

COUNTRY PROFILE

ON UNIVERSAL
ACCESS TO SEXUAL
AND REPRODUCTIVE
RIGHTS:
VIETNAM



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1. Introduction

With an estimated 90.7 million people in 2015, Vietnam is the world's 14th-most-populous country. Females accounted for 50.7% of the total population and 66.9% of the population living in rural areas (GSO, 2014). Vietnam is divided into 63 provinces and Hanoi is the capital city.

The annual population growth rate of Vietnam was 1.08% and the crude birth rate was 17.2 ‰ in 2014

(GSO, 2014). The average household size was 3.7 persons and small family sizes (households with 4 or fewer members) were very common (74.3%) (GSO, 2013).

There are 54 ethnic groups in Vietnam and the majority of people belong to the Kinh group. The adult (aged 15 and over) literacy rate in 2014 was 93.3% and the labour force at 15 years of age and above was 59.3% (GSO, 2014). Table 1 shows some other demographic and economic indicators for Vietnam.

Table 1: Demographic and economic indicators for Vietnam:

No.	Indicators	Year	
1	Total fertility rate (per woman) *	2014	2.09
3	Life expectancy at birth (year) *	2014	73.2
4	Gross national income per capita (\$) **	2014	1890
5	Total expenditure on health per capita (\$) **	2013	111
6	Total expenditure on health as % of GDP (%) **	2013	6
7	Sex ratio at birth (male/female) *	2014	112.2/100
8	Human Development Index (rank 116 in 188 countries) ***	2014	0.666
9	Gender Inequality Index (GII) (rank 60 in 155 countries) ***	2014	0.308
10	Poverty rate (Population below poverty line) (%) **	2014	13.5

Source: * Statistical Yearbook 2014 (GSO, 2014)

** <http://data.worldbank.org/indicator> and <http://data.worldbank.org/country/vietnam>

*** Human Development Report 2015 (UNDP, 2015)

Vietnam was among the first countries to sign the International Conference on Population and Development (ICPD) Programme of Action in 1994 and the Beijing Platform for Action in 1995. The country's leaders also signed and ratified a number of important international documents on human rights such as the UN's International Covenant on Civil and Political Rights (accession, 24 September 1982), the International Covenant on Economic, Social and Cultural Rights (accession, 24 September 1982), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (signed on 7 November 2013 but not ratified), the United Nations Convention on the Rights of the Child (signed on 26th January 1990 and ratified on 28th February 1990) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (signed 29 July 1980 and ratified on 17 February 1982). The human rights of individuals are recognized, respected, protected and guaranteed in the Vietnamese constitution.

The State shall guarantee and promote the People's right to mastery; recognize, respect, protect and

guarantee human rights and citizens' rights; and pursue the goal of a prosperous people and a strong, democratic, equitable and civilized country, in which all people enjoy an abundant, free and happy life and are given conditions for their comprehensive development. Article 3 Constitution (Socialist Republic of Vietnam, 2013).

The sexual and reproductive rights (SRR) concept used in this paper refers to the sexual and reproductive rights mentioned in the ICPD Programme of Action (United Nations, 1994) and the Beijing Platform for Action (United Nations, 1995). The following sections will discuss the current status of SRR in Vietnam with references to the general legal framework and specific cases of HIV and AIDS, abortion, adolescent SRR, gender-based violence, recognition of sexual orientation and gender identity. Grievance redress mechanism is also included. Description and analysis are based on ARROW's, "An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights" (2013).

2. The status of sexual and reproductive rights in Vietnam

2.1. Sexual and reproductive rights policies

While there is no single integrated sexual and reproductive health and rights policy in Vietnam, issues of sexual and reproductive health and rights are dealt with in several documents. Right after the ICPD conference, Vietnam passed the National strategies on Reproductive Health Care (RHC) for the period 2001-2010 in 2000, and the National Strategies on Population and Reproductive Health for 2011-2020 and vision to 2030 in 2011 (Nguyen, 2011). Reproductive rights are central in these documents including the right to informed choice, and rights to quality services and counselling. Responding to reproductive health needs of the most socially and economically vulnerable and marginalized groups, such as ethnic minority people, young people, people with disabilities, people with HIV, etc. are specified in these documents as important strategies to achieve the national goal on population and reproductive health (MOH, 2011; Phan, 2000).

