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Sex-selective abortion: Dilemmas in the silence

Hiên's face turned pale when the nurse in the surgical room called her name. She trembled as she climbed on to the abortion bed, with a mixture of fear and torment in her eyes. She put her legs in the stirrups and her hands on her belly with her fingers crossed. The doctor sat on a swivel stool, protected from head to toe by white surgical clothing, including a face mask and protective glasses. The nurse was also wearing a mask. In contrast to the noise in the corridors and waiting rooms outside, the surgical room was quiet and filled with tension. I heard the clinking of surgical tools as the nurse prepared them. Hiên looked around nervously, then screwed up her eyes. Without speaking, the nurse gave Hiên an injection of pain medication. Hiên winced and breathed slowly to calm herself. With skilful movements, the doctor inserted a speculum into Hiên's vagina, cleaned it and the cervix with antiseptic solution and grasped the cervix with an instrument to hold the uterus in place. The doctor inserted forceps into the uterus and grabbed a piece of the foetus's body, which he removed. It was streaming blood. Hiên curved her body in pain, her eyes brimming with tears, but she tried to constrain her groan. I experienced shock when I saw a leg being pulled out through the vaginal canal. The doctor continued and, one after another, pieces of the foetus were pulled out. The doctor then used a curette to scrape the lining of the uterus and sucked the uterine cavity with a cannula to ensure its contents were completely removed. Finally, the doctor gathered the extracted pieces of the foetus and laid them on a tray to make sure he had the complete

body. The nurse took this tray and put it in a fridge before helping Hiền on to a stretcher. Hiền was transferred to the postabortion room, which was crowded with women.

This is a description of a sex-selective abortion that was undertaken using the D&E method in a public hospital in Hà Nội. The abortion process is marked by pain, stress and, most notably, silence. Although the abortion client and providers uttered scarcely a word throughout this transaction, the evident fear and suffering experienced by all actors prompt many questions. Why was Hiền fearful and nervous? What was the meaning of her tears? Did she cry only in pain or did she also feel anguish for her foetus? What did the abortion providers feel? What for them would have been the hardest aspect of the process—the foetal dismemberment, their patient's trauma or the knowledge they were undertaking a sex-selective abortion?

This chapter will help us understand the meanings of this silence, and to pull aside the curtain shrouding sex-selective abortion in Việt Nam. One objective is to provide insights into women's and abortion providers' experiences and the role of the different people involved in the process. I also analyse the medical, emotional, ethical and policy problems surrounding such abortions through a critical discussion of Tine Gammeltoft's (2002: 328) observation: 'In public life in Việt Nam, abortion as a moral problem is shrouded in silence.' I argue that the public and private silences surrounding sex-selective abortion have personal, sociocultural and political meanings. Analysis of the dilemmas faced by women having a sex-selective abortion and the others involved points us towards deeply grounded sociocultural tensions within contemporary Việt Nam.

In describing sex-selective abortion, this chapter reveals the experiences, emotions and moral conflicts of those seeking the procedure. Researching abortion anthropologically entails uncovering the experiences of all those involved in the process, including women and their families, abortion service providers, health system managers and policymakers. From an anthropological perspective, 'the more widely and attentively these voices are heeded, the more likely the prospects are for reforming related social practices and public policies' (Jing-Bao 2005: 10). This chapter explores sex-selective abortion practices in Hà Nội today by utilising an ethnographic approach.

Sex-selective abortion in a public hospital: 'Removing a table that is larger than the door from a room'

In the public hospital where I conducted my observations, the abortion process had three main stages: the administrative procedure, the counselling sessions and the surgical procedure. In each section of this chapter, I describe the experiences of women and abortion providers during the process and explore the problems in the delivery of abortion services.

Administrative procedures: Bureaucratic formality

On a hot summer's day, the temperature and humidity inside Hà Nội's leading public hospital for abortion provision seemed even higher because of the crowds. The Department of Family Planning, where abortions are conducted, is one of the busiest departments in the hospital. Everywhere—along the corridor, at the counters, outside the professional rooms—clients and their families had to push their way through a mass of bodies. Nurses were sometimes grouchy because patients had not followed instructions or they did not have their receipt. In this hospital, women who want a second-trimester abortion must follow a standard administrative procedure. First, they are given an account number and medical book at the reception desk, before being sent to another gate to pay their fee. They then have an ultrasound scan and a vaginal check in the examination room and are given a medical record. They must bring this record to the counselling room, where the counsellor helps them fill in the record and their consent for the abortion. They return to the examination room to have blood and urine tests, before attending the accounting table to pay for the tests before the samples are sent to the laboratory. They need to wait several hours for the results, which they then bring back to the examination room. The nurse in the examination room hands their consent form and medical records over to the board manager. The hospital board manager approves their abortion by signing these documents. After the counsellor makes a final check of the documents, the woman is sent to the surgical room. Women have to pass at least 12 administrative procedures before their abortion.

