Addressing the Reproductive Health Needs and Rights of Young People since ICPD –

The Contribution of UNFPA and IPPF

Vietnam

Country Evaluation Report

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Addressing the Reproductive Health Needs and Rights of Young People since ICPD: The contribution of UNFPA and IPPF

Vietnam Country Evaluation Report

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EURO HEALTH GROUP

UNIVERSITY OF HEIDELBERG

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
CBD	Community Based Distributor
CCA	Common Country Assessment
CEDAW	Convention for the Elimination of All Forms of Discrimination Against Women
CO	Country Office
CP	Country Programme
CPRGS	Comprehensive Poverty Reduction and Growth Strategy
CRC	Convention on the Rights of the Child
CST	Country Support Team
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
EA	Executing Agency
EC	European Commission
ESEAOR	East and South East Asia and Oceania Region
FGDs	Focus Group Discussions
FLE	Family Life Education
FPA	Family Planning Association
HCMC	Ho Chi Minh City
HIV	Human Immunodeficiency Virus
IA	Implementing Agency
ICPD	International Conference on Population and Development
IDU	Injection Drug User
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
JPO	Junior Professional Officer
KAP	Knowledge, Attitudes, and Practice
MCH	Maternal and Child Health
MIS	Management Information System
MoET	Ministry of Education and Training
MoH	Ministry of Health
MPI	Ministry of Planning and Investment
MSI	Marie Stopes International
NCPFC	National Council on Population, Family, and Children
NPPP	National Professional Project Personnel
ODA	Overseas Development Assistance
PCPFC	Provincial Council on Population, Family, and Children
PDS	Population and Development Strategies (UNFPA sub-programme)
PE	Peer Educator
PLWHA	People/Persons Living with HIV/AIDS
RAFH	Centre for Reproductive and Family Health
RH	Reproductive Health
RHI	Reproductive Health Initiative in Asia (EC-UNFPA initiative)
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STPM	Strategic Thinking Planning and Management
TOT	Training of Trainers
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNFPA CO	United Nations Population Fund Country Office

VAM	Vietnam Association of Midwives
VINAFPA	Vietnam Family Planning Association
WHO	World Health Organisation
WPF	World Population Foundation
YP	Young People

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We also wish to emphasise that the views expressed herein are ours alone, not those of the evaluation sponsors.

ANALYTICAL SUMMARY

Introduction

The German Ministry for Economic Cooperation and Development (BMZ), the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs have sponsored an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994. The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future; the purpose is to assess the performance of UNFPA country offices and FPAs in six selected countries in promoting the reproductive rights and health of adolescents and youth.

This analytical summary presents the main conclusions and lessons from the evaluation of the UNFPA Vietnam Country Office and VINAFPA (the Vietnamese IPPF affiliate) against the five evaluation themes of strategic focus, institutional arrangements, policy and advocacy, service strengthening, and information and education. The summary highlights key findings against 10 key questions[1] set out in the original TORs for the evaluation under the following headings:

Strategic Focus:
The extent to which UNFPA and VINAFPA:
- Recognise and articulate the country-specific socio-cultural factors that impact on the reproductive rights and health of young people;
- Recognise and articulate the diversity of needs of young people;
- Promote the concept and practice of reproductive rights; and
- Are gender-sensitive in addressing RH needs and rights of young people.

Institutional Arrangements:
The extent to which UNFPA and VINAFPA:
- Contribute to the response of government and civil society to the reproductive rights and health needs of young people;
- Provide quality technical support and promote lesson learning and best practice in young people's reproductive rights and health;
- Promote the participation and empowerment of young people;
- Demonstrate complementarity, coherence and cooperation with each other; and
- Demonstrate relevance, scope and effectiveness in coordination arrangements and partnerships with other actors in the field of reproductive rights and health.

Policy and Advocacy:
The extent to which UNFPA and VINAFPA are:
- Stimulating enabling environments for policy development in relation to young people's reproductive health and rights.

The above issues are explored in detail in the main report, and further elaborated in the discussions on service strengthening and IEC.

[1] See section 2.2 of *Addressing Reproductive Rights and Health Needs of Young People After ICPD: The Contribution of UNFPA and IPPF. Description of the Evaluation/Substantive Requirements of the Bid/Description of Measures* (issued by BMZ 2002). Of the eleven key questions one has not been addressed (with agreement of the Steering Group): "The extent to which both organisations are effective in promoting behavioural change… in particular safe and healthy sexual behaviour".

Strategic Focus

The strategic focus of both agencies has shifted significantly since ICPD 1994. UNFPA's strategic foci and resources have been firmly aimed at the RH issues appropriate to the time period, whether FP or MCH or RH or ARH. By contrast, VINAFPA's strategy and activities have been focused on family planning awareness raising and service provision, with the emphasis on IEC and counselling. VINAFPA is emerging from a period of financial and organisational uncertainty at the end of the last decade. As VINAFPA is only just beginning to 'get back on its feet,' its strategic focus is being adjusted accordingly.

UNFPA

When the ICPD Programme of Action came into existence in 1994, UNFPA was at the end of its 4th Country Programme (1991-1995). The 5th Country Programme (CP5) was approved in September 1996, did not start until 1997 due to various delays, and lasted until 2000. The total budget allocation was US$24 million. CP5 mainly continued the strategies of CP4 through three sub-programme: reproductive health (RH), population and development strategies (PDS), and advocacy/IEC. The major emphasis was on capacity building of government partners. In addition to national/central level work, 8 provinces were supported. In CP5, however, there was a strategic shift away from a strong family planning and demographic emphasis towards provision of an overall reproductive health package and relevant policies, in line with the ICPD. Importantly, the EC-UNFPA Asian Initiative for Reproductive Health (RHI)[2] was started at the end of CP5. The government and UNFPA made a strategic decision to focus this initiative on youth from the start. Monitoring and evaluation of both CP 5 and RHI were extremely weak, rendering measurement of specific outcomes quite difficult.

In the 6th Country Programme (CP6: 2001-2005) the sub-programmes were reduced to two, RH and PDS. Since clear quantified achievements from CP5 could not be measured, UNFPA relied upon other data and studies in the design of CP6.The two foci under RH are the provision of quality services and gender-sensitive IEC. Under RH, the RHI continued, though a number of managerial shortcomings hindered more effective outcomes and synergy. Advocacy/BCC, gender equality/women's empowerment, and capacity building became cross-cutting issues. An improved M&E system in CP6 should allow for better assessment of outputs and outcomes. The overall budget increased to US$ 27 million, and 3 more provinces were added for a total of 11. UNFPA estimates it will be spending about 18% of its overall CP 6 budget on SRH for young people between 2001 and 2005.

UNFPA's recent country programmes articulate the priority RH and rights issues facing young people. It is also clear that the CO has a good appreciation of the socio-cultural and other factors that currently influence young people's RH and rights in Vietnam. They recognise the need to address diverse populations of youth. In Phase 2 of the RHI, now called the Reproductive Health Initiative for Youth and Adolescents (RHIYA), UNFPA propose to focus more in rural areas and upon a wide range of youth.

The need for implementing gender equity was discussed between UNFPA and RHI/RHIYA partners. However, the discussion appears to have been more rhetorical than practical. During a meeting with five RHI local and international partners, the partners stated that in the design of RHIYA UNFPA had not asked them how they planned *concretely* to address gender equity in their projects. One example was provided: though young males fall between

[2] Note that the RHI was the first phase of the EC-UNFPA Initiative. The second phase is known as the Reproductive Health Initiative for Youth and Adolescents (RHIYA) and likely will start in July 2003 and last for 33 months. The acronyms RHI and RHIYA are used throughout and represent Phase 1 and Phase 2, respectively.

the gaps in service utilisation, UNFPA staff reportedly did not ask the partners whether this should be redressed, and if so how. UNFPA disagrees with this statement, saying that they did emphasise such needs with partner. This may hold true for other partners who were not present at the meeting. Overall this raises the specific question about how gender issues, a cross-cutting issue for UNFPA, is addressed in practice. The question will only be resolved when the RHIYA planning stages are completed, which will be after this evaluation.

On the positive side, indicators for utilisation are included for both males and females, so this will perhaps address at least one component of gender equity. The challenge will now be for UNFPA to apply the gender equity focus in the materials used and the services provided. In addition, UNFPA state that in RHIYA the training manual on gender developed in RHI will be improved, adapted, and used to train the partners. UNFPA plan to organise training workshops for all project managers and project staff on integration of gender equity into the project activities.

VINAFPA

Since its formulation in 1993, VINAFPA's strategy and activities have been focused on family planning awareness raising and service provision, with the emphasis on IEC and counselling. VINAFPA is now mandated by the Government of Vietnam to meet the need for reproductive health and family planning services of the country, in cooperation with the Ministry of Health and the National Council on Population, Family, and Children (NCPFC), and so the Association's strategic focus and resources will continue to be directed towards this generalised FP/RH approach. The Association also wishes to move into focusing more on ARH. However, it currently has limited financial and human resources available to it, lowering capacity to deliver reproductive health services and counselling of sufficient and sustained quality.

Whilst VINAFPA staff and volunteers recognise and understand the diverse socio-cultural factors affecting the needs of young people, there is little evidence that this is translating into diverse programmatic responses. VINAFPA needs to decide where the balance should be sought in terms of coverage vs. quality of care. It also need to decide on whether it should develop a strategic response that is focused, for example on a particular client type, or geographical area, or service/IEC type, or whether to retain a comprehensive approach but at the cost of quality of care it can provide given current institutional capacity. Future expansion of VINAFPA activities is simply not realistic – the Association is overstretched as it is.

Attention on young people's reproductive health is limited to two programmes focusing on ARH, of which only one project is ongoing. Gender equity has not been effectively addressed. There is a strong bias towards women in VINAFPA's youth work. VINAFPA itself acknowledges that energies are mainly directed to IEC and awareness raising as opposed to service delivery. VINAFPA will need to address this imbalance if it is to fulfil its ambition to provide a comprehensive response to young people's reproductive health needs, and to take up the mantle as executing, as well as implementing agency, of the RHIYA.

Institutional Arrangements

UNFPA and VINAFPA fulfil different institutional roles within the government's response to the need to provide reproductive health services for young people. VINAFPA is an implementing agency, guided by the policies and overall goals of both the NCPFC and IPPF. UNFPA does not implement its Country Programmes (CP) directly, but through government, mass organisations and other local organisations. One key exception is the UNFPA HQ-mandated role in implementing the "Umbrella Project" which coordinates the activities and partners of the RHI (since 1 January 2001)/RHIYA. The UNFPA Country Programme is

largely executed by and through government, and its primary focus is to strengthen government capacity for direct execution of its population and RH programmes. VINAFPA by contrast is slightly less governmental. This means it is clearly and strongly linked to government, like a government agency. But it is not a government agency; it has its own facilities and own programmes separate from government services.

UNFPA

UNFPA developed capacity to implement SRH programmes for young people through CP 5 and 6 generally and through the implementation of RHI (and preparation for RHIYA) specifically. However, certain shortcomings were exposed. Though one staff member is considered to be an ARH specialist, there has not been enough staff to effectively coordinate and monitor activities, or provide sufficient technical assistance. This was partly due to the organisational structure of RHI, which was complex and muddled. For example, technical assistance was to have been provided by INGOs to the local partners; the quantity and quality of such assistance varied enormously, though that was not necessarily a reflection on UNFPA. A "lessons learned" booklet was written but it is not clear to what extent dissemination and discussion occurred. The coordinating "Umbrella Project" had been managed by an INGO, but this mechanism proved ineffective. An adjustment was made midway through Phase 1, and UNFPA took control of coordination, However, UNFPA lacked the staffing and mechanisms to coordinate well. RHIYA will be managed by expanded staffing in the UNFPA-implemented Umbrella Project.

Monitoring and evaluation was weak during the 5th country programme, as pointed out by internal evaluations of CP 5. Monitoring and evaluation in RHI were extremely weak, with unclear benchmarks, and no baseline or endline surveys. Though some data were gathered, it appears little useful analysis was completed. UNFPA has learned from this and has logical frameworks for the overall CP, for each component, and for the RHIYA. The logframes clearly set out what outputs and effects are being sought.

UNFPA has established its own monitoring and evaluation unit, reportedly the only one in Asian UNFPA offices. The new Unit will take on an assistant[3] solely dedicated to the RHIYA, and is already developing survey tools for baseline, midline, and endline measurements. The Country Support Team has provided limited but useful assistance to the UNFPA Office and government partners, mostly in development of logframes and M&E systems. These efforts should ensure that indicators are identified and appropriate, survey instruments are developed and implemented, and that useful analysis will be conducted to make conclusions about the programme effectiveness of RHIYA.

UNFPA has a remarkably close, trustful, and influential relationship with the government, which puts them in an excellent position to affect policy development and reforms. UNFPA works through local "mass organisations," but the main ones, such as the Youth Union, are themselves government institutions. This focus on local mass organisations is partly due to the lack of a legal framework that defines the rules for, and roles of, local NGOs. UNFPA did work with local NGOs in a very limited fashion in RHI, and this was an important example to the government as it demonstrated the ways in which LNGOs can be effectively used. Some international and local RHI partners criticised UNFPA for not involving them more in the initial

[3] Post-Evaluation Addendum: UNFPA reported in September that "there are 3 positions in the M&E unit (not 2) and another M&E officer will be dedicated to RHIYA supported by the expertise from the M&E unit but following the guideline from the Regional Dimension." In addition, "The institute of Demography of the Catholic University of Louvain will implement the monitoring and evaluation Regional Dimension component of the RHIYA by putting in place a routine monitoring system, by guiding and following up the realisation of the surveys and finally by strengthening the capacity of all RHIYA partners."

steps of the design of RHIYA. This reflected the partners worries that their voices might not be integrated strongly enough in RHIYA[4]. To their credit, UNFPA has addressed criticism by having a more participative approach in later steps of project development.

There are few mechanisms for young people's participation in the CP. Indeed, the concept of young people's participation in Vietnam is still very new. RHI took steps to address this by assisting the government in creating relevant national policies addressing SRH for young people. More pragmatically, the design of RHIYA included consultations with youth. This is a small step, but should be continued and expanded to make it a significant one.

UNFPA has also been instrumental in addressing ARH through the UN Interagency Working Groups, which now has a group on Youth. The current UNFPA Resident Representative is credited with putting youth on the Interagency agenda at a UN retreat in 2002. This will clearly help mainstream youth (including SRH issues where appropriate) in other UN programmes.

VINAFPA

VINAFPA has considerable human resource capacity constraints, with a Volunteer Board acting in a dual governance and management role, and the absence of a middle management layer within the organisational structure. Diminishing core funding from IPPF has meant that key posts such as an Evaluation and Monitoring Officer no longer exist, and this has had an effect on the organisations learning ability, to measure the effectiveness of its programmatic approaches, and thereby its ability to strengthen its strategic approaches for making them more appropriate to young people. Youth participation within the organisational structure of VINAFPA is negligible and has not been actively promoted.

VINAFPA's way of working demonstrates strong collaboration with mass organisations, other local organisations, and local and central government authorities and bodies. This makes attributing success at the door of individual organisations difficult if not inappropriate as success is usually achieved through partnership. VINAFPA itself relies on the support of the Youth Union, the NCPFC, MoH et al; VINAFPA is not seen as a major provider of technical assistance to others, or a promoter of best practices more broadly. This support is required, in large part, due to its volunteer structure (in which VINAFPA members are often officials from Mass Organisations and Government Departments themselves), but mainly because of the quasi-mass organisational status that VINAFPA holds, and the obligation at local level to include influentials within project steering committees to ensure project acceptance and a supportive environment for implementation.

Whilst most key informants had heard of VINAFPA, they were not aware of what the organisation did, and did not perceive VINAFPA as contributing significantly to ARH or RH in general. It is entirely possible that this invisibility to many other organisations is a positive reflection of the strength of collaboration that VINAFPA has with mass organisations and the Government, and is not a negative reflection of a lack of activity or impact.

If VINAFPA is to attract further funding and justify its existence, it urgently needs to identify, and promote its "niche" over other organisations, to increase its visibility, as well as to ensure that it is not duplicating work being successfully done by others. A case in point is the Youth Union, who has considerable expertise and geographical coverage in IEC work with young people. VINAFPA's strength or comparative advantage will lie in its ability to provide not only IEC and counselling but also service provision, and provide a holistic package of IEC and clinical services to young people.

[4] Consultation with sample of RHI partners, May 9th, Hanoi.

Complementarity and coordination between UNFPA and VINAFPA

UNFPA and VINAFPA relate to each other through two key projects, the EC-UNFPA RHI/RHIYA and UNFPA's capacity building projects for VINAFPA. UNFPA largely plays the role of donor while VINAFPA's is that of implementer. In this way the two play complementary and appropriate roles. For example, in RHIYA UNFPA will provide the overall funding for the Initiative, coordinate through the Umbrella Project, and through its other policy development work seek to create the needed policy frameworks to support the Initiative (and SRH for young people in general). VINFPA, on the other hand, will be the lead agency to coordinate (and implement) services. While this is a clear stretch given VINAFPA's limited capacity, they are arguably the best placed of all local agencies to fulfil this role.

Another clear coordination mechanism for both agencies is through the NCPFC. Both UNFPA and VINFPA work quite closely with them; VINAFPA is the only local organisation to be a member of the NFPFC. This shared role helps facilitate closer collaboration between the two agencies.

VINAFPA is now at the beginning of a new era, in which difficult decisions will have to be made both by the Association and by IPPF, as well as its supporting agencies such as UNFPA and NCPFC. Clearly, VINAFPA has the potential to be an important and influential player in the field of adolescent reproductive health. It is a national organisation operating on a scale considerably larger than other local organisations, with a physical and human infrastructure that, albeit basic, covers most of the country. It also has a unique relationship with the Government, and is identified by the NCPFC as a major contributor to the country's Population Policy. The question is whether it can transform this potential into reality. Given current capacity, this is perhaps unlikely unless VINAFPA receives considerably more financial assistance with which to address the key issues and recommendations raised in this and other evaluations. This will also require substantial institutional development and capacity building in areas of: governance and management, strategic planning, technical standards of care, internal policy development and adherence, and monitoring and evaluation.

Policy and Advocacy

Over the last 8 years several national policies and strategies regarding and/or affecting the reproductive health and rights of young people in Vietnam have been approved. Both UNFPA and VINAFPA have had close relationships to government, affording them a place at the policy and advocacy development table. However, the status of each organisation dictates different approaches. UNFPA, with a long history of trustful relationships with government, can play a more challenging role both formally and informally. VINAFPA, as a local organisation under a greater degree of indirect control by the government, tends (and needs) to tread more lightly.

The concept of rights in general, especially "human rights" is an extremely sensitive issue in Vietnam,[5] and discussions had to be taken in an oblique and non-threatening manner. That is not to say that rights are not discussed at all in Vietnam. Considerable progress in promoting rights has been made in the last five or so years. Discussing reproductive rights was less controversial. During the evaluation the team witnessed various discussions, and the controversy was often more about which specific reproductive health rights were being discussed.

[5] The Evaluation team was advised from the first meeting to be very careful about the questions we asked regarding rights as, in their own words, this was an extremely sensitive issue in Vietnam.

UNFPA

UNFPA has made enormous contributions towards RH and ARH policy development and reform in Vietnam; UNFPA is the recognised technical leader in providing (A)RH assistance and direction to the government. These key policies and strategies reflect the ICPD programme of action as well as the sexual and reproductive health and rights of young people. The key related documents include the Vietnam Population and Family Planning Strategy (during CP 4 and 5), the revised Vietnam Population Strategy (reflecting the shift to RH), National Strategy on Reproductive Heath, National Youth Development Policy (CP6), the National Standards and Guidelines for RH Care Services (plus the accompanying monitoring and evaluation guidelines). Finally, UNFPA has assisted the NCPFC in moving from its old “IEC strategy” to a more appropriate “BCC strategy.”

Various types of rights are included in UNFPA-supported ARH work. RHIYA focuses on rights to information, access to services, to choice, and to participation. The NCPFC’s “Core messages of population and reproductive health care,” developed with assistance from UNFPA, highlight the need for service providers to ensure adolescents have the "10 rights of clients." Similarly, one module for training used by the Hanoi Youth House talks about the “12 sexual and reproductive rights” which also should apply to adolescents.

Advocacy/IEC was a separate sub-programme under CP5. Yet advocacy is perceived by UNFPA as one of its key purposes. In order to make advocacy/IEC a central focus, it has been integrated as a cross-cutting issue into both the RH and PDS sub-programmes.

VINAFPA

VINAFPA addresses ARH “rights” indirectly mainly as “needs” that Vietnam and its people should be obliged to meet, and demonstrates how these needs can be met through “model” projects. This is a non-threatening and acceptable approach for Government.

Given the high degree of state control over local organisations, from determining levels of ODA received, to where they can operate, and the demands that they place on NGOs to report back to Government on activities and expenditure undertaken annually, the challenge role available to local organisations is limited.

VINAFPA, unlike many other local organisations, is also seen as the “right hand” of the government due to its membership in the NCPFC. This places it in a difficult position with regard to policy influencing. It cannot afford to directly challenge Government policy, and yet it is perhaps more ideally placed to influence policy because of its proximity to Government. Similarly to the rights issue, VINAFPA has to take a *softly softly* approach and therefore its visibility with regard to policy development is muted.

Reproductive Health Services

UNFPA has two vehicles to support RH, including ARH, services. The first is through their Country Programmes. In the second, through the RHI, both UNFPA and VINAFPA have focused specifically on providing ARH services, from basic information to clinical services. However, while VINAFPA’s strength has been in IEC and counselling, UNFPA’s other partners have focused on services as well.

UNFPA

UNFPA has included numerous ARH activities in both CP5 and CP6. In CP5 this included RH service provision through the MoH, improving competencies of health care providers in RH services, advocacy with key stakeholders (which included assisting the government in

policy development to address aspects of ARH), establishment of 140 youth clubs and numerous counselling centres, and IEC and training materials development. This firmly established UNFPA's increasing attention to ARH. However, most persons interviewed agreed that the most significant and systematic push to emphasise ARH – indeed, built upon the previous CP5 work – came with the RHI.

RHI started during CP5 and had a total budget in Vietnam of over 4 million euros. It was supposed to last for 4 years (1997-2000), but in fact was extended a further 2 years till the end of 2002. In Vietnam, the RHI started a year late due to bureaucratic difficulties. While UNFPA and the government chose to focus on young people from the start, RHIYA will focus on young people in all 7 countries where the initiative is being implemented. Umbrella projects were established in 6 countries, including Vietnam where World Population Foundation took the role. This design, however, was flawed and caused considerable problems in management and coordination. After the midterm review and midterm evaluation it was decided that UNFPA would take on this role themselves. However, the Vietnam CO, too, was felt not to have the requisite capacity to manage the Initiative. Low capacity almost prevented the EC from allowing Phase 2 to be implemented in Vietnam[6]. To address this concern, two additional staff will be hired to build up the CO capacity, and Phase 2 looks set to begin in the summer of 2003.

RHI activities were meant to focus on the provision of information and services. Relatively more resources were dedicated to IEC development and dissemination. Counselling was often the main service, or means of IEC dissemination, provided. There were various fora for this: Youth Union counselling centres, school clubs, commune youth clubs, community counselling, counselling corners at schools and so on. Actual clinical services were limited to a few demonstration sites in Hanoi and Hue, and other minimal services from, for example, VINAFPA. Neither programme nor cost effectiveness evaluation was not done, but it was generally felt that the clinical services such as the Hanoi Youth House were too expensive to replicate. It should also be noted that little effort has been put into making general health services more friendly for youth. UNFPA has learned from this and is proposing different service delivery models (i.e., youth-friendly corners in government facilities). It is hoped they will be less costly – but may not be necessarily more cost effective.

VINAFPA

VINAFPA has not focused strongly on the provision of services for young people, directing instead its attentions on IEC and counselling, and awareness raising about ARH in general. RHI provided VINAFPA with its first entrée into providing services dedicated to young people. Strategic approaches have tended to respond to young people as a homogenous group, but VINAFPA is gradually developing responses that are targeted to meeting the needs of diverse groups of young people.

Service statistics indicate clearly that more young women are being reached than young men – indeed, a snapshot of STI treatment statistics showed 100% of clients were women. This is a serious concern. Either the youth service is totally unsuitable for young men and they seek treatment elsewhere, or VINAFPA is not undertaking 'partner treatment' action, despite having trained its service providers in STI diagnosis and treatment protocols. Despite programme data/records clearly showing the significant lack of male involvement in ARH service provision, VINAFPA has not yet developed a strategy aimed at addressing the needs of young men, beyond engaging in condom social marketing.

However, VINAFPA is beginning to address the needs of diverse populations, targeting specific groups of young people with special needs. One such example is the recently

[6] Personal conversation with EC representatives, May 9th and 20th.

initiated project in Hanoi and Quang Ninh which focuses on HIV/AIDS prevention amongst commercial sex workers operating in hotels and restaurants. In Hue City, VINAFPA also works with street children/youth through "Moon Age Clubs" for young people aged 14-17 years. However, the IEC materials and outreach strategies VINAFPA tends to employ do not specifically differentiate between the youth being reached.

Measuring the effectiveness of the service provision by VINAFPA is difficult due to inadequate monitoring and evaluation systems and the lack of baselines and evaluation surveys using outcome measures and targets. The needs of young men are poorly addressed by VINAFPA's service providers, especially in STI diagnosis and treatment, and this needs to be tackled as a matter of urgency by the Association.

Reproductive Health Information and Education

As previously mentioned, much of the work of both UNFPA and VINAFPA under the RHI focused on the production and delivery of IEC materials. Both UNFPA and VINAFPA have been slow to move from an IEC focus to BCC, though this should change under the RHIYA. Similarly, IEC has not substantially addressed the needs of diverse populations, though this too is changing under RHIYA.

UNFPA

UNFPA has moved from a narrow focus on IEC towards a focus on behaviour change. This is also reflected in the NCPFC approaches (supported by UNFPA) where they reportedly had an "IEC strategy" from 1993-2000, but now have a "BCC strategy" from 2001-2005. Changes include adding a focus on "service provider and community leader BCC," including indicators on behaviour change (such as increase in utilisation), including "analysis of target audience" (e.g., a form of youth participation) for the first time, and improved monitoring and evaluation of behaviour change.