Guided by these national strategies, reproductive and sexual health policies in Vietnam are right-based in general. The law on HIV and AIDS prevention and control (2006) was the first law developed through consultations with individuals, groups, and non-governmental organizations with expertise on the topic. It is recognized as one of the most progressive HIV/AIDS laws in the world. Since then, consultation with civil society, especially people affected by the law, has become common practice in law development and amendment in Vietnam. The law on domestic violence prevention and control was passed in 2007 following a similar procedure. The amended Constitution of Vietnam (passed in 2013) and the amended Marriage and Family Law (passed in 2014) are the results of great involvement and lobbying by civil society in Vietnam, especially groups and organizations supporting human rights. The recently passed Civil Code in November 2015 recognizes the rights of transgender people. Vietnam is discussing the amendment of the Youth Law (2005) and Law on Child Protection, Care and Education (2004). Efforts have been made to advocate for integrating sexual and reproductive health and rights in these laws.

Despite the progressive legal framework, implementation and reinforcement of these laws and policies are in many cases problematic. The main reason is the lack of involvement of civil society in monitoring the implementation of the law and in several cases, the lack of motivation of local authority to implement the laws.

The National Strategies on Population and Reproductive health, as mentioned above, recognizes the sexual and reproductive health needs

and rights of disadvantaged and vulnerable groups. It also recognizes that the health system is not yet able to respond to the needs of these groups. Poor people including poor women, ethnic minority women and women living in remote areas have difficulty accessing and using reproductive health services. Health insurance coverage remains low¹. A CCIHP study in 2014 showed that most reproductive health services are not covered by health insurance. Payment for reproductive health services can put families, especially near-poor families, at risk of being poor. In the current situation, wealthy people benefit more from health insurance than poor and near-poor people for both general health services and reproductive health services. For many poor people, even they have health insurance, they cannot use the services because they cannot afford the indirect costs of accessing healthcare (such as transportation), which are not covered by the insurance (CCIHP, 2014).

In the recent meeting in November 2014 in Geneva, the Committee on Economic, Social and Cultural Rights (CESCR) outlined the status of sexual and reproductive rights in Vietnam. It was as follows:

(30) The Committee is concerned at unmet need for sexual and reproductive health services for certain groups, including women from ethnic minorities and in rural areas as well as unmarried women. (art. 12)

The Committee recommends that the State party accord priority to groups such as women from ethnic minorities and in rural areas, as well as unmarried and young people, in sexual and reproductive health programmes. The Committee also calls upon the State party to remove the birth control regulation in national laws so as to respect the right of everyone to freely and responsibly decide on the number and spacing of their children. (UN 2014)²

Unwanted pregnancy and abortion among adolescent and unmarried youth are high in Vietnam. One main reason is lack of sexuality education. However, due to heavy workload, it is very difficult to implement sexuality education in school and teachers often do not have enough knowledge and confidence to talk about this to students (Hoang, Tu-Anh, Pham, 2012)³.

¹ <http://www.worldbank.org/en/news/press-release/2014/09/17/social-health-insurance-in-vietnam-progress-made-but-challenges-remain-to-reach-universal-coverage>

² E/C.12/VNM/CO/2-4

³ <http://giaoduc.edu.vn/news/van-de-su-kien-665/giao-duc-sinh-san-trong-truong-hoc-khong-the-cham-tre-231456.aspx>

For example, while HIV infected and affected pregnant women are at high risk of being discriminated against in reproductive health services, there is no specific mechanism to monitor and prevent this.

In the Civil Code where sexual abuse and rape, including child rape, is mentioned, 'sex' is defined according to the definition of penil-vaginal intercourse in a document dated in 1967⁴. This fails to cover cases where there is no penis contact, where the victim is a child so sexual intercourse cannot be completed, or where the perpetrator and victim are of the same sex⁵⁶.

2.2. Age of marriage

The average age of marriage in Vietnam is 26.4 for men and 22.5 for women (GSO, 2013) and is increasing overtime. The age of marriage is significantly lower among ethnic minority people. According to Article Eight of the Vietnam Law on Marriage and Family, a man can get married at age 20 and a woman can at age 18 (Vietnam National Assembly, 2014). Setting different marriage ages for women and men puts women at an increased risk. While having sex before marriage becomes more acceptable in Vietnam, being pregnant before marriage is still highly stigmatized. A recent report from Quang Tri, a Southern Central province shows that within three years (between 2011-2013), about 500 girls dropped out of school to get married. Most of them were pregnant before their wedding⁷. These girls' marriages were not formally registered because the girls were not yet 18 years old. Without marriage certificate, their marital relationship could not be protected by the Marriage and Family law. The national survey on young people (SAVY) also shows that young people are having sex before marriage, with the time of first sexual intercourse becoming younger. According to the survey in 2009, the average age of first sexual intercourse is 18.1 (18.2 for boys and 18.0 for girls). This number was 19.6 in 2003 (20 for boys and 19.4 for girls). There was also a high percentage of women who got married before the age of 18 below the legal marriage age (11.2% in MICS 2014 and 12.3% in MICS 2011) (GSO & UNICEF, 2015; GSO, 2011). Noticeably, nearly 1% of women got married before the age of 15. 10.3% of young women ages 15-19 are currently married or in union (GSO & UNICEF, 2015).