Several points can be made about the nature of these procedures. First, such convoluted administrative routines are standard in most public hospitals in Việt Nam and similar steps are in place for all surgical procedures, not just abortion. The administrative formalities in this hospital attest to the status of abortion as a routinised medical procedure.

Second, abortion services attract a fee, even in public hospitals. Much of the administrative process entails determining, collecting and recording payment of that fee. Although the government subsidises health care, a large share of the cost of expensive surgical procedures has to be borne by patients themselves. Reproductive health in Việt Nam is significantly market-based, with patients shouldering the financial burden yet also setting the demand for medical procedures of all kinds. The administrative process at this hospital provides a window on to the sex-selective abortion process as a market-based transaction.

Third, the array of medical tests and failsafe procedures in place indicates the level of risk associated with abortion, and especially late-term abortion. Sex-selective abortion is conducted no earlier than the second trimester of pregnancy, because the sex of the foetus cannot be determined any earlier. These, like all late-term abortions, are considered to have a higher risk of complications. As a result, the government has mandated that second-trimester abortions must take place in provincial or national public hospitals. Local clinics are allowed to conduct abortions but not in the second trimester. The shortage of experienced staff and facilities at provincial hospitals means many women come to Hà Nội for a second-trimester abortion, increasing the burden on the capital's public hospitals.

The constrained supply of and high demand for abortion mean the facilities at the public hospital where I conducted my research are always overburdened. The overload of clients increases the waiting time for all administrative steps, so that the administrative process takes an entire day at least. Those women who can, seek out acquaintances who are employed in the hospital to help them. Most women from the provinces, however, have to spend several days completing the administrative procedures. Two women among my 35 core cases chose to have an illegal abortion at a private clinic near their home to avoid these complicated and time-consuming administrative procedures.

In spite of the complexity, confusing nature and often poor standard of administrative services in the public hospital in which I studied, many people still preferred it to a private clinic, because they knew it was safe. One woman's husband said:

The administrative procedure is so complex. This is the first time we have been to a hospital in Hà Nội. How can we know the procedure? I asked some nurses, but they are irritable. Registration is here and payment is there. It took us a day to do the administrative requirements. We had to continue the day after. I did not know when this procedure would be finished. I do not have any acquaintances in this hospital. We came to this hospital because we thought my wife would be safer here. (Hoa's husband, 39 years old)

We then come to a dilemma faced by hospital staff, some of whom would like to simplify the process to shorten waiting times. The regulations require women to present their identity card and family record book, but this procedure is often waived. Some counsellors want to eliminate these steps to make access to safe abortion services easier for women. One counsellor said:

Regularly, clients had to show identity cards or family records before having an abortion. But, in fact, clients can have an abortion without showing these documents. Showing identity cards or family records is not necessary and is time-consuming for clients. Administrative procedures should be simple. (Counsellor, 54 years old)

Conversely, other counsellors suggested family records should be collected, because they could help track the number and sex of the children of women seeking an abortion, which would help providers determine whether they were dealing with sex-selective abortion.

Herein lies an important dilemma of the administrative process for abortion in Việt Nam. Hospital staff believe that most patients seeking a late-term abortion are doing so because the foetus is of the unwanted sex. However, at no point in the round of medical tests, form-filling and mandated counselling sessions are clients asked outright whether they are seeking a sex-selective abortion. Women are required to record their reasons for seeking an abortion, but most say it is because they have enough children or because of economic constraints. To my knowledge, 'sex selection' is never recorded as the reason.

When women give their consent for the surgical abortion procedure, they must also accept full responsibility in case of any complications. Women and their families who asked counsellors why they had to give this written undertaking were told it was one of the regulations and if they did not consent, the abortion would not go ahead. Some women and their husbands told me they thought that if there were complications during an abortion, the medical professionals—and not the patients—should bear the responsibility. The explanation I received from abortion providers was more detailed:

Late-term abortion is dangerous for pregnant women. We have explained the danger for them. If they want to abort, they have to accept the danger. Complications are rare, but they have happened. We require women to do that [provide written consent of their acceptance of responsibility in case of complications] to avoid suffering a lawsuit. (Abortion provider, 52 years old)

The belief among counsellors that they can prevent patients suing by ‘making them take responsibility for complications’ is a misreading of their own professional ethics, founded on an incorrect assumption. It is true that patients need to be informed, but this is not the same as absolving the hospital of responsibility for complications if the hospital or healthcare provider is at fault.

