strategy for 2000 focused primarily on married couples and ignored unmarried youth. The situation gradually changed when ARH issues raised by social workers and researchers during the last decade began attracting the attention of policymakers and program managers. A number of interventions were carried out, but most of these interventions were pilot activities. Programs addressing ARH have not yet been institutionalized.[52] The result has been continuing inconsistencies and fragmentation in activities relating to ARH throughout the country. The National Plan of Action on ARH was drafted under the initiatives of Youth Union and some other national institutions in July 1999. However, it has not been officially adopted and, therefore, has not been widely disseminated.

Due to the awareness of these shortcomings in ARH programming, the newly formulated National Strategy on Reproductive Health (NSRH) for 2001–2010, approved by the Prime Minister on November 28, 2000, focuses attention on ARH. In this document, ARH is identified as second among seven outstanding problems that the new reproductive health program must address. One of the seven specific objectives of the strategy focuses on improvement of ARH through education, counseling, and provision of reproductive health services. The following targets have been set: 80 percent of reproductive health service delivery points must provide information, education and counseling to adolescents; and 70 percent of adolescents must receive reproductive health information, education, and counseling and have an understanding about reproductive and sexual health.[53]

The national strategy provides a number of recommendations to reach the target objectives. The strategy states that reproductive health programs provide information, education, and communication (IEC) and counseling about sexual development and sexuality for adolescents to help them understand more about healthy sexuality and to give them easy access to quality reproductive health and family planning services for prevention of unwanted pregnancy, unsafe abortion, and STIs. The strategy notes that the content of sex and sexuality education should be included in the school curriculum. In regard to service provision, the strategy stresses that centers for ARH services will be set up to provide counseling and medical assistance to adolescents, including contraceptive methods, safe

[50] MOH, 1999.
[51] Pham, 2001.
[52] VYU, 1997a.
[53] MOH, 2001.

abortions, and treatment of RTIs. Special attention should be paid to adolescents in rural and remote areas, from poor families, or with little education. The strategy also stresses the needs for social research on ARH issues such as adolescents' attitudes and behavior in regard to reproductive health. The Ministry of Education and Training (MOET) is responsible for outlining and guiding the implementation of the program on gender, and reproductive and sexual health education for students in schools, colleges, universities, and other forms of educational programming.

The MOET and the MOH will plan teacher training so that they can improve on their knowledge and skills in these areas. Mass (civil society) organizations will participate in IEC activities and the delivery of simple reproductive health services. Community health centers have to provide IEC and counseling for adolescents on safe and healthy sexual relations as well as other needed services including dispensation of oral contraceptive pills, emergency contraceptives, and condoms.

These changes note a great deal of progress in Vietnam in terms of the development of ARH policy. However, there are still no ARH impact or monitoring and evaluation indicators. This creates great difficulties for planning and implementation as well as the assessment of ARH services. While the national strategy was approved over a year ago, guidelines for implementing the program have yet to be developed.

In the Vietnam Population Strategy 2001–2010, which was formulated at the same time as the NSRH, ARH is included in IEC programming that focuses on promoting behavior change communication and service components. For the first time, women of reproductive age, men, youth, and adolescents are all being included as audiences for IEC behavior change activities. Emphasis has also been made on diversifying forms and methods and on raising the quality of education and training on population, FP/RH, sex, and gender both in and out of school. Provision of information and counseling on population, FP/RH, sex, and gender to teachers and parents also will be encouraged. The quality of FP/RH services and the delivery system will be improved to meet the needs of clients to minimize unwanted pregnancies and to reduce the incidence of abortions, particularly among adolescents. Adequate attention will be given to providing services to youth and adolescents.

ARH policy initiatives

A number of policy initiatives are in place in Vietnam. Among them are plans addressing safe motherhood, healthy living, life skills education, and service provisions.

***The safe motherhood master plan integrating ARH components*:** The MOH, with the support from the government of Netherlands, is currently in the process of developing the national safe motherhood master plan for the period 2001–2005. The master plan will integrate ARH throughout its components.

***Strategy for cooperation between the government of Vietnam and UNICEF on healthy living and life skills education for children and adolescents*:** The strategy focuses on the following major components: capacity building for teachers, education managers, and mass organization workers; strengthening close partnerships between families, schools, and communities; and linking life skills education with rights promotion and children protection activities.

***Support local nongovernmental organizations (NGOs) in ARH education and services provision*:** The government plans to revise the policy aimed at strengthening the role of local NGOs to maximize their contribution for the development process in general. This is a new and important initiative as local NGOs have been developing rapidly in both quantity and capacity in the last few years and increasingly contribute to various areas of health in general and ARH in particular. International agencies (UNFPA, UNICEF, WHO, and international nongovernmental organizations (INGOs) are widening their support to local NGOs in ARH education and service provision.

