

### **ANNEX 3: Aide Memoire**

This is the revised aide memoire that reflects the comments of participants at the debriefing meeting.

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#### **Addressing the Reproductive Health Needs and Rights of Young People: The Contribution of UNFPA and IPPF**

#### **Country Evaluation - Vietnam**

#### **Aide Memoire**

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## 1. Introduction

The Ministry for Economic Co-operation 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 this 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 - 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 five governments plus representatives of UNFPA and IPPF form the Steering Group that is managing the overall evaluation process.

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 six countries in promoting reproductive rights and health (with the aim of achieving behavioural change), with a particular emphasis on adolescents and youth.

The local partner for the country evaluation was Marie Stopes International/Vietnam. The Centre for Investment in Health Promotion (CIHP) undertook three 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). Nguyen Cuong Quoc was the national team member. The international team members arrived on 4 May 2003, and will depart 24 May 2003. The international team took the responsibility to write both the Aide Memoire and the Country Report. The draft country report will be finalised in June. After discussions with, and approval by, the evaluation's Steering Committee, the six country studies and synthesis analysis will be finished at the end of the year. The three CIHP reports will be available for distribution after approval by the Steering Committee in July.

The evaluation team spent the first week in Hanoi conducting a one-day stakeholders' workshop and following up with central-level meetings/interviews. During the first three days of week two, the team divided into two groups and made short visits to Danang 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 Aide Memoire preparation. This Aide Memoire represents the initial views of the consultants; further analyses will be presented in the draft report.

## 2. Methodology

The nature of the issues raised in the TORs meant that the evaluation was conducted using mainly qualitative methods. To the extent possible, more quantitative data (e.g., service utilisation) were reviewed, but no quantitative analyses were expected and therefore none conducted. The team used the following specific methods in conducting the evaluation:

First, the team conducted a review of existing documents relating to Vietnam, UNFPA (in general and in Vietnam), and VINAFFPA (including IPPF overall). This set the context for UNFPA's and VINAFFPA's activities since 1994.

Second, three local studies were commissioned previously for use by the Team. These studies were: (1) a "legal status review" of issues related to SRH for young people/adolescents; (2) a review of currently used IEC materials developed with support from UNFPA and/or VINAFFPA; and (3) a "youth opinion study," using data gathered through 18 focus group discussions held in Hanoi, Hai Phong, and Da Nang.

Third, the team held semi-structured interviews with key stakeholders at central level in Hanoi, and at provincial level in Thai Binh, Hai Phong, Da Nang, and Quang Nam. Questions were drawn from a wide-ranging list of issues identified by the Steering Group. There were a number of aims of the interviews, such as gaining clarity on issues found in the documentation, identifying new data and information, and "triangulating" information from various sources. Most of the interviews were held with groups of key stakeholders and only a few were conducted with individuals. This was largely due to time constraints and to the apparent preferred mode of consultation by most stakeholders.

Fourth, the evaluators observed a number of sites offering SRH services to young people/adolescents, including clinic sites, clubs, and counselling centres. These observations also included a limited review of records at some sites.

The evaluation process was a challenging one, especially given the simultaneous breadth and depth of analysis and historical perspectives demanded in the Terms of Reference (ToR). The timeframe available to undertake such an evaluation was unrealistic. The picture the team has drawn cannot be fully comprehensive. It aims to be as representative as possible, whilst fully appreciating that what is presented below is not necessarily the whole picture. Therefore, a number of caveats must be made:

**General Constraints:**

- Restricted time frame available for evaluation (to allow for in-depth discussions, longer field visits, etc.)
- Language difficulties making deep discussion on key issues difficult.
- Delays in documentation availability.
- Difficulty in finding useful written information going back to 1994.
- For those few people who can comment on UNFPA and IPPF/VINAFFPA strategies and activities farther back than the last few years, there is likely to be a high recall bias.

**Specific Constraints:**

- VINAFFPA and IPPF have limited institutional knowledge pre-1998/99.
- There is limited knowledge of key informants on VINAFFPA as an organisation, its activities in general, and with regard to adolescent reproductive health.

