Sexual and Reproductive Health of Adolescents and Youths in VIET NAM


WORLD HEALTH ORGANIZATION
WESTERN PACIFIC REGION
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>ASH</td>
<td>Adolescent Sexual Health</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>Doi Moi</td>
<td>Viet Nam’s Economic Renovations</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labor Organization</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitudes and Practice</td>
</tr>
<tr>
<td>MCH/FP</td>
<td>Maternal Child Health/Family Planning</td>
</tr>
<tr>
<td>MOET</td>
<td>Ministry of Education and Training</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
</tr>
<tr>
<td>NCPFP</td>
<td>National Committee for Population and Family Planning</td>
</tr>
<tr>
<td>PDI</td>
<td>Population and International Development</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Education and Sciences Cooperation Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population</td>
</tr>
<tr>
<td>VINAFPA</td>
<td>Viet Nam Family Planning Association</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Acknowledgement

WHO is grateful to the Government and Ministry of Health of Viet Nam, to all those who provided information and to the team of reviewers who contributed their time to this document. We hope that sharing the country’s experiences in implementing specific programmes and activities to address adolescent sexual and reproductive health issues will be of use to others both within and outside the Western Pacific Region.
This is one of the reviews on the literature and projects of sexual and reproductive health of adolescents and youths in eight Asian countries.*

Adolescents and youth make up one-fourth of the population in the Western Pacific Region. At least 17 out of 37 countries and areas in the Region have a median age below 25 years. The health of adolescents is, therefore, a key element and an investment for the social and economic progress in the Region. Many of the problems adolescents experience are inter-related and should be regarded in a comprehensive manner. However, adjusting to sexual development and protecting their reproductive health are the major challenges for adolescents.

Adolescents are vulnerable because they lack knowledge and skills to avoid risky behaviour and lack access to acceptable, affordable and appropriate reproductive health information and services. This is often compounded with environmental disadvantages such as poverty and unemployment. Social norms of sexuality have also changed in the past 2 decades and puberty comes 2-3 years earlier over one century, but the environment to support adolescents has not changed. There is still much to be desired in terms of governments’ institutionalization and allocation of funds. Also families and communities are still unprepared to provide accurate reproductive health information and

* Cambodia, China, Lao People’s Democratic Republic, Malaysia, Mongolia, Philippines, Republic of Korea, Viet Nam
services necessary for adolescents. Risks of unwanted pregnancies, unsafe abortions, pregnancy-related complications, sexually transmitted infections and HIV/AIDS, all of which are important elements of Millennium Development Goals (MDG), continue to threaten adolescents.

Since the International Conference on Population and Development (ICPD) in Cairo in 1994, where the importance of adolescent reproductive health was acknowledged, many studies and programmes have been carried out by various national and international agencies and nongovernmental organizations. In order to assist governments to achieve the objectives of ICPD and MDG, the WHO Western Pacific Regional Office provided technical and financial support to several countries to conduct literature and programme reviews.

As a result of these reviews, countries now have evidence-based information for the development of national policies and strategies for adolescent sexual and reproductive health. I appreciate the practical and cost-effective use of existing information for increasing awareness of adolescent reproductive health and for improving our work. Here, I also would like to express my thanks to the governments, the reviewers and researchers for your contributions to improving the reproductive health of adolescents and youths.

Shigeru Omi, MD, Ph.D
Regional Director
WHO Regional Office for the Western Pacific
1. Study objectives and methodology

1.1 Objectives

The review of studies on adolescent sexual and reproductive health in Viet Nam is part of a series of literature surveys in Asian and Pacific countries. It is hoped that this study will contribute insights to the general literature and provide fuller understanding of the current status of the adolescent reproductive and sexual health issues in Viet Nam. The report also outlines national strategies and policy measures pertaining to adolescent reproductive health (ARH) in the country. The study’s main objectives can be identified as follows:

- To develop a list of accessible and available studies on adolescent reproductive and sexual health in Viet Nam for the period 1995 to 2002.

- To highlight the main contents of the collected literature, especially the reproductive and sexual health status of the adolescents.

- To analyze key findings and identify major issues, problems and challenges hindering adolescent reproductive and sexual health.

- To produce a report based on the analysis, provide policy recommendations for action to improve adolescent reproductive and sexual health in Viet Nam.

1.2 Review methodology

The literature review was limited to accessible studies and research completed or published since 1995. This task was carried out by collecting available and accessible materials. Papers were obtained from the following sources:

- research and training institutions working on issues of adolescent reproductive and sexual health in Viet Nam;

- unpublished and published reports of projects and survey research on adolescent reproductive and sexual health, funded by the Government, international nongovernmental organizations (NGOs), and United Nations agencies;

- international agencies’ websites and libraries;
local and international, population, medical and social science journals, and abstract books from international meetings on ARH; and

- literature databases, such as population database (Popline) and medical database (Medline and Medpub).

The collected papers were of different qualities and levels of analysis; for instance, some were peer reviewed and others were not. As different studies are characterized by differences in research methods, sample representative, adolescence stage and specific contents, it is hard to compare them or make generalizations about them.

Of the reviewed studies, about 60% were published when the review started in July 2003. A considerable number of the studies are unpublished reports and papers produced by various projects of government institutions, universities, and research institutes. Some studies belong to projects carried out before 1995 but published or completed during the years 1995 to 2002. Based on this timeframe, the reported studies do not include those completed, ongoing and planned in 2003. Although some studies regarding adolescent reproductive and sexual health have come out during the first half of 2003, they are not included in the present report.

The goal was to obtain all studies regarding adolescent reproductive and sexual health in Viet Nam for the 1995-2002 period. However, due to time constraints and inaccessibility of certain materials, it may be that some studies are not included in this review. A total of 180 research reports (published and of colleges and universities. The collected materials have been listed in an alphabetic order by the first author’s name for reference (see References). However, due to the difficulties in following Vietnamese names, when a study is referred in the text, the reference number will be used instead.

