ADVOCACY STRATEGY FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

FOR RHIYA PROGRAM IN VIETNAM
2005–2006

Developed by the Central Youth Union
with technical assistant from CARE International in Vietnam
Preface

Adolescent sexual and reproductive health (ASRH) issues are increasingly attracting policy makers in the world, especially after the International Conference for Population development (ICPD) in Cairo, 1994. However, in the context of economic globalisation, information technology development, fast urbanisation, the emergence of HIV/AIDS epidemic and many other factors, ASRH are facing a lot of risks and challenges.

Based on the achievements of RHIYA program phase I, implemented in 1997, The European Union (EU) continues to fund RHIYA program, phase II, through UNFPA. Vietnam is still one of seven countries selected within the program.

Within Vietnam, the program is implemented in Hanoi, Hai Phong, Hoa Binh, Thua Thien Hue, Da Nang, Khanh Hoa and Ho Chi Minh city (HCMC). The overall goal of the program is to improve the situation of ASRH in Vietnam, especially for vulnerable and disadvantaged populations. The main beneficiaries of the program include adolescents from 10-24 years of age, who account for one third of the whole population. Adolescent sexual and reproductive health will be improved by improving knowledge, practice and behaviour change communication (BCC) and by enhancing the use of friendly services within the project sites.

One main objective of the RHIYA program in Vietnam is to create a favourable environment for the provision of information and services to ensure that BCC can be sustained through relevant decisions by policy makers, community leaders and influential partners in the community. To achieve this objective effectively, it is vital to develop an advocacy strategy for RHIYA program.

The development process of the strategy adopts rights-based and participatory approach with the strong focus on gender and sexuality issues. The advocacy strategy was developed by the Vietnam Youth Union (project RAS/03/P51) with the technical assistance of CARE International in Vietnam and RHIYA Co-ordination office in Vietnam, the Umbrella Program Support Unit (UPSU). The strategy was also developed with the active participation from other project implementation organisations such as UCNEV, LMF, VICOMC, SUSECON, Youth counselling centre, Youth House and other agencies of the second output project on services. The participation of other stakeholders of the program such as adolescents and representatives of Central and Provincial Youth Union has made the strategy more realistic and sustainable.

Within the strategy, the following issues will be advocated at central and community level. They are (1) unwanted pregnancy leading to unsafe and high rate abortion, (2) Reproductive Tract Infections (RTIs) and Sexually Transmitted Infection (STIs), (3) HIV/AIDS, and (4) sexual abuse. Objectives, messages, key stakeholders and tactics for each advocacy issue were also identified.

The successful development of an advocacy strategy for RHIYA in Vietnam is a very important achievement. However, it is only the initial step. The challenges for each of us are to implement the strategy effectively to create an enabling environment for ASRH activities
within RHIYA program. The strategy also will help the Youth Union strengthen their advocacy capacity for sexual and reproductive health.

In order to improve and further fulfil the strategy, the management board of the project RAS/03/P51 wish to receive comments from implementing agencies in the RHIYA program, government agencies, related Ministries and Departments and from national and international experts. For communication, please contact us by the following address:

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With thanks and best regards
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On behalf of the management board of Vietnam Youth Union, the executive and implementing agency of the project RAS/03/P51, I would like to express my sincere thanks for the support of the EU/UNFPA office in Vietnam. I would also like to thank CARE International in Vietnam and Ms. Malicca Ratne- an international expert who has supported us to develop the strategy. Thanks will be sent to the working groups and members of Vietnam Youth Union and local organisations from the output project number 1 and number 2 of RHIYA Vietnam. The youths, with their enthusiasm and passion, have contributed a lot in the development of the strategy. I would like to thank Dr. Quan Le Nga for her contribution to the completion of the strategy. Comments from the managers, experts of the governmental agencies, related Ministries and departments and of Vietnam Youth Union have really made the strategy possible.

The advocacy strategy will be continuously revised during implementation by RHIYA partners. The project management board, therefore, would like to receive continuous collaboration and support from all stakeholders during implementation.

With my sincere thanks,

Dao Ngoc Dung
Standing secretary of Vietnam Central Youth Union
Director of the project RAS/03/P51
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Section 1: INTRODUCTION

1.1 Summary of reproductive health situation and challenges facing by Vietnamese adolescents and youths

Vietnam has a total population of 82.5 million in 2004 and 52 percent are below 25 years of age. Despite falling birth rates and high contraceptive prevalence rate, Vietnam’s population is increasing by one million per year. By the year 2020 the population is estimated to reach 100 million, of which 22 million will be adolescents aged between 10 and 19. This percentage is expected to remain unchanged within the next 15 years.

Like most countries in the region, Vietnam is entering a period of high economic growth, but with negative social side effects. Societal changes have resulted in rapidly changing lifestyles, which have raised many new challenges for adolescents and youths such as HIV/AIDS, substance abuse, mental health issues, lack of access to quality health services and so on. According to a study of UNFPA in 12 provinces, the two most common adolescent reproductive health (RH) problems, as perceived by service providers, were inadequate knowledge on puberty and pregnancy signs and not using contraceptives during sexual encounters. The UNFPA study also revealed that in two of these provinces, the major adolescent RH problem was “having sex at an early age”.

The average age of first sexual contact has dropped to about 19 years and even lower for adolescents living in the streets. From 1960s to 1990s, due to the population growth pressure, the national family planning programs mainly focused on birth control and providing contraception to married couples and RH information, but not to adolescent and youth. This meant that youth and adolescents had limited access to RH services, including counselling and information on RH issues such as including HIV/AIDS and contraception.

Unsafe and high rate of abortion is an ASRH issue in Vietnam. Over 30% of abortions are performed on young, unmarried women, out of an estimated one million recorded abortion cases. Pregnancies and births are expected to peak by 2010 at almost 2 million and 1 million respectively among young people in the age group 15-24.