N.B. Evaluation of VINAFFPA is therefore based on limited range of information sources, but hopes to be as informative as possible, despite this.

### **3. Vietnam Country Context**

- Vietnam began its policy of reform, *doi moi*, only 16 years ago in December 1986. Since then, Vietnam has made tremendous progress, for example, in reducing poverty (1990: 70%; 2000: 32%) and the total fertility rate (1989: 3.8; 1999:2.3). Because of such successes, Vietnam received the United Nations Population Award in 1999. Such progress is unequalled in many post-conflict developing countries, and the same powerful

forces that are propelling Vietnam ahead are also driving the development of sexual and reproductive health (SRH) policies and programmes for young people/adolescents.

- It appears that Vietnam's development is assisted by strong governmental leadership linked with similarly strong grassroots consultation and action. This combination is unique to Vietnam, and therefore many of the outcomes seen in the last 10-15 years may not be applicable readily to other country settings.
- The Government of Vietnam has recognised the importance of reproductive health in general, and recently that of young people specifically. This can be seen in the increased funding for RH. Government resources for RH in 1992 were around 27 billion Dong, and by 1996 had increased tenfold<sup>1</sup>.
- The Government's commitment also can be seen in the promulgation of three relevant national strategies. The Vietnam Population Strategy (2001-2010) includes RH objectives. The National Strategy on Reproductive Health (2001-2010) has one objective (out of seven) to improve SRH status of adolescents. Finally, during the last two weeks the government has approved the National Youth Development Strategy (2003 – 2010), which is expected to further strengthen the environment for addressing SRH issues of young people/adolescents.
- The government takes a lead co-ordinating role for young people/adolescent SRH programming. Organizations such as UNFPA are widely seen as donors, not implementers, and this is largely true. Organizations such as VINAFFPA are clearly implementers. After a long wait there is still no official framework defining the legal status of local non-governmental organizations, but this has not prevented local organizations (e.g., VINAFFPA) from actively engaging in implementation. Further clarity on the respective roles of local NGOs, vis a vis each other and international NGOs, may follow if and when the legal status is defined.

The main findings, general conclusions, and country-level recommendations are presented separately for each organisation below.

#### **4. UNFPA/Vietnam: Main findings**

##### **Background**

- UNFPA has been working in Vietnam since 1977. Under Country Program 5 ("CP 5" 1996-2000) UNFPA supported 8 provinces. Under Country Program 6 ("CP 6" 2001-2005), UNFPA, in close collaboration with the government, added 3 more provinces for a total of 11.
- UNFPA acts mainly as a donor and co-ordinator, rather than an implementer. The main modality for implementation is through government execution. By 2000, UNFPA had provided over US\$ 110 million to assist in population and reproductive health, including maternal and child health and family planning.<sup>2</sup>
- UNFPA is viewed by many key stakeholders, especially the government, as being a critically important "friend of Vietnam" since they stood by Vietnam through the post-unification period. This closeness to the government is shared by most UN agencies who have worked for decades in Vietnam, and means that UNFPA is extraordinarily well placed to have influence within the highest levels of the government; they have a trustful relationship.
- UNFPA partners say that UNFPA has been a consistent advocate for the ICPD POA. Indeed, UNFPA has based its Country Programs within the framework of the POA.

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<sup>1</sup> NCPFC – personal communication.

<sup>2</sup> UNFPA "Briefing on UNFPA Assistance to Vietnam."

### **Attributing success**

- 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.