Under RHI, UNFPA sponsored the development and dissemination of a plethora of IEC materials focused on young people. These materials included books, booklets, leaflets, posters, videos, etc. These materials addressed a wide range of issues and, appropriate to IEC (not BCC), seemed to focus on providing accurate information on issues such as puberty, HIV/STI transmission and prevention, and drug abuse. However, many of the messages are not developed with behaviour change in mind. None of the materials reviewed addressed, for example, risk perception or other barriers to behaviour change.

Materials reportedly were developed using appropriate methods including field testing with youth. Many materials have great appeal to youth, but there were some shortcomings still. There is some concern that there was great duplication of efforts – different RHI partners producing similar materials. Materials still in circulation have a northern and urban bias focusing mostly on the dominant Kinh people as well as youth who are in school. Youth report the information is often too superficial and they seek more details. Rights usually are not explicitly addressed, but given the social environment at the start of RHI this was no doubt the correct approach. UNFPA decentralised its general RH IEC development to provincial level in order to encourage more diverse and appropriate materials. This same approach is planned for RHIYA and should help address these issues.

VINAFPA

Reproductive health information and education have been VINAFPA's main focus with regard to ARH. VINAFPA has taken a strongly IEC based approach as opposed to a BCC approach, of which there is limited conceptual understanding. IEC materials dedicated to young people's RH needs were centrally produced under RHI, with limited youth involvement

(pre-testing only), and mixed evaluations as to appropriateness – the materials tend to be, again, Northern in outlook, with a strong in-school "look", but still popular with some youth groups – and some of the products have been adopted by other organisations.

As with service delivery, VINAFPA is unable to measure the effectiveness of its IEC approaches as it does not undertake baseline and final evaluation surveys measuring knowledge increases and attitudinal changes. Therefore, it is difficult to assess how the Association has contributed to young people's knowledge and understanding of reproductive health issues. With regard to awareness raising in general, and creating an enabling environment, circumstantial evidence would suggest that VINAFPA has been particularly successful in this regard.

KEY FINDINGS AND RECOMMENDATIONS

The strategic focus of both UNFPA and VINAFPA has shifted considerably since ICPD from a demographic focus (population/family planning) to one based on reproductive health and, to a lesser extent, rights. Both organisations have been able to focus on ARH issues through the EC-UNFPA Asian Initiative for Reproductive Health. Both organisations demonstrate an appreciation of the complex socio-cultural context in which they are working, and the key reproductive health and rights issues facing young people in Vietnam. Both emphasise the need for the development of youth friendly services, and both have supported the development and delivery of youth-focused IEC.

UNFPA

- UNFPA has been an effective partner and good friend to Vietnam since the ICPD POA of 1994. UNFPA is recognised as a leader in RH programming and policy and has been instrumental in the development and promulgation of numerous national policies and strategies related to ARH. The successes UNFPA demonstrates are due to the close trusting relationship they hold with the government, the strong tide of reform and change within Vietnam, and good programming and staff over the years. It seems unlikely that similar successes could be replicated in countries where the same necessary antecedents (e.g., strong reform movement, trustful relationship) are not present.
- UNFPA's country programmes 1-4 made contributions to population, MCH and family planning issues, with a strong demographic focus. The Fifth County Programme (1996-2000) showed a significant programme reorientation from family planning to reproductive health. The introduction of the RHI, with a focus on young people in Vietnam from the start, is credited with moving forward to ARH agenda.
- The Sixth Country Programme (2001-2005) saw the continuation of RHI and will also see the start of its second phase, the Reproductive Health Initiative for Young People (RHIYA). CP 6 is contributing to/supporting service strategies that are responsive to the diverse needs of young people. They wish especially to target "poor and deprived young people" including both in and out-of school youth, street children, and ethnic groups.
- UNFPA staff recognise that discussion of rights in Vietnam is a sensitive issue. However, UNFPA does focus on promoting the concept and practice of sexual and reproductive health rights to the extent that it is possible in Vietnam, and various types of rights are included in UNFPA-supported ARH work. The RHIYA focuses on rights to information, access to services, to choice, and to participation.
- The quality and dedication of staff seems high. The evaluation of the RHIYA highlighted the need for more staff, and UNFPA is hiring two additional members for the Umbrella Project. UNFPA benefits from having international Junior Professional Officers, but these posts are largely training posts. As decentralisation increases, staff workloads and the need for programme monitoring will increase. In such a case, more (local) staff may be needed to ensure effective implementation.
- Young people have very limited participation in the design, implementation, monitoring, and evaluation of ARH services. For the design a RHIYA, youth were invited to a workshop to discuss their needs and how to effectively address them. However, youth do not have a more formal role, such as sitting on boards or participating in M&E exercises as such participation would go against a strong cultural norm.

- Gender equity and women's empowerment is a cross-cutting issue in CP6. However, practical ways to ensure "gender equity" have not been emphasised with partners of the RHI/RHIYA. The needs of young males, in particular, need further consideration and action. Data by age and sex have not been systematically collected, though there is some sign that this may change.
- UNFPA has moved from a narrow focus on IEC towards a focus on behaviour change. This is also reflected in the NCPFC approaches (supported by UNFPA) where they had an "IEC strategy" from 1993-2000, but now have a "BCC strategy." Changes include adding a focus on "service provider and community leader BCC," including indicators on behaviour change, including "analysis of target audience" for the first time, and improved monitoring and evaluation of behaviour change.

UNFPA Country-Level Recommendations

- Youth/adolescent SRH strategies compendium: There are a number of recent policies and strategies that address aspects of ARH. Compilation of these disparate policies and strategies into a complete ARH compendium might help in ARH planning, programming, co-ordination, and monitoring/evaluation nation wide.

- Sustainability and Scale up Strategy: Sustainability, in its different forms, and methods for scaling up programmes are currently more implicit than explicit in UNFPA's programming. The articulation, then dissemination, of UNFPA's approaches in a sustainability and scale up strategy/lessons learned document would clarify both the UNFPA and government positions on sustainability, and provide leadership and ideas to other agencies.

- Abortion services: RHIYA and UNFPA CP focus on prevention of unwanted pregnancy, preventive measures of abortion, promotion of contraceptive methods among adolescents and youth, and training health workers in counselling for prevention of repeated pregnancy among youth. If and where possible, UNFPA should also emphasise the provision of safe abortions, not only in RHIYA but across all programmes and projects in their 11 provinces. Where possible, innovative approaches should be documented and scaled up.

- Youth participation: "Youth participation is a new concept in Vietnam" was a frequent refrain. Greater youth participation is needed, not simply as recipients of project activities, but as "co-decision makers" involved in designing programmes, sitting within project steering committees, involved in monitoring and evaluation activities, etc. UNFPA should lead the way in explicitly demonstrating the value of such youth participation.

- Increase capacity of UNFPA CO: Current staff might benefit from specific basic and refresher courses on ARH issues, monitoring and evaluation of ARH programmes, BCC material development, and general management. Young people should be included systematically in the planning, implementation, monitoring, and evaluation of ARH programmes and projects. UNFPA needs to increase substantially its support to, and monitoring of, the Executing Agencies under RHIYA, VINAFPA and the Youth Union, to assist them to effectively fulfil these new roles.

- Further support for Monitoring and Evaluation: UNFPA/Vietnam should be supported in their efforts to enhance their monitoring and evaluation capacity. This would include hiring more staff if needed. Periodic reports should include analysis of achievements to date against logframe indicators, both quantitative and qualitative, and provide trend analysis. Implications of performance on changes in programming should be highlighted.

VINAFPA

- VINAFPA has branches in 47 provinces and cities and is considered an organisation with nationwide coverage with a history of ten years of IEC and service provision relating to family planning and reproductive health. It has over 1,400 community based distributors (CBDs), 20 reproductive health counselling centres and 1 community development-counselling centre.
- In the 2001 - 2010 Population Strategy, VINAFPA is mandated alongside the NCPFC as co-operating agencies. VINAFPA has a unique and privileged position with regard to its relationship with government, and the association is held in high regard by the NCPFC who acknowledge the contribution made by VINAFPA through strong collaboration with the MoH, NCPFC, and mass organisations.
- The extent to which VINAFPA has been able to capitalise on this unique positioning in terms of influencing policy development is difficult to gauge. As a quasi-governmental organisation, many see VINAFPA as unable to offer a strategic and formal 'challenge' role to Government. However, within VINAFPA, opportunities for influencing policy *are* identified and taken up whenever the chance arises.
- The staff structure is sub-optimal. VINAFPA has intertwined governance and management structure, which raises concerns about accountability of the Association. Head Office capacity is constrained, not through the quality of staff, who have appropriate skills and experience necessary for their posts, but through the limited number of staff available to the Association. Also, the lack of staff is having negative impact on ability to undertake regular monitoring of project activities. The result is widely varying quality of care being provided, lack of standardised approaches to key policy issues such as paying for services and client confidentiality. The absence of a dedicated monitoring and evaluation officer means that data collected is not routinely analysed. Outcome effectiveness is not measured, rendering ability to judge performance of "models" objectively almost impossible.
- VINAFPA has only been addressing ARH, with young people as a target client base, since 1999, with the advent of the EC/UNFPA RHI. This initiative has been instrumental in enabling VINAFPA to engage in ARH work. However, promulgation of young people's reproductive rights is not articulated clearly in VINAFPA's strategic goals or programme objectives. VINAFPA has tended to focus its management and implementation energies on information, education and counselling, rather than capacity building and service delivery. VINAFPA needs to rectify this imbalance if it is committed to supporting ARH in a *comprehensive* manner. At the same time, it must identify where its "niche" is, and ensure that it is not duplicating work being done by others.
- Since its establishment in 1993, and prior to RHI, the Association focused on provision of family planning to the general rural population. As such, young people might have receive services by VINAFPA, but service statistics collected under these programmes do not give age breakdown.
- Financial resources dedicated *solely* to ARH remain low in comparison to total budget/expenditure on non-ARH focused activities. However, this is in large part due to the comparatively high costs of general clinic service provision. In actual fact, expenditure of IEC focused on ARH has increased threefold over the last ten years, as has expenditure on service provision dedicated to young people. VINAFPA has also received considerable support "in kind" to its ARH work from Provincial authorities, increasing total budgetary allocations towards ARH.

- Participation of young people in the Association's decision-making, policy development, and programme planning is negligible. Young people are involved in awareness raising activities, and in testing of IEC materials, but not in any significant decision-making and internal policy development capacity.
- VINAFPA service providers have received training in ARH counselling, and IPPF have developed a Youth Friendly Services Checklist for service providers. However, there is a range in the standards of youth friendliness in service provision.
- None of the printed IEC materials produced by VINAFPA are tailored to specific sub-sections of youth population. They are all produced with a generic youth audience in mind, with no differentiation in age groupings, sex, or ethnicity.

VINAFPA Country-Level Recommendations

- Strategic Response – Focused vs. Comprehensive: VINAFPA needs to assess its comparative advantage over other local/non-governmental organisations, of being a national organisation with a RH/FP remit from Government, alongside its current limited financial and human resources capacity to deliver reproductive health services and counselling of sufficient and sustained quality, and decide where the balance should be sought in terms of coverage vs. quality of care.

- Youth Response – Focused vs. Comprehensive: VINAFPA should identify more accurately its target group(s) with regard to youth, and devise differentiated strategic responses more appropriate to the specific needs of these youth groups. The needs of young men urgently need to be addressed.

- Learning: Enhanced monitoring and evaluation capacity is urgently required – to assist in lesson learning, trend analysis, progress assessment, problem identification, and evidence based outcome effectiveness measurement – to allow for more rigorous "model" testing.

- Participation: Greater youth participation is needed – not simply engaged in project activities, but as decision makers sitting within project steering committees –for reasons of rights of participation, and also to improve quality and appropriateness of VINAFPA response to youth needs.

- Capacity Building: At this critical juncture in VINAFPA's engagement in ARH activities, with the onset of the EC/UNFPA RHIYA (Phase 2), it is essential that IPPF is better able to provide timely, regular, and sustained technical assistance than previously provided, especially at the institutional and managerial level.

Complementarity of UNFPA and VINAFPA

- VINAFPA's approach to young people's sexual and reproductive health is fairly complementary to that of UNFPA, mostly defined through the RHI/RHIYA. However, UNFPA's selection of VINAFPA to be the executing agency responsible for ARH services under RHIYA appears not to have been based on any absolute demonstrated expertise from VINAFPA under RHI but rather based upon VINAFPA's capacity and geographical reach when compared to the other very limited local organisation choices.
- UNFPA and VINAFPA coordinate through the NCPFC, with whom both organisations work closely.
- UNFPA has sought to increase VINAFPA's overall capacity through a separate capacity building project. VINAFPA will likely require continued capacity building, whether from UNFPA or other sources.

INTRODUCTION

The Ministry for Economic Cooperation and Development (BMZ) of Germany, the Danish Ministry of Foreign Affairs, the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs, and the Norwegian Ministry of Foreign Affairs are jointly sponsoring an evaluation of the contribution of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF) to addressing the reproductive rights and health needs of young people[7] - and especially adolescents - in the period since the finalisation of the Programme of Action (POA) developed at the International Conference on Population and Development (ICPD) in 1994.

The evaluation focuses on six country case studies: Tanzania, Burkina Faso, Bangladesh, Egypt, Nicaragua and Vietnam undertaken between March and May 2003. The findings from these six country studies will be synthesised into a final report to be presented at an international workshop in December 2003.

Objectives of the Evaluation

The overall aim of the evaluation is to clarify how UNFPA and IPPF contribute to the implementation of key aspects of the ICPD Programme of Action, relating to the reproductive rights and health of young people. UNFPA and IPPF have affirmed their commitment to the ICPD framework; central to which are the notions of gender empowerment, equity, and a rights based approach. IPPF's commitment to a rights based approach is outlined in the IPPF Charter on Sexual and Reproductive Rights (1995), and in the objectives and strategies of Vision 2000.

The goal of the evaluation is to contribute to a better understanding of the conditions necessary for achieving best practice, and to draw strategic lessons for the future.

The purpose is to assess the performance of UNFPA country offices and FPAs in selected countries (see below) in promoting reproductive rights and health (with the aim of achieving behavioural change), with a particular emphasis on adolescents and youth.

Composition, Timing and Schedule of the Country Evaluation

The local partner for the country evaluation was Marie Stopes International/Vietnam. Centre for Investment in Health Promotion (CIHP) undertook preliminary studies ahead of the international team's visit. The international team for the country evaluation was: Anthony Bondurant (team leader), Sophia Henderson (international team member) and Nguyen Cuong Quoc (national team member). The international team members arrived on 4 May 2003, and departed 24 May 2003.

The evaluation team spent the first week in Hanoi conducting a one-day stakeholders' workshop and following up with central-level meetings. During the first three days of week two, the team divided into two groups and made visits to Da Nang and Quang Nam (Group 1) and Thai Binh and Hai Phong (Group 2). The remaining days of week two and most of week three were spent in further meetings and writing the aide memoire/report. See Annex 1 for details on the itinerary and persons met.

[7] The evaluation adopts UN definitions: adolescents are aged 10-19 years, youths are aged 15-24 years; young people include both categories (10-24 years).

Report Format

The report is in six sections, relating respectively to the country context, the strategic focus of the two agencies' national programmes, institutional arrangements; and the contribution of each agency to policy reform, strengthening services and provision of information and education. Each section is structured around the criteria of the evaluation, which include relevance, integration of rights, capacity, efficiency, effectiveness, and sustainability. With the exception of section 1, the remaining sections are divided into two separate sub-sections on UNFPA and VINAFPA respectively, with each sub-section concluding with a short summary of the main conclusions.

SECTION 1: THE COUNTRY SPECIFIC CONTEXT

1.1 Demographic & Socio-Economic Context

1.1.1 Political environment

With the end of the American War in 1976, Vietnam became a socialist state unifying both north and south.[8] For the next 10 years it focused on implementing policies of centralised planning (including setting outputs targets for industry) and collectivised farming. By 1986, the country was experiencing serious food shortages, hyper-inflation, and other social and economic imbalances. This prompted the introduction in that year of *doi moi* ("renovation"), a policy of reform. Since then, Vietnam has seen dramatic improvements in virtually all key indicators.

Though elements of centralisation persist, many of the reform activities were conducted involving "local mass organisations," such as the Youth Union, Women's Union, and Peasants' Union. All are organs of the Party and all are extremely active still. The membership to such national organisations is huge, and has pre-empted somewhat the development of other local non-party organisations. Local NGOs, as such, exist in practice but not in law. The lack of a legal framework for local NGOs hinders further NGO development. This is not unintentional, as "non-governmental" appears to represent "anti-governmental" in some powerful circles. The effect is a blurring of the definition of "civil society organisations" in Vietnam, which has implications for the implementation modalities for development programmes such as those addressing adolescent reproductive and sexual health (ARSH).

Throughout the reform movement, the Party has remained ever strong and influential over social policies. One stark example is the policy on "social evils," which identifies sex workers, drug addicts, drug trafficking, those with STIs and HIV (and others) as social evils to be dealt with rather harshly. For example, sex workers and drug users can be interned in "re-education camps" know as "05/06 camps." The "social evils" policy even finds its way into the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) where an indicator for ensuring "grass-roots democracy" is "the percent of communes with no social evils."[9]

The implications of this milieu is that introducing ARSH programmes and policies, especially those related to rights, requires delicate handling. While the overall move is towards reform, agencies have to navigate long standing cultural and social attitudes, and Party influence, which often take longer to change.

1.1.2 Poverty profile of the country

Despite remarkable reductions in the incidence of poverty resulting from the implementation of *doi moi* reforms since the end of the 1980s, Vietnam remains a poor country. According to the Living Standards Measurement Survey (using the international poverty line), Vietnam's poverty incidence was over 37% in 1997/98, and is estimated at about 32% in 2000. Using the new poverty line developed by the National Poverty Reduction Programme, it is estimated that 17.2% of the total number of households are poor (Comprehensive Poverty Reduction and Growth Strategy [CPRGS] 2002). Though it is highly ranked in the UNDP human development index, other indicators of persistent poverty include high infant and

[8] Much of this section is drawn from the Vietnam Country Assistance Evaluation. November 21, 2002. Operations Evaluation Department, World Bank.
[9] Comprehensive Poverty Reduction and Growth Strategy, May 2002. P126.

maternal mortality rates, 57% of the population still lacking clean water, only one household in five having access to sanitation, and 41% of children being underweight (UNDP 1999).

Compared to other developing countries, Vietnam has a relatively even distribution of income and living standards, with a Gini coefficient of inequality of 0.35 (1997/98). Yet, there is a widening gap between rich and poor in terms of expenditure and income. Poverty remains a predominantly rural problem, with the rural poor constituting 94% of the total poor in 1997/98 (UN 1999). The incidence of poverty also varies by region, with the Northern Mountainous, Central Highlands and North Central regions worst affected. Poverty remains persistent among Vietnam's ethnic minority population, with almost double the rate of poverty among ethnic minorities compared to the Kinh majority in 1997/98. Young people and children are the most affected by poverty. They are less likely to attend school, more likely to undertake hard labour, and are more vulnerable to child prostitution, child trafficking, begging and drug abuse (UN 1999).

1.1.3 Demographic, population, and health indicators

Demographic indicators in Vietnam are improving considerably. The average annual population growth rate has declined substantially to 1.7% at the time of the 1999 Census, but remains high (3.6%) in rural areas. At the time of the 1989 Census, the TFR was 3.8. Only ten years later the TFR was 2.33 (1999 Census), the third lowest among 10 countries in Southeast Asia. In the first half of the 1990s, the TFR level had decreased slowly for women aged 30 and over, while in the second half of the decade, it decreased sharply even for those women aged 20-24 years old. The CPR is high at 75.3 in 1997.

Young people form a sizable proportion of the overall population. Young people aged 15-24 years comprise almost 20% of the population (Census 1999). A further 33.5% of the population are under 15 years, meaning that well over half of the population is less than 24 years old. The median age of a Vietnamese citizen is 23.4 years (Census 1999). 76% of the total population live in rural areas (Census 1999), but Vietnam is experiencing accelerating urbanisation and shifting internal migration patterns.

In 2000, the IMR stood at 36.7 per 1,000 live births, and Maternal Mortality Ratio (1999) was 100 per 100,000 births. Rates of abortion are relatively high. 15% of ever-married women reported experience with pregnancy termination, either abortion (vacuum aspiration) or menstrual regulation (dilation and curettage). However, this is a low representation on two counts. First, this figure only represents ever-married women; it is estimated that unmarried women account for 30% of total abortions.[10] Secondly, the MoH data for abortions is five-fold higher, suggesting a considerable under-reporting on the DHS (as it is unlikely that MoH data would be that over-reported). Women from the Northern Uplands and Red River Delta reported the highest amount of experience, 24% and 21%, respectively. Also pregnancy termination increase with age and educational background.[11]

1.1.4 Gender relations and status of young women

Equality between women and men in all respects has long been officially recognised in Vietnam's constitution and women's representation in the National Assembly is increasing. Yet men still dominate the most influential positions in the Party, legislative, executive and judicial institutions.

The CPRGS incorporates the goal of realising gender equality through the implementation of the National Strategy for the Advancement of Women in Vietnam to 2010. This includes the

[10] MoH (1998b) Annual Report, Maternal and Child Health Department, Hanoi, as reported in CCA.
[11] DHS, 1997.

aim of improving reproductive health and family planning for women, but does not identify the specific needs of young girls and boys.

Yet, within the household, poverty status can differ between male and female members, with women earning on average only 72% of men's earnings, lower education and nutrition status, and less control over and access to essential resources such as land (UN 1999). Son preference exists in many families, and male involvement in family planning and the sharing of family responsibilities remains very limited. A great need exists for a more gender-sensitive RH approach, particularly in family planning (UNFPA 2001).

Whilst data is difficult to find, several sources indicate that domestic violence against women is common. The IPPF Vietnam Country Profile cites that 70% of 22,000 divorces in 1991 were due to violence; the Committee who oversee the Convention on the Elimination of Discrimination Against Women in Vietnam (31/07/01) expressed concern about the prevalence of violence against women, in particular domestic violence.

1.2 National Policies, Strategies, Programmes and Laws

1.2.1 Policies and Strategies

The National Population Strategy

UNFPA participated in the development of the Vietnam Population Strategy, 2001-2010, produced under the auspices of the NCPFP. The previous strategy from 1993-2000 was called the Populations and Family Planning Strategy. During this time, the population policy and family planning programmes were focused on fertility control and were target-driven, with a 2-child policy enforced. The slight change in title reflects the overall move away from a narrow FP focus to a broader RH one. In fact, one key stated aim of the Strategy is to address points of the ICPD POA. Adolescents are specifically mentioned as a target group under the objective to promote behaviour change communication. Under improved RH services, adolescents are targeted for reductions in menstrual regulation/abortion.

The National Strategy on Reproductive Health, 2001-2010

UNFPA played a lead role in the development of the National Strategy on Reproductive Health, 2001-2010. The overall ("common") objective is "To achieve by the year 2010 a marked improvement in the RH status and narrow the gap between the regions and target groups by better meeting the diversified reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities, and pay particular attention to areas and target-groups having difficulties." Intended services include the supply of suitable contraceptive methods, condoms for STI prevention, safe abortion and STI treatment (UNFPA 2001).

There are seven specific objectives to the strategy, of which one objective is focused on ARH. However, this focus is more on provision of information and less on services. Still this is a major shift forward; until this RH strategy was developed, the MoH's health strategy did not contain any reference to reproductive health or the specific needs of young people (UN CCA 1999).

The National Standards and Guidelines for Reproductive Health Care Services (2003)

The National Standards and Guidelines for Reproductive Health Care Services (2003) were drawn up with the direct financial and technical assistance of UNFPA, with contributions from a number of individuals/national experts and other international organisations. The MoH seems especially happy to have this document which some say they had wanted to develop

for quite some time. There appears to be a high level of MOH ownership for the guidelines. The National Guidelines on Monitoring and Evaluation of Reproductive Health Standards and Guidelines is a companion piece to the National Standards. These guidelines are currently under development and are expected to be finalised by the end of 2003. UNFPA intends to provide training on these M&E guidelines in their 11 provinces, and the government is keen to have nation-wide training.

The National Youth Development Policy

UNFPA was a catalyst in the development of the National Youth Development Policy that was recently approved by the government while the evaluation team was in Vietnam (May 2003). The overall objective of Vietnam's youth development strategy is "to strengthen education and care for the young generations of Vietnam, for their comprehensive development, to become the high quality young human resource, to play the pioneering role and innovation of young people in the process of industrialisation and modernisation of the country." The document has a clear political tone, and largely emphasises the need to address education and unemployment. It also mentions the need to address the increasing HIV prevalence among youth. Other specific SRH issues are not highlighted. One of the six targets is stated, with commonly used language, as "Improve health, spiritual life, build the cultural life, suppress the social evils and law breaching among the youngsters."[12] However, in the 5 programmes outlined to implement these targets, health issues are not mentioned, though might be inferred from one programme dealing with "social evils" (e.g., if HIV is considered as such).

Comprehensive Poverty Reduction and Growth Strategy (CPRGS)

The CPRGS was approved by the Prime Minister in May 2002 and is an action plan that is meant to translate the Ten-year Socio-economic Development Strategy and sectoral development plans into a road-map for action. The CPRGS emphasises human resource development and poverty reduction, giving priority to health and education development, and environmental protection. It also encompasses goals for improving reproductive health, HIV/AIDS, gender equality, women's empowerment and child rights[13].

1.2.2 Laws regarding and/or affecting the reproductive rights of young people[14]

Reproductive rights in Vietnam were stated in law long before the ICPD in 1994. Reproductive rights currently are included in many laws and policies such as "The National Strategy on Reproductive Health," "The Strategy to Protect and Care of People's Health," "The Plan of Action for the Advancement of Women in Vietnam by 2005," "The National Strategy for the Advancement of Women in Vietnam to 2010," "The National Strategy on Population," "The National Strategy for Children," the "Civil Code," the "Labour Code," "Marriage and Family Law," and "Population Law."