Vietnam is experiencing a rapid increase in the number of new HIV/AIDS infections. According to the National HIV Strategy 2004, 50% of new HIV cases occurring among

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1 GSO 2002 Population Change and FP survey
2 Baseline survey in 12 provinces, UNFPA, 2003
3 Summary of Adolescent health studies in 5 provinces of Vietnam, June 1999, Thai Binh Medical College
4 MOH, Annual Health Statistic 1990 - 1998
5 Khuat Thu Hong, 2003
young people between 20-29 years old and 40% of all HIV/AIDS cases are between 15 –24 years of age. In spite of increasing evidence showing that sex education does not increase sexual activities among unmarried youth\(^6\), many adults still worry about exposing the youth to such "inappropriate" information. They think that adolescents are too young to know about sex and hesitate to accept that. In reality, young people actively seek related information from their peers, media or older partners. Under these circumstances, the community including parents will find it difficult to accept advocacy for increasing the awareness and knowledge of young people on sexual and reproductive health. Adolescents often feel awkward in looking for accurate and good quality reproductive health information and services. They rarely seek help from public health services because they are not 'youth-friendly' and do not provide supportive, confidential and non-judgmental services. As a result, youth have inadequate knowledge and misunderstandings about sexual and reproductive health, and in many cases, are not able to protect themselves. Moreover, youth do not receive positive support from influential adults, making adolescents less likely or unable to change their risk-taking behaviours and practice positive life skills\(^7\).

National policy support to RH programs for adolescents and youth need improvement, especially in implementation. Although public concern about SRH problems is increasing, information and knowledge about ASRH is lacking and little attention has been given in national policy to meet the rights and needs of young people. Also, there is no tradition of youth participation and empowerment in health programs and therefore the voices of young people are not heard. In the past, youth have been rarely consulted about issues and programs that affect them.

1.2 Legal and policy environment related to ASRH

There are no major legal barriers or substantial laws prohibiting the promotion of adolescent sexual and reproductive health. The Ministry of Health (MOH) is fully aware that not much has been done for adolescent reproductive health care, even though this is a high risk group in respect of RH. Hence it has taken the commendable initiative to focus attention on ARH in the National Strategy on Reproductive Health Care for the 2001 – 2010 period which was approved by the Prime Minister on November 28, 2000. In this document, ARH is identified as one of the major problems that the National RH program must address. Of the seven objectives of the strategy focuses on improving ARH through education, counselling, and provision of reproductive health services. Targets have been set as follows: 80% of RH service delivery points must provide RH information, education or counselling to adolescents; and 70% of adolescents must receive and understand about sexual and reproductive health. However while there are indicators to measure the achievements of the other objectives, there are no monitoring and evaluation indicators for ARH.

Other ARH policy initiatives in Vietnam include the Vietnam Population Strategy 2001 – 2010, the BCC strategy on population, family planning and reproductive health 2001 – 2005, the National strategy on HIV/AIDS 2001-2010 and the strategy on youth development 2001 – 2010. These strategies and policies have included ARH in the IEC programs focusing on

\(^6\) UNAIDS 1997, FOCUS 1997
\(^7\) UNESCO Bangkok, 2002
behaviour change communication and service components. Attempts will be made to improve the quality of education on sex and gender for in and out of school young people and as well as to teachers and parents. Quality of RH services will be raised to reduce the incidence of abortions, particularly among adolescents. Adequate attention will be given to providing services to youth and adolescents.

The government of Vietnam has plans to revise the policy for local NGOs providing support to ARH education and services. This is important as local NGOs are rapidly increasing in both number and capacity and they can make a significant contribution to ASRH programs.

Work on developing a National Master Plan for Adolescent and Youth Health is in progress. Adolescent reproductive health has been identified as one of the ten areas that need special attention. When this action plan is completed, it will further strengthen the existing policies on ARH.

1.3 Brief summary of RHIYA Vietnam

The Reproductive Health Initiative in Asia (RHI) began in 1998 in Vietnam as a new modality of international assistance, with EU and UNFPA partnering with international and local civil society organisations in order to accelerate the implementation of the ICPD 1994 in seven South and South East Asian countries. The overall objective of the RHIYA is to improve sexual and reproductive health of young people, particularly of those from vulnerable and disadvantaged populations, with emphasis on gender equity. It seeks to encourage responsible SRH behaviour by increasing access to and utilisation of SRH information, counselling and services in each of the seven countries.

Phase 1 of the RHIYA in Vietnam produced many positive results but final project evaluation revealed that adolescents and youths still lack adequate knowledge, and unsafe sexual behaviour is still prevalent. In addition, the project did not adequately address the political and legal framework on ASRH. Phase 2 of the RHIYA in Vietnam use participatory and rights-based approach to address the RH challenges facing adolescents and youth. To complement the UNFPA 6th country program of assistance 2001 – 2005, RHIYA will address the following SRH concerns:

- Improve the capacity of the Youth Union, mass organisations and community-based organisations to implement national strategies and policies related to RH programs for adolescents and youth.
- Increase access to appropriate SRH information
- Increase access to quality SRH services, including preventive counselling
- Enhance capacity of local NGOs in the planning and management of youth-oriented SRH programs

RHIYA Vietnam addressed the above concerns through two output projects. The first output project focused on creating an enabling environment and promote behaviour change communication. The second output project concentrated on the provision of services, associated with health-seeking behaviour. Both output projects will build capacity of mass organisations and local organisations.

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8 Policy environment review in selected provinces of RHIYA Vietnam, CARE 2004
Since the ICPD a decade ago, effective advocacy for the policies and principles had become a major concern for many reproductive health programs. The process of developing an RH advocacy strategy may have gone through many strategic shifts and changes. But a systematic planning process lie at its core: identifying issues, defining results to be attained, setting clear and realistic objectives, selecting approaches and tools to be adopted, specific actions to be undertaken and ways of assessing achievements and progress. This is the framework that directs and guides the development of the ASRH advocacy strategy for 2005-2006.

Advocacy can no longer be seen as the province of a few experts talking to a few policy or decision makers. All those who stand to benefit from it must learn to become effective advocates themselves. This means getting all stakeholders, including partners and beneficiaries involved right from the initial stage of the advocacy process. Hence in developing the advocacy strategy the participatory and rights-based approach used to develop the advocacy strategy involved the following steps:
An assessment to evaluate “the impact of executing SRH national strategies on the implementation of ASRH activities in Hanoi, Hoa Binh, Hue and HCMC” was firstly conducted. The assessment reviews national policy documents to understand how ASRH issues are addressed and how policy makers perceive the importance of these issues. Policy makers, community leaders, adolescents, teachers and parents were interviewed to provide information on their knowledge, attitude and practice toward ASRH from which barriers and challenges for advocacy will be identified. Results of the assessment are the inputs for training workshops and advocacy strategy development.