## **4.1 Strategies and Priorities**

### **Technical focus**

- The 6<sup>th</sup> Country Program'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).
- Lead co-ordinating agency in Vietnam for (A)RH: 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.
- Two main program components, Population Development Strategies (PDS) and Reproductive Health: ARH is one component of the CP6 logframe, and is supported through activities under both the PDS and RH sub-programmes. Approximately 8% of the budget is spent on PDS, which focuses on development of policies and plans in line with the ICPD POA (of this, about 20% is attributed to ARH policies/strategies). About 39% is spent on overall advocacy at both national and provincial levels (of this, about 20% on ARH), and 53% spent on overall RH services, mostly at provincial level (of this, about 10-15% is attributed to ARH services). This means that approximately 15-17% of the total budget is spent on SRH programs for young people/adolescents.
- The EC/UNFPA RH Initiative (RHI), with its focus on youth and adolescents (YA) in Vietnam since Phase 1, has been instrumental in moving Vietnam forward in addressing ARH needs and rights. It has provided a platform for discussion and advocacy. Vietnam chose to focus on youth and adolescents; it was not required. The RHIYA likely will be extended into a second phase starting in July 2003 and lasting for 33 months. The second phase mandates a youth/adolescent focus in each of the 7 Asian countries in which it operates.

### **Reproductive and sexual rights**

- 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. 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.
- However, the UN interagency Working Group on Youth feel that "rights-based programming" is not well understood by either UN staff or Vietnamese counterparts.

### **Sustainability and Scaling up**

- Demonstration models: UNFPA, and the government, report UNFPA's greatest strength is in testing demonstration models 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 (upgrading VINAFFPA; MoET's "Adolescent Reproductive Health Education: self learning with guidance manual for teachers (2001)"; advocacy/BCC for local leaders, service providers, and target populations, various clubs).
- Sustainability and scale-up strategy/documentation of approaches and lessons learned: UNFPA's implementation modality is mainly through government execution, and their program are designed with sustainability and scale up firmly in mind. Though their programs are predisposed to being sustainable/scalable, UNFPA has not written up a sustainability/scale-up strategy or "lessons learned" that readily outline their approach and effects.
- 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. The NCPFC, with UNFPA assistance, then developed "Core messages" on which training has now been conducted in all provinces. Other examples include the development of the HMIS, integration of ARH issues into the formal curriculum of high school, and integration of RH and ARH issues into the national micro credit program of NCPFC with Farmer's Association and Women's Union.
- 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 program models. This may be changing as cost-effectiveness studies may be proposed as part of the evaluation framework for RHIYA Phase 2.

### **Financing**

- Resource mobilisation: 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 program implementation.

## **4.2 Institutional Arrangements**

### **Capacity**

- The quality and dedication of 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 evaluation of the RHIYA highlighted the need for more staff, and UNFPA is responding by hiring an additional member for the Umbrella Project. UNFPA benefits from having international Junior Professional Officers, but these posts are largely training posts. As decentralisation increases, the need for program 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.
- The UNFPA Country Support Team, based in Bangkok, resources are reportedly used sparingly by the UNFPA country office. The UNFPA staff all report satisfaction from the limited assistance provided. Increased use of the CST is largely limited by the CST's

capacity. The CST has reportedly had relatively high staff turnover recently, though this was not confirmed with the CST.

### **Monitoring and Evaluation system**

- Monitoring and evaluation was weak during the 5<sup>th</sup> country program, as pointed out by internal evaluations of CP 5. This applied across the board, and included Phase 1 of the RHIYA. 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 staff report they are striving to make RHIYA Phase 2 more evidence-based.
- UNFPA has established its own monitoring and evaluation unit, reportedly the only one in Asian UNFPA offices. This is a critically important unit as it will demonstrate to what extent UNFPA programs are effective. However, there are only two positions planned, of which one is currently vacant.
- Given the weakness of M&E in CP 5, program design for CP 6 relied more on other studies (such as those outlined earlier) for their evidence base. This served the immediate purpose, but with the new M&E Unit and expected effectiveness evaluations in the future, even better and more specific evidence should be available to inform the program design of CP 7.

### **Partnerships**

- 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.
- 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. 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 organizations, 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<sup>3</sup>. However, the development of the follow-on detailed proposal has reportedly been very collaborative.
- 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. Even the practical definitions of "civil society" and "local NGO" in Vietnam are unclear. There is no legal framework as yet, for example, for LNGOs. UNFPA feels it is supporting long-term institutional change by supporting/promoting the role of "LNGOs" as executing agencies under RHIYA Phase 2 – a significant shift from the implementation modality of Phase 1.