In the process of review, the collected literature was sorted by using criteria such as year of completion, research contents, type of authors, sources of funding and methods used in the studies. The classification relied not only on the report title, but also on the actual contents and objectives of the studies. The following section will summarize the main contents and characteristics of the documents.
1.3 Profile of the studies and research on adolescent reproductive and sexual health in Viet Nam (1995 to 2002)

As mentioned above, a total of 180 items on adolescent reproductive and sexual health, completed from 1995 to 2002, were collected and reviewed. The number of studies since 1997 increased and peaked in 1999 (Table 1). This reflects the increased interest and focus of various donors on ARH in Viet Nam as well as the National Strategy on Reproductive Health.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Percentage of the 180</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>7</td>
<td>3.9</td>
</tr>
<tr>
<td>1996</td>
<td>14</td>
<td>7.8</td>
</tr>
<tr>
<td>1997</td>
<td>25</td>
<td>13.9</td>
</tr>
<tr>
<td>1998</td>
<td>23</td>
<td>12.8</td>
</tr>
<tr>
<td>1999</td>
<td>30</td>
<td>16.7</td>
</tr>
<tr>
<td>2000</td>
<td>23</td>
<td>12.8</td>
</tr>
<tr>
<td>2001</td>
<td>32</td>
<td>17.8</td>
</tr>
<tr>
<td>2002</td>
<td>26</td>
<td>14.4</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 2. Number of collected studies by contents 1995 to 2002

<table>
<thead>
<tr>
<th>Main content of studies</th>
<th>Number</th>
<th>Percentage of the 180</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent reproductive health</td>
<td>35</td>
<td>19.4</td>
</tr>
<tr>
<td>Adolescent sexual health</td>
<td>36</td>
<td>20.0</td>
</tr>
<tr>
<td>KAP</td>
<td>20</td>
<td>11.1</td>
</tr>
<tr>
<td>Sex education, ARH education</td>
<td>36</td>
<td>20.0</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>18</td>
<td>12.0</td>
</tr>
<tr>
<td>STI/RTI</td>
<td>14</td>
<td>7.8</td>
</tr>
<tr>
<td>Policy, strategy</td>
<td>12</td>
<td>6.7</td>
</tr>
<tr>
<td>Others</td>
<td>9</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
</tbody>
</table>
not done. Very few studies have attempted to explain sexual behaviours in a systematic fashion. For example, factors affecting adolescent sexual behaviours in relation to STI prevention and treatment have rarely been studied. Some topics, such as adolescent infertility, migrant adolescents, service providers’ perceptions and behaviours, are also missing in the literature. Little emphasis or in-depth analysis was found on such areas as gender differences in sexual behaviour, prevalence of STI/reproductive tract infections (RTI) among young people. There are gaps to be addressed in the future.

A considerable number of the studies were carried out primarily by Vietnamese researchers. Government ministries and organizations also carried out and published numerous studies. International researchers and international agencies participated, to a smaller extent, in the studies. The number of studies carried out by local NGOs is fairly small (Table 3).

Hanoi and Ho Chi Minh City were the locations most likely to be selected for studies. Key low-land provinces prioritized under the international donors’ support also received research attention. As a result, these areas had more reproductive health projects and programmes in the 1990s. Also, most scientific institutions, local NGOs, ministries and big hospitals that have the expertise to carry out

<table>
<thead>
<tr>
<th>First author</th>
<th>Number of studies</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viet Namese researcher</td>
<td>101</td>
<td>56.1</td>
</tr>
<tr>
<td>International researcher</td>
<td>15</td>
<td>8.3</td>
</tr>
<tr>
<td>Government institutions</td>
<td>17</td>
<td>9.4</td>
</tr>
<tr>
<td>International agencies</td>
<td>33</td>
<td>18.3</td>
</tr>
<tr>
<td>Local NGOs</td>
<td>14</td>
<td>7.8</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Table 3. Number of collected studies by first author 1995 to 2002**
reproductive health research are located in major cities.

Some caution is required in interpreting the data and results because numerous studies have methodological weaknesses. The most noticeable problem is the lack of methodological rigor. Many of the studies rely on the usual questionnaire-based survey, which may not have been appropriate or fine-tuned enough to address as sensitive a subject as adolescent sexuality. If the information was collected without attention to privacy or confidentiality, then it may reflect what the adolescents believed investigators wanted them to say and not what they really felt or did. This is true especially for research on sensitive issues.

No population-based studies on Vietnamese adolescents’ sexual and reproductive health have been published in peer-reviewed journals. The typical sample size of the studies was between 100 and 500 adolescents. Only a few of the studies had samples of 1000 adolescents or more. A larger number of studies used quantitative survey techniques. There were, however, some qualitative studies that aimed to collect in-depth information.

More studies combining both quantitative and qualitative methods were reported after 1999. This increase reflects improved technical research skills and methods in Viet Nam. Unexpectedly, very few studies used epidemiological or clinical-based methods. It the future, studies using medical files and hospital records should be explored as sources of potentially good data.

Insufficient analysis of data is a fairly common problem in reproductive health research in Viet Nam. After a survey is completed, the data is not analyzed in-depth and remains underutilized for policy or programming purposes. It is difficult to identify advanced techniques of data collection using experimental and retrospective methods. Most studies used simple analysis with univariate or bivariate tabulations. Very few of the studies used multivariate techniques, and did not use in-depth analysis to explore statistically causal relationships. Researchers have rarely taken advantage of data sets collected from extensive and rather costly surveys.

Similar cautions must be applied to qualitative research because qualitative analyses is also lacking. Data analysis included answers from a number of adolescent interviewees, but they are often mixed with some comments from the researchers. In many reports,
particularly those prepared by local researchers, there is a lack of interpretation and assessment of data reliability. Consequently, fragmented and inconsistent evidence has resulted from the studies, which is not helpful in constructing a comprehensive and common picture. This is a major concern to be addressed in future studies.

Overall the results in Table 4 show that domestic sources of funding represented more than half of the studies (51.4%). Adolescent reproductive and sexual health-related studies in Viet Nam appear to have been increasingly funded by domestic sources in recent years.

There are many important issues that deserve research attention in the future.

While many agencies and institutions have participated in reproductive health research, the dissemination of findings from those studies is not usually wide or user-friendly enough. This weak dissemination has contributed to the overlapping or duplication of research. Some topics, such as young people’s KAP, communication, education, and contraceptive use have been overstudied while other areas have been understudied. Many of the studies were restricted to adolescents attending school and ignored out-of-school youth.

Despite the above problems, the available evidence derived from the available studies gives an emerging picture of critical issues regarding adolescent reproductive and sexual health in Viet Nam.