This was followed by a one day seminar to validate assessment results with policy makers and get their recommendations for appropriate actions. This was an advocacy initiative among high level senior officials from various concerned ministries, including the Ministry of Health, National Committee on Population, Family and Children (NCPFP), Youth Union, Women’s Union, Ministry of Planning and Investment (MPI) and the media.

Two advocacy workshops were conducted involving about 50 participants from all the agencies and NGOs who are implementing the RHIYA program. The purpose of these workshops was to build the necessary advocacy skills for RHIYA partners to carry out the advocacy initiatives and to provide inputs for this strategy.

The process of drafting the advocacy strategy was undertaken by selected RHIYA partners who had attended the two workshops on advocacy skills. Every effort was made to ensure that there were national and local level representation from government and non-government organisations, as well as youth representatives.

Based on the draft advocacy strategy, an international consultant was assigned to compile the advocacy strategy and to put it in an acceptable framework. This work was undertaken in consultation with Vietnam Youth Union, CARE and UPSU.
Section 3: KEY ADVOCACY ISSUES

The key element of a successful advocacy is to identify, prioritise and analyse the issues that affect the reproductive health of a large number of adolescents and youths. Participants of the workshop discussed and agreed on four advocacy issues which are: unwanted pregnancy leading to unsafe abortions among unmarried girls, reproductive tract infections and sexually transmitted infection, HIV/AIDS and sexual abuse. An analysis of these four issues was done using the result of the policy environment review and problem tree approach, which involved: defining the focal problem or issue, its direct and indirect causes and consequences. There are several benefits to this kind of analysis:

- It results in better understanding of the underlying causes of issues
- Potential constraints are identified
- It helps in determining the resources that are needed to solve the problems, and
- Stakeholder consensus is reached.

Based on the analysis of issues, partners developed objectives, core messages, selected advocacy tactics and identified activities for ASRH advocacy.

The following is a brief summary of the major ASRH issues, based on the group discussions and on the available data from surveys, research findings, surveillance reports and government annual and statistical reports.

3.1 Issue 1 - Unwanted Pregnancy and Unsafe Abortion

Abortion rate has doubled in the last 10 years. The MOH 2001 records show that the number of abortions has increased in the last 10 years, from 800,000 in 1980s to 1.5 million in the 1990s. Records for the year 2001 from the national OB-Gyn hospital in Hanoi, revealed that 20 percent of abortions performed were on women aged between 16-24 years and 6 percent were 16-19 years old\(^9\). Nationwide, about one-third of all menstrual regulation procedures are performed on young, unmarried women\(^10\). This would mean about 833 per day\(^11\). Of more concern is that repeated abortions are becoming common among unmarried women using abortion services. Studies in Hanoi and Ho Chi Minh City revealed that 10-20 percent of unmarried women had more than one abortion\(^12\). The 2003 National Health Survey revealed that 14 per cent of women aged between 15 and 24 had two abortions\(^13\). Due to the social stigma associated with premarital sexual relationship, pregnancy among unmarried women and the lack of knowledge regarding the mechanism of pregnancy, many young women often delay seeking abortions until after the first trimester of pregnancy\(^14\). Second trimester or late abortions are also common among unmarried youth\(^15\). No data is available for abortion services provided by the private sector. But it is believed that many unmarried women prefer to use private clinics for abortion because these facilities have more flexible working hours and are more sensitive to women’s need to preserve their anonymity and confidentiality.

\(^9\) Nguyen Duc Vy et al, December 2001  
\(^10\) Khuat Thu Hong, 2003  
\(^11\) Vietnam Youth Union, 1998  
\(^12\) Belanger and Khuat, 1996 and Population Council, 1998  
\(^13\) National Health Survey, Sep 2003  
\(^14\) Khuat Thu Hong, 2003  
\(^15\) MOH, 1998 and Le Nham et al, 1996
According to the findings of policy environment review and baseline survey of UPSU and based on the problem tree analysis, the following factors are considered as the root cases of unwanted pregnancy and high rate of abortion:

- Social disapproval of premarital sex limits the possibility of using contraceptives
- Men do not care or use contraceptives irregularly
- Women expect men to take the initiative to use contraceptive. This is linked to the concept that women should not display too much knowledge on contraceptive use, to give the impression of innocence and chasteness.
- Incorrect knowledge and use of contraceptives
- Lack of wide range of modern contraceptives for unmarried young persons
- Misconception that contraceptives can harm single women

3.2 Issue 2 - HIV/AIDS

According to MOH estimates, as of September 2004, there are about 215,000 people infected with the AIDS virus. It also estimated that of those carrying the virus, 33% are intravenous drug users and 16% are commercial sex workers. One point seven percent is clients of sex workers. HIV carriers have been found in 93 percent of districts and in 49 communes. Quang Ninh province has the highest number of HIV/AIDS carriers.

Of the reported HIV/AIDS cases, 10 percent are young people under 20 years old and an estimated 50% of new HIV cases occur among young people under 25 years of age. Although the majority of HIV infected cases are related to intravenous drug use, there is an increasing risk of infection from sexual relationship. Sexual transmission of HIV has more than doubled among female sex workers, from less than 1 percent in 1994 to 4.33 percent in 2000. Given the current trend, it is predicted that the main HIV/AIDS transmission route will switch from drug injection to sexual contacts.

Among youths, HIV/AIDS infection is related to unsafe sexual behaviour. In 2004 RHIYA program conducted a baseline survey among 1390 adolescents/youth aged 15-24 and found that almost all respondents have heard about HIV/AIDS, but their level of understanding regarding mode of transmission and prevention received an average score of 6.8 out of 10 points. Both girls and boys have the same level of knowledge. Despite of knowledge about HIV/AIDS, many young people still do not use condoms. Young men are often the ones to decide on the use (or non-use) of condoms, and young women not only have difficulties refusing sexual advances from their boyfriends, but also to persuade them to use condoms. Although HIV/AIDS affect more urban youth, rural youth are still at risk, due to socio-economic constraints and limited access to information. Social stigma and discrimination toward people living with HIV/AIDS (PLWHA) are significant reasons that make people feel

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16 MOH, Workshop on Estimation and Projection, Hoi An, Sep 2004  
17 Trinh Quan Huan, MOH, Ho Chi Minh, Sep 2004  
18 Ruxruntham and Associates 2004  
19 National HIV/AIDS strategy 2004  
20 National HIV/AIDS strategy 2004  
21 RHIYA Vietnam baseline survey 2004  
22 Policy environment review in selected provinces of RHIYA Vietnam, CARE 2004
reluctant to seek counselling, testing and support services due to which HIV/AIDS is spread widely and without control\textsuperscript{23}.