5 ARH PROGRAMS

A national ARH program has not yet been developed and institutionalized. However, since the early 1990s, various ARH programs and activities, including school-based and community-based programs and activities, have been developed and implemented in different areas of Vietnam. It is worth mentioning that most of these programs and activities have focused primarily on IEC but have not included the provision of contraceptives or other reproductive services. Moreover, the content of IEC messages and the ways they are delivered tend to be moralistic lectures that may quickly disinterest young people. Young people have not been involved in designing programs. Finally, all programs depend largely on international resources and the majority of them are small in scale. This affects their sustainability and ability to replicate successful models.

School-based programs and activities

Since 1988, the Ministry of Education and Training (MOET) has implemented "Family Life and Sexuality Education and Population Education" with support from UNFPA and UNESCO in 17 of the 61 provinces of the country. The first phase, the "Family Life and Sexuality Education" program, took place between 1988 and 1993 and was a pilot. In 1994, the program was expanded to the whole country, and the term "population education" was incorporated into the title. Since the 1998–2000 phase, it has been called "Population and Reproductive Health Education." These programs are usually integrated into biology, civics, geography, or extra curricular activities of students from 8th grade on, but the program focuses primarily on the 10th–12th grades.[54] Although the programs have been positively evaluated, expanding these programs to reach more youth is difficult.[55] Most teachers feel uncomfortable talking about sex and sexuality with young students. Many teachers think that school is not an appropriate environment to talk about these issues and prefer that parents take responsibility for discussing these issues with their children.[56] Manuals for teachers and textbooks for students are in short supply and trainers are poorly trained and receive little follow-up.[57]

Since 1997, the MOET, with support from UNFPA, has conducted the National Education and Training Programme on Reproductive Health and Population Development.[58] Apart from broader family planning issues, the project addressed other issues including teaching young people about reproductive health issues, conducting a distance learning course for all teachers to provide them with information on population and reproductive health, and conducting another course for secondary school teachers to help them teach these sensitive topics. By the end of 2001, the Self-learning Guideline Manual for Teachers, "ARH Education," was developed and disseminated by the the MOET, which has requested the provincial Education and Training Department to urge teachers to use this manual to enrich their knowledge.[59] It is worth noting that while the manual contains rather comprehensive official material on ARH, it does not necessarily mean that teachers can maximize its use in their teaching; they are constrained by the poor and vague content of the school ARH curriculum.

Some other small-scale, school-based projects and activities have been conducted in different areas of the country. For example, since 1996, the Department of Educational Services in Ho Chi Minh City, with the support of Save the Children UK, has conducted school-based HIV/AIDS education for students from the primary to secondary levels in several schools in Ho Chi Minh City.

[54] Le and Borden, 1998.
[55] Ngo et al., 1992.
[56] Population Council and National AIDS Committee, 1997.
[57] NIES–MOH, 1997.
[58] Project VIE/97/P13 – MOET.
[59] MOET, 2001.

Community-based programs and activities

A number of community-based programs and activities are in place. These include clubs, counseling centers, mobile teams, information distribution programs, development and distribution of other types of information, and IEC programs.

Clubs, counseling centers, mobile teams: The Vietnam Youth Union (VYU) has been a major actor in conducting pilot ARH programs since the early 1990s. Various experimental models for IEC activities have been developed and implemented under small-scale pilot programs funded by international donors. These models include clubs for unmarried youth, clubs for young couples, and competitions and contests on population and family planning. The use of other intervention models and activities, including counseling centers, hotlines, and IEC mobile teams, were later developed and applied in six provinces of the country under the UNFPA-funded project in 1996–2000, "Support to Improvement of ARH."

Development and distribution of printed materials: Under the UNFPA-funded project "Support to Improvement of ARH", VYU has produced and disseminated various printed IEC material including posters, leaflets, and booklets. Among these materials, a set of booklets, including "Psychology and Physiology of Adolescents," "Friends and Love," and "Things that Young People Should Know about HIV/AIDS," has been published for large-scale distribution to young people.

Reproductive health and sex education books for youth: A three-year project (1995–1997) "Improvement of Youth Reproductive Health for Young People" has been carried out by the Women's Union, with support from Path (Canada), to produce books on reproductive health and sexuality education for youth and a general audience.

***IEC campaigns*:** The first national IEC campaign on ARH was organized under the UNFPA-funded project VIE/97/P12 by VYU in May 1998. The national campaign aims to raise youth awareness of the benefits of postponing sexual activity and to motivate those who are already sexually active to practice safe sex. Launched in Hanoi, the campaign covered eight provinces and cities. To ensure the campaign's success, the VYU has collaborated with the mass media at the central and provincial levels, schools, youth associations, health providers, counseling centers, and other institutions and organizations.