<table>
<thead>
<tr>
<th>Year</th>
<th>International sources</th>
<th>Domestic sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>1995</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td>1996</td>
<td>5</td>
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</tr>
<tr>
<td>1997</td>
<td>14</td>
<td>7.8</td>
</tr>
<tr>
<td>1998</td>
<td>14</td>
<td>7.8</td>
</tr>
<tr>
<td>1999</td>
<td>17</td>
<td>9.4</td>
</tr>
<tr>
<td>2000</td>
<td>4</td>
<td>2.2</td>
</tr>
<tr>
<td>2001</td>
<td>14</td>
<td>7.9</td>
</tr>
<tr>
<td>2002</td>
<td>17</td>
<td>9.6</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>49.4</td>
</tr>
</tbody>
</table>
2. Adolescent reproductive and sexual health: key findings and emerging issues

2.1 Key definitions

Adolescence is defined by the World Health Organization (WHO) as the age range from 10 to 19 years, and it is as a period of transition from childhood to adulthood. Adolescence is considered the stage of life during which individuals reach sexual maturity. Adolescence is a period of accelerating physical, psychological, social, cultural and cognitive development. Many of the adverse health consequences experienced by adolescents are, to a large extent, the result of risky behaviours. In today’s Viet Nam, however, adolescence has not been defined as a distinct development phase. The term refers generally to young people 10 to 25 years of age.

This report adopts the United Nations definitions of reproductive and sexual health. Reproductive health is “complete physical, mental, and social well-being in all matters related to the reproductive system.” This definition implies that people are able to have satisfying and safe sex lives; they have the capacity to have children; and the freedom to decide if, when, and how often to do so. Sexual health is part of reproductive health and includes “healthy sexual development; equitable and responsible relationships and sexual fulfillment; and freedom from illness, disease, disability, violence, and other harmful practices related to sexuality.”

2.2 Adolescents in Viet Nam

Adolescents in Viet Nam make up a large proportion of the population. Although fertility has declined considerably in Viet Nam, the population remains young because of relatively high levels of child-bearing. Viet Nam, like other developing countries, has a very young age structure, with more than half of the population (53%) under 25 years of age. Adolescents and young people account for approximately three out of ten

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1 International Conference for Population and Development (ICPD) Cairo 1994, definition of reproductive health.
2 ICPD, 1994, Cairo - definition of sexual health according to the Programme of Action at the ICPD.
people in Viet Nam. The population of adolescents has increased by 23% from 14.3 million in 1989 to 17.3 million in 1999.

Young people in Viet Nam today perceive that they are living in a society that is rapidly changing. They see themselves as both agents and victims of this change. Adolescents expect more today than before. The knowledge, attitudes and behaviours of Vietnamese adolescents is being influenced by media, the Internet, regionalization, and globalization. Young people are questioning traditional social values and attitudes towards sexuality, which are conservative among certain groups. With the removal of the subsidized system of health care, education and employment provisions, the pressing need for accessible and affordable social services among young people is critically felt.

The legal age of marriage is 18 for women and 20 for men. The average age when first married is 25.5 for men and 24.0 for women. Marriage prior to the legal ages is rare (2% of females) and this number has declined. National statistics are not available, but several studies on premarital sex revealed that the age at first sexual intercourse is 18 to 19 years for men and women [12, 23, 48, 96, 107, 133]. About 8% of young people aged 15 to 18 years old were sexually active. And 10% of males and 5% of females aged 15 to 22 had had premarital sex. While the practice may be more widespread than assumed, premarital sexual activity in Viet Nam is less frequent than in many other Asian countries.

The Doi Moi policy was introduced in 1986 and resulted in a shift towards a market economy and away from a planned socialist system. It has led to a more open economy, rising modern sector employment, increasing availability of cash and improvements in mass communication, including a greater familiarity with western culture. Following Doi Moi, private schools, people-founded schools and semi-public schools were introduced in Viet Nam. This change expanded educational opportunities for young people, especially for the 15 to 19-year old age group. During the 1990s, school enrollment of young people aged 15 to 17 years doubled from 27% to 54%. Urban students have higher enrollment rates, stay longer in school, and have better education facilities. Urban students are almost twice as likely to continue to higher secondary school than their rural counterparts. The enrollment rates among the poor are much lower than those of the rich.
The gender gap remains a concern as girls lag behind boys by about 9% in the enrollment rates. In rural areas, boys aged 18 to 24 years have a better level of education than girls do. This gap is a result of the traditional belief that boys can be more successful than girls in higher education and gain greater upward social mobility.

Similarly, the employment situation in Viet Nam has improved substantially since Doi Moi. Despite economic improvements, however, the country continues to face employment challenges, particularly with regard to youth employment. The number of new entrants into the labor force each year is increasing by over one million. An estimated 11 million new jobs need to be generated in order to meet this demand. The unemployment rate among youth is the highest of all age groups. Employment is a major concern for young people in Viet Nam.

2.3 Current status of adolescent sexual and reproductive health

The introduction of the Doi Moi policy resulted in greater exposure to western culture. It also brought about rapid social changes, which directly affected young people[120]. For example, there has been an increase in premarital sex and pregnancies among adolescents.

The growing body of studies on adolescent reproductive and sexual health has reflected these social changes. A major theme is that recent social and economic transformations have fundamentally altered young peoples’ experiences, expectations and behaviour [130, 80, 119]. The Confucian ideals of female chastity before marriage, patrilineal family structure, patrilocal residence, and close ties among family members, parents and young children have changed dramatically.

2.3.1 KAP of reproductive and sexual health

Over the past years, research on adolescent reproductive and sexual health has documented the status of adolescents’ knowledge, attitudes and practices regarding reproductive health and sexual relations.

Adolescents’ knowledge and understanding of reproductive health issues has improved remarkably due to extensive IEC projects and programmes. However, the literature review showed that young people’s

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3 The legal age for employment is 15 years in Viet Nam.
knowledge about reproductive and sexual health, as well as their negotiation skills for safe sex, are still inadequate [11, 170]. Young people, especially rural adolescents, have limited access to RH information. Adolescents also lack life skills and practical knowledge about puberty and sexuality. Many hesitate to talk about things related to sex and sexual relations.
Box 1. Knowledge, attitudes and practices among adolescents

A qualitative study of 120 adolescents carried out in Kien Giang and Quang Ninh provinces found that adolescents have inadequate knowledge about contraceptives. Females thought they would seek abortion services in case of pregnancy. Male adolescents, including those having sex with sex workers, did not use condoms because they wanted to maintain sexual pleasure [127].

A 1995 KAP survey of 1454 students aged 15 to 19 in Ho Chi Minh City found that contraception was known by only 57% of students. Nearly 85% had never heard of gonorrhea or syphilis [166]. Findings from a 1995 survey revealed that only 7% of males and 12% of females out of 2196 people aged 15 to 22 knew correctly when a woman is most at risk of pregnancy during the menstrual cycle [97].

A study conducted on 135 persons aged 15 to 18 in Hanoi and Ninh Binh showed that young people received information in puberty development from books in schools, but the information was poor and lacked details. Teachers were very reluctant to talk about puberty. Mass communication also did not provide adequate information about adolescent reproductive and sexual health [41]. Instead, reproductive health programmes focused on married couples.