3.3 Issue 3 - Reproductive Tract Infections and Sexually Transmitted Infection

Little is known about RTIs among youth because young women in particular do not regularly have gynaecological check-ups and are shy to discuss ‘intimate matters’\textsuperscript{24}. A survey conducted in Hanoi, Vinh Phuc and Thai Binh found that 53 per cent of the 4,000 adolescents interviewed (aged 10-19) reported having symptoms of RTIs\textsuperscript{25}.

Data on rate and incidence of sexually transmitted infections (STIs) is just as scarce and unreliable as that on RTIs. This is partly due to the stigma associated to STIs. According to MOH statistics, prevalence of STIs among the general population is low. In 2000, the rate of gonorrhea was 7.85 per 100,000 and the rate for syphilis was 3.31. Those below 15 years old accounted for 0.46 percent of the total. However, this could be underreported given the sexual behaviour of youths and their failure to consistently practice safe sex. Several empirical studies have shown that the prevalence rate of sexually transmitted infection among adolescents in Vietnam is very high and on the rise\textsuperscript{26}. A 1998 survey among 4,675 adolescents aged 10-19 from 5 provinces (Ha Noi, Thai Dinh, Binh Dinh, Binh Duong and HCMC) found that 12 per cent of girls and 7 per cent of boys had some symptoms of STIs. The same survey also found that about a third of them will not discuss their problem or seek medical treatment. The 2004 RHIYA baseline survey found that 23 per cent of youths and adolescents do not know about STDs. In rural areas, it is as high as 40 per cent. More boys (29 per cent) than girls (17 per cent) did not know of STDS; and only one third knew at least three ways of preventing STDs.

3.4 Issue 4 - Sexual Abuse

In 1994, UNICEF estimated that there were between 8,000 to 20,000 sexually exploited children in Vietnam, including children who had been raped and child prostitutes. According to the Supreme Court data in 1998, 50 percent of sexual abuse cases were among young people. These estimates reflect the paucity of data on the prevalence of sexual abuse. It is believed that the incidence of sexual abuse is on the increase. But there are no population studies to confirm this, and the main source is the number of child rape cases reported to the police over the years. Before 1990, child rape accounted for only 6% of all rape cases. By 1996 it had risen to 30% and in the first 6 months of 1999, the number had increased further to 25%. Young victims of sexual abuse raised from 15 per cent of all rape cases in 1993 to 31 per cent in 1996\textsuperscript{27}. The increase could be attributed not only to the increase in the number of cases but also to the increase in the level of reporting and better recognition of sexual abuse and its impact from the public and authorities.

\textsuperscript{23} Positive Perspective, CARE 2004
\textsuperscript{24} Policy environment review in selected provinces of RHIYA Vietnam, CARE 2004
\textsuperscript{25} Do Trong Hieu et al, ARH research in Ha Noi, Vinh Phuc, Thai Binh, MOH, 1996
\textsuperscript{26} Nguyen Thi Hoai Duc et al, 1997; Le minh Giang and Borden, 1998; Khuat Thu Hong and Tran Thi Phuong Mai, 1998; CPSI 2003
\textsuperscript{27} Overview report 1996, Ministry of Public Security
Based on the problem tree analysis, the following factors are considered as the root causes of sexual abuse in Vietnam:

- Lack of education about sexual abuse, its consequences and ways to prevent
- Lack of education and awareness among adults and children about child rights
- Inadequate attention and surveillance of children by family members
- Some offenders were under the influence of alcohol when the offence was committed
- Lax and untimely prevention and judgment of offences in certain localities

Sexual abuse victims suffer from a number of physical, psychosocial problems. They have low self-esteem, are rejected by family and stigmatized by society. They find it difficult to lead a normal life\(^{28}\). Sexual abused victims suffer mental illnesses such as fear, anger, shame and despair. They also have low academic achievements and often drop out of school. Females especially, have a significantly higher level of depression and anxiety. When sexual abuse occurs during adolescence, it is less likely to adjust problems than during other age periods.

### Section 4: STRATEGIC ADVOCACY ACTIONS AND OBJECTIVES

#### 4.1 Strategic Advocacy Actions

The four issues mentioned above have been framed into advocacy actions which can be implemented within the context of the RHIYA program activities. Advocacy actions identified for the RHIYA ASRH strategy focus on increasing greater involvement and contribution of Youth Union in ASRH activities. These will be done at two levels:

- At the Central Level, the Youth Union/RHIYA Project Management will seek a more active role in the development of the National Master Plan for Adolescent and Youth Health.

- At the provincial and commune level, the advocacy actions are to enlist more active support of local health authorities and local leaders to:
  
  - Increase the utilisation of ASRH services in the 22 youth friendly corners (YFC) established under the RHIYA
  - Obtain additional resources from provincial people committee and relevant departments to sustain ASRH services in selected YFC corners
  - Promote greater involvement of local NGOs and PLWHA in HIV/AIDS programs, especially on activities related to reducing the stigma and discrimination against PLWHA
  - Enable Youth Union to effectively implement ASRH extra curriculum activities for in-school adolescents
  - Get support from people committee for sexual abuse prevention activities among parents and adolescents in the community.

\(^{28}\) MOLISA 1999
4.2 Advocacy Objectives

Based on the four issues, and the above advocacy actions, seven objectives have been formulated. The objectives will provide the form and direction for the planning and implementation of these advocacy actions and for them to be evaluated on a more systematic basis.

Objective 1: Increase the role and greater involvement of the Youth Union and youth, especially vulnerable young people in the development of the National Master Plan for Adolescent and Youth Health by the end of 2005.

Objective 2: To increase support and encouragement from influential community leaders for adolescents to utilise more SRH services at the 22 YFC and to have more active participation in outreach activities by end of the 2nd quarter of 2005.