We can therefore detect a number of silences during the administrative procedure in this hospital. Clients seeking sex-selective abortion must silently endure the ordeal of the hospital’s administrative process to receive service in the place considered to provide the safest abortions. Money changes hands, a complex array of checks is undertaken and an agreement is signed, but never is the nature of the transaction made transparent. Instead, women have to take full responsibility for any problems that may happen during a surgical procedure whose very nature is itself not transparent.

Counsellors: The gatekeepers of sex-selective abortion

As noted, counselling is a mandated part of the administrative procedure for abortion service providers. Counselling is provided by nursing staff, who take turns working in the counselling room. These staff—all of them women—have the additional role of helping women

complete the administrative steps and form-filling. They are on hand at all stages of the process. As a consequence of their close interactions with clients, most likely learn the real reason an abortion is being sought. This knowledge can create a dilemma between their duty as a public health official and their sympathy for the woman. In their interactions, they elicit admissions that clients probably otherwise would not share. They also exhibit a degree of arrogance and sometimes make accusations against their clients that verge on unprofessionalism. The ethics and effectiveness of these interventions are open to question. However, these intermediaries—unpolished as their services may be—are typically the only staff to make explicit the nature of the transaction taking place in this hospital.

According to international professional standards, abortion counselling should have three basic aims. The first is to aid the woman in making a decision about an unwanted pregnancy. The second is to help her implement the decision. The third is to assist her in controlling her future fertility. These principles should result in a humane and understanding relationship between counsellor and client (Asher 1972). The WHO's (2003b: 26) guidelines on abortion counselling advise:

counselling can be very important in helping the woman consider her options and ensure that she can make a decision free from pressure. Counselling should be voluntary, confidential and provided by a trained person.

The Standing Committee of the Vietnamese National Assembly passed the Population Ordinance in January 2003 prohibiting sex selection by any means. It encourages any abortion clinic discovering a potential sex-selective abortion to prevent it. Counselling is the unique stage in the abortion process when abortion providers are able—by virtue of the verbal communications counsellors have with women—to uncover cases of sex-selective abortion. The questions raised are: Do counsellors follow the WHO guidelines? Can they act as required? When a sex-selective abortion case is discovered, how do they deal with it? The following observation is of counselling in practice in a public hospital.

'Come in', the counsellor said coldly in response to a tap on the door. The woman hesitated before entering and did not speak. She put her medical book with the ultrasound result on the table and sat opposite the counsellor. The counsellor glanced at the ultrasound result and said rapidly: 'Your foetus is 15 weeks already. It is nearly four months. Why

do you want to have a late abortion? Did you see the legs, the arms and the body of your baby?’ The woman spluttered: ‘I have three children. I did not know I was pregnant—’ The counsellor interrupted: ‘You have kept this pregnancy intentionally. You have three children, so you have experience with pregnancy.’ ‘Yes, I knew I was pregnant, but my husband said if it is a boy, we will keep it. We do not want to have another girl,’ the woman admitted. The counsellor responded:

Late-term abortion is not simple. Boy and girl, tuhh, tuhh ... Which era are we living in? Before having an abortion, you need to pay for medicines and the blood and urine tests. The fee for these tests and medicines is more than VND1 million. With the abortion procedure there is always a danger of haemorrhage or injury to the uterus. In case of excessive bleeding, you will need a blood transfusion and you will have to pay for it. If your uterus is punctured, which can cause severe blood loss, the uterus will be removed. You have to take responsibility in these cases. If you want to have an abortion, you need to fill in a consent form. Take the form over there and fill it in.

The woman kept silent. She was embarrassed as she filled in the form and gave her reason for the abortion as ‘have enough children’. (Author’s observation in counselling room)

In practice, this counselling session has not met the ideal espoused in the professional literature and the WHO guidelines. The counsellor was haughty and dismissive and outlined the potential complications in an abrupt manner. Her client was shamed and/or frightened into silence. The counsellor’s blunt accusations apparently succeeded in extracting from the woman the real reason for the abortion—it was indeed for sex selection. However, the counsellor’s intervention ended at that point and the woman provided a legally acceptable reason on the paperwork and went ahead with the abortion.