Two major surveys, one a sample of approximately 1600 university students aged 17 to 24 in Hanoi and Ho Chi Minh City and one a sample of over 1100 young people aged 15 to 24 in Hai Phong City, asked young people about their attitudes regarding premarital sex. The findings were similar. In the Hai Phong survey, 93% of young women and 70% of young men disapproved of sexual activity before marriage. The comparable percentages in the other survey were 88% and 74% [119, 6].

Findings from a sample survey carried out among 500 adolescents aged 15 to 19 in Hai Phong [116] show these attitudes towards premarital sex. Most of them (94%) said sexual relations should come after marriage. 33% said sexual relations only took place when there was a certainty of marriage, and over 10% said they would have sexual relations when they fall in love. The survey also showed that 11% of adolescents had sexual relations, 34% did not use any contraceptives, and 20% did not know the possible consequences of premarital sexuality.

Interviews with 1000 youths aged 15 to 20 in Thanh Hoa, Quang Tri and Can Tho provinces showed that 84% had some knowledge of STI [108]. Not surprisingly, HIV/AIDS was most widely known (83%) while few knew of gonorrhea (26%) and syphilis (23%). Even in such a large city as Hai Phong, not more than 20% of adolescents ages 15 to 19 knew when a woman's fertile period was [6, 116].
In a 1998 survey of 628 adolescents in Thai Binh, Quang Nam, and Binh Duong provinces, only one-third of the respondents had heard the term reproductive health. It is even more notable that quite a number of adolescents have heard of a contraceptive method but only a few know how it works [126]. Although traditional norms discourage premarital sex, attitudes toward sexual activity have changed in recent years. While the older generation strongly condemns premarital sexual relations, young people are much more inclined to approve of sex before marriage or at least not regard it with “disdain” [79]. A survey of college students in Ho Chi Minh City showed that 34% of the adolescents were accepting of premarital sex [67].

There are also perceptions among adolescents that premarital sex embodies love and sexual intercourse means love. A lot of adolescents supported the idea that sexual intercourse could not be bound by marriage. While adolescents may respond candidly to questions about their views regarding premarital sex, they may be unwilling to honestly report their own sexual behaviour.

It is important to recognize the growing incidence of premarital sexual activity among adolescents. There is also a widening gap between age at menarche and age at marriage. In Viet Nam, several studies found a trend towards premarital sexual activities among adolescents [157, 33, 38, 97]. These studies reported that sexual activity was more common among males. Male adolescents had their first sex with girlfriends, some with unfamiliar people, even with sex workers. Their first sex was usually without protection. They used a condom if the partner was a sex worker, and did not use a condom if she was a girlfriend. Male students admitted that they had their first sexual intercourse with a prostitute because their girl friends were virgins. Having sex with sex workers was not criticized by the peers. In some cases it created a competition among young people.

It should be noted that the above observations come mainly from small case studies, conducted among urban young people rather than rural communities. As a result, it is not possible to generalize the findings for the whole population. The level of premarital sex among sexually active adolescent, therefore, is difficult to ascertain for Viet Nam.
2.3.2 Contraceptive use and child-bearing

Given increasing adolescent sexual activity and decreasing age at first sex among adolescents, the use of contraceptives to prevent unwanted pregnancy is important. In Viet Nam, however, contraceptive use among adolescents is low. Survey data from the 1997 Demographic and Health Survey (DHS) showed that while knowledge of contraception was 97% among adolescent girls aged 15 to 19, less than 18% used any form of contraceptives. Young unmarried women who engage in premarital sex find it difficult or embarrassing to seek contraception and counseling. The consequences can be unwanted pregnancies and abortions.

There is a significant difference between contraceptive knowledge and practice. The rate of contraceptive use is much lower among the young than among the general population.

Box 2. Premarital sex among adolescents

An assessment report [180] found a growing number of adolescents who engaged in sexual activity without understanding of safe sex. Many had sexual intercourse for the first time at age 15. They experienced sexual activity just three months after knowing each other. The study also documented a high rate of abortions among adolescents (25%).

Another study of 82 young people conducted in Ho Chi Minh City found that 26% of respondents could not be sure to say “no” to sexual intercourse. Between 72% and 85% said that sexual experience made their friends respect them more. Only 14% to 46% were afraid of its consequences. The age of the first sexual intercourse was 16 to 18 years for girls and 15 to 17 years for boys [187].

In a study of 279 young unmarried people in Hanoi, researchers Belanger and Hong (1996) found that two thirds of female adolescents had their first sexual intercourse with their boyfriends and after the first intercourse, 75% continued having sex very often [12].

In the interviews with 1100 students [105], 63% had sex with their lovers and 16% said they had sexual intercourse with others, such as friends or bar girls. About 50% of the students reported using contraceptives when having sex for the first time. Condoms were used by 29% of them. The majority of the students (70%) did not use any contraceptives for various reasons, such as: unprepared for sex (30%); unwanted (29%); unavailable (2%); and don’t know (3%).

A recent survey of 300 college students in southern Viet Nam [18] showed that 79% of male students had sex with their girlfriends, 11% with street-based sex workers, and 7% with bar girls. Although female students had experienced their first sexual intercourse with their boyfriends, only 47% of them used contraceptives (including natural family planning methods).
lower than contraceptive knowledge. Use of contraceptives at first sexual intercourse is very low. The low level of contraceptive use among sexually active unmarried adolescents has been reported in a number of studies [133, 162]. To a large extent, the findings reflect the inadequate and limited reproductive health services for adolescents. Some young people believe that it is easier to obtain an abortion than to use contraception on a regular basis.

Condoms, withdrawal and rhythm were the methods most often used by adolescents. However, discontinuation and failure rates were common. A 1999 survey of 2126 young people found that only 41% of married males aged 15 to 22 who had had premarital sex had ever used a condom [97]. According to a 1998 survey, out of 65 sexually active adolescents, more than 60% used no contraceptive methods at all [23]. Girls were afraid to tell their boyfriends that they had sexual experience and had used contraceptives. When contraception was used, men often made the decision and chose the method. A common misconception is that only married women should use contraceptives and that they can harm unmarried women.

In 1999 the fertility rate for women aged 15 to 19 years was 29 births per 1000. Teenage child-bearing rates are quite low throughout the country, but young ethnic women in mountainous areas have higher rates. According to the 1997 DHS, about one out of five young married women gave birth to their first child between ages 15 and 19. About 4% experienced their first birth between ages 15 and 17. Adolescent child-bearing is more common in rural areas where 7% of 15 to 19 year olds had given birth, compared to only 1.6% in urban areas.4 The fairly low rate of adolescent child-bearing is due to a variety of factors. Almost all child-bearing takes place within marriage in Viet Nam where the average age at first marriage is quite high. To some extent, however, this phenomenon may be in part due to the extensive practice of induced abortion, particularly among the unmarried.