The Marriage and Family Law 2000 and Guidelines for implementation states clearly that "male and female must have followed (these) conditions when getting married with each other:

1. Man is from aged 20 and woman is from aged 18

[12] Vietnam's Youth Development Strategy by 2010. 29 April 2003.
[13] UNFPA Annual Report 2002.
[14] The following is taken from the Legal Review Study, May 2003, produced by Centre for Investment in Health Promotion which was commissioned for this evaluation.

2. The marriage must be voluntary decided by the man and woman. No one have right to force or betray other; no one have right to force or prohibit man and woman from marriage" (Article 9, Chapter II)

Anyone who violates this law will be punished by the court as follow "The one, who force other to marry without their willingness, prohibit other to marry or maintain their voluntary and advance marriage, by ill-treatment, threaten morale, ask for property or other ruthless ways, will be punished by warning, re-educated without to be in prison maximum one year or to be put in the prison from three months to three years" (Article 143, Chapter V, the Penal Code of Social Republic of Vietnam).

There is no specific legal restriction against reproductive health services, including contraception, for young people. Young people are considered as individuals in the country, so they have the right to voluntarily select contraceptive methods and to have abortions[15]. They also have the right to be provided information on population, and the right to be provided confidential, safe, convenient, and quality population services[16]. Standing as individuals in society, young people have a host of sexual and reproductive rights: the right to have a safe and secure life, health, and body; the right to be protected of honor, dignity, and prestige; the right to privacy; the right to marry; the right to equality in marital life; the right to receive care from other family members; and the right to divorce[17].

The legal framework in Vietnam provides Vietnamese women equal legal status relative to men. This is consistent in the constitution and laws related to women and men as individuals or as married couples. The Constitution of Vietnam (1992) states that *"Male and female civil (sic) had equal rights in all aspects of political, economy, cultural, society and family" and " all the action that discriminate and ill-treatment women (sic) were not allowed" (*article 63). The Marriage and Family Law (2000) mentions that *"Wife and husband are equal to each other, have equal responsibilities and rights in term of all issues in the family"* (Article 19. Chapter III).

An adult 18 years and older would be punished for having sex with an adolescent under 16, even with the willingness of the adolescent. The Penal Code of Social Republic of Vietnam 2000 does not mention anything about two adolescents aged 13 to under 18 having sexual relations.

1.2.3 Rights within the Constitution as they affect or relate to young people[18]

Vietnam has ratified international rights conventions including CEDAW, several International Labour Organisation conventions, Goals of the World Summit for Children, ICPD and the Beijing Platform for Action. Vietnam has submitted at least four reports on its implementation of CEDAW. The Committee overseeing the Convention on the Elimination of Discrimination Against Women expressed concern about the prevalence of violence against women, particularly domestic violence, and the lack of legal measures to address such violence; and highlighted the need to monitor trafficking of young women.

Vietnam was the first Asian state to sign and ratify the Convention on the Rights of the Child and to submit a report on its implementation. The Committee overseeing the Convention on the Rights of the Child expressed concern about the persistence of discrimination against women and girls in rural areas, especially relating to health and educational opportunities.

[15] As indicated in the Article 43, Chapter VIII of Law on Protection of People 1989.
[16] According to Article 4, Population Decree 2003.
[17] As identified in the Civil Code of Social Republic of Viet Nam. Articles 26 to 47.
[18] Parts of this section are drawn from the Legal Review Study, CIHP.

Equality and non-discrimination are enshrined in the Constitution and promoted through legislation, policies, and plans of action.

1.2.4 Young people's participation in policies and programmes

UNFPA provided assistance to the Ministry of Education and Training (MOET) resulting in a major reorientation of the Population Education programme to a more life-skills-oriented ARH Education approach. UNFPA's 6th country programme will continue support through supporting youth participation and youth utilisation of RH services in projects with MOET, MOH, youth union at the national level and provincial projects; the development and revision of the ARH education materials; training of selected groups of teachers; development of other support materials; and the adaptation of the materials for in-school and out-of-school adolescents and youth including unmarried young adults.

However, young people do not have a defined role in decision-making roles during the design, implementation, monitoring, or evaluation of ARH programmes. This is changing slowly; youth were involved in a two-day consultation exercise as part of the design of the RHIYA.

1.3 Sexual and Reproductive Behaviour

1.3.1 Social and cultural attitudes towards sex, marriage and fertility

As Vietnam's economy shifts from a largely agricultural and centrally planned base towards a more free market socialist economy, the social mores are also shifting. Talking with young people about their sexual and reproductive health is a sensitive issue in Vietnam, as in most countries. Social support systems are faced with the need to preserve cultural values in the face of economic, educational, social, and cultural changes. Parents, extended family members, teachers and other community members consider it their responsibility to ensure that young people are equipped with skills and information to have their own healthy families[19].

Although numerous studies have been conducted relating to youth and health, very few seem to have addressed the broader cultural and social atmosphere and attitudes. It would appear that society's awareness of SRH issues for young people is not adequate. The studies give some insight into young people's own attitudes:

- Most adolescents feel hesitation when talking about matters related to sex and sexuality, but they state that they indeed need a further education on sex.
- The concept of sexuality among young people is not as strict as before. Acceptance of premarital sex exists among a sigfinicant number of adolescents.
- Though some studies arguably state that awareness of youth about abortion risks is good, there are still a great number of unwanted pregnancies and induced abortion among adolescents. The researchers' phrasing of the reasons cited were enlightening; the reasons for abortion included "the change in concepts of love and marriage in a transforming society, in which the traditional rites are gradually forgot; the negative effects of the market economy, as well as the massive penetration of exterior depraved cultures."[20]

Although HIV/AIDS has been de-linked, at least formally, from the "social evils" policies, adolescent SRH issue are still sometimes represented in terms of social evils still. It

[19] EC-UNFPA RHI Assessment. June 2002. WPF.
[20] Adolescent health through collection and analysis of studies in 1995-2002. 2002. MoH and Thai Binh Medical College.

demonstrates that while advocacy and policy work have made great strides, the attitudes of certain segments of society will take longer to change. One example, taken from a recent compilation and summary of 129 studies on adolescent health, gives some flavor of attitudes, even of the researchers related to adolscent sex work:

> "Adolescent prostitution and sexual abuse tend to increase. Many young girls, even boys, involve in prostitution or are abused that result in both severe physical and mental consequences. They are not only infected with STIs and HIV/AIDS, but their future is also deteriorated. The reasons of this situation are, on one hand, the adolescents, who indulge in hedonism, pursue modern fashion, and ignore the public opinion, will be easily taken advantage of, or corruptible, lured or forced by bad guys when the adolescents have to rely on these guys,... On the other hand, there are a loose management of the State in some fields, poor management and education of family, poor responsibility of community for child education and management, and slack criminal prevention and judgement of executive bodies.[21]

1.3.2 Age disparities within sexual unions

Unlike other countries, the median age at first marriage in Vietnam has not increased in 25 years, but has remained stable at 21 years (VNDHS 1997). However, this data is disputed. In the newly released *Adolescents and Youth in Vietnam*[22], it is stated that age at first marriage rose from 24.5 years in 1989 for men to 25.5 in 1999. For women, the age of first marriage was 23.2 to 24.0 in the same period.

1.3.3 Sexual and reproductive risk-taking among young people

Several studies indicate that increasing proportions of young women and men are sexually active before marriage, particularly in urban areas. Yet taboos associated with premarital sexuality and inter-generational communication on sexuality persist. However, these studies also suggest that knowledge of safe sex, use of contraceptives and condoms for disease prevention are low in these early sexual encounters (MoH 2002).

Nationally, about 15% of all births are by women aged less than 19 years (MoH 1998 in UN 2001). According to a national survey in 1997, the overall level of teenage childbearing in Vietnam is 5.7%, of which 3.5% had given birth and 2.2% were pregnant with their first child. Among teenage women who have given birth, just under half had their first children by the time they were 18 years (VNDHS 1997). Teenage fertility rates are four times as high in rural areas as in urban areas and as high as 9.6% in the Northern Uplands (VNDHS 1997).

Abortion is a priority issue in Vietnam. Vietnam's menstrual regulation/abortion rate was listed among the three highest rates in the world (MoH 2002). Despite the apparently extensive use of contraceptives, more than half of pregnancies ended in abortion in 1998 (MoH 1998 in UN 1999). It is estimated that unmarried women (most of whom are adolescents) account for 30% of total abortions.

1.4 Priority Sexual and Reproductive Health Issues Facing Young People

According to the Common Country Assessment of Vietnam, adolescents are at high risk of unwanted pregnancy, maternal mortality and morbidity, and STIs, with limited access to SRH information and services.

[21] Ibid.
[22] NCPFC and Population Reference Bureau, 2003.

1.4.1 Access to quality RH services and to education

Young people have very limited access to information and services on sexual health and reproductive health, including family planning. Services available in government medical structures are either not available for young unmarried persons or are inappropriate for them. Adolescents and youth can only obtain condoms and pills in pharmacies/shops where no information or counselling is provided (UNFPA 2001). Evidence of limited access to information includes:

- Only one-third of 667 youth aged 15-24 in Thai Binh, Quang Nam, and Binh Duong provinces had ever heard of the words "reproductive health" (Population Research Consultants, as reported in Adolescents and Youth In Vietnam).
- Younger (15-24 year old) ever-married women are less likely to have been exposed to family planning messages on television or radio than older women (VNDHS 1997).
- 15-19 year-old currently-married, non-sterilised women who know a contraceptive method are about 10% less likely to discuss family planning with their husband than 20-34 year olds (VNDHS 1997).

The limited available data on utilisation of and access to health care services suggests that there is a growing gap between rich and poor, who often live in rural or mountainous regions. The poor utilise public health facilities less, spend less on health care, are under-represented in health insurance schemes, access poorer quality health services than richer groups.

- Though young women in Vietnam overall have low rates of childbearing, young women in mountainous and ethnic areas have very high rates. In rural areas, 6.6% of 15-19 year olds have given birth compared to 1.6% in urban areas. (Adolescents and Youth in Vietnam, 2003)
- Accessibility of maternal health care services ranges from as low as 20% in remote areas to more than 90% in urban areas (MoH 1998 in UN 1999).

1.4.2 Unwanted pregnancy and abortion

The Law on Protection of People's Health stated that "Women have the right to have abortion(s) if desired, to receive gynaecological examination and treatment and health check-up during pregnancy and medical services when giving birth at health facilities" (Article 44, Chapter VIII). The legal restrictions by age are not mentioned in the abortion law[23].

In addition to the statistics provided above in 1.1.2, other evidence showing that unwanted pregnancy and abortion is a key issue includes:

- Out of 65 sexually active adolescents, 60.3% used no contraceptives at all (Survey by Centre for Population and Rural Health Research, 1998).
- The 1999 Vietnam Adolescents and Social Change Survey reported that only 41% of married men aged 15-22 who had ever had premarital sex had ever used a condom. Only 51% of married females had used a modern method.
- At the HCMC MCH/FP Centre, adolescent abortion almost tripled in a one-year period.
- In a six-month period in 2001, almost 20% of abortions at the Institute for the Protection of Mothers and Newborns were among females aged 15-24.

[23] Legal Review Study. May 2003. CIHP.

1.4.3 Curable STIs and HIV/AIDS

National statistics on adolescent sexually transmitted infections (STIs) and reproductive tract infections (RTIs) are not available. Still, STIs are rising as seen in the increasing number of STI patients who are students. There was a six-fold increase in student STI patients at the National Institute of Dermatology, from 0.8% of all patients in 1997 to 4.7% in 1999.

According to the most recent estimates available from UNAIDS (at end 2001, based on estimates for 1997 and 1999 and recent trends in HIV/AIDS surveillance), HIV prevalence among the adult population (15-49) was estimated at 0.3%. An estimated 130,000 adults were living with HIV at the end of 2001. Of these 35,000 were women. (UNAIDS 2002)

HIV is also rising among youth. In 2001, 60.1% of HIV infected persons in Vietnam were under the age of 30. The proportion of HIV positive persons aged 13-19 rose from zero in 1992 to almost 10% in 2001[24]. Currently, 63% of cumulative HIV infections reported are among injecting drug users, but 81% of infections are sexually transmitted, and heterosexual transmission among young people is increasing (UNAIDS 2002). The number of registered drug users increased by 28% between 1998 and 1999. Almost three-quarters of those registered as drug addicts in 1999 are under 30, including 4,000 students and school children. With HIV prevalence estimated as 24% (in 2000) in injecting drug user populations, this is of concern for young people.

Knowledge of HIV and on its transmission and prevention is still low. According to the 1997 VNDHS, one in five 15-19 year old ever-married women have *not* heard of AIDS, and 14% do not know any way to prevent HIV. No data available of never-married young people's knowledge, attitude or behaviour.

In summary, the priority SRH issues facing young people include overcoming barriers to access to services; unwanted pregnancies, especially high rates of abortion; and increasing levels of STIs and HIV. Underpinning all of these is a tension between two strong forces. One the one hand, traditional cultural and social values ignore or downplay the SRH needs of young people. On the other hand, social changes brought through economic development support increased SRH risk taking among young people. While existing laws and existing policies are generally supportive of SRH for young people, the social mores are more intractable.

[24] MoH, Health Statistics Yearbook, 1997-2001. As reported in Adolescents and Youth in Vietnam, p30.

SECTION 2: THE COUNTRY PROGRAMMES' STRATEGIC PRIORITIES

Table 1 captures the differences in the scale of the UNFPA and VINAFPA programmes. The figures from VINAFPA are approximate, with specific notes highlighted.

Table 1

Area of comparison	UNFPA	VINAFPA
Budget for 2002 (approximate)	USD 5.4 million (*)	USD 0.5 million (**)
Number of staff	24	138(†)
Number of provinces/cities (††) in which they work (overall, not only in ARH)	11/61(‡)	47/61

(*) USD 27 million/5 years for CP6. This does not include the RHIYA budget, estimated to be 2.4 million euros for 33 months.
(**) This is only Total Project Budget. Total overall budget (or expenditures) is unclear.
(†) It is not clear who is captured in this figure provided by VINAFPA. According to the 2002 Annual report here are 16 staff in the Head Office, 40 Branch Project Officers, and 3 standing committee members. In interviews VINAFPA reported an additional 20 clinic managers, 40-60 and ancillary staff at the clinics.
(††) Out of 58 provinces and 3 municipalities.
(‡) But UNFPA also works at central level with a national reach for advocacy etc.

2.1 The UNFPA Country Programme

2.1.1 Relevance

UNFPA has been working in Vietnam since 1977, starting just after unification/post American war. By 2000, UNFPA had provided over US$ 110 million to assist in population and reproductive health, including maternal and child health and family planning.[25] UNFPA acts mainly as a donor and co-ordinator, rather than an implementer; the main modality for implementation is through government execution. UNFPA collaborates closely with the government, other UN agencies, mass and other local organisations. In this relationship of collaboration it is often difficult to attribute contributions to improvements in the field of adolescent reproductive health to specific agencies, as they are all involved in partnership approaches to achieving ARH goals.

UNFPA has been a consistent advocate for the ICPD POA. UNFPA has based its last two country programmes within the framework of the POA. When the ICPD came into existence in 1994, UNFPA was in the end of its 4th Country Programme ("CP4" 1991-1995). This report focuses on the next two CPs (CP5 and CP6) which cover most of UNFPA's activities since ICPD, from 1996 till the present.

Strategic objectives and priorities in the Fifth Country Programme (1996/7-2000)

According to the evaluation of CP5[26], CP5 was largely a continuation of strategies from CP4. However, where CP4 had emphasised family planning, following the ICPD there was a discernible shift towards RH in CP5. CP5 also emphasised, among other things, information and services for adolescents and youth. However, the design of CP5 was muddled, making final evaluation quite difficult. The original design of CP5 had followed an older UNFPA design style. Midway through CP5, UNFPA introduced logframes. Though UNFPA CO staff

[25] UNFPA "Briefing on UNFPA Assistance to Vietnam."
[26] Reynolds J, Chamratrithirong A, Duong DV. "External Evaluation of UNFPA 5th Programme," September 2000. Most of the description in this section is drawn from this document.

were not adequately trained in the logframe approach, they attempted to apply logframes retroactively to the CP5 framework. This reportedly created more confusion than clarity. In the end, there were no clear and measurable objectives, for either the programme overall or for the sub-programmes.[27]

The overall aim of CP 5 was:

To strengthen national capacity to further integrate reproductive health services, including family planning and sexual health, into the national primary health care system and to ensure the quality of those services so that they respond adequately to client demand and are made available to currently underserved populations. This will be done through enhancing capacity for programme management and service delivery at the provincial, district and commune levels in (eight) selected provinces, and through policy advice and technical assistance at the central level. Gender issues will be mainstreamed into all programme activities.[28]

"Procedural delays" with both the UNFPA and the Government resulted in most of the projects starting one year late. Planned activities were also curtailed or postponed to the next CP as a result of financial adjustments requested by UNFPA. Thus, effectively, the implementation period for the CP was short, limiting the delivery of programme outputs[29]. In spite of all this, the programme was felt to be consistent with the framework of the UNFPA Executive Board, national priorities and the ICPD Plan of Action.

Reproductive Health

The goal of this sub-programme was to improve the RH conditions in Vietnam in general, and in the eight participating provinces in particular. Special emphasis was given to ethnic minorities, underserved population groups and those in remote areas. Although not mentioned overtly overall, young people were explicit target groups of some projects. For the purposes of this sub-programme, the RH package included family planning, safe motherhood, menstrual regulation/abortion counseling and management of unsafe abortions, prevention and management of RTIs, and prevention of STIs/HIV.

At provincial and sub-provincial levels in the 8 UNFPA supported provinces, support was provided to improve the quality of and access to RH services; improve the technical and managerial capacity to provide RH services; and provide capacity building to mass organisations and NGOs.

Several adolescent reproductive health activities were implemented. With the arrival of RHI, ARH received a significant and targeted boost.

[27] Ibid.
[28] UNFPA. "Recommendation by the Executive Director: Assistance to the Government of Viet Nam." DP/FPA/CP/158, 30 July 1996p. 3, as cited in the Reynolds evaluation.
[29] Programme of Assistance to the Government of the Socialist Republic of Vietnam, 2 February 2001.

ARH: Country Programme 5[30]

Country Programme 5 had a number of activities related indirectly and directly to improvements in ARH. These include the following:

- National RH Strategy was drafted;
- MOH: Improvement of the overall Quality of RH Care through training of service providers and improvement in infrastructure, essential drugs, and equipment. The training appears to have been a general RH training with more theory than practice. These would be beneficial to young people if they chose to use the services. One reference mentioned that (general) counselling seemed to have improved, but highlighted that both (general) counselling and IEC remained weaknesses of CP 5;
- MOH developed national standards/guidelines for reproductive health services including Adolescent Reproductive Health component;
- ARH services were provided in some Community Health Centres but not all. Given the sensitivities in some communes, the key strategy chosen to address ARH was through the establishment of Youth clubs and counselling centres, especially through the Youth Union. 140 Youth clubs were established. Importantly, condoms were reportedly distributed free at the Youth Clubs to those who wanted them;
- Numerous IEC activities focused on young people: mass media campaigns, IEC and training materials developed, contests, etc.;
- MOET: SRH education for adolescents, in school text books and through the production of "ARH Education, Self Learning Guidance Manual for Teachers";
- Teacher training on Population Development issues;
- Numerous "advocacy" activities were conducted which would indirectly build a more supportive environment for ARH. These included training and IEC materials for key elected officials, policy makers, and "mass media practitioners."

ARH: The Reproductive Health Initiative in Asia (RHI)

The RHI started during CP5. Vietnam chose early on to focus this Initiative on adolescents and young people. The youth focus provided a catalyst for progress on ARH rights and services. The budget for RHI was over 4 million euros. In order to accelerate the implementation of the ICPD, the project aimed to:

- Develop local capacities for the delivery of quality RH services;
- Strengthen community participation;
- Promote gender equity and equality; and
- Target the most vulnerable groups.

Activities were meant to focus on the provision of information and services. Relatively more resources were dedicated to IEC development and dissemination. Counselling was often the main service (means of dissemination) provided, which followed on from the approach in CP5. There were various fora for this: Youth Union counselling centres, school clubs, commune youth clubs, community counselling, counselling corners at schools and so on. Actual clinical services were limited to a few demonstration sites in Hanoi and Hue, and other minimal services from, for example, VINAFPA.
RHI operated in 7 provinces/cities[31] and had an urban focus. Target groups varied according to the project: general youth, in-school and out of school, street children, and university students were all covered to some extent in certain areas. Although it would be wrong to expect changes in impact within only two years, clearer quantitative and qualitative analysis at lower levels should have been done.

[30] Much of the information on CP 5 is taken from the "External Evaluation of UNFPA's 5th Programme." J Reynolds. September 2000.
[31] Hanoi, Ho Chi Minh City, Danang, Hue, Hai Phong, Nghe An, and Tien Giang.

In addition, there were two more projects. One project promoted "gender equality and male responsibility in RH," and included development of IEC materials, workshops, etc. The second project was specifically aimed at supporting improvement in ARH through provision of information and development of three models of information and service delivery.

At the national level there was an emphasis on developing relevant policies. These policies included a national strategy on RH; national standards of care for each RH element; an IEC strategy; a national HMIS, logistics and training systems; and a social marketing programme for condoms and pills. Spanning both national and provincial lines was a project with the Ministry of Education and Training to include RH issues in the national curriculum as well as train teachers in RH issues in the 8 provinces.

PDS

The goals of this sub-programme seem to have been (i) to create an environment for policy makers to integrate population and development issues and gender considerations into national and multi-sectoral plans and programmes, and (ii) to review and adapt population policies in line with the country's sustainable social and economic development. The reason for the slight confusion is explained by the formulation of a PDS logical framework which was applied retrospectively. There appears to have been a simple mistake in the formulation of the Goal and Purpose statements, a not uncommon problem. The two goals here correspond to the Purpose level of the logical framework[32].

There were 4 projects with relevant PDS activities. Support was provided to the Ministry of Planning and Investment and NCPFP through workshops, trainings, and studies to integrate population issues into their planning as well as develop appropriate population strategies and programme of action. Assistance was also provided to the General Statistical Office to prepare for conducting the census, including building capacity to conduct appropriate analyses. Finally, there were many capacity building activities with the MOET to develop a national training programme on population and development. None of the projects seemed to focus on young people's SRH.

Advocacy

The overall sub-programme goal was to contribute to creating active support for policy development and an enabling environment leading to appropriate policies and investments (human and material resources) as a direct follow-up to implement the PoA of ICPD. This included social mobilisation to support ARH form provincial to commune levels[33]. Focus was placed on four agencies: the NCPFP, the Ho Chi Minh Academy (something like a party think tank), the Sub Academy of Journalism and Communication, and the Parliament Committee for Social Affairs. One project was dedicated to each of the 4 agencies.

[32] Reynolds, p 8.
[33] Comments on UNFPA Vietnam Country Evaluation Report, Sept 2003. P 7.

Strategic objectives and priorities in the Sixth Country Programme (2001-2005)

The overall goals of CP 6 are:

To contribute to the attainment of a higher quality of life for the Vietnamese people through improved reproductive health, and to contribute to a harmonious balance between population dynamics and sustainable socio-economic development. These goals will be pursued through two sets of interventions covering reproductive health and population and development strategies, each including advocacy interventions. Gender concerns will be mainstreamed into both sub-programmes."[34]

As mentioned, there are only two sub-programmes: Reproductive Health (RH), Population and Development Strategies (PDS). Advocacy, a stand-alone sub-programme in CP5, is now considered a cross-cutting issue. Through close discussion with the government, UNFPA added 3 more provinces for a total of 11.The two sub-programmes consist of 17 projects. There are three cross cutting issues: IEC, BCC, and advocacy; gender equality and empowerment of women; and national capacity building.

Where the design of CP5 had been muddled, that of CP6 was improved. There are now logical frameworks for the CP overall as well as for each sub-programme. See section 3.1.1 below for more details.

Reproductive Health

The goal of this sub-programme is to contribute to strengthening the quality of RH care through increased utilisation by women, men, and adolescents, particularly among disadvantaged groups, of: (a) quality integrated RH services including information and counselling; and (b) gender-sensitive RH information, education and communication promoting behavioural changes towards healthy reproductive and sexual practices.

This sub-programme has five sets of activities across 8 outputs:

1. Capacity building at the central level for RH programme management
2. RH advocacy and IEC/BCC
3. Adolescent reproductive health
4. RH research and formal training
5. RH interventions at the local level

Key issues identified in the RH sub-programme include abortion and STI/HIV, both of which affect young people. Importantly, ARH itself is also a key issue.

CP6 picked up on a number of ARH activities of CP5 and expanded them further. In addition, the RHIYA should come on line during the life of CP6, giving added emphasis to ARH issues.

[34] Programme of Assistance to the Government of the Socialist Republic of Vietnam, 2 February 2001.

ARH: Country Programme 6

In addition to the general support to RH improvements, CP6 has a number of objectives and activities related indirectly and directly to improvements in ARH.

Immediate objectives which relate to ARH include:
- improved knowledge of negative consquences of MR and abortion;
- improved preventive counselling on STIs/HIV/AIDS and management of STIs/RTIs as integrated with RH;
- improved access to RH information and services for adolescents; and
- increased male responsibilities and services in family planning, family life and sexual health.

Activities related to ARH include, but are not limited to:
- Assistance in developing clinical standards, protocols, and guidelines for the main components of RH, including ARH;
- In- and out-of-school education programme;
- Youth clubs and counselling centres;
- Training to improve ARH services;
- Advocacy and policy development/revision related to ARH;
- BCC materials and activities for adolescents;
- Behavioural research (eg KAP) on young people and SRH.