## **4.3 Enabling Policy Development**

### **Relationship with Government of Vietnam**

- The government is opening up slowly 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

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<sup>3</sup> Final Evaluation of the AIRH (Asia Initiative for Reproductive Health) and appraisal for proposal for Phase II RHIYA (Reproductive Health Initiative for Youth in Asia) November 2002. Euronet Consulting.

report high satisfaction with UNFPA because of this “trustful relationship” and because they feel UNFPA has demonstrated good outputs.

### **Influence on Policy Development**

- UNFPA continues to play a key role in the development of national policies and strategies that affect ARH. Notable examples include:
  - Ø UNFPA participated in the development of the **Vietnam Population Strategy, 2001-2010**, produced under the auspices of the NCPFP. One aim is to address points of the ICPD POA.
  - Ø UNFPA played a lead role in the development of the **National Strategy on Reproductive Health, 2001-2010**. This includes one objective (out of 7) on ARH, though the focus is more on provision of information and less on services.
  - Ø UNFPA says it was a catalyst in the development of the **National Youth Development Policy** that was recently approved by the government (May 2003). As an English copy was not available, the exact contents of the policy are unclear.
  - Ø **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.
  - Ø **National Guidelines on Monitoring and Evaluation of Reproductive Health Standards and Guidelines**. This is a companion piece to the National Standards just mentioned, expected by the end of 2003.
- UNFPA has also been instrumental in addressing ARH through the UN Interagency Working Groups, which now has a group on Youth.

## **4.4 Strengthening ARH Services**

### **Design, Quality, and Coverage**

- Given the relatively complex government HMIS system, and UNFPA’s formerly weak M&E system, UNFPA relied on other studies and documents (as mentioned above) as evidence for the design and evaluation of its support to service delivery. However, this should improve during the course of CP 6 through the new UNFPA-supported HMIS system as well as the previously-mentioned improvements in UNFPA’s own M&E systems.
- The main vehicle for strengthening SRH services for youth/adolescents is through the EC/UNFPA RHIYA.
- UNFPA consulted youth (urban, rural, ethnic groups) in the design of the RHIYA Phase 2. It remains to be seen how youth will participate in further implementation, monitoring, and evaluation.
- Although SRH rights of young people are not explicitly discussed in RHIYA Phase 2, the indicators and activities are intended to address the “supply side” of those rights: increase information, access, etc.
- Gender equity has been discussed “rhetorically”, but it appears ways of improving gender equity have not been fully explored with executing and implementing partners.

### **Monitoring and Evaluation of Services**

- There has been great improvement in the monitoring and evaluation framework since CP5 and RHIYA Phase 1. For the first time, UNFPA should be able to say more about the effectiveness of the programs they support. Indicators of behavior change among young people are now explicit, and baseline, mid-term, and end line surveys are proposed. However, since the M&E systems are new, it remains to be seen how well they will perform. UNFPA will need to ensure adequate support to the M&E Unit in order to meet the M&E needs of RHIYA (in addition to the multiple needs of the CP overall).

- It is not clear how young people will meaningfully participate in program monitoring and evaluation. Such participation plans should be explicit.
- UNFPA provided mixed messages on the extent to which UNFPA plans to conduct any cost-effectiveness evaluation. Such studies would have immediate use with government, and would complement and strengthen data on program effectiveness.

### **Capacity**

- There was insufficient time to assess 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).

### **Diversity of needs**

- CP 6 is contributing to/supporting service strategies that are responsive to the diverse needs of young people. It has targeted diverse groups of young people, mostly rural, in RHIYA. They wish especially to target “poor and deprived young people” which they say include both in and out-of school youth, street children, and ethnic groups. However, even this is a broad set of target populations. The final target groups had yet to be agreed with the EC.

## **4.5 Promoting RH Information and Education**

### **IEC/Behaviour Change Communication Strategies**

- UNFPA has itself moved from a narrow focus on IEC towards a focus 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.