***Life Skills Curriculum for Youth*:** Since 1996, MOET and the Vietnam Red Cross have implemented the Life Skills Curriculum for Youth Program in seven provinces and cities with support from UNICEF. The program focuses on life skills education and HIV/AIDS prevention. For in-school youth, a life skills curriculum (e.g., decision making, assertion, value clarification) was designed by MOET and integrated into different subjects of the formal school system. For out-of-school youth, a curriculum designed by Vietnam Red Cross and Australian Red Cross is used.

Other creative IEC activities: Since the mid-1990s, HIV/AIDS prevention activities for youth have been actively integrated into ARH programs. Efforts have been made to organize IEC activities, including counseling and peer education, in creative forms such as "condom cafés,"[60] "counseling cafés,"[61] "green shops," and "friends-help-friends groups." These facilities have been formed and run by the Youth Union at different levels, though mainly in cities. Young people who come to the facilities for coffee or drink may ask for counseling, clean items for drug injection, or condoms. However, few HIV/AIDS models are able to demonstrate ways of working more effectively with young people to facilitate and sustain behavior change.[62] Other creative projects focusing on HIV/AIDS and reproductive health education include: the three-province, Population Development

[60] Médecins du Monde (France) has funded the project in Ho Chi Minh City since 1995. Médecins sans Frontiers (Belgium) funded the project in Nha Trang in 1996–1998.
[61] Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) has funded a café in Hanoi since 1999.
[62] UNAIDS, 2001.

International (PDI)-funded project for the Youth Union, "Mobile Drama and Life Skills Curriculum for Youth;" a project using HIV/AIDS informational videos and theater for Khmer youth with the Population Council in Tra Vinh province; and Soccer and HIV/AIDS Prevention for Youth in Quang Ninh province.

***Integrating ARH in other programs and activities*:** ARH is also addressed in the programs and activities promoting gender equality and male participation in reproductive health care implemented by mass organizations like the Vietnam Women's Union, Farmer's Union, and Vietnam Red Cross. Most of these programs and activities are supported by international agencies and INGOs.

The programs and activities carried out by mass organizations have contributed to the dissemination of information on family planning, contraceptive methods, and HIV/AIDS prevention for adolescents. However, these organizations use IEC methods that are not innovative enough to attract youth, especially those youth who are outside the reach of formal institutions. Their approach tends to be dominated by moral directives issued in lectures and other, similar types of activities.[63]

[63] Le and Borden, 1998.

6 OPERATIONAL BARRIERS TO ARH

Various operational barriers to ARH exist, including young people's lack of knowledge and skills, a discomfort on the part of adults to discuss sexual matters with youth as well as a lack of knowledge and skills to do so, and limited resources and services.

Young people lack knowledge and skills

Studies found out that young people's knowledge about reproductive health and HIV/AIDS is insufficient as are their use of contraceptive methods and negotiation skills around safe sex.[64,65,66,67]

Adults hesitate to discuss ARH issues

Youth knowledge is limited largely because few of the relevant organizations or institutions—schools, families, social groups including mass organizations and community-based organizations, and health care providers—readily take responsibility for dealing with this issue. Many people, including policymakers, teachers, and parents, worry that sex education will expose youth to inappropriate information. Youth, on the other hand, expressed interest in learning about sexuality and related issues from as many sources as possible. Parents and adults are hesitant in accepting that youth want to learn about these issues and that they actively seek information from their peers, older partners, and the media. Many parents and adults believe that youth are too young to know about sex and that sex education will provoke their sexual desire and increase their sexual activity.[68]

Teachers and parents lack knowledge and skills

Studies showed that teachers and parents feel uncomfortable talking about sex and reproductive health because they feel that their own knowledge is insufficient.[69,70] Teachers believe that they need more skills training for teaching and should better equipped with knowledge on reproductive health issues in general and ARH in particular.[71]

Lack of capacity and resources

Few ARH programs and activities have been conducted in Vietnam, due, in part, to a lack of resources. Most of the ARH programs and activities carried out so far are pilot projects that have relied heavily on international resources. When the pilots are completed, activities associated with the pilots are often discontinued because no other resources have been assigned or allotted.