ARH: The Reproductive Health Initiative for Youth in Asia (RHIYA)

The RHIYA was estimated to start during CP6 in June/July 2003 and run for 33 months. This is a delayed start. At the time of the evaluation many issues were still be resolved. This included modalities of funding (with a move to more involvement and control by local organisations), activities, and management structures. The budget for RHIYA will likely be reduced to 2.4 million euros. RHIYA will be implemented in 5 provinces plus Hanoi and HCMC, targeting 13-24 year olds. RHIYA will reportedly continue with successful activities/models of RHI. Features will include, but are not limited to, the following:

- Continued work in urban areas but increased focus on semi-urban and rural populations;
- Explicit focus on achieving behaviour change;
- Emphasis on rights to access to services, to choice, to participation;
- Executing agencies to be local: VINAFPA for services and Youth Union for BCC/Advocacy
- Umbrella Project to be strengthened with more staff;
- Evaluation of service and perhaps cost effectiveness.

PDS

The goals of this sub-programme are (i) to consolidate and build on progress made towards the realisation of an integrated approach to population, RH, gender and socio-economic development policies, programme strategies, in pursuit of the ICPD goals and (ii) contribute to building political and social support for the broader principles and goals contained in the ICPD PoA and the new national population and reproductive health strategies to strengthen the country's technical capacity for designing and implementing effective population and socio-economic development programmes.

This sub-programme has four sets of activities:

1. Implementation of the new Population Policy and RH Strategy
2. Utilisation of population and socio-economic data
3. Policy-oriented studies
4. Population and development advocacy

The changes in strategic focus from CP4 to CP6 is summarised in table 2:

Table 2

Country Programme	Key Foci of Country Programme
4th (1991-1995)	• Family Planning/population reduction
5th (1996-2000)	• Increased quality of and access to broad reproductive health service package (not just population reduction) • 3 sub-programmes: RH, PDS, Advocacy • 19 projects: 8 at provincial level, 11 at central level • Information and services for youth included (RHI began)
6th (2001-2005)	• Continued focus on RH • 2 sub-programmes: RH and PDS (IEC/BCC/advocacy, gender equity, national capacity building are cross cutting) • 17 projects: 11 at provincial level, 6 at central level.

Determining CP focus and priorities

As mentioned earlier, the focus of CP5 was based on the activities of CP4, with a shift, post-ICPD, away from FP towards RH. It is not known exactly how the objectives and priorities of CPs 1-3 were determined.
The 6th Country Programme's focus and priorities were determined by (1) close discussion with the government, which included identifying "new" foci that are part of the ICPD's POA framework; (2) incorporating recommendations from the evaluation of CP 5; (3) a 1999 Situation Analysis of RH services at provincial level, plus a World Bank-funded Health Sector Review; and (4) discussions with other UN agencies as part of UN reform/interagency collaboration.

Government has highlighted the need to address issues related to young people (unemployment, HIV/AIDS, drug addiction, etc). Evidence for this can be found in the inclusion of ARH issues in national policies (e.g., RH policy), by the recent production of the National Youth Development Strategy, and by their clear support for the RHIYA.

Proportion of the CP devoted to policy development, service strengthening and IEC

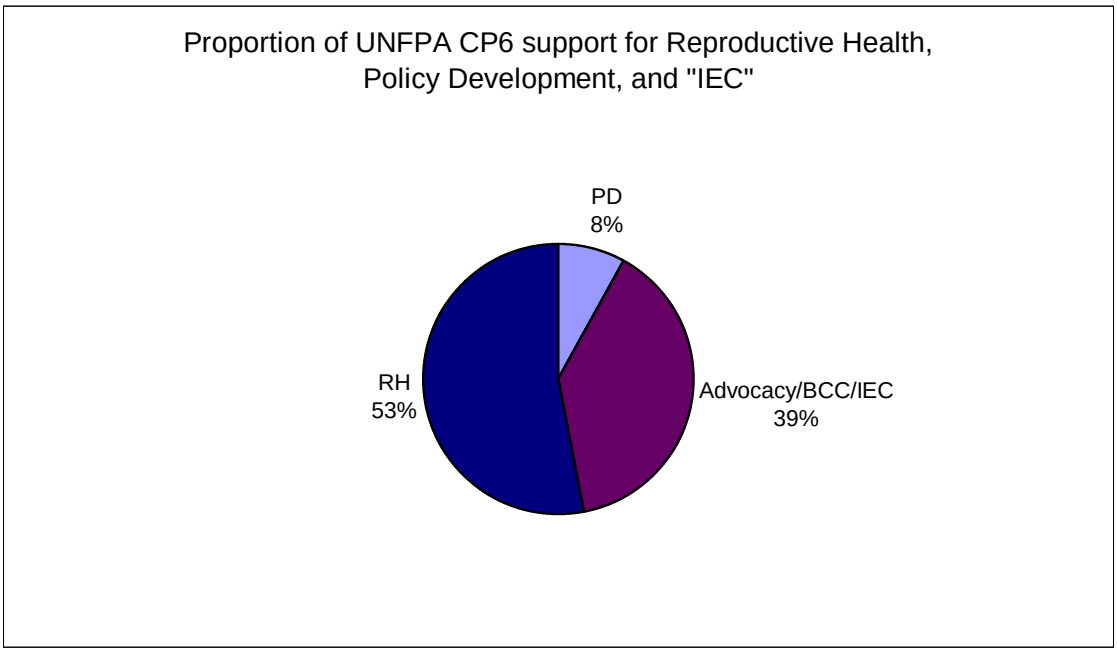
CP5 was approved in September 1996 with a total allocation of US$24 million for five years. There were three sub-programmes: Reproductive Health (RH), Population and Development Strategies (PDS), and Advocacy. Under these three sub-programmes were 19 projects. Eight of these supported work at provincial level and 11 projects focused on the centre. US$17 million was earmarked for the core programme area of reproductive health. Allocations for the PDS and Advocacy sub-programmes amounted to US$3.4 million and US$3.6 million, respectively. In addition to regular UNFPA funding, an amount of US$ 6.2 million was obtained from bi-lateral donors[35].

The proportions spent on RH service strengthening, policy development, and IEC (BCC) had to be estimated since there are only two sub-programmes. About half (53%) of the current CP budget is devoted to RH service strengthening. Of the remainder of the CP, 8% of the

[35] Programme of Assistance to the Government of the Socialist Republic of Vietnam, 2 February 2001.

budget is allocated to PDS, and 39% to Advocacy and (supply-side/provider) BCC. However, advocacy/BCC activities are spread out across the two sub-programmes, see graph 1.

Figure 1



UNFPA made rough estimates of how much of the budget went towards young people in particular. They estimate that about 8% (that is, 15% of the total 53%) is dedicated to service strengthening for young people. Similarly, about 8% (that is, 20% of the total 39%) is dedicated to advocacy at both national and provincial levels for ARH. Finally, about 2% (that is, 20% of the total 8%) is spent on policy development focused on ARH. This means that approximately 18% (US$ 4.8 million) of the total budget is estimated to be spent on SRH programmes for young people/adolescents. This is about equivalent to the RHI budget of about US$ 4 million over four years.

UNFPA's strategic role in sectoral and sub-sectoral national programmes

As mentioned earlier, UNFPA has an extremely close relationship with the government. UNFPA plays a leading role in promoting ARH policies and services in Vietnam. They have been instrumental in the development of the Vietnam Population Strategy, the National Strategy for Reproductive Health, the Youth Development Strategy, and the National Standards and Guidelines for Reproductive Health Care Services.

Addressing the range and diversity of needs of young people

Through CP5 and now CP6, UNFPA addressed ARH through numerous activities. However, the Team could not ascertain to what extent these services and information addressed the range and diversity of young people's needs.

Through the RHI/RHIYA, UNFPA is attempting to address the needs of a wide range of youth: out-of-school youth as well as those in school, rural and urban youth (with an emphasis in RHIYA on rural), poor and marginalised youth, street children, etc. Strategies are designed to provide both information and services. However, in RHI, evidence suggested that more emphasis had been placed on providing information than services. This evidence included the plethora of counselling activities through youth clubs, community counselling/information sharing, high numbers of IEC materials, and so on, compared to a

smaller number of RH service provision sites. There is a change of emphasis in RHIYA, where UNFPA reports that 50% of the budget is allocated for ARH service in support of youth friendly corners in public health centres[36]. This could not be confirmed by the evaluation team.

2.1.2 Integration of Rights

Discussion about rights has been a delicate issue in Vietnam. Workshop participants cautioned the evaluation team to be clear and specific when discussing the SRH rights of young people. While it was advisable not to use the phrase "human rights," it would be OK to talk about rights of the child, general SRH rights, even right of clients. Radio VN reported that civic rights, rights of children, and rights of women are discussed on the radio, though the team was not able to confirm this.

UNFPA does focus on promoting the concept and practice of sexual and reproductive health rights to the extent that it is possible in Vietnam. There is evidence that they push the envelope on creating discussion on adolescent/young people's rights issues. For example, critical thinking about adolescent and child rights is encouraged in the MOET's "Adolescent Reproductive Health Education: self learning with guidance manual for teachers (2001)" distributed to 22,500 secondary schools and teaching colleges.

Various types of rights are included in UNFPA-supported ARH work. The RH Initiative Phase 2 focuses on rights to information, access to services, to choice, and to participation. The NCPFC's "Core messages of population and reproductive health care" highlight the need for service providers to ensure adolescents have the "10 rights of clients." One module for training used by the Hanoi Youth House talks about the "12 sexual and reproductive rights" which also should apply to adolescents.

The UN interagency Working Group on Youth feel that "rights-based programming" per se is not well understood by either UN staff or Vietnamese counterparts. However, UNFPA's programmes are rights-based in that they seek directly to improve ARH information and services. This is more far-reaching than simply educating youth on their ARH rights.

2.1.3 Sustainability

See section 5.1.6.

2.1.4 In Summary: UNFPA Attention to the Priority RH Issues Facing Young People

As highlighted in section 1 above, the top priorities issues facing young people included getting access to SRH services (overcoming barriers), unwanted pregnancy and abortion, and increasing STI/HIV rates. UNFPA is clearly addressing all these issues. UNFPA specifically addresses ARH through their early and continued focus on youth in the RHI. In addition, UNFPA gives attention to these issues through appropriate policy development, advocacy, and improvements in a full range of RH services.

[36] Comments on the Vietnam Country Evaluation Report. UNFPA p 7.

2.2 VINAFPA

2.2.1 Relevance

Background

VINAFPA was formally established on 11th January 1993 under decision No. 13/QDTTG of the Prime Minister of Vietnam and is a member of both the International Planned Parenthood Association and the Vietnamese National Committee on Population, Family and Children.

Currently, VINAFPA has branches in 47 provinces and cities (out of 61) and is considered by the Government of Vietnam to be an organisation with nationwide coverage with a history of ten years of IEC and service provision relating to family planning and reproductive health. It has over 1,400 community based distributors (CBDs) providing outreach to over 100,000 households in 36 provinces and cities, 450 communes and villages, 20 reproductive health counselling centres and 1 community development-counselling centre (hot-line counselling centre and face-to-face counselling).

In the 2001-2010 Population Strategy[37], VINAFPA is mandated alongside the NCPFC as co-operating agencies to deliver reproductive health and family planning services by increasing use of modern contraceptives and by extending to services to difficult to reach areas, as well as by improving counselling and technical capacity of service providers.

Priorities and strategic approach

Rather surprisingly, VINAFPA itself does not have a detailed Strategic Planning document. This is despite the introduction by IPPF back in 1989 of the Strategic Thinking and Planning Management (STPM) process[38], whereby all FPAs in the ESEAOR would be assisted by IPPF in incorporating the STPM process into their management and programme development, and in reviewing and revising their Strategic Plans, taking into account global and national challenges that affect sexual and reproductive health. IPPF have tended to concentrate their support on governance and management issues that have faced VINAFPA since the late 1990s[39].

That said, in the absence of a detailed planning document, VINAFPA have devised a five-fold strategic approach for the organisation (see Box 1) together with principles of action (see Box 2).

Box 1 VINAFPA's 5 Strategies for 2002-2010

Strategy 1: Moving the focus on reproductive health/sexual health/family planning with better quality of care. Adolescents, underserved areas and family values are highly considered. FP/RH care should be conducted in combination with gender equity, living standard improvement and community development.
Strategy II: Promotion of IEC through mass media in combination with providing direct IEC coupled with providing available service for changing behaviour.
Strategy III: Capacity building.
Strategy IV: Strengthening and developing FPA.
Strategy V: Income generation for leading to making self-sufficient cover for activities.

It is difficult to make a detailed analysis of the strategic development undertaken by VINAFPA, in the absence of key documentation, and key informants with institutional

[37] Government of Vietnam's Population Strategy 2001-2010, p37
[38] See the *Performance Assessment of IPPF Feedback Workshop – Executive Summary Report, 1999*
[39] A strategic planning process assisted by IPPF Regional Office is scheduled for August 2003

knowledge pre-dating 1999. However, the impressions are that the strategic planning that has been undertaken is based on an appreciation of VINAFPA's strengths and weaknesses, and the demands put on it by the NCPFC to support the implementation of the National Population Policy. Unfortunately, what is missing are the more detailed implementation strategies that VINAFPA seeks to employ to translate these goals into action. Adolescents are included in Strategy I, but not as a specific strategic focus of its own. At the time of the evaluation, VINAFPA was about to undergo, with the assistance of IPPF, a strategic planning exercise, in which young people would, so it would seem, become a more focused strategic priority.

Box 2 VINAFPA's Principles of Action

1. Approaching to RH and FP with the humane, convincing and exemplary spirit.
2. Being appropriate with Vietnam customs and traditions.
3. Meetings needs for reproductive health care based on women's life cycle and their reproductive right.
5. Voluntarily working for better quality of RH care and doing society advocacy, generating resource for leading to bear self sufficient cover for activities.

VINAFPA is still shifting its focus from family planning to a broader reproductive health remit, and developing sufficient capacity to deliver quality reproductive health services and counselling through its nation-wide network of branches across Vietnam. Historically, and to present day, VINAFPA has tended to focus its activities on IEC and counselling, with the provision of family planning services through community outreach approaches. Clinical service provision is gradually being scaled up through institutional strengthening and capacity building that has been provided over the last three or four years from a range of donors, including UNFPA.

Focus on young people

Despite implementing a Family Life Education (FLE) project from as earlier as 1994, VINAFPA describes itself as only really addressing ARH, with young people as a distinct target client base, since 1999 with the advent of the RHI[40]. VINAFPA itself acknowledges that the RHI has been absolutely instrumental in enabling VINAFPA to engage substantially in ARH work, beyond a simple IEC only approach. Prior to this, since its establishment in 1993, the Association has really been focusing on the provision of family planning to the general population of rural communities. No doubt young people will have been included in this population and have been recipients of service provision by VINAFPA. Unfortunately service statistics collected under these programmes do not give age breakdown and so any young people reached through these initiatives are not captured in the service data.

The gradual shift in focus toward ARH also coincided with the appointment of the current President of VINAFPA. Professor Song has been instrumental in guiding the association's development since 1998/99 and helping to rebuild the public/external image of the organisation following a period in which VINAFPA was brought into disrepute by financial mismanagement and in-fighting amongst Volunteer Board members.

[40] The project is entitled 'Introduction of Adolescent Reproductive Health Services for Youth in Vietnam' – EC/UNFPA RAS 98/P19. Project funding was for 1999-2002, totalling $400,000 approximately.

How priorities were determined

Professor Song and other members of the VINAFPA Executive Committee take a pragmatic approach to the development of priorities within the Association. VINAFPA is keen to promote adolescent reproductive health as it is clearly recognised by the Association that there is considerable unmet need in terms of awareness about ARH and low levels of information and services available to young people across Vietnam. However, it candidly acknowledges that as an organisation with limited financial resources, VINAFPA also has to recognise the priorities held by donors, and maintain a flexible approach to priority setting in order to avail itself of further funding. VINAFPA therefore is extremely pragmatic in its priority setting, and uses both evidence base (of intervention need) and funding sources to guide it in its programmatic responses.

Resource allocation dedicated to ARH policy development, services, and IEC

The financial resources dedicated *solely* to ARH by VINAFPA remain low in comparison to the total budget/expenditure on non-ARH focused activities – as indicated in the table below. However, this is in large part due to the comparatively high costs of general clinic service provision that VINAFPA undertakes across its network of clinics, which skews the picture of proportionality. The Evaluators could not get consistent data on the relation between core programme costs and RHI funds. Expenditure of IEC focused on ARH has increased threefold over the last ten years, as has expenditure on service provision dedicated to young people. VINAFPA has also received considerable support "in kind" to its ARH work from Provincial authorities, increasing total budgetary allocations towards ARH. Therefore the figures detailed below should serve only as a *rough* indication of increasing budgetary commitments to ARH and not be scrutinised to heavily.

It was extremely difficult for VINAFPA to provide discrete figures on budgetary commitments to policy, IEC, and service delivery focused on ARH as there is a great deal of intersection between each area – the figures provided in table 3, should therefore be treated with caution.

Table 3

	1994	1995	1996	1997	1998	1999	2000	2001	2002
% Budget spent on Policy	8.8%	10.6%	8.3%	9.8%	1.5%	13.0%	7.4%	2.2%	9.4%
% Focused on young people	0.8%	1.7%	1.0%	1.2%	0.5%	3.7%	1.2%	0.3%	1.2%
% Budget spent on service delivery	35.5%	45.4%	30.5%	24.2%	16.3%	11.3%	15.2%	23.3%	16.1%
% Focused on young people	0.8%	0.9%	0.9%	0.9%	0.7%	1.3%	1.7%	2.6%	1.9%
% Budget spent on IEC	55.6%	44.0%	61.1%	65.9%	82.2%	75.6%	77.4%	74.5%	74.4%
% Focused on young people	4.4%	4.9%	6.2%	7.1%	8.5%	11.5%	14.1%	14.9%	14.4%

Figures provided by VINAFPA, May 2003

Responding to the diverse needs of young people

Whilst VINAFPA staff and volunteers recognise and understand the diverse needs of young people, there is little evidence programmatically that this recognition of diversity is translating into diverse programmatic responses, tailored to meet the different and varied needs of adolescent groups. This is in large part due to the relatively undeveloped programme response to youth, in terms of resources dedicated to youth; VINAFPA simply has not had the resources to broaden out its approach to young people, beyond a general response that reaches in and out of school young people. However, VINAFPA is now actively seeking to broaden its response, and will now be working with more vulnerable young people, such as

commercial sex workers, in a bid to be more responsive to the diverse needs of young people.

2.2.2 Integration of Rights

As described in section 1, interpretation and discussion of "rights" in Vietnam has a distinctly different flavour from that of other countries in the world. It is extremely important to bear this in mind when assessing the degree to which VINAFPA has promoted or supported reproductive rights or rights of young people into its work. This will be discussed in more length in section 4.

Given this environment, it is fair to say that VINAFPA is rhetorically and programmatically very supportive of young people's reproductive rights (in line with ICPD and IPPF Principles), in a fairly conservative manner apposite for an organisation that sees itself, and is seen by Government, to be a partner of the Government. Reproductive rights are implicit in its programme work rather than explicit. Similarly, VINAFPA does not *explicitly* articulate the promulgation of young people's reproductive rights as a strategic goal or programme objective, nor are any of its projects considered by VINAFPA to be rights-based.

Historically, family planning and reproductive health programmes in Vietnam have focused heavily if not entirely on *women* as clients; the needs of men have largely been ignored or overlooked. In discussions with VINAFPA and through document and data analysis, it would seem that little attention continues to be paid to gender *equity* in VINAFPA's work with young people – and that young women continue to be the main focus of attention, in ways that do not necessarily reflect or recognise the impact that gender relations have on women's access to reproductive health. The specific and different needs of young men are not strategically addressed by VINAFPA.

2.2.3 Sustainability

The Strategic Plan for VINAFPA for the next three years will include a focus on ARH. Additional financial resources are clearly required to fulfil this commitment, and VINAFPA has been aided in widening its donor base by UNFPA and by IPPF. The majority of VINAFPA's youth work is externally funded. The Association has been implementing the FLE project since 1994 with core funding. The funding allocated to this initiative currently represents only 2% (about USD 7,200) of VINAFPA's total project budgets for 2003 (approximately USD 360,000[41]). Sustainability and self-sufficiency through user fees and voluntary contributions from the community, whilst possible for some VINAFPA clinics reaching the general population, is not possible for its ARH initiatives which require substantial investment in creating and sustaining a supportive enabling environment, and providing services for young people, least able to pay for counselling and services.

As discussed in greater detail in section 3.2, VINAFPA has a rapidly diminishing core funding base. This makes it simply not possible for the Association to incorporate its externally funded time-bound youth focused activities into its regular programme - a situation that is likely to persist for the foreseeable future until such as time as VINAFPA is able to strengthen its core funding base.

[41] This figure is taken from a table that VINAFPA drew up at the request of the Team, but which could not be cross-referenced to any other document.

2.2.4 Summary

VINAFPA is still going through a paradigm shift from family planning to reproductive health, and working to build capacity in general to respond to unmet RH need, on a nationwide basis, broadening energies beyond counselling and IEC, into greater RH service provision. VINAFPA's Strategic Plan (as exists) identifies adolescents as a priority need area in its strategic focus on reproductive health/sexual health/family planning. However, there is no more detailed articulation of its strategic response to young people beyond that contained in specific youth focused project documents. In a very general sense, VINAFPA is aiming to address the unmet needs of young people in that it seeks to provide IEC and reproductive health services for youth with the intention of reducing unwanted pregnancy, termination of pregnancies, and STIs. However, these are the objectives of the Association's overall programme, and are not youth specific objectives. Future strategic plan development will increase attention on ARH.

The RHI has been instrumental in providing VINAFPA with ability to undertake dedicated ARH activities (including service provision). Current financial resources dedicated to youth work however remain very low.

SECTION 3: INSTITUTIONAL ARRANGEMENTS

3.1 UNFPA Country Office

3.1.1 Relevance

Organisational structure

A Resident Representative heads the UNFPA Country Office, with a total of 24 staff. The Assistant Representative is a local appointment. Relatively junior international staff fill three more posts. These are two Junior Professional Officers (JPO), one of whom assists the Resident Representative with donor coordination and one of whom is a programme officer. A UN Volunteer fills the third international post, another programme officer position. According to the organogram provided by UNFPA, the remaining core staff include:

- Two National Programme Officers (NPOs) and 3 National Professional Project Personnel (NPPPs), one MIS Officer, and two consultants; and
- One administrative/finance assistant, five secretaries, one finance assistant, two drivers, a gardener and a cleaner.

Four staff overall are proposed for the RHIYA Umbrella Project, a Programme Coordinator, an M&E Officer, assistant, a Financial Assistant, and a Secretary/Translator. These additions are necessary and follow on from recommendations made in the evaluation of RHI. UNFPA will implement the coordinating "Umbrella Project" itself and can only do so with these new posts. Lack of these positions in the latter half of RHI, when UNFPA took control of the Umbrella Project from WPF, limited the effective management of RHI. See the organogram on the next page.

Within the current staffing structure, the local staff play a key lead role and the international staff, except for the Resident Representative, are generally less senior. JPOs are training positions. Staff responsible for the RHI have gained expertise in young people's reproductive health and rights more through on the job training than formal training. Present staff have clearly demonstrated their abilities to conduct effective advocacy and influence in policy development. This has been aided by UNFPA's "trustful relationship" with the government, UNFPA having made advocacy a cross-cutting issue, and the leading role of local staff.

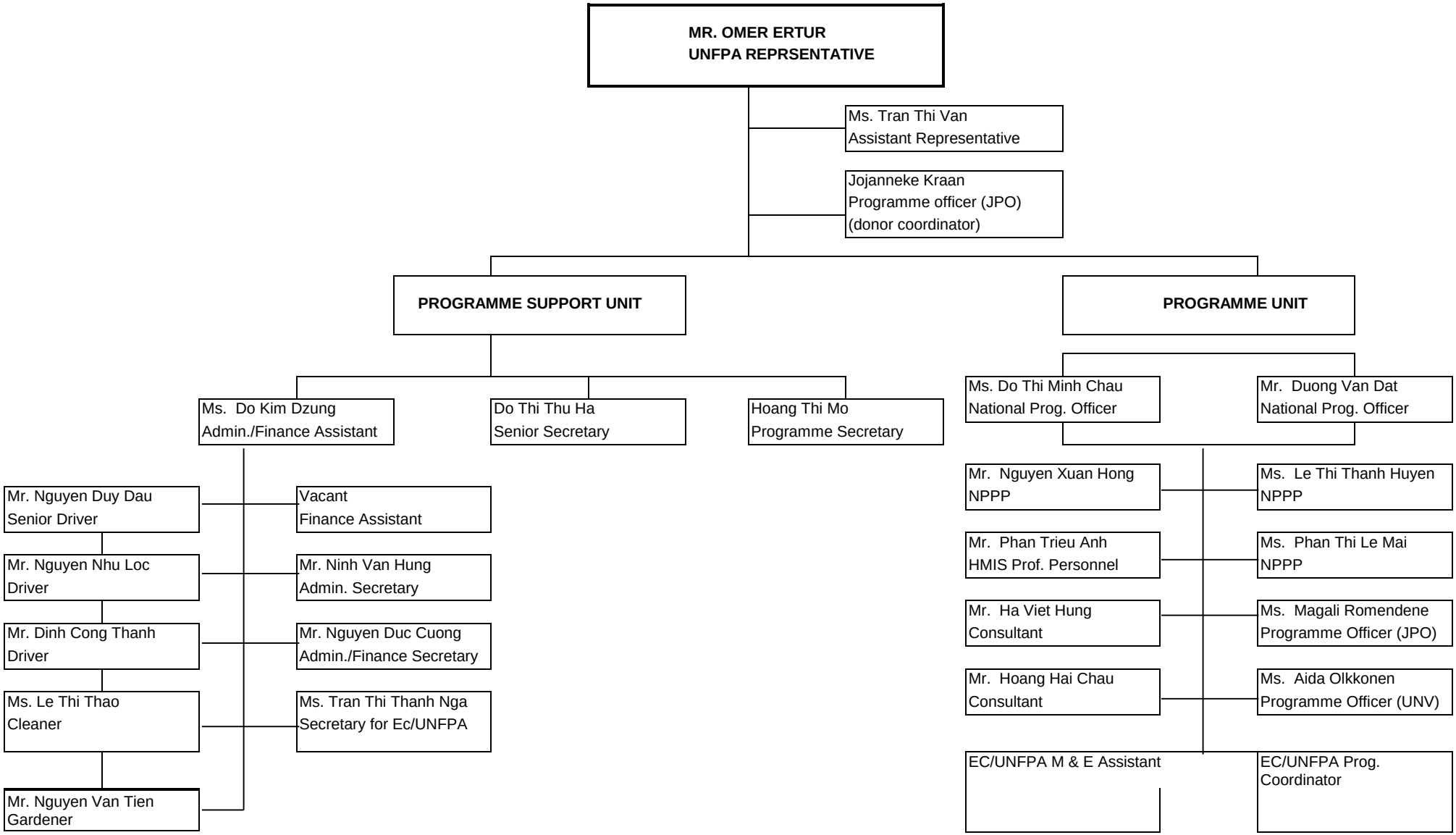
Resource Allocation to Young People's RH

As mentioned in section 2.1.1, UNFPA made rough estimates of how much of the budget went towards young people in particular. They estimate that about 8% (that is, 15% of the total 53%) is dedicated to service strengthening for young people. Similarly, about 8% (that is, 20% of the total 39%) is dedicated to advocacy at both national and provincial levels for ARH. Finally, about 2% (that is, 20% of the total 8%) is spent on policy development focused on ARH.This means that approximately 18% of the total budget is estimated to be spent on SRH programmes for young people/adolescents.