Objective 3: To increase financial support and commitment from Provincial Committees and relevant departments to sustain the provision of ASRH services at selected YFC by the end of 2005.

Objective 4: From the last 6 months of 2005 onwards, all provincial Youth Unions at RHIYA locations will get financial support from Provincial People Committee to implement ASRH related activities in their respective areas.

Objective 5: To promote greater involvement of local NGOs and PLWHA in HIV/AIDS programs, especially on activities related to reducing the stigma and discrimination against PLWHA by the end of the 2nd quarter of 2005.

Objective 6: Three months after Ministry of Education and Training (MOET) issue the decision to introduce SRH extra curriculum activities for adolescents in the schools, Youth Union will get support to implement gender-sensitive SRH activities with special emphasis on sexual abuse, STIs/RTIs, HIV/AIDS, unwanted pregnancy and unsafe abortion.

Objective 7: Chairperson of People’s Committee at district and commune levels will contribute and mobilise resources to reduce sexual abuse through education and prevention activities among parents and adolescents by the end of 2005.

Section 5: RHIYA ASRH STRATEGY (Objectives, Key Stakeholders, Core Messages, Advocacy Tactics and Key Activities)

5.1 Objective 1

Increase the role and greater involvement of the Youth Union and youth, especially vulnerable young people in the development of the National Master Plan for Adolescent and Youth Health by the end of 2005.

Key Stakeholders:
- RH Department, Ministry of Health, as implementing and coordinating agencies involved in developing the adolescent health strategy
- Other cooperating Ministries and agencies

Core message:

Within the National Master Plan for Adolescent and Youth Health, the RH Department of the Ministry of Health are in the process of developing 10 policy briefs for adolescent health which is scheduled to be completed by early 2005. These 10 policy briefs are identified as crucial if adolescent health needs are to be met. Of particular relevance to adolescents are the areas regarding reproductive health and sexual health, HIV/AIDS and youths, gender and youth friendly services. This strategy is a commendable effort and should have the active support and cooperation of the relevant ministries, agencies and the civil society. ASRH issues especially will have significant implications on the health of young people if left unattended. The Youth Union with their long term experiences in ASRH programs and the involvement in RHIYA Vietnam is well positioned to offer their assistance in developing the National Master Plan, especially on the areas relevant to reproductive and sexual health, HIV/AIDS and gender. The MOH can use their expertise to get the technical inputs to the National Master Plan for Adolescent and Youth Health, in particular on the advocacy and BCC aspects.

Advocacy Tactics: Policy Forums, Lobbying

Key Activities

1.1 Conduct seminar with officials from RH department from the MOH, and other relevant ministries and agencies to discuss the involvement and contribution of Youth Union and vulnerable people in the National Master Plan for Adolescent and Youth Health.

1.2 Organise meetings and forums to integrate ASRH issues identified in the strategy into the National Master Plan.

1.3 Call senior policy makers of Central Youth union do lobby to ensure that the project management board participate effectively in the development process of the National Master Plan.

1.4 Participate meetings and workshops which were organised by the MOH to stimulate the role of Youth Union and vulnerable people in the development process of the National Master Plan.

1.5 Write a position paper on BCC and advocacy as a technical input to the policy brief documents that are being developed on the basis of the survey findings from SAVY.

1.6 Disseminate information about advocacy and BCC strategy in the form of brief and succinct messages and updated information on adolescent sexual and reproductive health to policy and decision makers.
5.2 Objective 2

To increase support and encouragement from influential community leaders for adolescents to utilise ASRH services at the 22 YFC and to have more active participation in outreach activities by end of the 2nd quarter of 2005.

Key Stakeholders: President of commune people committee, school principals and religious leaders.

Core message:

Young people in Vietnam today face many challenges due to rapid societal and economic changes. As a result, they encounter many critical health issues including unwanted pregnancy, unsafe abortions, reproductive tract infections, sexually transmitted infection and HIV/AIDS. The number of young women and girls experiencing pregnancy before marriage and seeking abortions is high. Vietnam is experiencing a rapid increase in the number of new HIV infections. According to the National HIV Strategy 2004, 50% of new HIV cases occur in young persons below 25. The problem is further aggravated because an increasing number of young people are practicing unsafe sex and are reluctant to seek early RH treatment. In addition, access to youth friendly SRH services is still limited.

Traditional customs has made it very difficult for health service providers to offer confidential and youth friendly sexual and reproductive health services - especially to unmarried young people. In addition, societal discomfort at providing SRH education and information to adolescents had restricted the amount of accurate information that can be disseminated to them. And talking about sexuality is still considered by society as an ‘unhealthy activity’.

Within the RHIYA project we have established 22 youth friendly corners in the project areas. These corners will offer confidential youth-friendly SRH information and services. We appeal to all parents, teachers, other community leaders and adolescent/youth’s participation to support us in this activity. We want you to support and encourage more young people to come and utilise the services of these youth friendly corners.

Advocacy Tactics: Sensitisation, policy dialogue and lobbying

Key Activities

2.1 Conduct meetings with the Project Management Board (PMB) of RAS 03/P52 and RHIYA implementing partners at different levels to agree on the objective, strategy and collaboration mechanism among all partners.

2.2 Conduct meetings between PMB and local community leaders, parents and school principals to inform them about the project, in particular the Youth Friendly Corners, to provide ASRH knowledge, and to obtain their support.

2.3 YU leaders at project areas use their meetings and visits to lobby the above decision makers to include ASRH activities into their regular working agendas.
2.4 Organise site visits to some of the youth friendly corners for local leaders

2.5 In combination with quarterly review meetings and/or monthly meetings of YFC, conduct dialogues with community leaders to identify challenges, problems and solutions in order to increase their support

2.6 In collaboration with Youth Union in the schools, propose principals and teachers to introduce positive information about YFC and ASRH issues in the school activities

2.7 Youth Union and YFC support peer educators implement outreach activities and spread out information about YFC

2.8 Youth Union, YFC and implementing agencies pay attention to the recruitment process of peer educators in order to include vulnerable people and improve their capacity

2.9 Peer educators, Youth Union and YFC collaborate to provide counselling services and information on ASRH in the project areas

5.3 Objective 3

To increase financial support and commitment from Provincial Committees and relevant departments to sustain the provision of ASRH services at selected YFC by the end of 2005.