2.3. Abortion

Abortion is legal in Viet Nam and is provided upon request. Women's abortion rights, as well as other reproductive health services, are affirmed in the law on protection of people's health (1989). The national standard guideline on reproductive health services has a specific chapter on safe abortion. National Strategies on Population and Reproductive Health 2011-2020 and Vision to 2030 also has a specific component on safe abortion.

Though women's rights to abortion services are stated in the law, women have difficulty accessing and using the services. In the national standard guideline for reproductive health services, abortion service is provided for a pregnancy from 6 weeks to 22 weeks. However, depending on the gestation time, the service should be provided at a specific level of health administration. Abortion for gestation up to 6 weeks can be performed at commune health stations and private clinics which meet MOH's requirement on infrastructure and human resources. Abortion for gestation from 6 to 22 weeks can be performed at centre and provincial hospitals. Abortion for gestation from 6 to 12 weeks can be performed at district hospitals. This means it is more difficult for women who need second and third trimester abortions to access services. It can be difficult for women to travel to district and provincial hospitals for the services. Abortion is not covered by health insurance - article 23, Law on Health Insurance 2008 (National Assembly, 2008), thus it is difficult to afford for women from poor families and young people. Poor women from remote areas may not access and use the services, especially an abortion for after 6 weeks of gestation, because they cannot afford the travel and treatment costs. It is also difficult for adolescents and young people. Lacking financial support and too afraid to tell family members they're pregnant, adolescents and young people may delay their decision to have an abortion until it is too late. Medical abortions are allowed and medicine for medical abortions is available in the market (Mefepirstone và Misoprostol). This can lead to abuse of the medicine, especially by young people who are afraid of going to the clinic⁸.

Threatened by the imbalance sex ratio at birth, in 2003, the government issued decree 104/2003/NĐ-CP to prohibit fetus sex selection (article 10). The national standard guideline emphasizes screening for sex selective abortion during counselling before second trimester abortions. However, there are no details describing how to conduct the screening (MOH, 2009).

While unsafe abortion is uncommon in Vietnam, high abortion rates and repeated abortion are persistent problems. This could be attributed to poor post-abortion counselling.

⁴Document: 329/HS2 dated 11/5/1967: Sexual intercourse is the contact of a penis and woman's sexual organ.

⁷<http://www.vksnd.hochiminhcity.gov.vn/tintuc/Lists/Posts/Post.aspx?List=ad9f76af-6b80-4ea2-a8be-93f18b9cad72&ID=180&Web=1eac1f4b-1d0d-4ae2-8f9a-e7c7668eac57>

⁸<http://www.nguoiduatien.vn/xu-ly-nhu-the-khi-bi-chinh-nguoi-dong-tinh-hiep-dam-a106314.html>

⁹<http://www.anninhthudo.vn/nhip-tre/quang-ngai-hang-tram-hoc-sinh-bo-hoc-de-ket-hon-som/590328.antd>

¹⁰<http://benhvienphusantrunguoc.org.vn/news/tin-tuc-su-kien/pha-thai-bang-thuoc-vua-pha-vua-lo.html>

2.4. Policies on adolescent sexual and reproductive health services

In 2013, adolescents between ages 10 and 19 accounted for 15.6% of the total population, and were 13,962,000 people (1014 years = 7.6% and 1519 years = 8.0%). Of which, 48.6% were female (GSO, 2013).

Young and unmarried people have difficulty accessing and using reproductive health services. The unmet need for contraception among unmarried people is three times higher than among married people. The Ministry of Health produced guidelines on reproductive health services for unmarried and young people (MOH, 2009a). In the National strategy, the government aims to have youth friendly services in 50% of the reproductive health service facilities in 2015 and 75% in 2020. However, so far youth friendly services exist only in some pilot models. Stigma and discrimination toward pre-marital sex remains very high and prevents young people from accessing and using reproductive health services. While most adolescent and students are covered by health insurance, they cannot use it for contraception and reproductive health check-ups.