Monitoring and Evaluation

Monitoring and evaluation was weak during the 5th country programme, as pointed out by internal evaluations of CP 5. This was due to lack of clear objectives and indicators, a muddled and retroactive logframe, and poor monitoring systems and capacity. The Umbrella Project of the RHI gathered data for 2000 and 2001, but no analysis had been done at the time of the RHI evaluation. Data on trends, utilisation, etc. would have been invaluable for effective evidence-based designing of RHIYA.

Figure 2


MR. OMER ERTUR
UNFPA REPRSENTATIVE
Ms. Tran Thi Van
Assistant Representative
Jojanneke Kraan
Programme officer (JPO)
(donor coordinator)
PROGRAMME SUPPORT UNIT
PROGRAMME UNIT
Ms. Do Kim Dzung
Admin./Finance Assistant
Do Thi Thu Ha
Senior Secretary
Hoang Thi Mo
Programme Secretary
Ms. Do Thi Minh Chau
National Prog. Officer
Mr. Duong Van Dat
National Prog. Officer
Mr. Nguyen Duy Dau
Senior Driver
Vacant
Finance Assistant
Mr. Nguyen Nhu Loc
Driver
Mr. Ninh Van Hung
Admin. Secretary
Mr. Dinh Cong Thanh
Driver
Mr. Nguyen Duc Cuong
Admin./Finance Secretary
Ms. Le Thi Thao
Cleaner
Ms. Tran Thi Thanh Nga
Secretary for Ec/UNFPA
Mr. Nguyen Van Tien
Gardener
Mr. Nguyen Xuan Hong
NPPP
Ms. Le Thi Thanh Huyen
NPPP
Mr. Phan Trieu Anh
HMIS Prof. Personnel
Ms. Phan Thi Le Mai
NPPP
Mr. Ha Viet Hung
Consultant
Ms. Magali Romendene
Programme Officer (JPO)
Mr. Hoang Hai Chau
Consultant
Ms. Aida Olkkonen
Programme Officer (UNV)
EC/UNFPA M & E Assistant
EC/UNFPA Prog.
Coordinator

UNFPA has learned from these criticisms and is now in a better position to conduct more effective monitoring and evaluation. They have a better monitoring and evaluation framework; they have logical frameworks for the overall CP and for each sub-programme, which clearly set out what outputs and effects are being sought. Baseline, mid-line, and end-line surveys are planned, and survey instruments have already been developed. UNFPA has worked with the government to develop a revised HMIS, which is being tested and will be applied more broadly[42]. This could allow for more clear measurement of programmes in the 11 UNFPA-supported provinces. A monitoring and evaluation unit has been established and will have 4 staff assigned (one of which is dedicated to RHIYA).

In addition to monitoring and evaluation against the logframes, UNFPA has other mechanisms for programme-level evaluation. These include the Country Programme Mid-Term Review, the Common Country Assessment, and the final Evaluation of the CP. In addition to these, UNFPA HQ requires evaluation questionnaires to be filled in by each CO and attached (see below). UNFPA also supports the government in conducting project and sub-programme reviews, which include periodic field visits and unannounced spot checks. Quarterly meetings and discussions with national counterparts are usually conducted.

UNFPA produces Annual Reports that summarise overall achievements. The focus is more on inputs and activities than outcomes, and is qualitative in nature. There is little high level analysis presented. In the last 5 country reports there was no quantitative analysis of any kind, except for occasional presentation of financial issues. Progress of individual projects is not reported; it is left to each project to produce their own reports. In the 2000 annual report the new results management system is reflected. This should help to focus more on effectiveness, both programmatic and financial, but this remains an area for improvement.

Recommendation: Further Support for Monitoring and Evaluation

- Ø UNFPA/Vietnam should be supported in their efforts to enhance their monitoring and evaluation capacity. This would include hiring more staff if needed.
- Ø UNFPA's periodic reports should include analysis of achievements to date against logframe indicators, both qualitative and quantitative, and provide trend analysis.
- Ø Implications of performance on changes in programming should be highlighted.

Partnerships and collaboration

UNFPA is the most efficient donor working in RH. They fully support the MoH. They do not impose their own ideas.

- MoH official

UNFPA plays a leading role in RH programming in Vietnam. They, and the other agencies involved, are credited with being a prime mover of ARH issues, largely through the RHIYA.

As mentioned earlier, UNFPA has an extremely close relationship with government, especially the MPI, MoH, and MoET. This is largely due to its historical role in Vietnam in the last 30 years as outlined above. Given this relationship, UNFPA plays a leading role in RH

[42]However, regarding indicators, the two indicators/targets in the ARH section of the National RH Strategy only focus on the provision of information, not services[42]. Furthermore, the Evaluation Team reviewed the "List of Basic Indicators of the Health Branch" and "List of Basic Indicators of the District Level," which the team understood represented the government's proposed new HMIS, and found only two indicators related directly to ARH: "Percentage of women age from 15-35 vaccinated with TT $\geq$2 (%)" and "Percentage of pregnant women <19 years of age" [42].

programming. They, and the other agencies involved, are credited with being a prime mover of ARH issues, largely through the RHI. Collaboration has increased even more in the last couple of years, coinciding, for example, with the work of the UN Interagency Working Groups. UNFPA has links with all the most of the major actors working in ARH, including multi- and bi-lateral donors, local/mass organisations, international NGOs. There are a number of fora for co-ordination (e.g., Sectoral Aid Co-ordination meetings, RH working groups, UN Interagency working groups) on which UNFPA is either a leader or a participant.

There was some criticism of UNFPA's limited consultation with partners or youth in the development of the initial Country Strategic Framework for Phase 2 of the RHIYA[43]. This may, however, have been due to some extent to the short time frame allowed for its development, around 2 weeks[44]. However, the development of the follow-on detailed proposal has reportedly been very collaborative, and local partners have had more input. It is interesting to note, though, that at the debriefing meeting for this consultancy, it became clear that VINAPFA had not updated the IPPF Regional Representative on design developments that had significant impact on the role of VINAFPA. See below for more details on the relationship between VINAFPA and IPPF.

Civil Society and local NGOs

UNFPA links with civil society and the private sector are limited by the lack of clarity of the roles of civil society and the private sector (otherwise known as "the non-state sector"). Even the practical definitions of "civil society" and "local NGO" in Vietnam are unclear. There is no legal framework as yet establishing clear rules and roles for LNGOs – though one reportedly has been in development for years. The government focuses on mass organisations such as the Youth Union, Women's Union, Farmer's Union and so on, though these are all part of the government, and party, structure.

This does not mean that LNGOs, in practice, do not exist. Many do, and UNFPA works with some of them, mostly in the RHI. UNFPA feels it is supporting long-term institutional change by supporting/promoting the role of "LNGOs" as executing agencies under RHIYA – a significant shift from the implementation modality of RHI. This itself acts like an institutional demonstration project, not only for programme effects but to show what "LNGOs" can (or cannot) do.

UNFPA is also planning to reach some private sector doctors (who also work in the public sector) via training on the new RH standards. This activity is to start later in 2003. Beyond that, little other work with the private sector has taken place or is planned.

RHI/RHIYA

UNFPA has very specific and documented relationships with government, international NGOs (e.g., CARE, MSI, WPF), local NGOs (e.g., RaFH), and local/mass organisations (Youth Union and VINFPA). There were a number of problems in RHI with the roles and relationship structures mandated. Various evaluation reports from RHI, and discussions with key stakeholders, highlight these issues: weak coordination of projects by the Umbrella Project, possibly related to unclear roles and responsibilities; communication difficulties, perhaps exacerbated by personality differences; limitations in the roles between international and local NGOs; and questions of control and responsibility for implementation processes. Midway through RHI, WPF stopped implementing the Umbrella Project, and UNFPA took over. This was, at least partly, an attempt to improve management of the Initiative. This

[43] Final Evaluation of the RHI and appraisal for proposal for Phase II RHIYA, November 2002. Euronet Consulting.
[44] Discussion with UNFPA Resident Representative.

management role – as close to implementation as UNFPA gets – seems to have been an improvement and will continue into RHIYA.

Relations with other UN Agencies

UNFPA has been an active player in UN Reform in Vietnam, which started in 1997. CO staff participate in a number of (sometimes monthly) coordination meetings, such as the Health Sector Working Group and Heads of Agency meetings. In addition, there are numerous interagency working groups or task forces focusing on key cross-cutting issues: on youth, on gender, on human rights, on knowledge management, on external communication/advocacy, and of course the UN Theme Group on AIDS. There is an annual workplan for the UN Country Team (UNCT) that outlines the strategies of the working groups.

Relations with bi-lateral Agencies

UNFPA maintains professional relationships with key bi-lateral agencies, though arguably not as closely as with other UN agencies. Programmatic links, all with a specific focus on young people according to UNFPA, include the following:

- The Netherlands: Support at central and provincial level
- Denmark: Window of Love project; Support of Youth Union; MOET project
- Luxembourg: Support of VINAFPA
- AusAid: Window of Love project; Ho Chi Minh Academy project
- New Zealand: Support at provincial level
- Switzerland: Domestic violence (central and provincial level)
- Canada: Domestic violence (provincial level)
- JICA, Belgium, ADB: Support Hoa Binh Province

In addition to programmatic linkages, bi-laterals offer another important link – to funding. Since UNFPA HQ and the Vietnam CO need to raise 26% of their budget from external funds, UNFPA needs to maintain close contact with any agencies that might be able to co-fund UNFPA activities.

3.1.2 Integration of Rights

The Country Office definition and conceptualisation of rights

Some UNFPA staff have received training on rights-based programming. UNFPA's programmes seek directly to improve ARH information and services, focusing on the "supply side" of key ASRH rights issues. See section 2.1.2 for more details.

Young people's rights as reflected in CO employment practices/conditions of work

There are no young people working in the UNFPA CO, and the Office does not have an explicit employment rights policy for young people. UNFPA, through UN employment regulations, adopts an equal opportunities approach to employment and conditions of work.

3.1.3 Capacity

The quality and dedication of UNFPA staff seems high, but there was no time to conduct an in-depth capacity assessment. When asked, UNFPA staff would benefit from regular (not just on-the-job) and needs based training, perhaps, for example, in such areas as ARH programming and monitoring/evaluating, BCC material development, further rights-based programming training, advocacy.

Similarly, it was not possible to accurately gauge whether the numbers of staff are sufficient. The RHI evaluation team questioned whether to proceed with RHIYA in Vietnam under the current institutional structure. This recommendation was based upon the RHI evaluation team's assessment of UNFPA's low level of demonstrated capacity in managing the Initiative since it took control of he Umbrella Project (in January 2001). The evaluation states, "Unless comprehensive capacity building has taken UNFPA-FO (field office) Vietnam is not in the position to provide the necessary oversight of the implementation and execution of the RHIYA. The capacity building needs to take place *before the commencement of implementation* of the next phase."[45]

UNFPA is response is to hire a new Project Coordinator and M&E assistant for the Umbrella Project. As decentralisation increases, the need for programme monitoring will increase. One might expect staff workloads similarly to increase. In such a case, more (local) staff may be needed to ensure effective implementation, and achieve the comprehensiveness sought by the RHI evaluation team.

The Country Office and UNFPA HQ is responsible for raising 26% (USD 7 million) of the UNFPA/Vietnam Country Office budget for CP 6. The opportunity cost of this resource mobilisation has not been calculated by UNFPA HQ. This is a problem across the UN system globally. The practical implication is that UNFPA staff in country spend part of their time focused on fund raising (anecdotally: at least 15% of time, and likely more for senior staff) instead of programme implementation.

<u>UNFPA CO staff's understanding of socio-cultural and economic factors influencing young people's RH & rights</u>

As articulated in key Country Programme documents (e.g. the sub-programme and project documents), and through CO staff members' participation in key fora and committees, it is clear that the Country Office has a good appreciation of the factors which currently influence young people's RH and rights in Vietnam. Such understanding has been incorporated into the design of its programmes and projects.

The following examples provide some evidence of this view:

- UNFPA staff recognise that IEC materials have to address youth from different cultural backgrounds, and under RHIYA plan to apply UNFPA's decentralised approach to material development. While money for new materials will not be provided, money for adapting existing materials will be.
- In the workshop at the start of the evaluation, UNFPA staff identified social and cultural barriers to access to SRH services for young people as a top priority.
- UNFPA has supported the subsidisation policy of SRH services at Hanoi House, whereby services provided to older clients (i.e., not young people) help offset costs of services for young people.

<u>Institutional mechanisms to enable young people to participate in planning, implementation, monitoring and evaluation of CP components</u>

There are few mechanisms for young people's participation in the CP. Several respondents (from government at all levels, local organisations, UNFPA, VINAFPA, etc) felt that this was at least partly due to the fact that there is a cultural bias against involving youth in decisions, or seeing the need to consult with youth. This norm is being challenged a bit through the RHIYA. For the design of RHIYA, a 2-day workshop with youth was held. Participants included youth from both urban (Hanoi) and rural (Ninh Binh) areas, two ethnic minority

[45] Final Evaluation of the AIRH, Vietnam section, p 10. Euro Consulting.

groups, and included both males and females. This gave the participants a chance to clarify their issues and concerns, especially related to SRH. In addition, youth are reportedly involved in the development of IEC materials, through field testing.

At least some partners report getting feedback from youth via peer educators who work at youth corners and in counselling centres. Another initiative is the "letter box" or "blue box" which is a place where young people can write in questions they have about SRH, to be answered in group "counselling" (information sharing) sessions.

When asked about youth participation, the common refrain in Vietnam (not only with UNFPA) was that the "Youth Union is involved." Indeed, the Youth Union is the largest mass organisation with a focus on young people. However, most of the representatives the team met were in fact well over 30 – even into their 50s. So while participation by Youth Union members is seen as youth participation, it is at best indirect.

Young people do not participate directly as members of boards of any of the RHIYA partners.

Capacity of staff to use evidence-based planning, and to promote lesson learning and best practice in planning, implementation, monitoring and evaluation

Though the M&E systems in CP5 and RHI were weak, the staff have made efforts to use other data to provide evidence for designing both CP6 and the RHIYA. As mentioned above, the design of CP6 incorporating recommendations from the evaluation of CP 5, a 1999 Situation Analysis of RH services at provincial level, plus a World Bank-funded Health Sector Review, and discussions with other UN agencies as part of UN reform/interagency collaboration.

However, some decisions around the RHIYA design appear to be more political or opportunistic than technical. For example, one of the criticisms of WPF as the lead of the Umbrella Project in Phase 1 was that there was a conflict of interest since WPF also implemented projects within the Initiative. If that was true and generalisable, then the decision for VINAFPA to be both an executing and an implementing agency in RHIYA flies in the face of practical evidence to the contrary. Clearly there are other forces driving programme decisions; there may be no other local organisation that offers a better choice (or geographical reach) for the executing role.

There is room for improvement in sharing lessons learned. In RHI there were only limited efforts at formal promotion of lessons learnt. One small booklet outlines the lessons learned from Phase 1[46]. But even here the lessons are for individual projects only, and do not draw out the broader strategic issues for the programme as a whole. Some of the lessons have already been incorporated, such as the need for baseline surveys and endline surveys to measure achievement on key indicators. It is not clear how, or if, the final design of Phase 2 will be built upon other lessons For more related information see sections 2.1.1 and 2.1.3 above.

Capacity-building and support provided by the CST

The wider goal of the CST system is defined by UNFPA as "to build national capacity, sustainability of national programmes, and promotion of self-reliance to achieve ICPD goals". Support to COs is supposed to focus through technical assistance on sectoral context (SWAps, UNDAF etc), design of CP and sub-programmes, capacity building/implementation of CPs, and M&E. In Vietnam, support has been provided accordingly.

[46] Adolescent Reproductive Health Initiative Programme1998-2002: lessons learned. EC-UNFPA.

The CST in Bangkok was recently scaled down by 50%. This is part of a wider UNFPA initiative to encourage Country Office's to develop and access a register of international consultants for technical support. Currently there are only two CST staff with expertise in RH. This has meant that support from the CST has been limited and used sparingly by the CO. The UNFPA staff all report satisfaction from the limited assistance provided, and the support is useful as long as the CO is not reliant only upon them for TA. Increased use of the CST is largely limited by the CST's capacity.

Most recently, CST has provided assistance in improving the CO M&E system. This included training in logical frameworks and development of M&E tools such as questionnaires and checklists. They have also provided technical backstopping to project partners, such as in the development of the MOET's "Adolescent Reproductive Health Education: self learning with guidance manual for teachers (2001)".

3.1.4 In Summary

On partnerships: UNFPA has extremely close and effective partnerships with government. UN interagency collaboration is strong, and UNFPA has played a key role in interagency working groups and task forces. UNFPA has multiple partnerships with bi-laterals. UNFPA works with local NGOs under the RHI project, but in general work with "civil society" groups and private sector is limited by lack of national legal and conceptual clarity on the rules, roles, and responsibilities of these two groups of stakeholders.

On youth participation: youth play only a limited and often indirect role in the design, implementation, monitoring, and evaluation of UNFPA-sponsored activities. There is a cultural bias against such participation, though this is slowly changing.

On CO capacity: The CO has strong local staff capacity that has built up through the implementation of RHI Phase 1. Except for the Resident Representative, international staff positions are filled by trainees; more local staff in those position would make the office stronger. The CO intends to hire two new staff to help manage the RHIYA, and these will be critically important positions. The CST, whose staff have been reduced by 50% in the recent past, has provided limited but valued support particularly in improving the monitoring and evaluation systems and tools.

Recommendation: Increase Capacity of UNFPA CO

- Ø Current staff might benefit from specific basic and refresher courses on ARH issues, monitoring and evaluation of ARH programmes, BCC material development, and general management.
- Ø Young people should be included systemically in the planning, implementation, monitoring, and evaluation of ARH programmes and projects.
- Ø UNFPA needs to increase substantially its support to, and monitoring of, the Executing Agencies under RHIYA, VINAFPA and the Youth Union to assist them to effectively fulfil these new roles.

3.2 VINAFPA

3.2.1 Relevance

Constitution and organisational structure

VINAFPA did not have an organogram based on posts and post holders. The team requested VINAFPA to create one, but VINAFPA could not provide it.

VINFPA has a composite governance and management structure in which senior management and governance responsibilities are currently provided by a core team of three Standing Committee members of VINAFPA's Volunteer Board. Prior to 1998/99, there has been an Executive Director post within VINAFPA providing a senior management role distinct from the Volunteer Board. However, since the loss of the last Executive Director and the former President, and the placement of Professor Song by the NCPFC as the new President of VINAFPA, this position of Executive Director has not been filled. It was not possible to get clarity on the reasons why this has happened as key informants provided somewhat divergent explanations for this situation, but it is clearly an issue of tension between IPPF and VINAFPA, and one containing some 'political' sensitivities.

Whilst VINAFPA do not conceive it to be a problem, this current intertwined governance and management structure, with Senior Volunteer Board members acting in governing as well as management capacity raises concerns within IPPF and by the Evaluators about the level of accountability the Association is able to ensure. This clearly needs to be addressed through discussions with IPPF and the NCPFC. In order for VINAFPA to fulfil the IPPF accreditation process (scheduled for July 2003[47]), the Association will have to ensure that the governance and management structure is compliant with IPPF Standards and Responsibilities of IPPF Membership criteria, otherwise IPPF funding will be at risk. Aware of the serious governance weaknesses within VINAFPA, IPPF have sought to provide support to the Association to address these, assisting in basic governance and management procedures.

Staffing levels have been reduced over the least three years; a result of reduced income from donors, notably IPPF. Financial support from IPPF in 2001-2002 dropped by 5% on the previous year. In 2002-2003, VINAFPA experienced a further 11% reduction in core funding. This has seriously impacted on the institutional capacity of the organisation, right at the time when additional challenges are being set to VINAFPA, by the NCPFC to implement the RH strategy, and shortly, by UNFPA in RHIYA, in which VINAFPA is to be given an executing agency role, as well as an implementing role.

The latest Annual Report 2002 lists staff at headquarters. There currently are four project coordinators who are responsible for oversight of ten projects; three staff involved in accounts, two secretaries, one stockkeeper, and six ancillary staff (guards, drivers, cleaners). There is no longer an Evaluation Officer, or Training Officer, or Chief of Programmes or Chief of Services. These roles are now shared by Project Coordinators. This means that the Standing Committee have even more of a responsibility for providing technical guidance and oversight in the operations of VINAFPA than before, and are not simply providing a governance role.

VINAFPA now has 20 clinic managers overseeing clinical activities and a further 39 "project coordinators" at the branch level, 18 of which are engaged in youth work, overseeing outreach activities. Half of these project coordinators are working part-time. Reproductive health care service provision and awareness raising is supported by the employment of

[47] Post–evaluation addendum - It is understood that following the Regional Council meeting of July 2003, VINAFPA has agreed to the need to recruit an Executive Director for the Association.

cadres of doctors, midwives, district assistants, as well as drivers and guards; on average four staff working at each clinic. Staffing at provincial/local level has increased considerably over the last three years in direct contrast to the diminishing staffing levels at Head Office.

Membership of VINAFPA's Volunteer Board is considerable and represents a vital resource for the association in terms of human resources and in terms of political influence and networking available to it. However, such dependence on the Board also raises questions of accountability and management – to whom are volunteers accountable for their actions – and how can VINAFPA manage the behaviours and actions of volunteers acting on VINAFPA's behalf? Certainly, when volunteers are of good quality, of which undoubtedly VINAFPA has many, they are an asset to the Association. However, they can also represent a liability to VINAFPA's credibility. This requires strong oversight from the Standing and Executive Committees, a responsibility that may be constrained by the considerable project and activity management oversight responsibility that the Standing Committee also shares.

Resource allocation to young people's reproductive health

It was not possible to get a completely clear picture of budgets and expenditures for VINAFPA. The table below provides the breakdown of *annual project budgets* for VINAFPA from 1994 to 2003. The figures provided by VINAFPA giving budget breakdown for each of the projects do not match the figures in the annual reports[48]. The audited accounts provide yet another set of figures, mainly expenditures, which further confuse the picture. Total Annual Project Budgets (taken from Annual Reports)[49] is provided in table 4.

As described in section 2.2, there are limited resources available to VINAFPA in its ARH/YP work. The FLE project that has been running since 1994, with support from IPPF, has gradually been experiencing a diminished resource allocation. This project aims to provide quality information to young people through educational and promotional activities, focusing on family life, sexuality, STIs/AIDS, through the establishment of youth clubs and student clubs, with the collaboration of the Youth Union across twenty provinces. Funding in 2000 was approximately US$19,000 (at today's exchange rate); it is now only US$8,000 for 2003. Whilst the project has wide coverage, with twenty clubs/centres still operating, the extremely low resource allocations available to this initiative are indicative of the limited project activities that are actually undertaken through this project.

Table 4: Total Annual Project Budgets

Year	Amount (in USD)
1994	201,962
1995	328,840
1996	259,692
1997	342,128
1998	no annual figures available
1999	379,597
2000	432,284
2001	582,374
2002	486,127
2003	360,000 (estimated by VINAFPA)

Rate of Exchange: USD 1 = Dong 15,000

The funding from the RHI (project RAS/98/P19), which started in 1999, has now finished. This project, entitled 'Introduction of Adolescent Reproductive Health Service for Youth in

[48] There are a number of anomalies including missing projects, differing totals, budget figures not spend figures being used, etc).
[49] Note that this is not an accurate measure of total income or expenditure.

Vietnam', was in VINAFPA's opinion, and that of Government officials, as well as UNFPA, the most significant entrée by VINAFPA into working to meet the reproductive health needs of young people. Overall budget for the programme was approximately US$450,000; in 2002 the budget was for US$50,000 approximately, and in 2003 there were no more funds available for the continuation of the initiative. Given the focus on ARH described in VINAFPA's Strategic Plan for the next three years, additional financial resources will be clearly required to fulfil this commitment.

Monitoring and evaluation

The monitoring and evaluation system in operation in VINAFPA is somewhat basic. However, this does compare with many of those in other local and non-governmental organisations operating in Vietnam. Attention is focused on measuring activities and outputs and there is no real sense from VINAFPA, and other stakeholders in general that attention is paid to evaluating outcomes and the impact of project and programme work. Formal baseline surveys are not routinely undertaken by VINAFPA, against which targets for outcomes can be set. Formal evaluations, measuring outcomes are also not undertaken.