Key Stakeholders:

- Chair/Vice chair persons of people committee at provincial, district and commune level
- Directors of Health Departments at provincial, district and commune level

Core Message:

RTIs/STDs and HIV/AIDS among adolescents have reached alarming proportions in Vietnam. According to the Ministry of Health, about 10 per cent of total HIV/AIDS cases in Vietnam are young people below 20 years old. Over 50 per cent are between 20 -29 years old. According to WHO, RTIs/STDs increase the risk of contracting HIV by 5 to 10 times. In Ha Noi and the two provinces of Vinh Phuc and Thai Binh, out of a total of 4,000 adolescents, 53% of those between 10 to 19 years old reported having RTIs symptoms. We know of a very sad case of a young couple at an obstetric clinic in HCMC, who are undergoing treatment for infertility. Their medical history revealed that the wife was infected by her husband but she was too embarrassed to seek proper diagnosis and treatment. As a result, her infection was left untreated until it was too late and she became infertile.

To reduce such cases and to protect young couples - especially young girls - form the consequences of untreated RTIs and STDs, central YU, in partnership with VINAFPA within the RIHYA project, are implementing the RH/SH care activities for adolescents and youth, including RTIs/STDs prevention and treatment first at the 22 Youth Friendly Corners, which have been established. These corners are contributing to reducing RTIs/STDs and risk of
HIV/AIDS. We want these centres to attract the attention of in and out-of-school adolescents/youth, especially those who are most vulnerable, and for them to use the services being offered at the centres. We request the People’s Committee at all levels to approve the work plan to support the ASRH activities in the corners and to provide financial resources to sustain these Youth Friendly Corners beyond the RHIYA project life.

**Advocacy Tactics:** Sensitisation, dialogue, negotiations and lobbying

**Key Activities**

3.1. Provide ASRH information and update project progress for community and influential leaders in the meetings, workshops, seminars and forums.

3.2. Participate in monitoring, evaluation and draw lessons learned and provide recommendations for decision makers regarding sustainability of the program and YFCs.

3.3. Based on the lessons learned, organise meetings with different partners and stakeholders including vulnerable people, to develop sustainable plans for project activities and get their committeemen for these plans.

3.4. Organise meetings and lobbying activities with People’s Committees in the project areas to get their commitment and approval on the annual budget for sustaining activities at YFCs.

**5.4 Objective 4**

*From the last 6 months of 2005 onwards, all provincial Youth Unions at RHIYA locations will get financial support from Provincial People Committee to implement ASRH related activities in their respective areas.*

**Key Stakeholders:** Chairman of Provincial People’s Committee

**Core Message:**

Many Provincial Youth Unions (PYU) are getting financial support from Provincial People’s Committee (PPC) annually to carry out activities that are directly related to population and development for youth. For example, PYU in Hoa Binh was provided with 30 millions from Hoa Binh PPC to implement the above-mentioned activities. The PYU had made effective use of the funds to carry out activities that have benefited a large numbers of youth in Hoa Binh. Adolescent sexual and reproductive health is a significant issue in the National Population Strategy. The RHIYA program in Vietnam is implementing ASRH activities in 7 provinces/cities and 22 locations. Therefore, it is necessary to have financial support from PPC to enhance the influence of RHIYA in these provinces/cities. PYU hopes that from June 2005 onwards PYU will receive the financial support from PPC to carry out activities on ASRH.

**Advocacy Tactics:** Sensitisation, policy forum
Key Activities

4.1 Provide RHIYA-related documents, information, results of evaluation to provincial YU leaders and other related departments

4.2 Conduct site visits for Provincial People Committee members to study YFS models in the RHIYA project sites

4.3 Organise workshops to disseminate evaluation results documenting the success and weaknesses of the RHIYA's activities

4.4 Draft and submit plan of action and budget for ASRH activities to PPC

4.5 Conduct periodic monitor and evaluate project activities

4.6 Based on the results of monitoring and evaluation every year, develop a plan to reinforce and replicate the YFC models in other provinces in 2006

4.7 Organise regular meetings and lobby activities with decision makers to follow up and get approval for the plan

4.8 Central Youth Union provide guidelines on the development and implementation of ASRH initiatives which engage active participation of adolescents, especially vulnerable people

5.5 Objective 5

To promote greater involvement of local NGOs and PLWHA in HIV/AIDS programs, especially on activities related to reducing the stigma and discrimination against PLWHA by the end of 2005

Key Stakeholders: Vice Chairman/Chairman of Provincial People’s Committee

Core Message

At the moment, there are many local NGOs who are active in the area of HIV/AIDS prevention. It is also recognised that they have an important role to play in various aspects of HIV/AIDS prevention, especially in working with local communities to reduce the discrimination against people living with HIV/AIDS. In fact there is potential for these organisations to contribute even more, if they are given more opportunities for involvement. Unfortunately this is not normally the case. So far, local NGOs are rarely invited to meetings and workshops related to HIV/AIDS which are organised by the government. For example at the workshop reviewing activities of the first 6 months of 2004 Organised by HIV/AIDS Prevention Committee of Hoa Binh province, UCNEV who has project activities in the province was not invited.

We wish that the Provincial People’s Committee will issue a decision to support the greater involvement of local NGOs and PLWHA in HIV/AIDS programs, especially on activities related to reducing the stigma and discrimination.
Advocacy Tactics: Sensitisation, dialogue

Key Activities

5.1. Local NGOs will regularly provide information on their organisations and project activities on HIV/AIDS to community leaders and other related organisations in order to get their attention and support. Provide information on the importance of reducing stigma and discrimination towards PLWHA

5.2. Organise site visit for community leaders to demonstrate activities on prevention, care and support and reducing stigma and discrimination

5.3. Draft documents to encourage support for creating more favourable conditions to promote greater involvement of local NGOs and PLWHA in HIV/AIDS activities in the project areas

5.4. Organise workshop to get agreement on the involvement mechanism

5.5. Organise lobby activities to leaders of people committees and relevant departments to get their support and approval for the documents

5.6. Disseminate information about project activities of the local NGO and PLWHA in the monthly newsletter with focus on reducing stigma and discrimination and promote greater involvement of PLWHA

5.7. Local NGO adopt policies to promote greater involvement of PLWHA in their planning, implementing, monitoring and evaluation activities

5.6 Objective 6

Three months after Ministry of Education and Training (MOET) issue the decision to introduce SRH extra curriculum activities for adolescents in the schools, Youth Union will get support to implement gender-sensitive SRH activities with strong focus on sexual abuse, STIs/RTIs, HIV/AIDS, unwanted pregnancy and unsafe abortion

Key Stakeholders:

- Director of Provincial Education Department

Core Message:

According to the policy environment review which was carried out by CARE in some selected provinces of RHIYA program, most interviewed adolescents expressed the common concern that they are badly in need of information and want to get answers for a number of questions about sex, reproductive and sexual health from school activities. At the moment, the Ministry of Education and Vocational Training has only carried out a pilot program in
some schools to introduce ASRH education which is integrated in the biology and citizenship lessons.