### **IEC Materials development**

- UNFPA reportedly went through a process of decentralising RH material development to the provinces. However, this does not appear to have applied 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.
- UNFPA-sponsored materials are being used by many partner agencies.
- The messages reviewed still reflect an IEC approach. For example, there was little in the materials reviewed that focused on “risk perception” or other messages to persuade behaviour change.
- UNFPA reportedly follows an appropriate materials development process, i.e., one that includes field testing with key target groups. It remains to be seen to what extent this process – when applied more systematically to diverse youth – will produce more diverse and effective ARH materials.

### **Capacity**

- UNFPA staff co-ordinate and monitor TA for the production of materials. However, their capacity to do so has been questioned<sup>4</sup>. This is being addressed through plans to have four staff assigned to the Umbrella management unit for the RHIYA. It remains to be seen whether this will be a sufficient solution.
- Similarly, it appears that there are not enough staff to provide much needed follow-up to ensure that key skills have been imparted to partners. The expanded Umbrella team is meant to address this as well.

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<sup>4</sup> Euronet Report.

#### 4.6 UNFPA: General Conclusions

UNFPA has been an effective partner and good friend to Vietnam since the ICPD POA of 1994. 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. They have demonstrated their ability to strengthen their programs when needed, through what is undoubtedly a dynamic (and therefore sometimes difficult) environment. 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.

#### 4.7 UNFPA: Country-level Recommendations

##### 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. However, 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.

##### 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, organizational, and impact sustainability and methods for scaling up programs) would clarify both the UNFPA and government positions on sustainability, and provide leadership and ideas to other agencies.

##### 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.

##### Increase capacity of UNFPA CO

Current staff might benefit from specific basic and refresher courses on ARH issues, monitoring and evaluation of ARH programs, BCC material development, and general management.

##### 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.

## 5. VINAFFPA: Main Findings

### Background

- VINAFFPA was formally established on 11<sup>th</sup> 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, VINAFFPA 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) providing outreach to over 100,000 households in 36 provinces and cities, 450 communes and villages, and 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, VINAFFPA 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.

### Attributing success

- VINAFFPA collaborates heavily with other mass organisations, local organisations, and Government authorities. 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.

### 5.1 Strategic Focus

#### History:

- VINAFFPA has only really been addressing ARH, with young people as a target client base, since 1999 [a family life education project was implemented five years earlier but with limited results], with the advent of the EC/UNFPA project on ARH. This initiative has been absolutely instrumental in enabling VINAFFPA to engage in ARH work. Prior to this, since its establishment in 1993, the Association has been focusing on 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 VINAFFPA but unfortunately service statistics collected under these programmes do not give age breakdown and so it is not possible to provide figures on this.

#### Technical Focus:

- As an organisation, VINAFFPA is still shifting its focus from family planning to reproductive health and developing sufficient capacity to deliver quality reproductive health services and counselling through its nation-wide network of branches in 47 locations across Vietnam, as remitted by the NCPFC. VINAFFPA has tended to focus activities on IEC and counselling, and provision of family planning services through community outreach. Clinical service provision is gradually being scaled up through institutional strengthening and capacity building in recent years.

#### Financing:

- 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, which skews the picture of proportionality. 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. VINAFFPA has also received considerable support “in kind” to its ARH work from Provincial authorities, increasing total budgetary allocations towards ARH.

- The Strategic Plan for VINAFFPA for the next three years does state a focus on ARH. Additional financial resources are clearly required to fulfil this commitment, and VINAFFPA has been aided in widening its donor base by UNFPA and by IPPF. Sustainability and self-sufficiency through user fees and voluntary contributions from the community, whilst possible for some VINAFFPA 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.

### **Reproductive Rights:**

- Whilst supportive of young people’s reproductive rights (in line with ICPD and IPPF Principles), promulgation of young people’s reproductive rights is not articulated clearly in VINAFFPA’s strategic goals or programme objectives. This is an area which VINAFFPA has a greater role to play, both at local level, raising awareness and advocating for ARH within community, but also at central level with Government and is well positioned to do so through its relationship with the NCPFC.