Branch Offices collect routine data on IEC and counselling work and service provision on a monthly basis. The recording formats used have greatly improved over the last three or four years, with assistance from UNFPA, as well as from IPPF. Data for the RHI is sex and age disaggregated. Data for other RH/FP projects is not age or sex disaggregated. This information is submitted to Head Office to the respective Project Coordinator. Quarterly (or other) reports are produced by the Project Coordinator and/or a Standing Committee member, for submission to the donor, according to the donor stipulations.

Monitoring visits by Head Office are undertaken by Project Coordinators, Standing Committee members, the frequency of which was not possible to ascertain from discussions. Monitoring is also undertaken by VINAFPA volunteers at Branch level. The impression given is that these visits are more supervisory visits rather than monitoring visits. There is no longer dedicated capacity in VINAFPA head office for regular monitoring of routine data collected in branch offices. The former Evaluation Officer left VINAFPA approximately a year ago, and the post has not been filled, nor is there any indication from VINAFPA that there is the intention to fill this post in the foreseeable future.

It is evident that VINAFPA does generate a lot of routine data. However, there is no capacity for this information to be analysed and used effectively. There is no sense that the information gathered is seen by VINAFPA as being valuable in providing insights into progress being made by the Association, or highlighting where weaknesses are. One example of this concerns data on young men reached with STI services. Branch monitoring data clearly show that almost no young men are being reached with STI diagnosis and treatment services by VINAFPA. However, this picture clearly portrayed by the service statistics has not been picked up by VINAFPA head office and addressed accordingly. Another example, provided by a VINAFPA member of staff when discussing the analysis of routine data, was the seasonality of youth clients. This member of staff who collated the RHI statistics for submission to UNFPA (for analysis) described her impression that there were considerably more clients after the New Year period, but this period coincided with a period in which funding availability was delayed (due to holiday delays), creating a problem for VINAFPA in facing increased demand and an inability to meet that demand. However, this situation was not being routinely examined by VINAFPA enabling them to devise a strategy to overcome this difficulty. Simple analysis of routine data is all that is required.

Partnerships and collaboration

VINAFPA has strong collaborative partnerships with the Government (mainly the NCPFC) and Mass Organisations, such as the Youth Union and Women's Union. VINAFPA is a local organisation but is supported by the NCPFC, of which it is a member, and so is often thought of as a quasi-mass organisation (despite not receiving core funding support from the Government). VINAFPA's partnership with the Youth Union is especially appropriate given the increasing focus that VINAFPA is giving to ARH. Partnerships with other local organisations appear less of a priority for VINAFPA. This is perhaps because of VINAFPA's identity as a *national* organisation, whilst other local organisations have a much more limited geographical coverage. There is a small but emerging private sector within Vietnam. At the moment, however, its level of development is so minimal that partnerships with the private sector by VINAFPA would yield limited returns. VINAFPA therefore continues to focus its partnership efforts on Mass Organisations.

Given that the significant contribution that VINAFPA has made to ARH was through the RAS/98/P19 project that was part of the RHI, there is a reasonable degree of complementarity and coordination of youth approaches between VINAFPA and other local organisations. The relationship between VINAFPA and UNFPA is described as good. VINAFPA clearly looks to UNFPA for support in its RH activities, in financial terms for project activities, as well as for capacity building and institutional strengthening. UNFPA has been good to VINAFPA in this regard, facilitating a grant of US$450,000 from the Government of Luxembourg to VINAFPA for capacity building.

VINAFPA also ensures that members of mass organisations are members of local project steering committees, thereby providing opportunities for sharing information on each organisation's activities on ARH, and ensuring duplication does not take place. VINAFPA's engagement in the ARH agenda will continue under the forthcoming EC/UNFPA Reproductive Health Initiative for Youth in Asia Phase II, in which it will take not only an implementing role, but also an executive role. This should continue to enable VINAFPA to maintain good coordination of its ARH work with that being undertaken by others.

3.2.2 Integration of Rights

VINAFPA staff and volunteers demonstrate a strong, albeit culturally nuanced grasp of reproductive rights as defined and promulgated by IPPF, in line with ICPD. All programmes concerning young people are formulated around the right to information and education, access to services, privacy and confidentiality. Working practices, especially at branch level where programmes are operationalised, reflect these reproductive rights. Broader rights relating to employment policies are in line with Vietnamese law, and are supportive of an equal opportunities approach, though are not articulated as such. The concept of *reproductive health and rights*, as distinct from broader equal opportunity rights, are not reflected in VINAFPA's employment policies. Certainly VINAFPA does not have any gender equity policies or internal policies on PLWHA.

Right to youth participation

Participation of young people in the Association's decision-making, policy development, and programme planning is negligible. The right to participation is still strongly interpreted by VINAFPA as the right to be *involved*, for example, in awareness raising activities, and in testing of IEC materials, but not in any truly consultative and significant decision-making and internal policy development capacity.

VINAFPA is working towards the IPPF principle of youth participation in its central governance structure, in which 1 in 25 board members should be a youth representative.

The difficulty at the moment is that VINAFPA constitution stipulates that to be on the Executive Committee, you have to be a President of a local branch of VINAFPA. VINAFPA Standing Committee recognise this as an area for improvement and are to raise this very issue in the forthcoming Board meeting.

3.2.3 Capacity

Capacity to promote young people's reproductive health rights and needs

VINAFPA has experienced severe staffing constraints at head office over the last few years related to cuts in IPPF core funding. Capacity in terms of quantity of staff at Head Office, especially at a Middle Management level, is at a minimum. Senior Management roles are undertaken through the governing board/steering committee, hence there is a duality of roles at that level. Capacity is therefore compromised because of this. Assessment of the qualitative aspects of capacity, such as staff competency is hard to gauge in an objective manner in such limited time frame. However, the evaluation team and other key informants sense that whilst there is a widely held commitment to working with youth, there is not necessarily a strong competency and skills base in this area, upon which the association is able to draw. Within the Standing Committee there is clearly a strong skills and competency base regarding reproductive health in general, and some individuals do clearly have experience in the field of "adolescence", and have been recruited specifically because of this competency.

Whilst difficult to quantify, it is fair to say that there is a considerable range of understanding amongst staff and volunteers on the socio-cultural and economic factors influencing young people's reproductive health and rights, from which it is difficult to draw a definitive picture. Those interviewed during the Evaluation process do have a sound, basic grasp of the factors affecting young people's reproductive health and rights, and it would seem that this has been achieved through assimilation as well as through direct training on these issues. Some staff showed high level of understanding, others less so. So, whilst there may not be a shared common understanding amongst the staff about these factors, there would appear to be a basic level of comprehension.

Recommendation – Coverage vs. Quality in Capacity Constrained Situation

VINAFPA should assess its comparative advantage over other local/non governmental organisations, of being a national organisation with a RH/FP remit from the Government, alongside its current limited financial and human resources capacity to deliver RH services and counselling of sufficient and sustained quality, and decide where the balance should be sought in terms of coverage vs. quality of care.

Institutional mechanisms for young people's participation

As described in section 3.2.2, participation of young people within VINFPA is seen predominantly in terms of their *involvement* in youth focused activities, and not in terms of policy-making and governance decision-making capacity. At an institutional level, there are no specific arrangements and mechanisms in place to enable young people to participate actively in planning, managing, monitoring, or evaluation of VINAFPA's activities. At a local level, project steering committees do have youth "representation" but on the whole tend to see representatives of the Youth Union (who are not usually young people) as providing the "youth perspective". Youth participation in project implementation is mainly focused on IEC work and awareness raising activities in which young people are encouraged to participate in running forums, competitions, and clubs. However, despite the limited insight available to the evaluation team, it would appear that young people are not given autonomous oversight

of these activities, and there is a strong and dominant level of adult involvement in the youth work.

Recommendation: Participation of Young People

Greater youth participation is required. Young people should be involved not just in project activities, but as decision makers sitting within project steering committees and VINAFPA's governing structure, not just for reasons relating to rights of participation, but also to improve the quality and appropriateness of VINAFPA's response to youth needs.

Capacity to reach marginalised and excluded young people

Whilst VINAFPA staff and volunteers talk of the heterogeneous nature of young people, the strategic operational response by VINAFPA to adolescent reproductive health needs has until recently reflected a strongly homogenous approach. Until last year, VINAFPA had no specific strategies developed to meet the specific and different needs of the varying client base, except for a differentiation in terms of in and out of school youth. VINAFPA is now developing approaches for reaching commercial sex workers, and increasing a focus on responding to HIV/AIDS and IDUs. This is a somewhat bold step for VINAFPA, as commercial sex work and drug use are deemed "social evils" by the Government of Vietnam, against which it has limited if not zero toleration. Under government legislation CSWs and IDUs can be interned in detention camps, and "re-educated". Acknowledging that CSWs and IDUs have reproductive and sexual health, including HIV/AIDS needs, and working to address them is a significant step for VINAFPA, who are usually seen as a "right-hand" of the government. Whether VINAFPA has sufficient capacity and expertise in this area remains to be seen.

Capacity for lesson learning and promotion of best practice

As discussed in Section 3.2.1, VINAFPA has extremely limited capacity to promote lesson learning. This is not because of the quality of staff, who have appropriate skills and experience necessary for their posts, but through the limited number of staff available to the Association. This is having negative impact on the ability to undertake regular and sufficient monitoring of project activities. The result is widely varying quality of care being provided, lack of standardised approaches to key policy issues such as paying for services and client confidentiality. The absence of a dedicated monitoring and evaluation officer means that routine data collected is not routinely being analysed, and is a somewhat wasted resource. Outcome effectiveness is not measured, rendering ability to judge performance of "models" objectively almost impossible. This kind of lesson learning would greatly assist VINAFPA in strengthening its strategic approaches to adolescent reproductive health. At a broader level, VINAFPA does attempt to lesson learn through its annual board meetings, in which branch offices share their lessons with other staff and volunteers in VINAFPA. However, there is no other system institutionalised across the organisation to assist in lesson learning.

Recommendation: Learning

Enhanced monitoring and evaluation capacity (including baseline activities and purpose level target setting) is urgently required – to assist in lesson learning, trend analysis, progress assessment, problem identification, and most urgent of all, evidence based outcome effectiveness measurement – to allow for more rigorous "model" testing.

Capacity to acquire and manage financial resources

Similarly, the Association has limited capacity to pursue, acquire and manage financial resources through lack of staff dedicated to these activities. Fundraising is steered by the Standing Committee, with the support of IPPF and UNFPA, and it would appear that they have been effective in this, as witnessed by the relatively steady growth in annual project budget, despite diminishing IPPF income. Certainly, the funding base is gradually being broadened, and IPPF have helped VINAFPA to achieve this, through proposal development support.

VINAFPA currently has a comparative advantage over a number of other local organisations through the extremely high regard in which the President is held by local and central government authorities. This high level of esteem for the individual clearly provides the organisation with opportunities for income generation. But this is not institutionalised, and will last only so long as Professor Song is in office.

Institutionally, VINAFPA also has considerable potential for local fundraising through its Volunteer structure. Members pay membership fees contributing to local income generation. Volunteer members are also often influentials within their local communities, and are able to generate considerable in-kind contributions, in terms of land, equipment, as well as working over and extra time without charge, due to their commitments to the Association's activities and overall purpose.

Capacity to manage financial resources have improved over the last year or so, with two accountants and one Chief Accountant working at Head Office. Efforts to diversify VINAFPA's funding base have been made, with the assistance of UNFPA, and IPPF, especially in project proposal development for donor-supported projects.

Capacity support from IPPF and others

The support VINAFPA has received from IPPF Regional Office has been variable over the last ten years. Financially, IPPF has provided nearly US$4.5 million funding to VINAFPA from 1993-2002, but VINAFPA has recently been experiencing considerable cut backs in the level of financial support it receives from IPPF. In terms of technical assistance and capacity building focusing on ARH, VINAFPA itself claims that it has received most support from UNFPA, and not IPPF.

Support from IPPF, not only financial, but also technical support through monitoring and technical assistance visits from IPPF Regional Office have seen a gradual increase over the last year or so[50], following a period in which VINAFPA received very little tangible support (coinciding with the period in which there were financial mismanagement issues and in-fighting amongst the Volunteer Board). Most notable amongst the support provided by IPPF is the Quality of Care training that VINAFPA has received directly from IPPF in 2002. The approach learnt by VINAFPA is to be rolled out to all its branches in 2003. The number of monitoring visits undertaken by IPPF is increasing, with at least three review trips being held per year. However, given VINAFPA's historical financial and management weaknesses, and current capacity constraints there is still considerable scope for additional support from IPPF.

UNFPA have been vocal in calling for this additional support, as they feel that IPPF has been remiss in this. Through UNFPA's assistance, VINAFPA has received a US$450,000 grant from the Government of Luxembourg for general capacity building. VINAFPA also received the support of an UNFPA volunteer placement for nine months in 200/2003 to assist in

[50] Over the last three years, IPPF has provided TA to VINAFPA in the following key areas – financial management, monitoring and evaluation, proposal development, MIS development, quality of care.

capacity building of the Association. In 2001/2, VINAFPA received over US$18,000 from KfW for peer education training and CBD training on adolescent reproductive health. This was extremely valuable training for VINAFPA, but for sustainability reasons, VINAFPA need repeat training for outreach workers.

VINAFPA readily acknowledges that despite the capacity building that it has received thus far, it is still in need of greater institutional strengthening. This will become even more necessary if VINAFPA is to successfully fulfil its remit as executing agency, as well as implementing agency, in the forthcoming RHIYA.

3.2.4 Summary

VINAFPA is an organisation that has considerable institutional strengthening and capacity building needs if it is seriously intending to achieve its national programme objectives in a strategic and coordinated manner, and ensuring consistent quality of care to be delivered across the country. Diminishing core funding from IPPF has not assisted matters, though support is being given by IPPF and UNFPA in widening VINAFPA's funding base.

There are clear human resource constraints, from the lack of an Executive Director, and Senior Management Board, that is distinct from the Steering Committee Volunteer Board, that impinge upon VINAFPA's ability to demonstrate accountability, as well as ability to provide strong management and technical oversight roles.

VINAFPA is being placed under considerable duress by the NCPFC to act as co-agency in delivering RH/FP services to the general population on a nationwide basis, as well as, shortly, by UNFPA, to act as executing as well as implementing agency in RHIYA. Whilst this is a positive reflection on how the NCPFC and UNFPA value VINAFPA's contribution to reproductive health, it is happening at a time when the Association is experiencing diminishing core financing, with fluctuating external project support. Capacity is therefore overstretched - not in terms of quality but in terms of quantity, compounded by a lack of middle management within the organisational structure to provide technical and oversight roles.

The extent to which VINAFPA has been able to assess the effectiveness and impact of its programmes on improving young people's reproductive health and rights is severely constrained by its weak MIS and lack of baseline and final evaluations using outcome level indicators. Success is currently measured in terms of the successful delivery of outputs, with little or no measurement of how or if these outputs have translated into behaviour change.

VINAFPA's main partnerships are with Mass Organisations, such as the Youth Union with whom they collaborate heavily on ARH activities. Partnerships with other local organisations appear less of a priority for VINAFPA. This is perhaps because of VINAFPA's identity as a *national* organisation, whilst other local organisations have a much more limited geographical coverage, and it identifies more readily with the Mass Organisations

3.2.5 Complementarity between UNFPA and VINAFPA

The complementarity between UNFPA and VINAFPA is not accidental. UNFPA recognises the implementation role that VINAFPA plays, and has provided funding and technical assistance through both a capacity building project and the RHI/RHIYA Initiatives. In addition, both UNFPA and VINAFPA (to a lesser extent) play an influencing role on the NCPFC. The evaluation team did not see how these relationships and activities could be usefully expanded beyond what is already planned, except in one critical area.

The RHI evaluation team went as far as to suggest that the collaboration with IPPF (VINAFPA) be terminated[51]. This advice was ignored, and VINAFPA was given an even stronger role in RHIYA. VINAFPA will be very stretched in taking on this role. However, the critical area of cooperation that needs to be strengthened is UNFPA's relationship to VINAFPA through the Umbrella Project of RHI/RHIYA. UNFPA will need to more closely monitor VINAFPA's new Executing role, providing additional support throughout. It is not clear that UNFPA has fully understood how much work will be required for this.

[51] Final Evaluation of the AIRH, Vietnam section, p 9. Euro Consulting.

SECTION 4: ENABLING POLICY DEVELOPMENT AND REFORM

4.1 UNFPA Country Programme

4.1.1 Relevance

Focus on policies and legislation relating to young people's RH and rights

Policy development and reform could be considered UNFPA's greatest strength, and an area with clearly demonstrated impact. Formal policy development work occurs primarily under the PDS sub-programme, but policy development activities also take place under the RH sub-programme. Details are provided below.

Understanding of policy and laws which affect young people's RH and rights among UNFPA staff and agencies supported by UNFPA

Policies and laws which affect SRH rights and services for young people are a relatively new topic in Vietnam. It can be expected that not all partners are fully aware of the exact policies and their implications.

UNFPA CO staff, and most of their key partners, are aware that various youth-related policies exist. Senior UNFPA have a very clear understanding of how policies are developed and implemented, and how to influence that process. The youth-specific issues are arguably less clearly understood by partner agencies. For example, there is some debate about which sets of rights formally apply to youth in Vietnam. The arguments (is it three basic rights, or 10 rights, or 12 rights?) are not themselves so critical; the important point is that discussion on rights has been stimulated, brought into the public arena, and is being addressed as far as possible in partner programmes and projects.

4.1.2 Efficiency

UNFPA has made significant contributions to stimulating an enabling environment. Advocacy is a cross-cutting issue in both sub-programmes; advocacy activities can be found throughout the UNFPA programme, at national, provincial, and sub-provincial levels. It is quite hard to get a quantitative measure of efficiency. But given the close relationship with government which facilitates advocacy, the high involvement of local staff compared to international staff, and judging from the amount of policy influence achieved (as evidenced by the key policy document developed with UNFPA assistance), a case could be made that UNFPA has made fairly efficient use of resources for policy development.

> *Advocacy is the primary purpose of our work.*
> - UNFPA Resident Representative

4.1.3 Effectiveness

The extent of UNFPA's influence in the development of national policy and guidelines to promote young people's RH & rights

The government has been opening up through the *doi moi* reform agenda. Still, advocacy and introduction of "new" or "outside" ideas requires more sensitivity than in many countries. Such advocacy, arguably, can be most effective when levels of trust between government and external agency are high. This is the case with UNFPA. Government report high satisfaction with UNFPA because of this "trustful relationship" and because they feel UNFPA

has demonstrated good outputs. UNFPA continues to play a key role in the development of national policies and strategies that affect ARH. Examples are included in section 1.2 above.

Perception by key partners of UNFPA's impact on national policies, protocols and standards/norms for reproductive health

All UNFPA partners – government, international and local NGOs, mass organisations, other UN agencies - recognise UNFPA's leading role in the assisting the government with the development of RH policies and strategies in general, and especially with those associated with young people. They acknowledge that UNFPA has been a consistent advocate for the ICPD POA. UNFPA has also been instrumental in addressing ARH through the UN Interagency Working Groups, which now has a group on Youth. The current UNFPA Resident Representative is credited with putting youth on the Interagency agenda at a UN retreat in 2002. This will clearly help mainstream youth (including SRH issues where appropriate) in other UN programmes.

4.1.4 In Summary

UNFPA's work in policy and strategy development related to adolescent SRH has been highly successful, due in no small part to their close relationship with the government and an implementation modality that places advocacy at the centre of their work. As *doi moi* proceeds, UNFPA has demonstrated its ability to assist the government in establishing the necessary policies and strategies under which SRH issues for youth might be usefully addressed. This is no small achievement in an environment more comfortable with thinking of HIV as a social evil. Where only a few years ago one could not talk about SRH rights for youth, this is now a topic for (more or less) public discussion. Where the SRH needs of youth were only a few years ago largely ignored, now they appear in many national policies, strategies, and implementation guidelines. This of course does not guarantee that such needs will be better met. But UNFPA has played a pivotal role in influencing the public discourse on these issues, a necessary step towards progress.

Recommendation: Youth/adolescent SRH strategies compendium

There are a number of recent policies and strategies that address aspects of ARH. However, these are not conveniently found in a single document. Compilation of these disparate policies and strategies into a complete ARH compendium might help in ARH planning, programming, co-ordination, and monitoring/evaluation nation wide. This would be contraindicated if the government felt that such a compendium would inappropriately overemphasise the issues and therefore detract from the progress made thus far.

4.2 VINAFPA

4.2.1 Relevance

Focus on influencing policy reform and legislation relating to young people's RH and rights

None of VINAFPA's programme work is expressly focusing on influencing reform of policies and legislation that relate to young people's RH and rights. As described in section 1, the concept of civil society is not one appropriate to Vietnam, and challenging State policy is actively discouraged. However, some local organisations do undertake a challenge function, including those involved in the reproductive health field. But VINAFPA is not considered by any stakeholders interviewed in this evaluation process to be one such organisation, mainly because of its proximity to government, through its membership of the NCPFC.

This is not to say that VINAFPA does not undertake an influencing role; it is just that it is not undertaken explicitly through any programmatic approaches. Much of VINAFPA's work at provincial level has been focused on creating an enabling environment in which their ARH work can operate more effectively. In this regard, the Association has demonstrated its success in advocating for ARH. VINAFPA will continue this action, expanding when and where they feel it is appropriate.

How can VINAFPA increase such work? The most important thing is for VINAFPA to expand its profile, and hence credibility, as an active player in the world of ARH. Most people met by the Evaluation Team did not link VINAFPA with ARH explicitly. An informal "public relations" campaign of sorts could position VINAFPA, in the eyes of their colleagues, as playing a major role. This has been aided by UNFPA giving them the role of Executing Agency in RHIYA, and should be further emphasised and supported by IPPF.

Understanding of policy and laws affecting young people's RH and rights

Staff/steering committee at head office demonstrate a sense of the policy and laws that effect young people's reproductive health and rights as they have to operate strictly within those laws and policies under strict Governmental oversight.

Promotion of young people's involvement in policy/legal reform

There is no indication at all of VINAFPA actively promoting young people's involvement in identifying and articulating their needs and rights in relation to policy/legal reforms.

4.2.2 Efficiency

Human and financial resources allocated to policy reform/advocacy

There are no human or material resources dedicated specifically to policy reform within VINAFPA. There simply is no capacity for that at the moment. However, it is clear from discussions with VINAFPA and with Government officials that the Standing Committee, notably Professor Song, do engage in policy reform work. But it is not possible to quantify this human resource contribution. There is a strong sense of the potential and actual influence that the Association's President holds within the NCPFC at Central level, and the People's Committee at provincial level. Clearly, though, this is not a formalised and institutionalised approach to policy development.

4.2.3 Effectiveness

VINAFPA's influence on development of national policy/laws to promote RH and rights of young people

VINAFPA has a unique and privileged position with regard to its relationship as an association, and through its individual members notably the President Professor Pham Song, with the NCPFC. The Association is held in high regard by the NCPFC which acknowledges the contribution that VINAFPA has made to family planning and reproductive health in the past and present.

This relationship with Government, and the esteem with which the Association is held by the NCPFC, is a distinct comparative advantage that VINAFPA has over other local organisations working in the field of reproductive health, especially for young people. The extent to which VINAFPA has been able to capitalise on this unique positioning and relationship with Government in terms of influencing policy development is difficult to gauge. Whilst it is by national definitions a local organisation, its special position within the

Government of Vietnam renders it a quasi-governmental organisation[52]. It is often described by others as a mass organisation - illustrating its unusual classification, and many local organisations and UN agencies see VINAFPA as unable to offer a strategic and formal 'challenge' role to Government (in terms of influencing policy) because of this special relationship with government.

However, within VINAFPA opportunities for influencing policy *are* identified and taken up whenever the chance arises. Areas in which VINAFPA has engaged with central Government to influence policy is on HIV/AIDS and commercial sex workers and intravenous drug users. The extent to which VINAFPA has been able to influence national policy and law is distinctly overshadowed by that achieved by UNFPA.

At the Provincial level VINAFPA also maintains close relationships with leaders of the People's Committee who often are VINAFPA Volunteer Board members. But whether this translates into influence is difficult to gauge. Influence in policy development has been described by VINAFPA as achieved not just through positioning, whereby VINAFPA is able to influence local authorities through its volunteer board, but through actual demonstration of results. The RHI has been instrumental in this respect. Through this project, VINAFPA have been able to loosely demonstrate the effects that such interventions can have on reproductive health statuses of young people, and the value in undertaking adolescent reproductive health focused activities. This has enabled VINAFPA to receive greater support from, and have influence with, the People's Committee and other provincial level authorities. It would be fair to say that "policy development" has been achieved more by "doing" than by "saying".

VINAFPA's impact on the development of professional standards and best practice for young people's reproductive health

There is little evidence of VINAFPA's effectiveness in impacting on the development of national guidelines, norms, standards etc, unlike that achieved by UNFPA. One clear example of VINAFPA's engagement in the development of guidelines is its involvement in the drafting of the Ministry of Health's National Standards and Guidelines for Reproductive Health Care Services (2003). These were drawn up with the assistance of a number of individuals/national experts and international and local organisations of which VINAFPA was one. To the most part, these guidelines do conform to IPPF "best practice". One deviation from the standards of best practice is that young women, and not young men, are to be asked for their marital status, when receiving counselling or services from health practitioners; this is the only form of discrimination identified in the guidelines by the evaluators.

4.2.4 Summary

None of VINAFPA's work is expressly articulated as focusing on influencing reform of policies and legislation that relates to young people's ARH rights and needs, and there are no human or material resources dedicated specifically to policy reform within VINAFPA. However, members of the Standing Committee do engage in policy reform work, despite other stakeholders perception that VINAFPA is unable to offer a challenge role to the Government because of its special status within the NCPFC.

At the Provincial level VINAFPA has been influential in advocating for ARH in general, through its relationships with leaders of the People's Committee. Much of VINAFPA's work at this local level has been focused on creating an enabling environment in which their ARH

[52] VINAFPA does not have governmental status like other mass organisations, in that it does not receive financing from the Government for staff salaries, building costs or work budgets.

work can operate more effectively. Influence in policy development has been described by VINAFPA as achieved not just through positioning, whereby VINAFPA is able to influence local authorities through its volunteer board, but through actual demonstration of results.