Unwanted pregnancy and abortion among adolescent and unmarried youth are high in Vietnam, largely because they lack sexuality education. However, due to a heavy workload, it is very difficult to implement sexuality education in school and teachers often do not have enough knowledge and confidence to talk about this to students (T.-A. Hoang, Pham, Quach, Nguyen, & Nguyen, 2012)⁹.

Although improving adolescent sexual and reproductive health is integrated in numerous policies in Vietnam, there is no specialized policy addressing adolescent SRH. Strategies and some policy initiatives relating to adolescent sexual and reproductive health services are presented below.

Before the year 2000, although some legal documents such as the Laws of People's Health Protection, the Laws of Protection and Care for Children, and the Laws on Marriage and Family ensured the right to health care for all people, none of them specifically addressed adolescent reproductive health (ARH). Adolescents, especially unmarried youths, are often neglected even in population and family planning policies. For example, the Vietnam Population and Family Planning Strategy 2001-2010 in 2000 focused primarily on married couples and ignored unmarried (Khuat, 2003).

At the end of 2000, the prime minister approved a national strategy on reproductive health for 2001-2010 which focused attention on adolescent reproductive health for the first time in Vietnam (Khuat, 2003). The strategy called for universal access to low-cost, community based, quality reproductive health services to better meet the

needs of the population. Adolescent sexual and reproductive health (ASRH) was identified as second among seven outstanding problems that RH programs must address. Objective number six of the strategy stated the goal of improving the status of sexual and reproductive health of adolescents through education, counseling and provision of RH services. With this plan, 80% of RH delivery points giving RH information, education and counselling to adolescents and 70% of adolescents receiving RH information, education or counselling and having an understanding of SRH (MOH, 2000).

Two year later (2002) the national standards and guidelines for reproductive health care services was issued (according to Decision number 3367/QĐ-BYT) and this guideline was revised in 2009 (according to Decision number 4620/QĐ-BYT). The guidelines constituted the legal foundation for delivering SRH services and was a manual for health professionals in delivery services. It was also a basis for developing training materials for health personnel and monitoring the quality of reproductive health services in the health facilities. The importance of providing supportive and friendly RH services for adolescents on the national and communal levels was stressed. The guidelines provide health providers with standard procedures on how to improve life-skills, counsel, check-up and treat adolescents for sexual health, contraceptive methods, pregnancy, and sexual violence (MOH, 2009).

The *National Master Plan for Protection, Care and Promotion of Adolescent and Youth Health for the period 2006-2010 and strategic orientation until 2020* in 2006 was a policy initiative which marked an important step in reproductive health care activities for Vietnamese adolescents and youth. The plan was to protect and improve adolescent and youth health status, enhance their access to reproductive health services and reduce unwanted pregnancy and HIV infection, and deal with other adolescent and youth health issues. This is the first time that the MOH has developed a long-term, comprehensive and concrete plan that has clear objectives, targets and indicators and the budget estimation needed to reach those objectives (MOH, 2006). However, the review of health policy making revealed some shortcomings of the plan. For example, some of the proposed objectives, indicators and estimated budget for implementing the Master Plan were neither feasible nor sufficient, the Masterplan inadequately included the specific role of stakeholders (such as the Ministry of Education and Training, Youth Unions) and the mechanisms for integration and collaboration in solving existing problems, such as service delivery and the availability of human resources (UNFPA, 2012).

⁹<http://giaoduc.edu.vn/news/van-de-su-kien-665/giao-duc-sinh-san-trong-truong-hoc-khong-the-cham-tre-231456.aspx>

the Provision of Adolescent and Youth Friendly Health Services was approved by the MOH in 2008. The purpose of this guideline was to provide basic guidelines for health facilities on how to plan for, implement and improve health service provision to be more friendly with adolescent/youth and to serve as a basis for the MOH to objectively evaluate and assess the friendliness of health care facilities especially those that serve adolescents/youths. This guideline stated that every adolescent/ youth should be provided with sufficient information on their right to access RH/SH information and services from YFS providers and involved staff without barriers and discrimination against their marriage status (MOH, 2008).

In 2011, The National strategy on population and RH 2011-2020 was approved. This strategy incorporated population and RH into one single strategy. Improving the SRH of youth and adolescents is one among 11 objectives with two indicators, increasing youth-friendly reproductive health sites (among total RH sites) to 50% in 2015 and 75% in 2020 and reducing 20% of unintended pregnancies among adolescents in 2015 and 50% in 2020 (GOPFP & UNFPA, 2011).