## **5.2 Institutional Arrangements**

### **Governance:**

- VINAFFPA has intertwined governance and management structure, with Senior Volunteer Board members acting in governing *and* management capacity. This raises concerns about accountability of the Association and needs to be addressed through discussions with IPPF and the NCPFC.

### **Capacity:**

- 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. This is having negative impact on 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, allowing for measurement of progress towards targets, problem identification, trend analysis. Outcome effectiveness is not measured, rendering ability to judge performance of “models” objectively almost impossible.

### **Participation:**

- 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.

## **5.3 Enabling Policy Development**

### **Relationship with Government of Vietnam:**

- VINAFFPA 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 (of which it is a member). The association is held in high regard by the NCPFC who, whilst making clear that the Government has a dominant role in the provision of reproductive health services, acknowledge the contribution that VINAFFPA

has made in the past and continues to make, through strong collaboration with the MoH, NCPFC, and mass organisations.

- This relationship with Government, and the esteem with which the Association is held by the NCPFC, is a distinct comparative advantage that VINAFFPA has over other local organisations working in the field of reproductive health, especially for young people. The extent to which VINAFFPA has been able to capitalise on this unique positioning and relationship with Government in terms of influencing policy development, is difficult to gauge. As a quasi-governmental organisation<sup>5</sup> (often described by many as a mass organisation - illustrating its unusual classification), many see VINAFFPA as unable to offer a strategic and formal 'challenge' role to Government (in terms of influencing policy). However, within VINAFFPA, opportunities for influencing policy *are* identified and taken up whenever the chance arises. Areas in which VINAFFPA has engaged with central Government to influence policy is on HIV/AIDS and commercial sex workers and drug users. It is not possible to quantify the impact of these negotiations.

#### **Role of EC/UNFPA project:**

- The EC/UNFPA RHI project has been instrumental in providing VINAFFPA with the ability to demonstrate to local authorities and decision makers, the value in undertaking adolescent reproductive health focused activities. This has enabled VINAFFPA to receive greater support from, and influence with the People's Committee and other provincial level authorities. So "policy development" has been achieved more by "doing" than by "saying".

#### **National Guidelines and Standards:**

- The Ministry of Health National Standards and Guidelines for Reproductive Health Care Services (2003) were drawn up with the assistance of a number of individuals/national experts and international and local organisations. VINAFFPA was involved in the drafting of these guidelines.

### **5.4 Strengthening Reproductive Health Services**

#### **Getting the balance right:**

- VINAFFPA 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. VINAFFPA needs to rectify this imbalance if it is, as a national organisation, committed to supporting ARH in a *comprehensive* manner.
- Whilst VINAFFPA is clearly an organisation that works to collaborate with others, especially other mass organisations, it must identify where its "niche" is, and ensure that it is not duplicating work being successfully done by others. A case in point, is the Youth Union, who have considerable expertise and geographical coverage in IEC work with young people. VINAFFPA's strength or comparative advantage will lie in its ability to provide not only IEC and counselling but also service provision, and provide an holistic package of IEC and clinical services to young people.

#### **Capacity:**

- VINAFFPA service providers have received training in ARH counselling and IPPF have helpfully developed a Youth Friendly Services Checklist for service providers. However, there is a range in the standards of youth friendliness in service provision – not all service providers are able to offer services to young people in a youth friendly manner – an example being that some clinics/centres are taking young people's names and addresses unnecessarily, undermining client confidentiality in some cases.

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<sup>5</sup> VINAFFPA 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.

- Again, this relates back to the lack of monitoring capacity within VINAFFPA staff, and the reliance of VINAFFPA on association members to undertake monitoring roles. Using VINAFFPA 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.

**Diversity of needs:**

- There is strong bias towards women in VINAFFPA's youth work. Service statistics indicate clearly that more young women are being reached than young men – indeed, a snapshot of STD treatment statistics showed 100% of clients were women. This is a serious concern. Either the youth service is totally unsuitable for men and they seek treatment elsewhere, or VINAFFPA is not undertaking 'partner treatment' action. Despite programme data/records clearly showing the significant lack of male involvement in ARH service provision, VINAFFPA has not yet developed a strategy aimed at addressing the needs of young men, beyond engaging in condom social marketing.
- VINAFFPA 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, VINAFFPA also works with street children/youth through "Moon Age Clubs" for young people aged 14-17. However, the IEC materials and outreach strategies VINAFFPA 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.