Findings from studies on abortions of unmarried women suggest that pre- and post-abortion counseling should be provided for women seeking abortion.[72,73] However, until recently, no government policy has dealt with the need for pre- or post-abortion counseling. As such, clinics have

[64] Dang, 2001.
[65] VYU, 1997b.
[66] Care International, 1997.
[67] Belanger and Khuat, 1998; Belanger and Khuat, 1999.
[68] Population Council and National AIDS Committee, 1997.
[69] Population Council and National AIDS Committee, 1997.
[70] Nguyenand Doan, 2001.
[71] Nguyenand Doan, 2001.
[72] Belanger and Khuat, 1998; Belanger and Khuat, 1999.
[73] Nguyen, 2001.

no capacity, incentives, or resources to provide adequate counseling services. Many providers believe that counseling is an unnecessary, nonessential component of health care.[74]

Limited RH services available for unmarried adolescents

Efforts have been made to improve young people's knowledge of reproductive health, safe sex, and contraceptive methods. However, the information provided is often limited and insufficient to change behavior as young people are unable to access services. Studies indicate that the use of contraceptives by single men and women is very low due to a lack of access to contraceptive supplies, counselors, and health providers. Contraceptive services are targeted to married couples in the national family planning program and are generally unavailable to single youth. Even pharmacies are reportedly reluctant to sell condoms to youth. The main factors contributing to these problems include a government policy targeted at married couples that virtually ignores unmarried people and health providers' poor communication skills with young people. Other obstacles include cultural difficulties and overall social disapproval of premarital sex and contraceptive use, leading to a disdain for planned sexual activity and a lack of pre-procurement of contraceptives.[75]

[74] Population Council, 2000.
[75] Care International, 1997.

7 RECOMMENDATIONS

Drawing from the information presented above, a number of recommendations are presented below that are needed to enhance ARH programming in Vietnam.

Conduct a national baseline survey on ARH: The studies on adolescents conducted during the last 10 years have not fully convinced policymakers and program managers about the importance of providing information and services to adolescents. Most studies have been small scale and do not represent the situation of Vietnamese adolescents, as a whole. Results of a well-designed and well-conducted national survey on ARH would provide comprehensive information for designing appropriate policies and programs.

Develop a national gender-sensitive ARH strategy: A national, gender-sensitive ARH strategy should be developed on the basis of findings from surveys and research. Participatory approaches should be used to involve relevant governmental agencies, NGOs, researchers, social activists, parents, teachers, and representatives of young people. At a minimum, the ARH strategy should cover the following components:

- An IEC component including:
  - School-based programming targeting students and teachers; and
  - Community-based programming targeting youth, communities, family, and social organizations.
- A service provision component including:
  - Counseling on RH;
  - Supply of contraceptive methods;
  - Treatment of STIs and HIV/AIDS; and
  - Safe abortion including pre- and post-abortion counseling.

In the ARH strategy, gender must be a crosscutting issue that is mainstreamed into all components. It is important to design and implement specific IEC for changing gender norms and delivering gender-sensitive services to meet the reproductive health needs of young people. Clear, realistic targets and a system of indicators for monitoring and evaluation should be an essential part of the strategy.

Institutionalizing the ARH program: Once an ARH strategy is adopted, detailed guidelines for implementation should be developed and disseminated throughout the country. At a minimum, the guidelines should clearly and precisely indicate the following:

- Allocation of resources;
- Agencies responsible for implementing the ARH program;
- Health facilities assigned for ARH services provision; and
- Building human capacity for provision of ARH services.

Intervention research: Research should be encouraged to explore new issues and problems of ARH as well as to develop and implement creative forms of interventions.

Mainstream ARH in health laws and policies and other policies related to people's well-being: ARH advocacy should use major legal documents such as the Labor Codes, the Law of People's Heath Protection, the Law of Marriage and Family, and the Laws of Protection and Care for Children.

Develop guidelines and indicators on ARH for the National Strategy on Reproductive Health and the Population and Development Strategy for the period 2001–2010: Given the importance of these strategies to ARH, an immediate step is to develop guidelines and indicators relating to ARH.

APPENDIX 1. Data for Figures 1 through 4

1. Adolescent Population (15–24) (000's)	2000	2005	2010	2015	2020
Males	8,025	8,750	9,059	8,602	8,133
Females	7,899	8,568	8,848	8,386	7,920

2. Level of Education (%)	1997 Males	1997 Females
No Education	4.3	4.9
Some Primary	13.6	14.0
Primary Complete	35.9	37.6
Lower Secondary Complete	33.6	30.6
Higher Secondary Complete	12.5	12.8

3. Pregnancy Outcomes (000's)	2000	2005	2010	2015	2020
Total Pregnancies	1,750	1,902	1,996	1,922	1,788
Births	832	905	962	938	863
Abortions	656	711	734	696	657
Miscarriages	262	285	299	288	268

4. Unmet Need (%)	1997
Total Unmet Need (15–19)	9.7
Total Unmet Need (20–24)	13.3

Assumptions and Sources:

Figure 1. Adolescent Population Projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education was taken from the 1997 Vietnam DHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. Total fertility rate (TFR) and age-specific fertility rate (ASFR) for the base year were taken from the Vietnam 1997 DHS report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 83 per 1,000 (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 4. Levels of unmet need were taken from the 1997 Vietnam DHS report.

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