Findings from several studies have proved a poor knowledge of SRH among adolescents which lead to unsafe behaviours. According to some qualitative studies, victims and offenders of sexual abuse tend to have a low level of education\textsuperscript{29} and offenders often have misconceptions about sexual relations\textsuperscript{30}. In a survey with adolescents in the secondary schools in Hanoi, only about 7-15\% adolescents could name chlamydia and 7-8\% adolescents could name hepatitis B as sexually transmitted infections\textsuperscript{31}. The report of Population Reference Bureau and NCPFC\textsuperscript{32} showed that among sexually active adolescents and youth, only 19.1\% used contraception on a regular basis. As a result, from the statistics of MOH, adolescents and youth account for 20-25\% of the total abortion cases every year\textsuperscript{33}. There is a case of a female student from a secondary school in Quang Ngai town. She had engaged in premarital sex without the aid of contraceptives and became pregnant. She was in an advanced stage when she discovered that she was pregnant as she was ignorant about the physiology of pregnancy. She stopped going to school and was shunned by both her friends and neighbours. Her family was ashamed of her and she now lives in difficult economic situation.

Therefore, in order to improve the sexual and reproductive health of adolescents the Director of Provincial Education department is requested to issue a timely decision asking district education departments and schools in the project areas to cooperate and create favourable conditions for youth union to effectively implement the extra-curriculum activities on gender-sensitive SRH activities.

\textbf{Advocacy Tactics:} Negotiation, pressuring

\textbf{Key Activities}

6.1. After MOET issue the decision, provincial youth union will organise meetings with leaders of provincial education departments to issue decision to support YU implement successfully extra-curriculum activities on gender-sensitive SRH activities and to monitor the implementation of this decision.

6.2. In each district of the project areas, district YU will organise an official meetings with district education department, principals of schools, committees on population, family and children, representatives of people’s committees and provincial project management boards to get agreement on the implementation of the decision.

6.3 District YU continue to work with district education department and schools to develop detailed plans for carrying out ASRH extra-curriculum activities and identify required resources.


\textsuperscript{31} Institute of Sociology and La Trobe University 2001

\textsuperscript{32} Adolescent and Youth in Vietnam, PRB & NCPFP 2003

6.4 Commune YU with YU in the schools create conditions for adolescents to participate actively in the planning and implementation activities, organise meetings in partnership with them to develop plans for ASRH extra-curriculum activities

6.5 Organise ASRH extra-curriculum activities on specific subjects in a diversified and attractive way to adolescents and provide information about YFC

6.6 Organise counselling and information sessions on SRH

6.7 Monitor and evaluate the implementation of ASRH extra-curriculum activities and withdraw lessons learned

5.7 Objective 7

Chairperson of People’s Committee at district and commune levels will contribute and mobilise resources to reduce sexual abuse through education and prevention activities among parents and adolescents by the end of 2005.

Key Stakeholders: Chairperson of People’s Committees at District and Commune levels.

Core Message:

Sexual abuse is increasing at an alarming rate. It happens particularly among out-of-school adolescents and youth, those who live in special situations such as living in poverty, separate from parents, and among street children.

Findings from a study on street children as reported by ‘Xa Me” newspaper group, revealed that about 71.4% of street children left home mainly because they were physically and sexually abused and abandoned by parents or step parents. Sexual abuse forces children out into the streets. Consequently, street children are more vulnerable to being sexually abused than other children. According to a study among 50 sexually abused children from 12-17 years old in Ho Chi Minh city, around 48% of them live in difficult circumstances, 30.6% are living with parents and the rest live in single parent households. A 15 year old girl was sent to the social sponsorship centre after being sexually abused several times by her step father. She became depressed and mentally disoriented, fearing and hating men.

In order to prevent sexual abuse and support sexual abuse victims, we would like to call all chairmen of people’s committees, local NGOs and local authorities in the project areas to increase their support, and mobilise resources to implement sexual abuse prevention activities for adolescents and parents.

Advocacy Tactics: Sensitisation, dialogue

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35 Reference needs to be defined
**Key Activities**

7.1 Talk about the issue of sexual abuse and the need to implement sexual abuse prevention activities in annual planning and reviewing meetings, quarterly and monthly meetings with relevant departments.

7.2 Integrate this issue in the meetings and training workshop for community leaders.

7.3 Update information about sexual abuse in the monthly and quarterly newsletter of the project RAS/03/P51, LMF and VICOMC.

7.4 Introduce sexual abuse issues and the need to implement sexual abuse prevention activities in workshops and forums with representatives of relevant ministries and government organisations at provincial level in which adolescents and youth will officially participate and play a key role.

7.5 Organise communication and training activities on sexual abuse for parents and adolescents, in which at least 20% beneficiaries are from vulnerable groups.

7.6 Advice president of district people committee write a letter to call entrepreneurs in the project areas for financial support for communication and education on sexual abuse. Organise lobby and meetings entrepreneurs to persuade them.

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**Section 6: LINK BETWEEN BCC AND ADVOCACY STRATEGY AND ASRH SERVICES**

Keep this section here – its better and makes more sense than moving it to intro section

The advocacy strategy aims to bring about changes in ASRH policies, laws, and programs and to promote a conducive environment for policy and program implementation. The BCC strategy aims to induce changes in knowledge, attitudes, beliefs, values, behaviour or norms. The purposes of advocacy and BCC thus complement each other in creating a favourable legislative and policy climate, which will enhance individual choice and decision making. In this respect, every effort will be made to ensure that the ASRH advocacy and BCC strategy are complementary and work as a synergistic whole.