Why is such counselling not done according to international protocols? One reason is the weakness of available human resources. Although this public hospital is considered one of the leading obstetrics and gynaecology hospitals in Việt Nam, providing counselling in accordance with the WHO guidelines is impractical because of the lack of trained staff and the heavy workload. As noted, there is no specialised abortion counsellor in this hospital and the nurses take turns working in the counselling room. Some experienced nurses have been trained in counselling by reproductive health projects funded by the Pathfinder organisation and the UNFPA. These nurses are aware

of the requirements for abortion counselling, but they are unable to achieve the appropriate standards because of general work pressures. This hospital's Department of Family Planning is usually crowded, with 50 to 70 abortion cases a day. An experienced nurse/counsellor (52 years old) told me: 'I know the abortion counselling standards, but if I follow the appropriate standards for abortion counselling, I can counsel only 10 patients a day.' However, the remainder of the staff had not been trained in counselling. A young nurse/counsellor (36 years old) said: 'I have never been trained in abortion counselling. I have heard other nurses talking to patients and I imitate them.' The WHO guidelines on counselling are idealistic, but are they feasible? How can they be applied when resources and health system support are lacking? These questions are highly pertinent in Việt Nam.

There seems to be more at stake here than just the counsellors' presumed lack of education and their failure to internalise international abortion counselling protocols. Institutionally, the public health system does not have in place any mechanism for implementing the state's ban on sex-selective abortion. When faced with the market demand for abortion of this kind, the administrative obstacle course in place in public hospitals presents only a feeble barrier. Nurses and counsellors—the only staff who communicate with clients and understand what is at stake—are thus directly exposed to the conflict between the law and the nature of the services provided. I surmise that, placed in this position, these intermediaries tend to abandon a neutral professional position and step more into the role of surveillance and deterrence.

Observing counsellors and talking with them, I sensed that many were proud of their ability to know, even without being told, a woman's 'real' reason for seeking an abortion. Most nurses/counsellors affirmed that they could guess a sex-selective abortion case by a woman's characteristics, such as the timing of her pregnancy and the gender and number of her existing children. A nurse/counsellor said:

I can guess if it is a case of sex-selective abortion. If a woman has two or more daughters, or a woman has one daughter and her child is not small, and she has a late-term abortion without any medical reasons, she may well be having a sex-selective abortion. (Nurse/counsellor, 50 years old)

Counsellors and nurses also seemed to believe their role was to deter women from having a sex-selective abortion. The information they exchanged with clients was provided not with the intention of offering them neutral advice for contemplation, but rather to actively dissuade them from going ahead with the abortion. In one counsellor's opinion, when a case of sex-selective abortion is identified, it is important to mention three issues: the inaccuracy of sex determination, the potential complications of abortion and the moral issues.

First, I tell them that the accuracy of ultrasound in sex determination is not 100 per cent; sometimes, albeit in a small number of cases, it is inaccurate. Second, they should be counselled on abortion complications. Third, I mention moral issues. The babies are human beings; abortion like that is immoral. (Nurse/counsellor, 50 years old)

For this counsellor, airing such issues in a counselling session might help dissuade a woman from having a sex-selective abortion. She reasoned that a woman might decide to keep the foetus when she heard about the possibility of complications or was prompted to consider the moral or religious issues related to abortion. The following exchange between a nurse and a client is an example of this approach.

As the clinic was less crowded than usual one day, some of the Department of Family Planning staff gathered in the counselling room to chat. A woman, about 30 years old, arrived to ask about the administrative procedure for an abortion. She said she was 14 weeks pregnant and wanted an abortion. The senior nurse asked, 'How many children do you have?' 'I have a four-year-old daughter,' the woman replied diffidently. The nurse said: 'Your child is not too small. It is time to have your second child. You want to have an abortion because the foetus is female, don't you?' The woman remained silent. The counsellor continued: 'Where did you have your ultrasound scans?' 'I have had several ultrasound scans in different places. They all said it is a girl,' the woman said confidently. 'Are you sure about the accuracy of the ultrasound scans?' the nurse asked doubtfully. She continued:

Do you know you can have complications such as haemorrhage or perforation of the uterus if you have an abortion? You have only one child and you may become infertile. Furthermore, the baby in your womb has a face, body, arms and legs. Are you not afraid of her resentment? The baby in your womb is normal, but you want to abort her and put her in the fridge. Do you want to see the foetuses in the fridge? If you do, let us go and see them in the next room.

At this point, the woman panicked and hastily left, without saying goodbye. (Author's observation in a counselling room)

We can see from this example that the nurse's attempt to dissuade the client by overwhelming her with a variety of confronting arguments was so effective that the young woman abandoned the scene in panic. Although such an approach may deter some women from having a sex-selective abortion, there is a need to discuss the ethical issues involved. This counselling method may not prevent all women from having a sex-selective abortion, because there are other places they can go. Moreover, as John Asher (1972) mentions, the aims of counselling are to help women explore their feelings about their situation and make a decision without being judged by providers. Some women reported that, while the thought of abortion was not traumatic at first, it became so during the counselling process. The counselling did not relieve their anxiety. Conversely, counsellors tended to pass judgement and try to impose their own moral, ethical or religious beliefs.