2.3.3 Adolescent induced abortion

In Viet Nam, abortion has been legal since the 1960s and widely accessible through the public services. In fact, the abortion rate in Viet Nam is one of the highest in Asia and ranks fifth in the

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world.\textsuperscript{5} Repeat abortion accounts for a considerable proportion of the abortion rate in Viet Nam. In many cases, repeated abortions are referred to as a contraceptive method. According to the 1997 DHS, a Vietnamese married woman has an average of 1.34 abortions during her reproductive life span.\textsuperscript{6} The reported number of abortions appears to have doubled during the last decades from 800,000 cases in the 1980s to 1.5 million cases in the 1990s [102, 13]. It is estimated that there is one abortion every two minutes [171]. The high abortion rate is a key indicator of the unmet need for accessible, affordable, and effective contraceptive services.

Despite the lack of reliable statistics, estimates suggest that adolescents form a high risk group for unwanted pregnancies and account for a large

\begin{quote}
Box 3. Research findings about adolescent abortion in Viet Nam
\end{quote}

A KAP survey of 1005 young people aged 15 to 24 in Hai Phong,\textsuperscript{6} found that 94.3\% said that abortion causes harmful problems for women’s health; 71\% knew possible complications from abortion procedures. Girls knew more than boys and 60\% understood that abortion was not a contraceptive method. Knowledge about abortion complications was detailed: hemorrhage (29\%); abdominal pain (12\%); uterine perforation (20\%); infertility (29\%); sepsis (24\%); and weakened health (82\%).

A study of 340 people aged 15 to 19 in Hanoi found that 15\% of them had experienced premarital sex. About 5\% gave birth before age 18 and 13\% gave birth before age 19. The study also found that 80\% of pregnant girls under 20 did not know they were pregnant [43].

Of the 2775 abortion cases reported at the Hung Yung hospital in Ho Chi Minh City, 281 cases were unmarried women and 30\% of them were under age 20 [70].

In 1998, interviews with 182 persons aged 15 to 20 in Thanh Hoa, Quang Tri and Can Tho provinces showed that about 28\% chose abortion when they became pregnant before marriage. Young unmarried women aged 15 to 19 accounted for 40\% of the abortion cases [115].

A 2000 qualitative study revealed that of 160 women having examinations prior to abortion procedure, 48 people were under three months gestation and 34 people had a gestation of three months or older. Twenty-two women discovered their pregnancy at least two months before. Most (88\%) disclosed it was their first abortion and 12\% said they had experienced more than one abortion before [43].

\textsuperscript{6} NCPF (1999)
proportion of the high abortion rate, particularly in the major cities and urban centres. For the age group 15 to 24 in 2000, about 37% of the pregnancies resulted in abortion, 48% in birth and the remaining resulted in miscarriage [171], Viet Nam Youth’s Union 1998. Case studies conducted in Hanoi and Ho Chi Minh City showed that 10% to 20% of abortions were performed for young married women [178, 155, 130].

The stigma associated with premarital pregnancy and young people’s failure to use contraceptives are the main factors behind the high abortion rates. Poor knowledge, fear, and shame are also barriers that have kept adolescents from seeking safe and early abortions [25].

A number of recent studies found that adolescents, particularly the unmarried ones, often seek abortions from private or untrained providers and suffer life-threatening complications [132, 155, 113]. Unfortunately, no statistics are available regarding the abortion services in the growing private health sector. Many unmarried women seek private abortion services to protect their anonymity. Pre- and post-abortion counselling is rarely provided. For a high price, service providers have performed third trimester or late abortions, which have high rates of complications.

### 2.3.4 Sexually transmitted infections (STI) and HIV/AIDS

Little is known about STI among young women in Viet Nam because many of them do not regularly use health services for gynaecological examinations. The fact that STI are heavily stigmatized by the society has discouraged their diagnosis and treatment. Many unmarried youth feel shy about discussing “intimate issues.” The incidence of STI has increased substantially in Viet Nam since 1995 when 44,138 cases were recorded. The number rose to 71,274 cases in 1997, to 118,099 cases in 1998 and to 161,080 cases in 2002. The Ministry of Health estimated that for 2000 there were about one million cases of STI in Viet Nam [102, 103]. The most common STI were chlamydia followed by gonorrhoeae and syphilis.

In the absence of a health information system, however, no national data has been found to reflect STI prevalence among adolescents and youth. However, it is believed that STI are prevalent given what is known about adolescent sexual behaviour and their failure to practice safe sex regularly. The increase in premarital sex could result in an increase in the spread of HIV among young people.

In Viet Nam, the cumulative reported
numbers of HIV infection up to mid-2003 was 64,800 cases. The number of AIDS cases was 9,944. About half of the HIV/AIDS infected persons were under the age of 30 (Nga 2000). In 2001, more than 9% of all HIV+ persons were between 13 to 19 years old. The rate of infection for that age group is on the rise. Although most adolescents have heard about HIV/AIDS, only 64% have heard about STI. They knew more about transmission than they did about prevention [97].

In general, the literature suggests that adolescents and young people in Viet Nam are increasingly vulnerable to HIV/AIDS. There is a big gap between

**Box 4. Sexually transmitted infections and HIV/AIDS**

In a landmark 2001 survey of 4,875 adolescents aged 16 to 19 in five provinces, 12% of female respondents reported ever having had abnormal symptoms in their genital area and 8.5% of boys reported infections as well [22].

Although adolescents know about STI and HIV/AIDS, the knowledge is inadequate. A 2000 study conducted among ethnic minority students aged 10 to 21 in boarding schools [57] found that 53% of the students had an inadequate understanding about STI, 17% with wrong knowledge and 30% misunderstood the diseases.

A sample survey carried out with 500 people aged 15 to 19 showed that 13% did not know any STI, 14% did not know any common preventive measure. Understanding about HIV transmission and preventing HIV/AIDS was fairly high, and only 4% had not understood adequately about HIV/AIDS [116].

A survey conducted with young people aged 15 to 24 in Hai Phong [6] revealed that 70% knew about HIV/AIDS; 56% knew about gonorrhea; 48% knew about syphilis; and 26% did not know any diseases. A very low number of respondents knew about hepatitis B.

A 1995 study in Hanoi and Nghe An, conducted with 271 young people [2] showed that 80% of respondents did not know about the HIV/AIDS situation around their local areas. The respondents thought that HIV/AIDS infection was only a problem of foreigners and prostitutes, and that they had no chance of being infected.