In the above SRH policies, guardian or parental consent for accessing SRH services for adolescents was not mentioned. However, for HIV testing, the law on HIV/AIDS prevention and control in 2006 (Article 27) said that people below 16 years old needed written consent from their parents or guardians before HIV testing because they are legally still children (National Assembly, 2006).

In the Laws of People's Health Protection in 1989, women have the right to abortion regardless their marital status. Although consent from a parent or guardian isn't mentioned in any policy in Vietnam, it's still required of girls below the age of 18 in many health facilities¹⁰. This might encourage young girls seeking abortions to go to private clinics where the procedure is more flexible or misreport their age at the time of the abortion procedure (Mensch, Clark, & Dang, 2002)

Despite integrating adolescent SRH into the above policies, the implementation of these policies remains inadequate. In 2014, the Committee for Culture, Education, Youth, Adolescents and Children of the National Assembly (CCEYAC/NA) conducted an assessment on "Implementing policies and laws on adolescent and youth sexual and reproductive health" in five provinces, central-level cities and of relevant ministries and line agencies, held peer-review workshops across the North-Central-South parts of the country, and reviewed report findings from the Socio-cultural Committees and People's Councils of 52 out of the total 63 provinces and cities. The assessment report showed that a number of adolescent SRH policies are still not practical enough and not properly managed or implemented (UNFPA, 2014). Moreover, the budget

allocated for implementing ARH policies and programs was limited, which created a barrier to conduct them in some provinces. For example, although the Masterplan was developed for implementation across the whole country, only 31 out of 63 provinces could develop their own action plan and implement the activities, such as training and piloting friendly health services for adolescent and youth due to limited budget allocation (UNFPA, 2012). In addition, it is worthy to note that most of those policies do not recognize that adolescents are not a homogenous group. They have a wide variety of needs related to SRH information and services, so a single set of interventions cannot address the needs of many groups. For example, those who are ethnic minorities, in-or-out-of-school, or living with disabilities.

Although SRH education for adolescents has been recommended in the National Strategy on Reproductive Health since 2000, SRH education is still not a formal subject in schools in Vietnam. It is integrated in others subjects (i.e. biology, literature, civic education, geography) and extra-curricular activities. In the places where sexuality is taught, it is in the form of moralistic lectures and with a bio-medical focus, while youth really need practical information and skills for their decision-making on sexual issues. Four shortcomings in the implementation of sexuality education in Vietnam are recognized, including the lack of enabling mechanisms for sexuality education; the lack of an official teaching manual; insufficient knowledge and teaching skills among teachers; and a lack of qualified educational managers (Ministry of Education and Training & Save the Children US, 2005).

The provision of SRH for young people is not diverse, friendly and convenient enough for young people to access (UNFPA, 2014). The target group of family planning services is married couples only. Sexual and reproductive healthcare providers have negative attitudes and stigmatize adolescent sexuality so adolescents are reluctant to access public health services (Hoang, 2009). Furthermore, there are not many youth-friendly sexual and reproductive health services in Vietnam. Most youth friendly services were only piloted with funding from international donors rather than from the government's budget and not made permanent by integrating them into the regular healthcare system. Therefore, they have not been made sustainable.

¹⁰<http://tudu.com.vn/vn/cac-bien-phap-ngua-thai/pha-thai-13002/>

2.5. Legislation and policies on sexual orientation and gender identities

Same-sex sex and relationships are not criminalized in Vietnam. The regulation to ban same-sex marriage in the Law on Marriage and Family in 2000 was removed in law revision which was passed in 2014. Though same-sex marriage and co-habitation are still not recognized in the current law, recognition of same-sex weddings is a great success of the LGBT movement in Vietnam. In recent news coverage of Bloomberg, Phil Robertson, Human Rights Watch Deputy Director for Asia remarked, 'No other country in Southeast Asia has taken as big a step toward accepting same-sex marriage as Vietnam.'¹¹ The removal of the same-sex marriage ban is significant in the current regional context where legal status for same-sex relationships and marriage seems to be going backward. For example, it is banned in Singapore, discriminated against in Indonesia, Malaysia and criminalized in Brunei. It's not discussed on the national agenda in Cambodia, Burma and Laos. In Thailand, the new military government has stopped all the effort to advocate for same-sex marriage since May 2014.