Women said they were under a lot of stress and wanted to be able to discuss their feelings with someone in private. My observations show that little or no communication occurs between health staff and clients before and during the surgical abortion procedure or afterwards in the recovery room. This is a result not only of providers being too busy, but also of the providers' attitudes.

Providers should ask our situation and give us counselling. I have been urged to hurry up when I was still indecisive. The clinics are crowded with patients and staff have a heavy workload, but sometimes the staff are very authoritarian. (Hà, 39 years old, 15 weeks pregnant)

While empathetic counselling is generally recommended, women in this study have been judged by staff or not given the opportunity to share their feelings and discuss their difficulties. As a consequence of poor counselling, women face a multitude of anxieties and psychological issues or end up seeking multiple sex-selective abortions. Similar limitations in terms of counselling in abortion care in Việt Nam were found in recent qualitative studies (Trần 2005; Gammeltoft and Nguyễn 2007).

The evidence suggests women would be receptive to counselling that helped them vent their feelings of ambivalence. Not all women who came to the hospital looking for an abortion service decided to

proceed. At the same time, the great number of abortions taking place in an institution that lacks adequate counselling might, by default, sway those who are ambivalent. As Cúc said:

At first, I thought it [abortion] was a sin. When I came to the hospital, I saw so many women who had had an abortion. Some women were in later pregnancy than me, so I was not as worried as before. [There were] numerous [women having] abortions, not only me. (Cúc, 30 years old, 13 weeks pregnant)

Cúc's comments suggest that counselling could make a difference at this stage.

It needs to be noted that in the overwhelming number of cases I observed, counselling staff did not prevent sex-selective abortion from going ahead, despite the sometimes blunt efforts at dissuasion employed. In several cases, once their stern lecture was delivered, they ushered women through the remaining formalities with little fuss. What accounts for the failure of these state agents to prevent acts in contravention of the law? I suggest that, ultimately, these women's membership of the same sociocultural milieu as their clients, and their own experiences of the kinds of dilemmas they face, led them to understand intuitively and sympathise with women's circumstances and accede to their decision to have the abortion. Nursing staff were split between their role as public health professionals and their membership of the same sociocultural milieu as their clients. This perhaps accounts equally well for the 'noisy' irritability and haughtiness staff displayed towards clients and their 'silent' acquiescence to the abortions.

How should nursing staff approach sex-selective abortion seekers? Should they—can they—change their clients' preference for a son? Many are conscious of the role of counselling in sex-selective abortion, but are confused as they have not been adequately trained. Some nurses/counsellors were mindful of the social consequences of sex-selective abortion, but they did not know how to share this with their clients. A nurse/counsellor shared her thoughts:

Maybe we can tell women that if they want to abort female foetuses and try to have sons, their sons will not be able to get married. In neighbouring countries like China, men cannot get married. In the future, men will find it difficult to get married because of the shortage of girls. At the same time, girls will choose rich men to be their husbands. Men who are not rich and live in rural areas will find it difficult to get

married. Perhaps people have not thought about these matters. I think so, but I do not know how to talk with women effectively. (Nurse, 52 years old)

A number of studies report that partners play a positive role in decision-making and support throughout the abortion process (Beenhakker et al. 2004; Becker et al. 2008). This is especially relevant in patriarchal societies and for sex-selective abortion. In evaluating the role of counselling for women's family members, a nurse/counsellor said:

There are cases of women who have had several sex-selective abortions. A number of women feel pressure to have a son from their husbands or their husband's family. So, the people who provide this pressure should be present at the counselling.

She added:

Counselling for a woman's husband is very important. If they are not counselled directly, they will not know the danger of abortion. If we counsel only women then they can pass on the information to their husbands and their families, but I am sure they cannot convey everything that they have been advised. (Nurse/counsellor, 52 years old)

Although counsellors understand the importance of counselling a woman's family members, it rarely happens. The reasons are not only their overloaded work schedules, as mentioned above, or the lack of training in abortion counselling, but also the fact that counselling as an intervention lies halfway between providing deterrence and providing sympathy. This has led to men and other relatives who accompany women to abortion clinics being neglected. The shortcomings associated with counselling mean men experience their own personal crises while their partners undergo abortion. Furthermore, lack of knowledge about abortion-related complications and contraception, as well as son preference, can contribute to women repeatedly seeking sex-selective abortion. Tuấn and Hùng are examples.