An in-depth interview on 815 high school students and a group discussion with 101 children indicated that the STI knowledge of the students was quite limited. About 98% were able to name HIV/AIDS but 99% did not know much about HIV transmission.

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a relatively high level of knowledge of HIV/AIDS and a low level of condom use [16, 10, 105, 56]. The epidemic is seriously affecting children and young people as a result of more injected drug use, unprotected sex, and sexual abuse.

2.3.5 Sexual abuse and child prostitution

Child sexual abuse is on the rise in Viet Nam. Of 1407 rape victims in 1998, children accounted for 50% of them. The offenders were mostly young teenagers. The reported number of teenage rapes and sexual molestations increased from 17% in 1994, to 31% in 1996, and 35% in 1999 (of the total number of cases reported nationwide). In 1998, of 1404 rapes prosecuted, 50% of the victims were adolescents [86]. Sexual abuse adversely affects the mental and physical development of the child victims. Many became infected with HIV and other STIs.

The number of homeless and abandoned children has increased together with the growing incidence of alcohol and drug abuse, begging and prostitution among youth [114, 159]. Some research looked at the sexual harassment of children in several cities and provinces. The victims were often street children aged 10 to 16, and some were even younger than 10 [165].

Reports of human trafficking for sexual activity within and outside Viet Nam have increased. Thousands of girls and women have crossed national borders, either being deceived or moving voluntarily. Vietnamese women and children have been trafficked to many countries, including Japan, France, Taiwan, Macao, Hong Kong, Malaysia, and Singapore. Due to the nature of their work, sex workers and entertainers are particularly vulnerable to exploitation. More children are falling victims of trafficking as the demand for virgin children and child prostitutes increases due to such factors as the HIV/AIDS epidemic.

Often women and children are brought from poor rural areas to major cities, some have been abducted from their home villages and sold to several brokers and pimps on the way to border areas. According to official statistics, there were 60 000 female sex workers in Viet Nam in 2002. However, the actual number of sex workers was estimated to be closer to 500 000 (see 86). The proportion of child prostitutes (under 18 years) increased from 11.4% in 1995 to 26.8% in 2000. In Hanoi and Ho Chi Minh City, 70% of sex workers were under 25 years of age. In Cambodia, of the 14 725 foreign sex workers found in one survey, 2291 were children under age 18 and 78% of them came from Viet Nam [86].
The youth make up a significant proportion of sex workers in Viet Nam, especially for karaoke-based sex work. A study conducted in Ho Chi Minh City [29] showed that between 75% and 85% of sex workers and drug users were adolescents. There were 40,000 young people under 18 years who work as prostitutes. A number of them used drugs. Of the 5700 restaurant waitresses and bar girls, who also served as sex workers, 12% were between the ages of 13 and 16. Many child prostitutes believed that having sex with a man they ‘know’ was relatively safe, putting their own safety and other clients at risk.

Awareness of HIV/AIDS has led to an increased demand for virgins. Children are considered ‘clean’ and there are hidden networks where virginity can be sold, usually to Chinese, Taiwanese or Korean businessmen (37). These foreign clients believe having sex with a virgin is lucky for business, gets rid of bad luck, or is protective against HIV transmission. Since clients often do not want to use condoms, STI and HIV/AIDS can spread, putting many young girls at risk [37]. Many children started in prostitution by selling their virginity.

Given their physical immaturity, children are at very high risk for HIV infection and other STI.

A 1997 evaluation report by Save the Children (United Kingdom) of an intervention programme for adolescent men who have sex with men found that half of the men had never used condoms when having sexual intercourse [139]. Only 27% reported using a condom during the last time they had sex with men. Only one out of three respondents considered the practice to be high risk.

A study of 219 men who have sex with men in Ho Chi Minh City [31] revealed that the average number of sexual partners in the month before the survey was conducted was two persons. More than 60% of young men had engaged in anal sex. Findings from the study also showed that 42% of young men got paid for having sex with other men. The group was less likely to use condoms, and only 29% reported using condoms in the last sexual intercourse. The reasons given for not using a condom in anal sex were either a condom was not available or their partners did not like condoms.
2.4 Problems and challenges of adolescent reproductive and sexual health

The literature provides an emerging picture of factors that impede adolescents’ use of reproductive health services. These include: inadequate access to information; limited access to quality youth-friendly services; and economic constraints and hardships. These factors can lead youth to practice unproductive and risky behaviours. Addressing these challenges would improve the health and well-being of Vietnamese adolescents and young people.

2.4.1 Inadequate access to information

Although adolescents’ sexual and reproductive health knowledge has improved considerably, much of it remains superficial and ridden with myths and misperceptions. Adolescents are not well informed about pregnancy to prevent unwanted pregnancy and enhancing their sexual health should be a priority.

A substantial number of adolescents who have risky or unwanted sex do not receive appropriate services and may suffer adverse reproductive health outcomes, such as unintended pregnancy. Some adolescent girls did not know they were pregnant until four to six months into their pregnancy, at which point it is too late for an abortion. Many believe that ‘such thing cannot happen to me’. The level of contraceptive use among sexually active young unmarried people in Viet Nam appears to be low (see section 2.3.2).

Young people’s reproductive and sexual knowledge is limited because many people, including policy-makers, teachers, and parents worry that sex education will expose unmarried youth to inappropriate information and activities. Parents and adults are hesitant to talk to adolescents about sexual health and sexuality. Many parents believe that adolescents are too young to know about sex and that sex education will give rise to sexual desire and increase their sexual activity.

Sex education at schools is limited. Adolescents are given basic information about family planning and population. More sensitive subjects, such as STI, pregnancy, and abortion, have not been included in the curriculum. Teachers often find these topics embarrassing or feel uncomfortable talking about sex and reproductive health [36, 175]. Consequently, young people have to seek information from their peers, older partners, video, media and the Internet.
There have been increasing demands from adolescents for more comprehensive information about reproductive and sexual health [161]. However, the IEC materials and messages are not innovative enough to attract young people, especially those who are hard to reach. Many adolescents still lack sex education and misunderstand puberty. They hesitate to talk about matters relating to sex and sexuality [138]. They need clear, sympathetic explanations to their fears about menstruation, masturbation and wet dreams. Adolescents should be better equipped with knowledge and information [47].

2.4.2 Limited access to quality youth-friendly health services

Young people make limited use of health services, whether for contraception, pregnancy, STI or abortion. In Viet Nam, the reproductive health needs of adolescents have been largely ignored by the existing health services. The obstacles that have impeded adolescents’ use of services include: providers’ attitudes; accessibility; affordability; lack of confidentiality and privacy; and quality of care.  