The SRH problems which are addressed in the BCC strategy are similar to those identified in the advocacy strategy. Both strategies seek to address the issues of teenage pregnancy, unsafe abortion, HIV/AIDS (in particular the discriminatory practices against people living with AIDS, RTIs/STIs, and sexual abuse.

Advocacy should not be seen as something separate from the process of individual behaviour change. Changes in individual behaviour must occur, in particular among its key stakeholders, in order for changes in policies, laws and programs to happen. Just like most of the widely used behaviour change models, the advocacy behaviour change model recognizes that behaviour change follows a series of steps beginning with knowledge and approval and ending with action and confirmation of a particular action. Hence, advocacy is placed within
the framework of a behaviour change model and is measured according to appropriate behaviour change indicators.

Programs for young people always need to start with advocacy to win the support of the community and parents. Lessons learned from successful ASRH programs in other parts of the world have clearly documented the importance and necessity of carrying out advocacy at the initial stage of the program. By winning the support of local community leaders and influential people, advocacy processes can minimise the backlash from those who tend to erroneously equate ASRH education with ‘sex education’. Successful ASRH programs have advocacy and BCC working in a symbiotic relationship.

The RHIYA program will also try to improve the ASRH situation in the project sites, especially among vulnerable groups, through the provision of youth friendly ASRH services. The program recognises the need for such services, especially since through BCC and advocacy activities the demand and utilisation for them may increase among adolescents and youths. The three pronged approach of the program, which includes the provision of ASRH services and information and advocacy to create a favourable climate, have great potential to improve the quality of ASRH services, sustain demand for them and win the support and approval of community leaders and parents.

### Section 7: ADVOCACY IMPLEMENTATION PLAN

#### 7.1 The Work Plan

The strategy has developed an indicative work plan for each of the seven objectives in terms of key or main activities, identifying the responsible person or organisations, timeframe, budget (where possible), and place or location where activities will take place. A more detailed work plan was developed by Youth Union, together with its implementing partners. Please see the Appendix 1 for more information.

There are a number of preparatory activities that are needed before implementing the activities of the work plan. They are:

- Conducting a stakeholder analysis, especially of the key stakeholders identified in the strategy;
- Identifying other organisations who could be part of the network of partners and supporters of the project; and
- Developing and distributing an advocacy manual which can be used as a guidebook to help Youth Union and its implementing partners to plan, carry out and evaluate their advocacy activities.

#### 7.2 Monitoring and Evaluation

Monitoring and evaluation are critical elements of the advocacy strategy. After the advocacy activities have been implemented, it is important to find out if the advocacy program had been successful in attaining the objectives as set out in the strategy. The objectives have been formulated to aim at bringing about changes in ASRH related to legislation, policies and programs and to foster a favourable environment for policy and program implementation.
Hence, the overall impact of advocacy needs to be measured in terms of whether these changes have taken place or not. In other words, program managers need to measure the overall impact of advocacy in relation to these advocacy outcomes. To accurately measure these outcomes, it is essential to establish observable and measurable indicators.

The monitoring and evaluation plan consisting of output indicators, means of verification for each indicator, time of data collection, risks and assumptions are included as part of this strategy. They were developed during the advocacy development workshop.

Unlike evaluation, monitoring is the continual review of the efficiency and effectiveness of program implementation. It serves to identify strengths and shortcomings in order to correct them. Monitoring tools will be developed at a later stage.

Please see the Appendix 2 for the Monitoring and Evaluation Plan

**Section 8: CONCLUSION**

Undertaking ASRH advocacy work in Vietnam involves many challenges. By laying out a strategic and operational framework for advocacy as done in this strategy, it will be easier to establish and implement ASRH advocacy programs in Vietnam. Two years (2005-2006), are clearly not enough to yield many results or to achieve one hundred percent success. But at least initial steps are taken from which valuable experiences and lessons can be drawn and during which the advocacy capacities of implementing partners in RHIYA will be strengthened.

The ASRH advocacy strategy focuses on a limited number of issues. But these are crucial issues that affect a large number of young people and are regarded as national priorities. These revolve around unwanted (teenage) pregnancy, unsafe abortion, HIV/AIDS, RTIs/STIs and sexual abuse. From these issues, the strategy has identified specific advocacy actions that will need the support of national and local political and community leaders in order to:

- Increase the involvement and contribution of Youth Union and vulnerable young people in the development of the National Master Plan for Adolescent and Youth Health.
- Seek commitment and support from local community leaders in order to increase the utilisation of ASRH services in the 22 youth friendly corners (YFC) established under the RHIYA
- Obtain additional resources from provincial people committee and relevant departments to sustain ASRH services in selected YFC corners
- Promote greater involvement of local NGOs and PLWHA in HIV/AIDS programs, especially on activities related to reducing the stigma and discrimination against PLWHA
- Enable Youth Union to effectively implement ASRH extra curriculum activities for in-school adolescents
- Get support from people committee for sexual abuse prevention activities among parents and adolescents in the community.
Based on the advocacy actions, seven objectives have been formulated indicating the desired changes or outcomes and specifying the key stakeholders and timeframe. Core messages and key activities, followed by an indicative work plan for each of the objectives have been developed to make it easier for program managers to establish and implement the ASRH advocacy program and specific ASRH advocacy activities. Accurate and systematic evaluation of the advocacy program will be possible as measurable indicators have been identified in the monitoring and evaluation plan.

The first phase of the RHIYA project experience have resulted in the development of the ASRH strategy. That experience also included efforts to clarify the concept of advocacy and to develop the advocacy skills of implementing agencies and partners. It also covered the initial attempts at setting up institutional arrangements and forming coalitions and networks for ASRH advocacy. The second phase will involve developing a more realistic work plan and monitoring and evaluation systems. At this stage, implementation of the advocacy activities will begin. The final phase is the assessment of the progress and directions of the advocacy program. So far, there is no advocacy program for sexual and reproductive health in Vietnam that has run its full course. Advocacy programs are still in progress and too early to undertake evaluation and draw specific lessons from it. Therefore, the RHIYA ASRH advocacy output project is quite advanced when it comes to creating a workable strategic framework for effective advocacy on ASRH issues, including monitoring tools and evaluation indicators.