Tuấn's case

Tuấn looked tired as he sat outside the operating room. Behind the closed door, his wife was in pain undergoing an abortion. He told me he had been unable to sleep and had a headache from the stress of struggling with his conscience. He did not want his wife to have this abortion because he felt sorry for his baby and he was worried for his wife's health. However,

if they had this baby, they would not have an opportunity to have a son. He wondered about the accuracy of the ultrasound result. He said he would be inconsolable if the foetus was male.

While we were talking, a nurse who was an acquaintance of his rushed over to inform Tuấn that his wife's abortion had been successful. He sighed in relief and told me: 'My worries have been lessened, but I feel sorrowful. Anyway, the baby is our child, it is my blood. I feel heartbroken and anxious.'

Hùng's case

I saw Hùng sitting in the postabortion room while his wife was resting after her procedure. He looked tired and his hair was ruffled. I sat next to him and asked about his circumstances. He confided to me that he did not want to see his wife in this situation and he felt pity for her. She also had an abortion the previous year. He said:

My wife has had two abortions. She had an abortion last year in May, when she was 17 weeks pregnant. Last time she had ovulation detection in order to conceive a male foetus, but unfortunately it was not successful.

I asked if he wanted to pursue his dream of having a son. He was not sure at that moment, but he wished there was a way to ensure he could have a son. He said he would pay tens of millions of dong if he could have a son without becoming implicated in sex-selective abortion.

In summary, it is not easy to follow the WHO guidelines on abortion counselling in clinical settings such as those in Việt Nam today. Because counsellors have not been trained for sex-selective abortion cases, they improvise their own rough-and-ready approach. At times the nurses can be intimidating and offensive. It should also be noted that their improvisations do little to reduce the number of sex-selective abortions. Significantly, their exchanges with clients were the only time in the whole transaction when the pact of silence around sex-selective abortion was threatened. The adequacy of such counselling is impacted not only by poor clinical conditions (lack of and overworked staff and untrained counsellors), but also by counsellors' personal perceptions and by weak regulatory frameworks for healthcare practitioners.

The sex-selective abortion process

In Việt Nam, first-trimester abortion is provided at the central, provincial, district and commune level in both public and private sectors. Second-trimester abortion has been restricted to central- and provincial-level public health facilities because lower-level facilities and the private sector lack trained healthcare providers, adequate medical equipment or the necessary emergency support (MOH 2003).

For second-trimester abortion, D&E¹ has been recommended by the WHO and approved by the Vietnamese health ministry since 2003. In Việt Nam, D&E has been introduced at some central and provincial hospitals and is carried out at 13–18 weeks of pregnancy. D&E requires preparing the cervix with mifepristone and must be done by skilled and experienced providers, with proper equipment.

As well as D&E, saline abortion is still often practised in many provincial hospitals (Gallo and Nghia 2007).² This method is used only for pregnancies of 18–24 weeks gestation. It usually requires one week of hospitalisation, which increases the cost and contributes to the hospital's work overload. It is associated with serious complications such as haemorrhage, uterine rupture and sepsis. This method delays women receiving services until after 18 weeks of pregnancy, even if they first present early in the second trimester. Waiting for the pregnancy to advance sufficiently can create a lot of emotional pressure.

The combination of mifepristone and misoprostol is now an established medical method and is highly effective for termination of pregnancy, including in the second trimester (Dalvie 2008), and has been included in Việt Nam's National Standards and Guidelines, which are currently being updated. This method is also starting to be applied in some central and provincial hospitals following regimens of misoprostol alone

1 Dilatation and evacuation (D&E) are used from about 12 weeks of pregnancy onwards. D&E requires preparing the cervix with mifepristone, a prostaglandin such as misoprostol or laminaria or a similar hydrophilic dilator; dilating the cervix; and evacuating the uterus using electric vacuum aspiration with 14–16 mm diameter cannula and forceps. Depending on the stage of pregnancy, achieving adequate dilatation can take anything from two hours to a full day. Many providers find the use of ultrasonography helpful during D&E procedures, but it is not essential (WHO 2003a).

2 Saline abortion during the second trimester is effected by replacing 200 mL of amniotic fluid with 200 mL of 20 per cent saline solution, which stimulates uterine contractions, followed by foetal delivery in 12–24 hours (Segen 2002).

to terminate second-trimester pregnancies: 400 mcg of misoprostol inserted vaginally every three hours for pregnancies of 16–19 weeks and every six hours for pregnancies of 20–22 weeks. This method is safe and effective, but the woman must be monitored closely throughout the process (Hoàng et al. 2008).