Health providers are reluctant to provide services to young unmarried people. Many expressed disapproval of premarital sex. Even providers who believe that adolescents should have access to information about adolescent reproductive and sexual health may not have the training to counsel young clients. In many cases, adolescent clients are overcharged, cheated and threatened by medical staff at public hospitals (8). Unmarried young women who have abortions often leave service delivery points without contraceptive methods or counselling.

Although the establishment of adolescent-friendly services at public hospitals may be feasible, it is difficult to attract adolescents to hospital settings. Outpatient clinic and outreach services should be made available for young people.

In the meantime, the use of contraceptives among adolescents is low because they cannot easily access contraceptives and health providers. Reproductive health services are aimed at married couples, and are generally unavailable to the unmarried young.

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While the actual number of unwanted pregnancy and abortions among young women is difficult to ascertain, there is a sufficient unmet need to argue for affordable and accessible contraceptive services for unmarried and married adolescents. While an increasing number of service delivery projects has been implemented for adolescents, their feasibility and effectiveness of different models have rarely been evaluated.

### 2.4.3 Economic hardship and resource constraints

Economic constraints can influence adolescents’ attitudes and sexual behaviour. Limited resources can affect their ability to access contraceptives and health care. Today’s reproductive health services are unaffordable for many people. Unemployment, low-income jobs and poverty have prevented many young people from accessing and using health services.

The costs of health care and reproductive health services have been quickly increasing in Viet Nam. The current medical fees and lack of a sound health insurance system can push young people into vulnerable situations. Adolescents are more likely than adults to engage in risky sexual behaviours, such as being paid for sex to earn money. The growing number of child prostitutes in Viet Nam suggests that some young men earn money for their own needs and to support their families.

### 2.5 Intervention models for adolescent reproductive and sexual health

A number of reproductive and sexual health interventions have been carried out in Viet Nam. Most have focused on IEC, life skills education and service provision. UNICEF and the Government have a cooperation strategy on healthy living and life education for children and adolescents. The strategy includes: capacity-building for teachers, educators, and mass organization workers; strengthening relationships among families, schools, and communities; and linking life skills education with children protection activities.

There are plans to revise the policy for strengthening the role of local NGOs to contribute to development. Local NGOs work in various areas of health, including adolescent reproductive health. Donors have been supporting both government agencies and local NGOs to carry out projects. These include: IEC campaigns; information development and distribution; mobile teams; clubs; counselling; and service
centres. Below is a brief description of intervention and initiatives regarding adolescent sexual and reproductive health. A number of available studies have already documented the interventions in detail [32, 53, 55, 56, 59, 77, 101].

IEC campaigns
The most common intervention is the IEC campaign. With funding from UNFPA/EU, the first national IEC campaign on adolescent and sexual health was organized by Viet Nam Youth’s Union in 1998, covering eight provinces. The campaign aimed to raise awareness about the benefits of postponing sexual activity. It also promoted safe sex among those who were already active. The Youth’s Union collaborated with mass media, schools, health providers, counselling centre and other institutions to ensure the success of the campaign. It organized contests focusing on raising awareness among youth on key adolescent reproductive health issues. The contests and campaigns have contributed to reducing risks of young people for unwanted sex, pregnancies, unsafe abortions, STI, including HIV/AIDS.

Reproductive health and sex education books for youth
A three-year project (1995-1997) “Improvement of Youth Reproductive Health for Young People” has been carried out by the Women’s Union, with support from PATH Canada, to produce books on reproductive health and sexuality education for adolescents and youth as well as a general audience.

Development and distribution of printed materials
As part of a UNFPA-funded project, Viet Nam Youth’s Union produced and disseminated printed IEC materials, including posters, leaflets, and booklets. Among these materials, a set of booklets — “Psychology and Physiology of Adolescents,” “Friends and Love,” and “Things that Young People Should Know about HIV/AIDS” — has been published for an extensive distribution.

Youth clubs, counselling and service centre
The Viet Nam Youth Union has been a major actor in conducting pilot adolescent reproductive health projects since the early 1990s. A number of experimental models for IEC activities have been developed and implemented under small-scale pilot programmes funded by international donors. These models include clubs for unmarried youth, and competitions and contests on population and family planning. The use of other intervention models, including
IEC mobile teams, counselling and service centres, hotlines, weekly radio phone-in programmes, were later developed and carried out in provinces of the country under the UNFPA-funded project “Support to Improvement of Adolescent Reproductive Health” (1996-2000). The model of reproductive health services provision for young people initiated by Marie Stopes International (MSI) has proved to be excellent, meeting the RH needs of adolescents.

**Life skills curriculum for youth**

Since 1996, the Ministry of Education and Training and the Viet Nam Red Cross have implemented the Life Skills Curriculum for Youth Programme in seven provinces. The intervention focuses on life skills education and HIV/AIDS intervention. For in-school youth, a life skills curriculum (e.g. decision-making, values clarification) was designed by the Ministry and integrated into different subjects of the formal school system. For out-of-school youth, a curriculum designed by Viet Nam Red Cross and Australian Red Cross is used for improving youth’s life skills.

**Other creative interventions**

Since the mid-1990s, HIV/AIDS prevention activities for youth have been actively integrated into adolescent reproductive health programme. Efforts have been made to organize IEC activities, including counseling and peer education, in creative forms such as “condom cafés,” “green shops” and “friends-help-friends groups.” These models have been run by the Youth Union at different levels, but mainly in major cities. Young people, who come to the facilities for coffee or soft drinks may ask for counseling or for condoms.

However, few models for HIV/AIDS prevention are able to demonstrate ways of working more effectively with young people to facilitate and sustain behaviour change. Many HIV-infected persons are young. They may not know that they have already been infected. Other creative interventions focusing on HIV/AIDS reproductive health education include: the three-province project for the Youth Union; “Mobile Drama and Life Skills Curriculum for Youth”. The Population Council’s projects on HIV/AIDS information videos and theater for Khmer Youth; Soccer and HIV/AIDS Prevention for Youth; peer education and edu-entertainment for HIV/AIDS prevention among core communication group of young residents of rehabilitation centre of the Family Health International (FHI).
Integrating adolescent reproductive health in other programmes and activities

Some intervention activities promote gender equality and male participation in reproductive health care. They are implemented by mass organizations such as the Viet Nam Women’s Union, Farmer’s Union, and Viet Nam Red Cross. International agencies and donors support most of these programmes and activities. Interventions have disseminated information on sexual and reproductive health and HIV/AIDS prevention. However, the approach tends to be uncreative, dominated by moral directives, lectures and similar types of instruction and may not be as effective as needed.
None of the national polices specifically address adolescent reproductive health although the general national legal documents ensure and promote the rights for the safety and health care for all people. Unfortunately, no youth-targeted health policy exists in Viet Nam even though it is evident that adolescent behaviour patterns and reproductive health needs differ substantially from those of adults and children.