In Viet Nam, stigma and discrimination towards same-sex people remains common in the workplace¹². Transgender people in particular usually experience stigma and discrimination and are rejected by potential employers (UNDP & USAID, 2014). Currently there is no law prohibiting stigma and discrimination in the workplace on the basis of sexual orientation and gender identity in Vietnam (Roca, 2015).

There are many same-sex couples who want to adopt children in Vietnam. At present, Vietnamese law does not mention sexual orientation and gender identity of adopting parents (USAID & UNDP, 2015). However, the law on Adoption 2010 regulated that "a person may be adopted by only one single person or two persons being husband and wife" (Article 8) (National Assembly, 2010). Therefore, because same-sex marriage is not recognized in the law, same-sex couples are not allowed to have a joint adoption.

Recently (November 2015), the Vietnamese transgender community has celebrated revision of a law that legalizes sex-affirming surgery and introduces the right to legal gender recognition for transgender people who have undergone such surgery¹³. Before that, being transgender was not recognized in Vietnamese laws. Decree 88/2008/ND-CP on sex reassignment allows sex changes for people who have incompleting or unidentified sex characteristics such as intersex people (article 1). This decree forbids sex change operation for people who have completed biological sex characteristic as a woman or man (article 4)¹⁴. However, the government recognized that the regulation on transgender people

was causing them trouble. Many transgender people went to Thailand to have their sex-change operation. Because they cannot change their name and sex on their identity card and passport, they meet a lot of difficulty when travelling. Many transgender people who cannot afford to go abroad for sex change will do them in Vietnam using cheap and unsafe services and even do it by themselves which is harmful and even life threatening. They are also discriminated against using health services.. The new law - a revision of article 37 of the 2005 Civil Code and Decree No. 88/2008/ND-CP which is expected to come into effect on January 1, 2017 allows transgender people to undergo gender reassignment surgeries in Vietnam rather than abroad, and then to change the gender marker on their official documents. However, Human Rights Watch is concerned that "the requirement for surgical procedures as a precondition for legal gender recognition imposes a burden on transgender people that is at odds with their fundamental rights to be recognized in the gender with which they identify."¹⁵

¹¹ <http://www.bloomberg.com/news/2015-01-07/gay-weddings-planned-as-vietnam-marriage-law-is-repealed.html>

¹² <http://vietnamnet.vn/vn/doi-song/87676/tri-thuc-dong-tinh-chat-vat-tim-viec-lam.html>

¹³ <https://www.hrw.org/news/2015/11/30/vietnam-positive-step-transgender-rights>

¹⁴ http://www.moj.gov.vn/vbpq/Lists/Vn%20bn%20php%20lut/View_Detail.aspx?ItemID=24624

¹⁵ To answer to question of CESCR member in the meeting to discuss Vietnam's report in November 2014.

2.6. Extent of gender-based violence

In 2010, the National Survey on Domestic Violence in Vietnam showed a relatively high national prevalence of intimate partner violence and non-partner violence against women. In which, 32% of ever-married women aged 18-60 had experienced physical violence by their husbands, 54% had experienced emotional violence, and 10% had experienced sexual violence. The lifetime prevalence of women who experienced physical and/or sexual violence by their husbands was 34% and 58% of women reported at least one of these three types of violence in their lifetime (GSO & WHO, 2010). The survey also revealed that the violent acts usually started early in a woman's relationship and they were not incidents but often were repeated behaviors (GSO & WHO, 2010).

For non-partner violence, about 10% of women reported physical violence by someone other than their husbands since their age of 15. Most women (65%) reported that the perpetrators were male family members. About 2% of women reported sexual violence since the age of 15 and perpetrators were mainly strangers and boyfriends and only rarely were family members. The comparison of partner and non-partner violence indicated that Vietnamese women were three times more likely to have experienced violence by partners rather than by non-partners (GSO & WHO, 2010).

The Law on domestic violence prevention and control was passed in Vietnam in November 2007 and came into effect in July 2008. However, implementation of the law is challenging. Reconciliation is still the first method used to deal with the case which can prolong the violence and put the woman at risk. The need to keep family intact and stigma toward divorced women make many women not find divorce a suitable recourse in the context of violence (Vu, Schuler, Hoang, & Quach, 2014). Local authorities and related agencies are hesitant to interfere in the case of sexual violence. In addition, while systems to deal with domestic violence such as reconciliation groups, health facilities, counselling, legal aid, etc. are established, effectiveness of these systems is in question. The prevailing traditional gender norms lower the motivation of people in these systems to effectively deal with cases and to protect women.