**Accessibility:**

- With the lack of M&E capacity, VINAFFPA is not able to measure the impact of its charging for services policy (for those over 18 years) and whether this is affecting accessibility. This needs to be assessed, especially as VINAFFPA 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.

**5.5 Promoting Reproductive Health Information and Education**

**Main focus:**

- As described above, VINAFFPA has focused heavily on IEC in its response to ARH. The question it needs to address is how it complements or duplicates the work of the Youth Union which has strong capacity in this area. What is its comparative advantage/niche in this respect and is it able to provide a comprehensive response to young people's reproductive health needs? VINAFFPA consider their niche area to be the provision of counselling combined with IEC. It will need to sustain and scale up work in this area, in order to maintain its niche, ensuring sufficiently strong referral networks operate between youth friendly outreach IEC, counselling, and clinical service provision.

**IEC Materials:**

- The EC/UNFPA project provided VINAFFPA 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. Evaluations of these 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).

#### **Diversity:**

- None of the printed IEC materials produced by VINAFFPA 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. Most of the IEC materials have a 'Northern Vietnamese' outlook, both in terms of language and pictorially, despite being used nationally, and tend to portray young people in "in-school" settings, carrying books, etc.

#### **Key Messages:**

- VINAFFPA 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, 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 VINAFFPA 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. Effectiveness of IEC materials is not measured.

#### **Outreach:**

- VINAFFPA undertakes a great deal of outreach and awareness raising work, through the mass media, general forums, etc. which raise general awareness on ARH issues, and have a useful advocacy role. This role is recognised by UNFPA who identify VINAFFPA as having a significant contribution to make to scaling up of advocacy at the local level, in the forthcoming EC/UNFPA Phase II project. VINAFFPA 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 VINAFFPA has had, the success of VINAFFPA 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 VINAFFPA, similar to other local organisations, as not been able to carry out survey work to quantitatively measure the impact of its outreach activities.

#### **Peer education:**

- A strategy of using peer educators (demonstrated internationally to be an appropriate and effective approach of reaching young people) is used by VINAFFPA to reach young people with key information on ARH and to offer them information on seeking services. 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.

### **Impact Assessment:**

- IEC/BCC very much seen in terms of process and output – delivery of IEC messages, production of IEC materials, counselling provision etc, without a sense of focusing on the outcome of these activities, whether they are changing behaviours at all. VINAFFPA 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.

### **5.6 VINAFFPA: General Conclusions**

VINAFFPA is an organisation that is slowly emerging from a period of financial and organisational uncertainty at the end of the last decade. Whilst there is a strong relationship still with Government, relating to the Association's historical origins within the then titled NCPFP, and a large membership network across the country, bringing with it strong links with local administration, VINAFFPA currently does not have a very high profile amongst many organisations, excluding mass organisations, working in the field of ARH.

It is now at the beginning of a new era, in which difficult decisions will have to be made, both by VINAFFPA and by IPPF, as well as its supporting agencies such as UNFPA and NCPFC. Clearly, VINAFFPA has the potential to be an important and influential player in the field of adolescent reproductive health. The question is whether it can transform this potential into reality. Given current capacity, this is perhaps unlikely unless VINAFFPA receives considerable 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.

### **5.7 VINAFFPA: Country-level Recommendations**

#### **Strategic Response – Focused vs. Comprehensive**

VINAFFPA must 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**

VINAFFPA 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.

#### **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.

#### **Participation**

Greater youth participation – 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 VINAFFPA response to youth needs.

### Capacity Building

At this critical juncture in VINAFFPA's engagement in ARH activities, with the onset of the EC/UNFPA RHI for youth – phase II and VINAFFPA'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.

### **6. List of Persons met**

See Annex 1.