SECTION 5: STRENGTHENING RH SERVICES

5.1 UNFPA Country Programme

5.1.1 Relevance

Support to RH services for young people

The current UNFPA country programme aims to have a strong focus on adolescents and young unmarried adults through specific ARH IEC, and the provision of RH services through both the public health sector and Vietnamese NGOs. These services will include counselling and contraceptives. UNFPA will continue to support the youth counselling centre and the youth clubs. As part of the RHI, several Vietnamese NGOs (e.g. VINAFPA, Vietnamese Midwives Association, Centre for Reproductive and Family Health) and mass organisations (including the Youth Union) were supported to increase access of RH and sexual health information to youth, and to sensitise policy makers on ARH issues. RHIYA will continue this focus. See Section 2.1.1 for details on RHI.

RHIYA and UNFPA CP currently focus on prevention of unwanted pregnancy, preventive measures of abortion, promotion of contraceptive methods among adolescents and youth, and training health workers in counselling for prevention of repeated pregnancy among youth. In other words, they are focusing on reducing the need for abortions. Given the prevalence of abortions, however, might also work to ensure that when some needs an abortion that the abortion is a safe one. UNFPA report that other organisations, such as Pathfinder, IPAS, and the Ford Foundation are working alongside the government on provision of safe abortions. The Team could not ascertain the scope of coverage of these activities. If allowed by UNFPA/HQ, UNFPA/Vietnam may with to consider adding "safe abortion" to its current support activities to assist in broadening such coverage across the nation.

Recommendation: Abortion Services

If and where possible, UNFPA should also emphasise the provision of safe abortions, not only in RHIYA but across all programmes and projects in their 11 provinces. Where possible, innovative approaches should be documented and scaled up.

Responsiveness to diverse needs

The RHIYA draft logframe shows that it aims to reach a wide range of youth, with a higher rural focus than in RHI. They plan to target "poor and deprived young people" whom they identify as in-school and out-of-school youth, ethnic minorities, and street children. UNFPA consulted youth (urban, rural, ethnic groups) in the design of the RHIYA in order to include their diverse needs. But it remains to be seen how youth will participate in further implementation, monitoring, and evaluation.

Evidence base

As already noted, UNFPA's M&E system was chronically weak in CP5. This also applied to RHI. One small booklet outlines the lessons learned from Phase 1[53]. But even here the lessons are for individual project only, and do not draw out the broader strategic issues for the programme as a whole. Some of the lessons have already been incorporated, such as

[53] Adolescent Reproductive Health Initiative Programme1998-2002: lessons learned. EC-UNFPA.

the need for baseline surveys and endline surveys to measure achievement on key indicators. It is not clear how, or if, the final design of RHIYA will be built upon other lessons. In other non-RHI projects, UNFPA relied on other studies and documents (as mentioned above) as evidence to use for the design and evaluation of its support to service delivery. See section 3.1.1 above.

5.1.2 Integration of Rights

Incorporation of concept of rights

See section 2.1.2 for more detail on incorporating the concept of rights.

Gender sensitivity and equity

Gender issues have been a part of UNFPA's approach since at least CP4. "Gender equity and women's empowerment" is one of the three cross-cutting issues in CP6. As such it has high visibility on paper, but there are two concerns. First, by linking gender equity with women's empowerment, UNFPA runs the risk of defining gender equity as largely supporting females. It was unclear to the evaluation team whether UNFPA's addressing of men's involvement in RH was adequate. As noted in the Analytical Summary, though young males appear to fall between the gaps in service utilisation, UNFPA staff reportedly did not ask the RHIYA partners whether this should be redressed, and if so how. UNFPA disagrees with this statement, saying that they did emphasise such needs with partner. This may hold true for other partners who were not present at the meeting. Overall this raises the specific question about how gender issues, a cross-cutting issue for UNFPA, is addressed in practice. The question will only be resolved when the RHIYA planning stages are completed, which will be after this evaluation.

Second, unlike the other two cross-cutting issues, advocacy and national capacity building, money is not and indeed probably cannot be earmarked specifically for gender equity. UNFPA estimated that 39% of it's budget is for advocacy/BCC/IEC. Whole projects have been devoted to capacity building. But gender equity is not a stand-alone issue or project. This means it is incumbent upon UNFPA to demonstrate in programme, not just financial, terms how gender equity is emphasised and implemented.

The evaluation team attempted to gather UNFPA-supported government clinic utilisation data by age and sex. Such data were not readily available. On the basis that "if it cannot be measured it cannot be managed," UNFPA needs to work with government and partners on improving data collection systems. It seems this is starting to happen. UNFPA is working with the government to pilot a new HMIS system. Indicators for the system include "Percentage of women age from 15 to 35 vaccinated with TT $\geq$2(%)". Such indicators might force recording of age and sex where health facilities must report using this HMIS. But this single indicator is not enough.

5.1.3 Capacity

Competencies and skills of service providers

There was insufficient time to meaningfully assess, based on strong evidence, the competencies and skills of providers supported by UNFPA to provide accessible, acceptable and quality services to young people (i.e. to provide "youth friendly" services). For VINAFPA's skills, see section 5.2 below.

The one exception was a visit at length at the Hanoi Youth House, operating with technical support from MSI and following MSI's quality standards. While service delivery could not be

assessed, the premises, programme design and approach, and utilisation suggested that they were providing very high quality and user-friendly services. The biggest concern expressed by others, including the government, was that the costs of running the facility were quite high. However, no objective cost analyses had been performed, for example comparing the approaches, cost, and outcomes of MSI versus VINAFPA. Such studies would strengthen the evidence base for decisions, but this opportunity has been lost as the RHIYA design has essentially been completed.

5.1.4 Efficiency

Provision of accessible, acceptable, and quality services

UNFPA support to services is targeted exclusively at public health facilities. However, through the RHI it is providing services through other local organisations also. In RHIYA this will include VINAFPA, the Vietnamese Association of Midwives (VAM), and the Centre of Reproductive and Family Health (RaFH). Where VAM and VINAFPA are more clearly like mass organisations, RaFH seems more like a local NGO.

As noted earlier, clinical services through a separate structure like the Hanoi House was perceived to be too expensive to be scaled up. The response by UNFPA was to establish youth friendly corners in existing government health services for RHIYA. The assumption is that this will prove more cost efficient and as effective as Hanoi House services. However, one of the reasons youth utilise Hanoi House services is because they are more anonymous and confidential. It will be quite a challenge to demonstrate to youth that the same type of friendly services can be replicated in a completely different institutional setting. Since no comparative cost-effectiveness study was conducted on earlier models, such as Hanoi House, one can question whether the new approach will be, firstly, as effective as Hanoi House or, secondly, a cost-effective model. This would be a good topic for further detailed evaluation.

Young people's participation

At least some partners report getting feedback from youth via peer educators who work at youth corners and in counselling centres. Another initiative is the "letter box" or "blue box" which is a place where young people can write in questions they have about SRH, to be answered in group "counselling" (information sharing) sessions.

Recommendation: Youth participation

"Youth participation is a new concept in Vietnam" was a frequent refrain. Greater youth participation is needed, not simply as recipients of project activities, but as "co-decision makers" involved in designing programs, sitting within project steering committees, involved in monitoring and evaluation activities, etc. Including representatives of the Youth Union, who are often not in fact "youth," is necessary but not sufficient. UNFPA should lead the way in explicitly demonstrating the value of such youth participation.

Monitoring and cost-effectiveness

See section 3.1.1 for more details.

The Umbrella Project of the RHI gathered some data for 2000 and 2001, but no analysis had been done at the time of the RHI evaluation. Data on trends, utilisation, etc would be invaluable for effective evidence-based designing of Phase 2. UNFPA staff report they are striving to make RHIYA Phase 2 more evidence-based. The logframe for the RHIYA Phase 2

is being finalised now. A monitoring framework has been developed, and baseline, mid-line, and end-line surveys are planned. The survey instruments have already been developed.

UNFPA provided mixed messages on the extent to which they plan to conduct any cost-effectiveness evaluation in either CP6 or RHIYA. Such studies would have immediate interest to government, and a broader audience as well, as they could compare costs (and, possibly, effects) of different demonstration models thereby providing more compelling evidence for decision making. Such cost data would complement and strengthen data on programme effectiveness. However, UNFPA has not even been able to measure programme effectiveness in the past, so additional studies may be beyond their capacity.

5.1.5 Effectiveness

Effectiveness of support to government

Effectiveness can be judged in many different ways. If effectiveness of support to government is measured by the appreciation expressed by multiple government actors, than UNFPA appears to be very effective. If effectiveness is measured by the size of its budget/inputs, UNFPA has also been effective in implementing approximately $110 million dollars over the years. UNFPA has also provided numerous capacity development projects over the years. If effectiveness is measured by the capacity of government before and after UNFPA support, UNFPA has had a number of successes in assisting in policy formulation, improvements in RH services in 8 (now 11) provinces, and in improvements in the HMIS. If effectiveness is measured quantitatively, as in the "numbers of persons trained under CP5," this is virtually impossible to ascertain during the evaluation since this data was not collected by either UNFPA or MoH. If effectiveness of support is measured by service delivery, or RH, outcomes, the attributable evidence also could not be ascertained during the evaluation. [54]

Under RHI, services were provided through the government Youth Union – the Hanoi Youth House and a similar house in Hue. These examples are limited in their scope and reach No detailed effectiveness assessment has been done or could be done within the limitations of the evaluation. However, the focus group discussions indicated that only young people who live near the UNFPA-supported clinics (e.g. Hanoi House) attend, suggesting that advertising has been limited. RHIYA will need to improve service provider friendliness and stigmatisation associated with attending MoH's RH (MCH/FP) clinics[55].

Government has reportedly said that if replicable models of ARH services can be demonstrated by RHIYA, they will seek funding from the World Bank to expand those services across the nation.

5.1.6 Sustainability

UNFPA's implementation modality is mainly through government execution, and their programmes are designed with sustainability and scale up firmly in mind. By design, UNFPA's central level work (not specifically ARH) has often been applied nationally. For example, UNFPA say they started decentralising IEC development and adaptation to "their" provinces in 1996. This prompted the NCPFC, with UNFPA assistance, to develop "core messages" for IEC nationally. Training on the core messages has reportedly been conducted in all provinces. There are other examples. UNFPA supported the MoET's "Adolescent Reproductive Health Education: self learning with guidance manual for teachers (2001)" has

[54] For example, see "Evaluation of Project VIE/97/10 'Strengthening the MoH's capacity to manage its reproductive health programme." February 2002. Also see "Viet Nam: Thematic Evaluation of UNFPA Contributions to National Capacity Development, 1997-2002. J. Reynolds.
[55] Youth Opinion Study. May 2003 Centre for Investment in Health Promotion.

been distributed to almost 3000 teachers nationally. At the same time, UNFPA worked with the MoET to integrate ARH issues into the formal curriculum of high school. Similarly, UNFPA supported the integration of RH and ARH issues into the national micro credit programme of NCPFC with Farmer's Association and Women's Union.

UNFPA, and the government, report UNFPA's greatest strength is in testing demonstration models, especially at provincial level, which the government can then, potentially, take to scale. These models are reportedly developed with eventual government sustainability in mind. There is evidence of some UNFPA work being replicated or scaled up. For example, approximately USD 10,000 of UNFPA funds were given to upgrade VINAFPA in Thai Binh province (Project 63). VINAFPA used these funds to leverage more funding from the People's Committee. UNFPA is assisting MoH to develop a unified HMIS system in one province, which the government plans to take national.

A classic example, if it comes to pass, is the RHI itself. UNFPA states that the government has said that if RHIYA can create effective and replicable models of RH service and information provision for young people, it would seek funding from the World Bank to take the project to scale. Such an intention could not be independently confirmed, but it does demonstrate that UNFPA is designing RHIYA with such long term aims in mind. However, given that RHIYA is only 3 years, all actors will need to be realistic about what levels of change can reasonably be expected.

Though their programmes are predisposed to being sustainable/scalable, UNFPA's approach is more implicit than explicit. The examples above frame the basic tenets (e.g., government execution, demonstration models) and demonstrate that there is a clear concern for sustainability. However, UNFPA has not written up a sustainability/scale-up strategy, or "lessons learned," that explicitly outline their approach and effects. Such a document arguably would be useful to other agencies that are seeking to find effective methods for sustainability and scale up.

UNFPA had reportedly supported a cost-effectiveness study related to RH in 1996/97, which they report was "very useful to the government." It appears other cost analyses have not been conducted, though such studies might be of interest to the government when comparing various programme/demonstration models. This may be changing as cost-effectiveness studies may be proposed as part of the evaluation framework for RHIYA. See section 5.1.6 below for more details.

Recommendation: Sustainability and Scale up Strategy

Sustainability, in its different forms, and methods for scaling up programmes are currently more implicit than explicit in UNFPA's programming. The articulation, then dissemination, of UNFPA's approaches in a sustainability and scale up strategy/lessons learned document (to include financial, organisational, and impact sustainability and methods for scaling up programmes) would clarify both the UNFPA and government positions on sustainability, and provide leadership and ideas to other agencies.

5.1.7 In Summary

UNFPA and Vietnam have benefited from the presence of the RHI. Though there were significant management and implementation difficulties, the Initiative had remarkable effects. Firstly, Implementation of the Initiative allowed for public discussion on the SRH needs and rights of young people, a taboo subject only a few years before. Secondly, the Initiative has demonstrated to some extent what roles local NGOs can usefully play in the health field, potentially providing evidence for finalisation of a legal framework for LNGOs. Thirdly, the

initiative has reportedly helped de-link ARH (specifically issues relating to HIV/AIDS) from the Social Evils policy.

However, weaknesses in monitoring and evaluation in Phase 1 will need to be overcome so that more concrete quantitative effects can be demonstrated. The CO will better staffed for RHIYA and should be able to provide such evidence.

5.2 VINAFPA

5.2.1 Relevance

Support to reproductive health services for young people

In the Vietnamese Population Strategy 2001-2010, VINAFPA is identified together with the National Committee on Population and Family Planning (now the National Committee on Population, Family, and Children), as the main key co-operating agency with the Ministry of Health, in the provision of reproductive health and family planning services. This is an extremely large remit and the question often raised by key informants is whether VINAFPA has the financial and human resources required to fulfil this remit. VINAFPA certainly has the coverage, operating 47 branches. The question is whether it is reaching the parts that the NCPFC and the MoH are not already reaching, notably young people.

VINAFPA itself recognises that with regard to young people, it has focused most of its attention on providing IEC and counselling services. The advent of the RHIYA RAS/98/P19 project has provided VINAFPA with the necessary injection of finances, and significantly, the necessary technical assistance and supervision with which to expand its activities into youth friendly service provision.

Under the RHI project, VINAFPA expanded ARH activities including service delivery, into six provinces across Vietnam; Hai Phong, Hue, Ho Chi Minh City, Da Nang, Nghe An, and Tien Giang. Focusing just on service delivery (IEC is discussed in Section 6), VINAFPA supported ARH services strengthening through a number of ways in the period 1993-2002:

- Sixty-eight clinical staff (doctors, midwives, nurses) were trained in ARH counselling and service provision (as well as 102 youth club members, 216 peer educators, and 620 CBDs – counselling and IEC only).
- Over 200 mobile trips were conducted providing counselling and services to over 12,000 young people.
- Clinical services were provided at Hai Phong, Hue, Ho Chi Minh City, Da Nang, Nghe An, and Tien Giang through new or renovated clinics/centres.

Despite this however, the provision of sexual and reproductive health services specifically for young people is an area in which VINAFPA has limited capacity. This sentiment was shared by the evaluation team of the RHI, who claim that VINAFPA's and IPPF's expertise does not lie in clinical services[56]. Assessment of the financial resources available, staffing levels, technical abilities and general competence in *adolescent* RH service provision would support this conclusion. Within the stakeholders workshop meeting held at the beginning of the evaluation process, the capacity of VINAFPA service providers was described as weak[57]. The capacity of MoH providers was also considered to be weak, especially in counselling

[56] EC/UNFPA Reproductive Health Initiative in Asia (Final Evaluation) – Aide Memoire, 2002

[57] At the wrap-up meeting to the evaluation, the IPPF-EASOR (regional office) representative was told for the first time the VINAFPA would be the lead agency for clinical services under RHIYA. She expressed considerable surprise at this since it had already been broadly acknowledged that this was not VINAFPA's greatest strength.

skills for young people. It was not clear who were the standard bearers for all aspects of ARH in Vietnam. Indeed, no single provider appears to have the required capacity in all areas related to ARH.
This is in large part a reflection of the general operating constraints that VINAFPA is working under, with reduced staff capacity and financial resources available to it. VINAFPA certainly is able to demonstrate in some of its branches an adequate level of youth friendly service provision, Haiphong branch being one such example. Others, such as the Danang branch are less able to demonstrate such quality of care, indicating the variability of standards VINAFPA provides across the country.

Recommendation – Comprehensive ARH Response

VINAFPA has tended to focus its management and implementation energies with regard to ARH, on information, education and counselling, rather than capacity building and service delivery. VINAFPA needs to rectify this imbalance if it is, as a national organisation, committed to supporting ARH in a comprehensive manner.

Use of evidence base for programme design

There are loose applications of evidence base for the design of programmes to support service delivery to adolescents. These tend to be based on high level, large scale surveys undertaken by research institutions etc, from which general indicators of unmet need (such as levels of sexual activity, and incidence of abortion) are interpreted by VINAFPA to indicate the need for programmes to reach young people with IEC and counselling and services, but are no more specific than that. VINAFPA does not have the capacity to undertake baseline surveys by itself, to determine more local level needs from which to develop more context specific approaches to meet the specific and diverse needs of young people. As with the evaluation of its IEC work, VINAFPA does not approach the evaluation of its "models" of service delivery from an outcome or impact perspective, and asserts success of its models based predominantly on the successful completion or delivery of outputs.

Responsiveness to diverse needs

There is strong bias towards women in VINAFPA's youth work. Service statistics indicate clearly that more young women are being reached than young men. This is a serious concern. Either the youth service is totally unsuitable for young men and they seek treatment elsewhere, or VINAFPA is not undertaking 'partner treatment' action, despite having trained its service providers in STI diagnosis and treatment protocols. Despite programme data/records clearly showing the significant lack of male involvement in ARH service provision, VINAFPA has not yet developed a strategy aimed at addressing the needs of young men, beyond engaging in condom social marketing.

VINAFPA is beginning to target specific groups of young people with special needs, and this is to be further encouraged. One such example is the recently initiated project in Hanoi and Quang Ninh which focuses on HIV/AIDS prevention amongst commercial sex workers operating in hotels and restaurants. In Hue City, VINAFPA also works with street children/youth through "Moon Age Clubs" for young people aged 14-17 years. However, the IEC materials and outreach strategies VINAFPA tends to employ do not specifically differentiate between the youth being reached, and so there are questions as to whether these strategies are significantly different from each other, depending on the target population trying to be reached.

Recommendation: Youth Response – Focused vs. Comprehensive

VINAFPA should identify more accurately its target group(s) with regard to youth, and devise differentiated strategic responses more appropriate to the specific needs of these youth groups, rather than responding to a homogenised categorisation of young people. The needs of young men urgently need to be addressed.

Technical support from IPPF

VINAFPA believes that it has received most support in service strengthening *for adolescents* not from IPPF but from UNFPA. The hands-on and intensive oversight role played by UNFPA during the RHI has proved immensely valuable. UNFPA have undertaken a number of 'spot-checks' and 'mystery client' exercises, as well as supporting the development of the Management Information System related to the ARH project.

Recommendation: Capacity Building

At this critical juncture in VINAFPA's engagement in ARH activities, with the onset of the RHIYA and VINAFPA's heightened role as executing agency in the initiative, it is essential that IPPF is better able to provide timely, regular, and sustained technical assistance than previously provided, especially at the institutional and managerial level.

5.2.2 Integration of Rights

See section 5.1.6.

5.2.3 Capacity

Competencies and skills of service providers

It is extremely difficult if not impossible to undertake a comprehensive assessment of staff competencies and skills in providing youth friendly services, in a three-week evaluation period. This assessment is therefore based on an extremely limited sample of service providers, and observation techniques, which are not necessarily the most ideal way with which to base such an assessment.

The majority of VINAFPA service providers have received training in ARH counselling, either directly or through step-down training of trainers. IPPF has developed a checklist for its FPA members on Youth Friendly Service Provision, which provides a comprehensive framework against which FPAs are able to self assess their quality of service provision for young people. This checklist was used in the evaluation process to measure the degree of youth friendliness service provision in the two youth project sites that were visited. Mindful of the fact that funding for the RHI RAS/98/P19 project ended in 2002, with activities in 2003 without external support, there is considerable variation in the youth friendliness of service provision that VINAFPA is currently offering its younger clients. One example is that some clinics/centres are taking young people's names and addresses unnecessarily, undermining client confidentiality in some cases.

Whilst staff have received training in ARH (mainly from UNFPA), some branch level staff continue to express the need for more training in adolescent reproductive and sexual health issues. This is not necessarily a reflection on their actual competency or capacity to deliver appropriate services to young people, but does indicate a lack of confidence needed to

actively promote the concepts and practices of young people's reproductive health and rights more widely.

The lack of monitoring capacity within VINAFPA staff, and the reliance of VINAFPA on association members to undertake monitoring roles is critical in this respect. Ensuring youth friendly service provision requires regular monitoring and supervision from people technically skilled in ARH. Using VINAFPA volunteers to undertake such a monitoring role is an appropriate use of resources, if and only if, members themselves have received sufficient training in ARH and their contribution is also monitored by Head Office.

5.2.4 Efficiency

Contribution to improving accessibility and quality of services for young people

It is difficult to measure the contribution that VINAFPA is making through its youth focused activities; figures are hard to get hold of and are not necessarily reliable because of reporting inaccuracies[58]. VINAFPA has not undertaken any baseline and final evaluation surveys to measure the outcomes of its youth initiatives making it difficult to illustrate any impact of its work. Comparing VINAFPA's contribution to the contributions made by others is beyond the scope of this project because many other service providers have not been collecting service statistics with age disaggregation, against which comparisons can be drawn. The evaluation (process focused) of the RHI project implemented by VINAFPA comments that whilst quantitative targets (read outputs, not purpose level targets) were met, there was "*much room for improvement on the qualitative aspects of service delivery*"[59].

Youth participation

There is no indication that young people have been involved in service design or monitoring and evaluation of service delivery. Young people are very much seen as recipients of the services offered and that is all. Evaluation or monitoring of services offered is seen as the responsibility of clinically trained staff or volunteers, and quality of care is not measured taking the young person's perspective into account.

Monitoring and cost-effectiveness

VINAFPA does not undertake any form of cost-effectiveness evaluation of its youth programmes. The monitoring and evaluation systems and current capacity are simply insufficient to do so. General effectiveness measures in terms of outcomes achieved are not yet undertaken by VINAFPA, nor it would seem, by most other reproductive health organisations, including UNFPA. Monitoring is often undertaken by VINAFPA volunteers using the IPPF Youth Friendly Service checklist. As described in Section 3.2.1, there is little analysis of the routine data collected to measure accessibility variations. The evaluation team was not informed of any client satisfaction surveys held by VINAFPA, or focus group discussions and other qualitative methods being used by which VINAFPA could assess the quality and appropriateness of its service provision.

[58] The output statistics reported in the Annual Report 2001 are identical to those in Annual Report 2002.
[59] Project RAS/98/P19 (VINAFPA) – Evaluation Report 2002.

5.2.5 Effectiveness

Utilisation of services

Whilst evidence, however patchy, shows that young women are being reached with services by VINAFPA, as described in section 5.2.1 it is clear how few young men are being reached by VINAFPA service providers. The response from the Standing Committee to this issue was that young men preferred to go to the public clinic for STI treatment, and to purchase condoms privately, and that this was an acceptable situation. The response from service providers themselves was that they wished to be able to provide a more male friendly service, but were uncertain as to how to go about this.

Best practice

As described in section 4.2.3, VINAFPA was involved in the development of the Reproductive Health Service Delivery Guidelines, in which there is a section on Adolescent Reproductive Health, and so has had some degree of involvement in supporting the government adopt 'better practice' in service delivery for young people.

VINAFPA, unlike some other FPAs, does not directly train Government health service providers in youth friendly service provision, thereby missing the opportunity to promote best practice in service delivery amongst the public sector. Many would question whether VINAFPA had the capacity to do this, and certainly one gets the impression that the Vietnamese Government would not consider such technical assistance from a local organisation to be appropriate. However, indirectly, VINAFPA is contributing to the youth friendliness of MoH service providers through the training that it provides to its volunteers, many of whom are Department of Health clinicians, on adolescent reproductive health.

Evaluations such as that undertaken by IPPF in the final evaluation of the RHI project RAS98/p19, and by external evaluators as part of the evaluation of the RHI, indicate that there is a real variation in quality of care provided by VINAFPA and that there is considerable scope for improvement. During the FGDs commissioned for this evaluation, youth had no specific responses about quality of VINAFPA services. During the visits to VINAFPA clinics the Evaluators were not able to adequately and independently verify youth perceptions of VINAFPA or other ARH services.

5.2.6 Sustainability

Sustainability of externally funded projects

VINAFPA has a number of strategies it implements in order to achieve some form of self-sufficiency. Unfortunately, due to limited information sources, it is not possible to make an assessment of how successful these strategies actually are. This evaluation will simply serve to outline these approaches and provide a somewhat subjective appraisal. None of the strategies are specifically dedicated to ARH, and are more strategies employed by VINAFPA as a whole.

As an association, VINAFPA operates a membership system, generating income though its members' fees (at 500 Dong[60] per month). Expected annual income from membership fees is estimated at 20,000,000 Dong. However, this income is not always secured, and often is much less than expected (in 2002, it was only 1,860,000 Dong). The reasons for this are not clear, and VINAFPA needs to ensure that this potential income is not lost.