It is also important to say that traditional gender norms still very much influence the law in Vietnam. For example, the difference in retiring age of women and men in Vietnam is justified based on the traditional gender norms of the women in taking care of family and children (UN 2014).

Mr. Nguyen Chi Dung (Viet Nam) said that the earlier retired age of the women is based on their traditional role which is taking care of family and children besides their paid job. (UN 2014)

While public awareness on violence toward women and children has increased, violence toward LGBT people is still very much rampant and tolerated. This is due to the prevailing heteronormativity in Vietnamese society. The recently revised Marriage and Family Law (2000) which does not recognize same-sex marriage has reinforced this normativity and created inequality in realizing the rights of LGBT people.

2.4. Grievance Redress Mechanisms for sexual and reproductive health services

Currently, there is no policy or guideline on grievance redress mechanisms for sexual and reproductive health services. However, grievance redress for SRH services might be addressed following the general law on complaints and denunciation (passed in 1998 and amended in 2004, 2005 and 2011), which enabled Vietnamese citizens to complain about publicly provided services and MOH's guidelines on solving complaints in the health sector (2005).

The guidelines for solving complaints for implementation within the health sector (Decision N44/2005) was issued by MOH in 2005. It aimed to solve complaints from patients in three areas: medical examination and treatment; quality of drugs; and hygiene and food safety. There were five steps for dealing with complaint cases related to public healthcare facilities in Vietnam, including (1) receipt of the case, (2) classification of the case, (3) settlement of the case, (4) resolution of the case and (5) reporting on and closing the case (MOH, 2005).

Depending on health facilities, mechanisms for collecting complaints are different, for example, mailbox, direct feedback, or telephone hotline. When grievance redress cases cannot be addressed within local institutions or complainants are not satisfied with the decision of local institutions, the case can be sent to a higher level (PHD, MOH), people's council on different levels, the mass media or the court (HSPH, 2012).

Table 2: Number of complaint cases in health sector in 5 years in Vietnam

Year	2006	2007	2008	2009	2010
Provinces submitted GR reports to MOH	40	32	53	45	42
Total GR cases in health system	570	539	2219	275	1300
GR cases received by MOH	113	134	149	152	289
GR cases received by Public Health Departments	457	405	2070	123	1011

Source: Hanoi School of Public Health (2012). Country Report on health system stewardship in Vietnam - HESVIC project (HSPH, 2012)

In reality, there are not many complaint cases in the health sector sent to the MOH and PHD during the five years between 2006 and 2010 in Vietnam (table 2). It might be due to the fact that most health facilities tried to resolve the cases by themselves through negotiating and offering compensation to complainants. This could help them prevent a bad reputation from the cases if they were brought to higher levels, the court or the media. Once the complainants accepted the justifications and compensation and removed the grievance redress letter, the case would be closed (HSPH, 2012). Moreover, limited awareness on complaint procedures, perceived lack of power within

society (compared to healthcare providers), cost barriers for using lawyers and the court, and unfamiliarity with using legal services made patients and their families accept the explanations and compensation from the health facilities (Bui, Mirzoev, & Morgan, 2015; HSPH, 2012). Therefore, only a few cases were sent up to a higher level or involved the courts and lawyers (HSPH, 2012).

Complaints against private healthcare providers are regulated by Ordinance on Private Medical and Pharmaceutical Practice in 2003 (Article 50) and the Law on Examination and Treatment in 2009 (Chapter VII) (National Assembly, 2003, 2009). However, due to lack of resources to manage all private health facilities, the PHD responsible for managing private practice - does not monitor grievance redress cases involving private facilities. Moreover, although the above policies regulated patient's rights to report and denounce the illegal behaviour relating to private medical and pharmaceutical practice, there are no guidelines for handling complaints and no separate category for recording grievance cases in private health facilities (HSPH, 2012).

In addition, there is a hotline (**19009095**) to receive complaints and feedbacks on healthcare services which has been operating 24/7 since 2016. Before that, there were about 1,200 hotlines of different hospitals and after checking those hotlines in October 2015, the MOH revealed that nearly one third (366) of those hotlines are problematic (no one received the calls, non-existing number, turn-off mode). The received calls to current health sector hotlines will be transferred to targeted individuals or organizations for solutions.