In the past, if women wanted an abortion in the second trimester, they had to wait until after 18 weeks gestation and undergo a saline abortion, which is associated with serious complications. Recently, for pregnancies of 17–22 weeks, medical abortion has been applied. The new method has been approved for its safety and efficacy. Medical abortion has brought more options for women seeking to terminate a pregnancy, and is safer and more effective than D&E. According to the National Standards and Guidelines, D&E can be carried out at 12–18 weeks of pregnancy. In the hospital where this study was conducted, D&E was used from 12 to 16 completed weeks of pregnancy. A doctor experienced in second-trimester abortion in this hospital explained that ‘the little one’s bones become hard after 16 weeks, and its size is too big to conduct a surgical abortion. Abortion after 16 weeks pregnancy conducted by surgical methods has a high complication rate’.

He compared surgical abortion after 16 weeks to ‘removing a table that is larger than the door from a room’. However, D&E has been preferred for early second-trimester abortion because it reduces the cost and avoids adding to the work overload of public hospitals. The D&E method has been used since 2000 in the hospital where I conducted this study. This method is safer and shortens the hospitalisation time as well as meeting the demands of women who want an abortion early in the second trimester.

Generally, progress in making abortion safe has advantages for women’s health care. However, these advantages have been exploited for other reasons. Abortion providers are conscious of these matters.

Previously, later term abortion was not safe. It is safer now, and complications have significantly reduced. People found that later term abortion is safe, so they have more induced abortions during later stages of pregnancy. (Doctor, 43 years old)

The improvement in the quality of abortion techniques gives women more options. Although this improves women’s reproductive health, it can also facilitate sex-selective abortion. Improvements in reproductive

health do not cause sex-selective abortion, but such advances facilitate sex-selective abortion when new technologies are used for nonmedical purposes with insufficient management and supervision.

In the hospital where I conducted this research, a hysterectomy³ is also used as a method of abortion for women with a high risk of complications, such as those who have had several caesareans, those in second-trimester gestation and those who have had ‘enough children’.

Vân’s case

I met Vân when she was in a state of confusion. It took her three days to complete the complicated administrative procedures at the public hospital. We had several conversations during that time, in which she told me about her pitiful condition.

Vân had all three of her daughters by caesarean section. Her husband’s mental health was not good; sometimes he could work, sometimes not, so she had the difficult responsibility of supporting him and their three children. Despite this, she had always wanted a son. A fortune teller told her she would have a boy if she became pregnant in the Year of the Mouse (according to the lunar calendar). Believing the fortune teller, Vân decided to become pregnant after the Tết holiday. She had several ultrasound scans and learned that her foetus was female when she was 14 weeks pregnant. However, she wanted to be sure about the sex of the foetus, so she waited until she was 16 weeks pregnant and had another scan. She was 17 weeks pregnant when she decided to have an abortion. Having had three caesareans, she was considered a high-risk case. Instead of a D&E, her uterus would be cut out with the foetus inside (hysterectomy). Vân was still confused when we spoke before she went into the operating room. When I asked Vân if she knew about hysterectomy, she was in tears and said:

3 A hysterectomy is the surgical removal of the uterus. There are four types of hysterectomy. Total hysterectomy is the removal of the entire uterus, including the fundus and the cervix. Hysterectomy with bilateral salpingo-oophorectomy refers to the removal of both ovaries and the fallopian tubes. In supracervical hysterectomy, the body of the uterus is removed, but the cervix is left intact. Radical hysterectomy is the removal of the uterus, the cervix, the top portion of the vagina and most of the tissue surrounding the cervix in the pelvic cavity. Pelvic lymph nodes also may be removed during this surgery.

The doctor said it is a total hysterectomy [*cắt tử cung cả khối*]. The doctor asked me to sign my consent and I did, but I do not know what it means. I am confused and know nothing. I wonder is it possible to have a caesarean to take out my baby without cutting out my uterus; then I will use contraceptive pills? I will become a man if I do not menstruate.

After this conversation, I took her concerns to the responsible doctors, who explained that conducting a medical abortion in cases like this was highly risky. The rate of uterine rupture in a subsequent delivery is said to be 50 per cent. If the uterus is ruptured, it must be cut out, the woman will need a blood transfusion and there is a high risk of infection. If the woman is in a difficult economic condition and has enough children—two or more—removing the uterus is the best way to save her life and reduce the risk of needing a blood transfusion. A blood transfusion is also very expensive and the patient must pay for it out of her own pocket. A woman can have a caesarean to remove her baby without removing her uterus, but it will be dangerous for her if she falls pregnant again. In cases like this, hysterectomy is now rarely carried out in Western countries. According to studies from the 1970s in the United Kingdom, the rate of uterine rupture in subsequent deliveries was 6 per cent (Clow and Crompton 1973). These rates are higher in countries where women do not have access to good delivery services.