Successful pilot activities have not been developed into a national adolescent reproductive health programme that could be consistently implemented throughout the country. Most of the programmes and projects regarding adolescent reproductive health have relied heavily on international resources. This affects the sustainability and replicability of successful models. Activities are often discontinued after the pilots are finished. There are no monitoring and evaluating indicators to measure and document the impact of the projects and programmes.

### 3.1 Toward a national policy on adolescent reproductive and sexual health

Although the Youth’s Union drafted a national plan of action on adolescents in 1997, it was not officially adopted and disseminated. The National Strategy on Reproductive Health for 2001-2010 approved by the Prime Minister in 2000 pays attention to adolescent reproductive health. One of the seven specific objectives of the strategy focuses on the improvement of adolescent reproductive health through education, counseling and the provision of reproductive health services [103].

The Viet Nam Population Strategy 2001-2010 was formulated at the same time as the reproductive health strategy. Adolescent reproductive health is included in IEC programmes that focus on promoting behaviour change, communication among women of reproductive age, men, young people and adolescents. The strategy also
encourages the provision of reproductive health information, quality services and counseling to meet the needs of young people, minimize the number of unwanted pregnancies, and to reduce abortions [109].

Besides the national strategies, a number of policy initiatives have been carried out with support from international donors. Among them is the master plan on safe motherhood, integrating adolescent reproductive health throughout its components. The healthy living and life skills education for children and adolescents forms another strategy to tie life skills with the right promotion and child protection activities. It strengthens the linkages among families, schools and communities. The government also plans to revise the policy aimed at strengthening the role of local NGOs in adolescent education and services provision.

These policy initiatives, however, seem to have little impact on adolescent reproductive health. While the national strategies on population as well as reproductive health were approved nearly three years ago, the government’s circulated guidelines for implementing the programme are not yet in place. The strategies do not recognize that adolescents are not a homogenous group. They do not all have the same needs for information and services. A single set of interventions can not meet the needs of the many groups of adolescents, such as those who are married, sexually active, in- or out-of-school, and living in urban or rural areas.

### 3.2 Recommendations

Adolescent sexual and reproductive behaviour is changing, in ways that potentially undermine the physical health and social and economic well-being of young people. These recommendations should enhance adolescent well-being and meet the challenges posed by risky behaviours.

#### 3.2.1 Develop a national adolescent health strategy

A national policy on adolescent reproductive and sexual health should be developed to address the specific needs and concerns of young people. It could be regarded as society’s commitment to young people. The strategy should be supported by other agencies at various levels as well as communities. Participatory approaches involving key stakeholders, such as relevant government agencies, NGOs, parents, teachers and employers, should be used to achieve this goal.
The Government will also need a sound system of indicators for monitoring and evaluating the strategy. Adolescent reproductive health should be mainstreamed in health laws and policies and other legal documents related to the well-being of young people.

3.2.2 Promote and strengthen behaviour change communication (BCC)

Behaviour change communication strategies in Viet Nam have been widely promoted in campaigns that aim to change social behaviour. The Government has used visual and acoustic aids to promote messages. A common approach has been to use multiple communication channels or maximize the role of popular media channels, including radio and television, to bring about changes in awareness and behaviour.

Communication campaigns should tell the adolescents what they can do to protect their health. They should aim to reduce unsafe sex among adolescents. Young people are more likely to adopt a new behaviour if they are offered choices among the alternatives. The communication should, therefore, limit the use of fear messages which can hinder behavioural changes. Once positive changes take place, effective support is needed to maintain and reinforce the new behaviours.

An integrated approach should seek to understand adolescent behaviour and help to set up an environment that encourages healthy behaviours. Private should be provided for the youth to discuss and access information about sex. They are often afraid to talk about contraceptives and abortion out of fear of public judgement. Most successful behaviour change programmes use community leaders to influence social norms, recruiting them to adopt the changes being advocated and encourage others to do the same. Seeing examples of other people engaging in healthy behaviour will help an adolescent believe that they too can engage in such behaviours.

3.2.3 Research on adolescent reproductive and sexual health

Research that examines the relationship between social change and adolescent sexual and reproductive health is needed. Most of the studies on adolescents have been small and do not provide a representative portrait of adolescent reproductive health in Viet Nam. They have not fully convinced policy-makers and programme managers about the importance of providing information
and services to adolescent. It is recommended that a national survey on adolescent reproductive health be carried out to collect national and relevant data on adolescents. The WHO office in Hanoi in collaboration of UNICEF and the Government have been planning a survey in this direction. It would be necessary to include study sites in rural, remote and disadvantaged areas where socio-economic conditions are very poor as well as in cities, towns, crowded areas and new industrial zones.
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## Annex. Country profile of Viet Nam

| **Location** | Southeast Asia, bordering China, Lao People's Democratic Republic, Cambodia, the Gulf of Thailand, the Gulf of Tonkin and the South China Sea |
| **Coordinates** | 16 00 N, 106 00 E |
| **Total area** | 329,560 km²; Land 325,360 km²; Water 4,200 km² |
| **Land borders** | Boundaries with China, Lao People's Democratic Republic and Cambodia (3,260 km²) |
| **Terrain** | Low, flat delta in south and north; central highlands; hilly mountainous in far north and northwest |
| **Land use** | Arable land 17%; permanent crops 4%; permanent pastures 1%; forests and woodland 30%; other 48% |
| **Coastline** | Pacific Ocean coastline of 18 600 km² |
| **Population** | 76 327 919 persons (in 1999) |
| **Sex and age structure** | Sex ratio is 96.7 males per 100 females; 0-14 years 33%; 15-24 20%; 60 years and over 8% |
| **Religions** | Buddhist, Taoist, Roman Catholic, Islam, Protestant, Cao Đài, Hoa Hao, indigenous belief |
| **Ethnicity** | Kinh majority (84% of the population) and 60 different ethnic minority groups (16% of the population) |
| **Languages** | Vietnamese (official), Chisene, English, French, Khmer |
| **Major cities** | Hanoi (capital), Hai Phong, Da Nang, and Ho Chi Minh City |
| **Administration** | 5 municipalities and 56 provinces |
| **Geographic regions** | Eight regions include Red river delta, northeast, northwest, north central coast, south central coast, central highlands, southeast, and Mekong delta |
| **GNP per capita** | US$411 per head (in 2002) - Monetary unit: US$1 = VND15 450 |