[60] Current exchange rate is approximately 15,000 Dong : US$1.00

VINAFPA has over 60,000 volunteers, and the in-kind contributions these local volunteers provide are considerable. In 2001 the in-kind contribution through over and extra time to VINAFPA's clinical and outreach work was estimated to be 449,600,000 Dong, which is equivalent to US$30,000. It is not possible to disaggregate this contribution to those services supporting young people, and those supporting the general population.

Because of VINAFPA's close relationships between the volunteer board and local authorities at the provincial and district level, the organisation has taken up opportunities for community financing where possible. This is an area in which VINAFPA appears to have a unique advantage over other non-governmental and local organisations, and has been particularly successful in garnering local support for its activities. One such example is the donation by the local council in Haiphong of over 1,000m^2 of land for a VINAFPA clinic and counselling centre, from which young people are served with IEC, counselling and reproductive health services.

Cost-recovery

VINAFPA operates a fee-paying policy for its RH services. Those aged 18 and over are meant to be charged for services, with a waiver system for those deemed unable to pay. Those aged under 18 years are not meant to be charged a fixed price for services. However, during the evaluation, a conflicting picture was painted of the implementation of this policy. In some project sites, young people are not being charged for counselling, contraceptives, or reproductive health services. In others, they are being charged regardless of their age, the decision to charge being on a somewhat ad hoc basis, with no clear waiver system in operation, nor a price list clearly displayed.

With the limited monitoring and evaluation capacity available to the Association, VINAFPA is not only unable to ensure that the policy is being upheld by each branch, but also unable to measure the impact of its charging for services policy and whether this is affecting accessibility. This needs to be assessed, especially as VINAFPA is pursuing a strong self-sufficiency strategy through use of client fees, and needs to ensure that it is not reducing accessibility through its user fee system, and that its waiver-system is actually effective and being implemented properly.

Community involvement in financing and management

The "community" is involved in VINAFPA's planning and management of its services for young people, in as much as "community" members, usually senior members of local authorities and Government departments, are members of the local project steering committees. Communities are not involved in the financing of service provision in any form beyond community donation of land, or other in-kind resources, usually through the local authority.

5.2.7 Summary

VINAFPA has a remit from the government to provide RH/FP services in support of its Population Strategy 2001-2010 across Vietnam, and is recognised by the NCPFC for its contribution to FP service provision over the last ten years. It is gradually undergoing a paradigm shift from FP to RH, and has only really been able to provide RH services dedicated to young people through the RHI project, RAS98/P19. VINAFPA itself, other stakeholders, and evaluators, acknowledge that the Association has limited capacity with regard to service provision for young people. This is in large part due to the limited number of staff operating at Head Office as well as the limited training that VINAFPA has been able to provide (because of limited financial resources) to service providers at branch level.

The programmatic response taken to date in terms of service delivery, has tended to be directed to a generalised youth group, with no evidence of different strategic approaches being devised for different youth needs. VINAFPA is now beginning to develop specific approaches designed for diverse needs, exemplified in its work with commercial sex workers in Hanoi and Quang Ninh.

However, the needs of young men are not being addressed by VINAFPA. A snapshot of STI service data showed that whilst young women were being diagnosed and treated for STIs, no men were being reached at all. This is a serious weakness in VINAFPA's service delivery approach.

It is difficult to assess the degree to which VINAFPA has contributed to increasing access to services, as the monitoring and evaluation system is not sufficiently robust to measure this. Statistics on youth clinics/centres clients are routinely gathered but unfortunately not presented in ways that enable trends in utilisation to be assessed. Baselines and final evaluations are not undertaken from which to assess the outcomes of VINAFPA's service delivery activities. The impact of charging for services is not measured and neither is the cost effectiveness of service delivery approaches.

SECTION 6: PROMOTING RH INFORMATION AND EDUCATION

6.1 UNFPA Country Programme[61]

6.1.1 Relevance

Evidence base for approaches

Country Programme and RHI partners produced and disseminated a plethora of IEC materials. UNFPA asked its partners in the RHI to follow a set pattern for IEC development:

- Develop TORs for IEC development
- Identify a local consultant
- Develop IEC through field testing with youth, which includes review and appraisal

If done properly this provides a good base from which to develop IEC. However, without assistance this process did not always guarantee that the messages developed were effective. One criticism of RHI was that the INGOs, who were aligned with individual LNGO partners and meant to provide technical assistance, provided mixed levels of IEC development support. IPPF provided little support to VINAFPA in IEC development (baseline surveys, target group analysis), and the resulting products were of questionable quality. By contrast RaFH, supported by WPF, conducted a number of KAP-like surveys on ASRH resulting in a wide range of IEC materials addressing SRH needs and rights.

Appropriateness and relevance of information

According to the FGDs with youth, the quantity and quality of IEC materials are mixed. The youth felt that there were three categories of information mostly covered: (1) puberty and its consequent physical and emotional changes, (2) transmission and prevention of STIs and HIV, and (3) drug abuse, including links with HIV (presumably via injection drug use). However, this is emphasised especially by youth who have attended school[62]. However, the quality of the information is questionable. For example, many of the youth expressed concern about getting HIV through barbers and fingernail care, but few of them consider condoms as a prevention method.

Another concern expressed was that the materials have been rather superficial, and youth wish to have greater details on specific issues such as irregular and painful menstruation, wet dreams, sexual diversity, and safe sex methods. Youth in the FGDs expressed difficulty in getting access to such information on sexuality, and fear the possible corresponding stigma in seeking such information.

> *Many leaflets have similar information. Most of them mention condom and/or other contraceptive methods. However, the information is very surface. We are fed up with this information. Thus we often not keep the leaflet.*
>
> - Female FGD respondent, Hanoi[63]

There is some concern that the IEC materials developed by UNFPA and VINAFPA – and still in circulation - do not explicitly deal with different gender-specific issues for males and females, and differential stigma in health and information seeking behaviours. They also

[61] Two studies commissioned for this evaluation, the IEC Review and the Youth Opinion Study, were used to inform this entire section. Specific references are noted as appropriate.
[62] In fact, there is an urban bias in the FGDs.
[63] Youth Study Opinion. May 2003. Centre for Investment in Health Promotion.

seem to have a predominantly urban context. This means that the majority of youth – those who live in rural areas – are not necessarily getting IEC materials that address their perspectives and realities. Similarly, the materials use pictures and language that reflected a northern orientation. There were exceptions in the two RHI projects based in Ho Chi Minh City (in the south) and in some advocacy films developed under RHI. Also, except for one project working with street children, most of the materials portray youth who are in school. Finally, almost all of the materials reviewed were focused on the Kinh people, the main ethnic group in Vietnam. Only one project adapted its materials to the needs of the ethnic groups with which it was working[64].

The messages reviewed still reflect an IEC approach, that is, providing information and "education" but not moving youth to want to change their behaviours. For example, while there are many materials that talk about technical issues on puberty, there was little in the materials reviewed that focused on "risk perception" or other messages to persuade behaviour change.

On the positive side, UNFPA has a host of general RH materials, not specifically for young people, that are more diverse. The local adaptations have been encouraged since UNFPA decentralised its IEC development to provincial level in the mid-1990s. Under Phase 2 of RHIYA there will be no budget for new IEC materials but there will be budget for adaptation of existing IEC. This bodes well for developing more diverse and appropriate materials.

Contribution to coherent IEC/BCC policies and programmes

UNFPA has moved from a narrow focus on IEC towards a focus on behaviour change. This is also reflected in the NCPFC approaches where they had an "IEC strategy" but now have a "BCC strategy." Changes include adding a focus on "service provider and community leader BCC," including indicators on behaviour change (such as increase in utilisation), including "analysis of target audience" (e.g., a form of youth participation) for the first time, and improved monitoring and evaluation of behaviour change.

6.1.2 Integration of Rights

As mentioned elsewhere, discussion of rights in general has been a sensitive issue. No material reviewed mentioned rights explicitly. However, some materials address young people's needs, which, as mentioned, is a proxy for addressing rights. See section 6.2.2 below.

6.1.3 Capacity

Skills and competencies

Two UNFPA staff manage most of the IEC development. The two staff responsible have received mostly on-the-job training in IEC development. They co-ordinate and monitor TA (from the CST, international and national consultants) for the development and adaptation of materials, and draw on inputs of other professional UNFPA staff. However, their capacity to do so has been questioned[65]. These staff have not received training on *BCC*. Given the clear shift towards BCC, and the lack of materials that reflect this, the staff would benefit from an update training. There are not enough staff to provide much needed follow-up to ensure that key skills have been imparted to partners. By expanding the Umbrella team UNFPA hopes to partly address this as well.

[64] IEC Review. May 2003. CIHP.
[65] Euronet Report.

Peer educators

Young people are trained as peer educators (PEs) in at least some of the RHI projects. The evaluation of the MSI supported work, including that of the Hanoi House and other counselling centres, was very positive. It highlighted the good ARH and counselling knowledge displayed by the PEs; the evaluators of MSI work felt the PEs were "excellent advocates for the services of the Centres."[66]

The counselling centres run by the Youth Union offer services at both fixed counselling centres as well as in the communities through "community counselling." The counsellors met were not always peers, i.e. they were well over 25. They seemed trained and able to provide information, but the fundamental tenets of peer education were lost. The Youth Union also worked through youth clubs, which included volunteer peer educators. These people were truly peers, for example, school children. In discussions with them (as part of a large group discussions), they reported "reaching" many of their friends. While the numbers reached varied, and could not be verified, the PEs seemed confident and able to talk about difficult issues, including condom use and HIV transmission.

6.1.4 Efficiency

Development and distribution of IEC materials

As mentioned above, UNFPA went through a process of decentralising RH material development to the provinces started in 1996. However, this did not apply to ARH materials. Initial review of materials from UNFPA-supported ARH projects - materials that are currently in use, even if developed a couple of years ago - suggests there is still a strong northern and urban bias. The materials developed by UNFPA sponsorship are distributed widely, in directly UNFPA-sponsored agencies (e.g. VINAFPA, Hanoi Youth House) as well as indirectly sponsored agencies (e.g., MoH's MCH/FP clinics).

Cost-effectiveness

It is not possible to ascertain cost-effectiveness of strategies and approaches. "Programme effectiveness" – effectiveness or impact of the IEC materials – has not been measured.

6.1.5 Effectiveness

Effectiveness and acceptability of IEC/BCC approaches

For the Youth Opinion Study, twelve pieces of IEC materials were reviewed by the FGD participants (e.g., 3 books, 7 booklets/leaflets/song sheets, 1 flipchart, 1 poster). The youth were asked to rate the materials on 9 areas measuring appropriateness, ease of understanding, attractiveness, etc.

All twelve materials were recognised by the youth who had been reached through RHI interventions. For those not covered by the interventions, fewer materials were recognised. In summary, their responses were:

- Books/booklets were preferred because they had more detailed information. However, sometimes the technical language used is too technical and difficult to understand.
- Most of the information presented was explained in simple easy to understand words, especially the Youth Union leaflets;
- Youth felt that most of the material presented was accurate;

[66] EC/UNFPA Reproductive Health Initiative Assessment. June 2002. World Population Foundation.

- Youth felt that few materials focused on "encouraging male and female young people to take healthy behaviour on RH", that is, behaviour change.
- Youth liked the smaller "handy size" of some of the leaflets.
- Many of the materials were very attractive. However, some of the people pictured are older than the target group, and made the materials less persuasive.

6.1.6 Sustainability

Different kinds of sustainability have been addressed through UNFPA's efforts to promote RH IEC. Partners in the RHI gained the skills – some organisations better than others – in development of IEC, such that it is likely a certain "skills sustainability" was achieved, which itself is a type of institutional sustainability. While totally new materials will not be promoted, funds will be available for adapting old materials to new situations and places. Promotion of IEC, per se and as part of BCC, is still part of RHIYA, leading to "sustainability of use" in the ongoing programme. Financial sustainability has not been achieved. However, if the government is satisfied with the models developed in RHIYA – which will include the promotion of materials – and if the government and/or World Bank or other donor picks up the cost of expanding the models across the country, then a certain kind of financial/programmatic sustainability will be achieved.

6.2 VINAFPA

6.2.1 Relevance

VINAFPA first became involved in promoting adolescent reproductive health information and education in 1994, through its FLE project, and then more recently and more actively through the RHI project in 1999. VINAFPA has then tended to focus its management and implementation energies with regard to adolescent reproductive health, on information, education and counselling, rather than capacity building and service delivery.

Relatively innovative at that time, the FLE project aimed to impart *"correct knowledge on sexuality, responsible behaviour, family planning methods and to provide learning through the experiences of others on the current social illness e.g. STI, drug abuse, AIDS, alcoholism, smoking….."* through the establishment of over a dozen youth clubs and student clubs, in collaboration with the Youth Union, Women's Association and local health authorities. Discussing issues such as sex education at that time was, and still is to a great extent, taboo in Vietnamese culture and society.

The EC/UNFPA project has, as with service delivery, provided VINAFPA with the necessary technical and financial support with which to undertake ARH IEC and counselling activities more rigorously. The EC/UNFPA project provided VINAFPA with the first real opportunity to produce IEC materials dedicated to ARH issues. A small range of materials (leaflets, booklets, poster, training manuals) has been developed using needs assessment (secondary data analysis and youth participation) and field-testing.

<u>Contextual relevance and appropriateness of IEC/BCC programmes</u>

Evaluations of the IEC materials in terms of appropriateness of message, diversity of intended audience, conveyance of information etc. are mixed. Some materials such as the SexWise Booklet are well received by youth and by other stakeholders; some such as the leaflets are less well received and thought to have limited value because of the limited information that they provide and the messages they convey. Printed materials are targeted at a broad range of youth with little recognition of diverse needs of young people (e.g. older or younger youth, in or out of school, male or female, ethnicity, regional identifications).

None of the printed IEC materials produced by VINAFPA is tailored to specific sub-sections of youth population. They are all produced with a generic youth audience in mind, with no differentiation in age groupings, sex, or ethnicity. Despite country unification in 1975, there still persist strong cultural differences between the North of the country and the South, differences that are visually identifiable. This means that IEC materials have to a balance and variety of Northern or Southern aspects.

VINAFPA appreciates that the IEC materials are too general in their targeting, and wish to expand the range of materials available. However, there are serious concerns about the key messages being conveyed even in these general ARH materials. Given that the average age of marriage is in the mid twenties, and around 30% of unmarried youth are sexually active[67], it is inappropriate to convey messages such as " *A true love must have respect and lead to marriage, if you want to have a nice life, think of your career and future, do not have pre-marital sexuality*". The Evaluation Team appreciate the Vietnamese situation when these materials were developed, in which discussing about ARH was (and still is to a great extent) an extremely sensitive issue, and that VINAFPA felt that it must not in any way be seen as encouraging sexual activity before marriage. However, messages such as these are in themselves stigmatising and do not promote reproductive rights or choice.

VINAFPA undertakes a great deal of outreach and awareness raising work, through the mass media, general forums, festivals, etc. These raise general awareness on ARH issues and have a useful advocacy role and are popular with young people who enjoy the singing and game-playing that these forums and festivals often contain. This awareness and advocacy role is recognised by UNFPA who identify VINAFPA as having a significant contribution to make to scaling up of advocacy at the local level, in the forthcoming RHIYA. VINAFPA has managed, with collaboration with other mass organisations, to break down conceptual barriers amongst decision-makers, parents, and young people themselves, concerning open dialogue on adolescent reproductive and sexual health.

However, despite the evident success in *advocacy* through outreach that VINAFPA has had, the success of VINAFPA outreach in raising substantive knowledge of young people on RH is less evident. As with IEC materials, there is little/no differentiation between youth groups in the youth focused outreach strategies employed and VINAFPA, similar to other local organisations, has not been able to carry out survey work to quantitatively measure the impact of its outreach activities.

6.2.2 Integration of Rights

Reproductive rights are not demonstrably integrated into VINAFPA's IEC approaches or materials produced for young people. However, many of the materials, especially the IEC leaflets do talk of adolescents' *needs*, which in the Vietnamese situation can be seen as proxy statements of young people's rights. For example, one of the ARH leaflets clearly states:

"What do adolescents need from adults? – help from adults to know correctly their physical and emotional development – a sympathy, share and right attitude toward adolescent [sic] – provision of life skills and reproductive health protection."

Much of the printed material talk of responsibilities, rather than rights; *the responsibilities of individuals in ARH programmes to impart knowledge and information to young people; the responsibilities of citizens to support ARH work in their communities for the betterment of society; and the responsibility of young people to control their behaviour and have safe,*

[67] EC/UNFPA Reproductive Health Initiative in Asia (Final Evaluation) – Aide Memoire, 2002

healthy and responsible sexuality [taken from VINAFPA's Adolescent Reproductive Health Training Manual for CBDs, 1999]

VINAFPA's counselling centres do clearly list the rights of the client (as identified by IPPF). Those centres visited for the purpose of this evaluation also operated according to those principles, providing privacy, and confidentiality up to a certain extent – it is not necessary to take clients' addresses unless for purpose of follow up visits, but some youth centres visited routinely took this information.

6.2.3 Capacity

Competencies and skills of VINAFPA staff and volunteers

The IEC materials targeted at young people were created at VINAFPA head office using VINAFPA staff with experience in IEC development, a number of "external experts", and young people for pre-testing of the materials developed. There is a dedicated IEC officer at head office who is also a project coordinator, as well as one of the Standing Committee members with experience and a reputation outside of VINAFPA of being an expert in IEC.

Counselling is a new concept in the Vietnamese medical field and many service providers who are formal health workers did not receive counselling training as part of their medical training. VINAFPA invested quite heavily in counselling training for those service providers that it employs, and its volunteers, and considers this to be an area in which it has particular expertise. Counselling is undertaken by VINAFPA clinic/youth centre staff, as well as by CBDs, by peer educators, and through telephone hotlines.

Whilst the term BCC was often used by VINAFPA staff in discussions (and by others during the stakeholders workshop at the beginning of the evaluation), upon probing, there was little real understanding of what BCC actually means and implies in terms of how to achieve it. Indeed it was seen to be synonymous with IEC by most key informants within VINAFPA. This impression is strongly reflected in the IEC messages that VINAFPA and other mass organisations employ which are usually didactic in nature (with language around not engaging in pre-marital sexual activity and true love recognising the sanctity of marriage). An even more basic illustration of this is that despite young people having high levels of awareness about safer sexual practices, using condoms etc, none of the young people the evaluation team spoke with, felt confident in knowing where to go for condoms. Whilst these young people might have high information levels, they are not being equipped with the ability to translate this information into behaviours that will safeguard their reproductive and sexual health (whether now or later, when they become sexually active).

Use of peer educators

VINAFPA use a strategy of using peer educators to reach young people with key information on ARH and to offer them information on seeking services. These peer educators work out of school through youth clubs imparting key reproductive health messages and information for members of these youth clubs. However, there is insufficient technical and financial support given to this approach in terms of specific training manuals for peer educators, communication skills and techniques for them to employ, materials for demonstration purposes, monitoring of their activities and regular supervision to provide support and to oversee quality of information imparted.

Feedback from the FGDs held as part of this evaluation process show that many of the young people are concerned about the skills and knowledge base of the peer educators:

> *"… the topic is interesting, but the peer facilitator is not able to explain it clearly"* Female (age not noted), Hanoi
>
> *"… I know about it, but I do not know how to communicate these sensitive issues to my peers"* Female (age not noted), Hanoi

Whilst it was not possible during the evaluation to observe peer educators in operation, VINAFPA itself acknowledges that considerable extra support is required to make the peer educator approach more effective. Whilst they recognise that the Peer Educator approach has strong evidence base for its success, it does require strong initial investment in terms of training, and regular monitoring and supervision to maintain motivation and standards of care provided. Such levels of sustained investment are simply not available to VINAFPA at the moment.

6.2.4 Efficiency

Production of IEC materials

VINAFPA pre-tests its adolescent reproductive health IEC materials, using experts and young people to provide feedback. Young people are not more actively engaged in the development of the IEC materials, such as in determining the messages being conveyed or the imagery employed. The printed IEC materials are developed at Head Office using VINAFPA staff with IEC experience as well as external experts.

A repeated message from branch offices and from head office concerned the lack of sufficient quantities of IEC materials being produced and supplied to VINAFPA clinics and centres. This was explained as being the result of insufficient budget available for the production and reprinting of IEC materials to meet demand; a refrain that is often heard amongst FPAs. The quantity of IEC materials available to VINAFPA branches and to their outreach outlets is clearly insufficient. However, this is a problem that was experienced not only by VINAFPA but also by a number of similar local organisations. For IEC materials to be effective, clients need to be able to take leaflets and pamphlets with them to read at their convenience. VINAFPA was rarely able to do this.

Monitoring

The strategies employed by VINAFPA to raise awareness and provide IEC are monitored only in so much as the activities undertaken are recorded, in terms of quantity. IEC is very much seen in terms of output that VINAFPA can provide – the delivery of IEC messages, the production of IEC materials, the numbers of people counselled etc. There is very little sense of VINAFPA focusing on measuring and monitoring the *outcome* of these activities - whether they are changing behaviours, increasing knowledge, at all. To date, VINAFPA has not (nor has the capacity to) undertaken any form of pre/post intervention KAP surveys, with which to assess the impact of its IEC/BCC work.

6.2.5 Effectiveness

In Vietnam, atypical of many other countries, there is an overwhelming sense of "civic duty", and responsibility to the state, in which conscientious behaviour is expected or even demanded of every citizen. Section 6.2.1 describes the main means in which VINAFPA sees itself as promoting positive sexual and reproductive behaviour change among young people. The focus is on IEC, life skills, and advocacy, with little understanding of what is needed to *motivate* people to behaviour change beyond simple 'demands' on all to behave

conscientiously. There is little or no focus on "risk perception" or "negotiation techniques" or any other methods of encouraging and supporting behaviour change. One such example of this comes from a FGD held as part of this evaluation process:

> *"If one encourages male to use condom, it should also encourage female on how to persuade their partners to use condoms."* (Female, age not noted, Danang)

With the lack of project indicators on behaviour change, and lack of pre and post intervention data it is simply not possible to make an assessment on the effectiveness of the methods employed by VINAFPA to raise awareness on ARH and promote behaviour change.

Acceptability

In terms of acceptability to young people of the material devised by VINAFPA, there is a range of responses from young people when discussing presentation, content, appeal etc. The SexWise Booklet, originally produced by the BBC in association with IPPF, and distributed by VINAFPA, is a 37-page text only product. Many of the young people spoken with thought that the leaflet was excellent, with a rich source of information; others thought that it was visually unappealing and therefore limited in its reach to many young people, especially those with limited literacy abilities. The Ministry of Education and Training has however approved of this booklet for use within secondary schools.

Feedback from focus group discussions held for the purposes of this evaluation and for the final evaluation of the RHI RAS98/p19 project shows that young people find the IEC leaflets not to be terribly useful, because of the limitations on the information contained within. The main messages are to abstain from sexual activity until married, but if this is not possible, to protect one's sexual health through the use of condoms and contraceptive pills. The leaflets appear very much catering to those youth who are not yet sexually active, and have limited use for those who are already engaging in sexual intercourse or other sexual activity.

The telephone hotlines that VINAFPA operates are popular with the young people who participated in the FGDs held for this evaluation. Unfortunately, VINAFPA does not gather age-dissagregated statistics on the numbers of people reached through its telephone hotlines, so it is not possible to get a sense of reach achieved through this approach. None of the young people who participated in the FGDs had attended a VINAFPA counselling centre as they 'were afraid of talking directly with others about their issues', but they were aware of their existence.

6.2.6 Sustainability

Sustainability of externally funded projects

Under VINAFPA's Project 92-02, which is core funded by IPPF, VINAFPA is able to continue much of the outreach work that the RHI project was supporting in the implementation period 1999-2002, especially through the network of youth clubs that the Project 92-02 has established. So to a certain extent, VINAFPA is able to incorporate some of its externally funded IEC work into its regular programme, but this is at a much scaled down level.

Adoption of IEC/BCC approaches by others

It is very difficult to get a sense of which agencies have adopted or adapted other agencies' approaches in Vietnam, as all organisations, mass or local, speak of developing "models", that are often described as innovative, but in practice look very similar to each other. Also, VINAFPA collaborates very closely with the Youth Union, especially with its youth clubs, and therefore it is difficult to differentiate initiatives from different organisations, and attribute

"intellectual property rights" to separate institutions – youth union speak of developing the youth club approach adopted by others, as too does VINAFPA; who adopted the approach from whom is impossible to say.

As discussed in 6.2.1, through the engagement of IPPF with the BBC Sexwise Programme, VINAFPA produced a Safe Sex booklet for young people. This booklet has been selected by UNFPA for adoption by other agencies/local organisations with which it is collaborating under the EC/UNFPA RHI programme. The Youth Union has also adopted a number of VINAFPA's materials, and adapted them for their "own" work.

6.2.7 Summary

VINAPFA has focused most of its ARH energies on IEC and counselling as opposed to service delivery activities. The RHI project RAS/98/P19 provided the Association with the first real opportunity to develop IEC materials dedicated to ARH. These materials are developed centrally, with some youth participation in pre-testing, and with generalised messages for young people as a homogenous whole. Some of the IEC materials have been adopted by other agencies, notably the BBC SexWise leaflet. Other materials such as the IEC leaflets are considered by evaluators (this team and others) and by young people to be weak in terms of information conveyed, and inappropriate in terms of stigmatisation of sexually active youth. There is little or no sense of what is meant by BCC as opposed to IEC, and this reflects strongly in the didactic approaches taken by VINAFPA in its IEC and counselling work.

VINAFPA has contributed considerably at provincial level to awareness raising and advocacy on ARH, but this outreach work has little demonstrable impact on raising substantive knowledge on ARH issues amongst young people. Again, lack of monitoring and evaluation capacity has meant that the Association is unable to demonstrate impact of its IEC work.

There has been some adoption of IEC materials by other agencies. It is difficult to gauge the degree to which IEC *approaches* have been adopted by others, as there is a strong degree of collaboration between VINAFPA and other organisations, especially the Youth Union, which also undertakes IEC work. Indeed, the Youth Union has particular capacity in this respect, which means that VINAFPA has to identify its niche in this field, and scale up its work in order to maintain its comparative advantage.