3.Recommendation

Given the above situation and policies of sexual and reproductive rights, we call upon our government, international organizations, UN agencies, civil society and all relevant stakeholders to implement the following recommendations:

1) Sexual and reproductive rights in general

- Strengthen the health system to achieve universal sexual and reproductive health care access for everyone, especially disadvantaged groups such as ethnic minorities, people living with disabilities, young people and migrants.
- Build capacity for healthcare providers to have a rights-based approach, non discrimination and good service quality in providing sexual and reproductive health services for different groups.
- Increase the national budget for sexual and reproductive healthcare and prioritize funding for disadvantaged group.
- Involve civil society organizations (CSOs) in policy-making and program planning and

implementation and monitoring relating to sexual and reproductive health and rights. The collaboration between the government and CSOs should be strengthened and clear guidelines for this cooperation should be established.

- Sexual and reproductive health and rights indicators for different groups should be collected in an annual national survey and health information report system.

2) Abortion services:

- Strengthen the management of abortion drugs/services provided by private providers and pharmaceutical market.
- Reinforce pre and post-abortion counselling on family planning to prevent repeat abortion.
- Contraceptive methods should be made available and affordable for all groups, especially young people, ethnic minorities, migrants and people living with disabilities

3) Adolescent sexual and reproductive health services

- Develop a national policy on sexual and reproductive health specialized for adolescents, addressing their specific needs. This policy should be meaningfully incorporated into the work of agencies at various levels, civil society, as well as communities, parents, teachers and adolescents themselves in designing, implementing and monitoring. There should be a sound system of indicators for monitoring and evaluating the policy. The policy needs to target different groups of youth: in-school and out-of-school, urban, rural and mountainous areas, and vulnerable and disadvantaged groups.
- Develop a sexuality education curriculum for different age ranges and deliver sexuality education for in-school and out-of school young people with a national coverage. Sexuality education should provide youth with a holistic understanding of sexuality and sufficient life skills to take responsible decisions and practice safe sexual behaviours.
- Training and refresher training for teachers, pedagogy students, policy-makers, local leaders, media practitioners, health workers on sexuality of young people and necessary skills (such as communication skills, teaching skills, etc.) to work with them should be conducted regularly.
- Set up youth-friendly services on a large scale that ensures privacy, confidentiality and youth involvement in designing and implementing these services. Service providers at all levels should be required to do training in youth and adolescent SRH.
- Improve the national reporting system on adolescent and sexual reproductive health,

including services. Data on adolescent and sexual reproductive health should be included and analysed in the annual national survey on population change and family planning to monitor the magnitude, trends and other epidemiological characteristics and annual indicators of the general statistical office (GSO).

4) Gender-based violence

- The essential services for violence survivors should be made available and accessible. Those services include emergency shelter, counselling services, healthcare and referral services, and legal support.
- Improve the health sector to adequately respond to violence. Healthcare provider should be trained on screening for violence survivors and providing counselling and services for them. Responses to GBV should be integrated into different areas of care such as emergency, sexual and reproductive health, mental health and HIV/AIDS-related services.
- Empower women to address violence in their lives through life skills training, self-help groups, education, job training and legal and financial support
- Increase the engagement and mobilization of community leaders and local authorities to address violence against women and promote gender equality.
- Build collaboration between different sectors in dealing with GBV: health sector, police, judges, social workers and strengthen the capacity of those sectors to handle GBV cases properly.
- Integrate GBV indicators into the national monitoring and reporting system to update annual data for policy-making and program planning.

5) Sexual orientation and gender identities

- Enact the law prohibiting stigma and discrimination towards LGBT people in all settings such as employment, education, and healthcare services and protect LGBT people from violence based on their sexual orientation and gender identity.
- Include LGBT people in country policy and strategy on sexual and reproductive health, gender equality, education, and human rights.
- Advocate for the legalization of joint adoption for same-sex couples.
- Increase the awareness of the community about sexual orientation and gender identity.

6) Grievance redress mechanisms for sexual and reproductive health services

- Improve the transparency of the complaint handling process by establishing a neutral and independent organization that is responsible for grievance redress.

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About CCIHP

Established in 2008, the Center for Creative Initiatives in Health and Population (CCIHP) has been one of leading NGO in Vietnam in public health. CCIHP's mission to promote equality, diversity and health for all in society is achieved through a multidisciplinary innovative approach of action research, advocacy and intervention. CCIHP actively seek the meaningful involvement and engagement of individuals and communities in its research and innovations. Some examples include Archive of Lesbian, Gay, Bi-sexual and Transgender history, the Health Market photovoice project and exhibition, We saw we say – a project with ethnic minority women. CCIHP is also a pioneer in Vietnam to promote rights, especially sexual and reproductive health and rights of people with disabilities.

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