Discussing the solutions to a case like Vân's, some of the hospital's leading gynaecologists supposed it would be possible to conduct a medical abortion under close supervision in a hospital with adequate emergency facilities. Having a caesarean section to remove the foetus without cutting out the uterus (hysterotomy) is also possible; however, the woman would have to follow this up with sterilisation or contraception because of the risk of rupture in any future pregnancy.

Let me put the discussion of abortion methods aside for the moment. The most important issue here is, once again, counselling. While informed consent counselling that supports women to make a free and fully informed decision is recommended, Vân and other women in this study did not receive adequate information before they decided to have an abortion. They did not know enough about the abortion process. They allowed the doctors to choose for them without knowing all the details and associated risks. Women need to feel comfortable they can make an informed decision about whether hysterectomy is right for

them. They have a right to know the risks and potential benefits of the medical options they are being offered and the right to choose among the available options.

Abortion complications

Assessing the real number of abortion complications is difficult as one must rely on complaints reported by patients and diagnoses by physicians and consider the distinction between complications that are a direct or an indirect result of the termination. Some complications are apparent immediately, while others may not become apparent until days, months and even as much as 10–15 years later. In the hospital where I conducted this study, the direct complication rate was not recorded; however, doctors estimated it was about 2 per cent. The most common complication was excessive bleeding (haemorrhage), which was more likely to affect women who had one or more caesarean sections. For these women, doctors usually chose a safer solution, such as in Vân's case.

Data from the Reproductive Health Department in the MOH (2002) showed that haemorrhage was the leading cause of maternal mortality in the country (40 per cent). Unsafe abortion also made a significant contribution to maternal mortality (11.5 per cent) (MOH 2002). Complications are also associated with multiple abortions. One nurse told me of a case she witnessed in 2008, of a woman who had an abortion at 14 weeks. Fifteen minutes after the abortion, the patient started bleeding excessively, and it proved very difficult to stop. After regaining consciousness, the woman confessed she had undergone three sex-selective abortions in two years.

Underreporting and misdiagnosis are widespread because of the shame and grief associated with the loss of a pregnant or recently delivered woman. Neither the family nor the health facilities like to admit to maternal death. It is likely the rate of death due to unsafe abortion in Việt Nam is also underreported because such procedures are not registered at all or are classified as 'haemorrhage' or other causes. Even though data on maternal mortality are unreliable and may understate the reality, it cannot be denied that late-term abortion, including sex-selective abortion, contributes to higher maternal mortality and morbidity.

Seasonal distribution of abortion

One day when the counselling room was quieter than usual, I took the opportunity to have a conversation with the nurse who was working as counsellor. I wanted to know why things were so quiet. She laughed and explained to me: 'It is the 1st day of the lunar month. Women rarely have an abortion on the 1st or in the middle of the lunar month. These times are for worship.' 'The number of clients is different at different times?' I asked. She replied:

Counting by the working day, there are more patients on Monday and Friday compared with Wednesday and Thursday. It is usually quiet on the 1st and the 15th of the lunar month. According to the season, it is more crowded just before and after the Tết holiday.

A 2005 study by the National Hospital for Obstetrics and Gynaecology produced similar data. Abortion rates across the year ranged from 7.5 per cent to 10.6 per cent, with the lowest rate in June and the highest in January. The abortion rate also varied throughout the week. Friday had the highest rate compared with the rest of the week (22 per cent on Fridays versus 17.6 per cent on Thursdays). The data also showed that 1.7 per cent of clients attended on the 1st day of the lunar month, 2.2 per cent on the 15th day of the month and 4.6 per cent on the 16th day of the month (Nguyễn and Nguyễn 2009).

I have found the hospital deserted on common ritual ceremony days, as in the following observation.

At 3 pm on 15 January, there were almost no clients in the family planning department. The staff were in a hurry to prepare offerings for the first 15th day ceremony of the year (*Lễ cúng Rằm tháng Giêng*), which is one of the most important ritual ceremonies for Vietnamese people. It is said: 'To make offerings the whole year is not equal to making offerings on the 15th of the first lunar month.'

Nguyệt, 16 weeks pregnant, was sitting in the counselling room. She looked sad and tired. The doctor told Nguyệt her pregnancy could be terminated by D&E, but if she delayed, she would have to undergo a medical abortion. A medical abortion would require more time than a D&E. Nguyệt's husband was away on business and she had someone taking care of her little daughter, so she wanted to have the abortion as soon as possible. However, the nurse in the counselling room advised

her to go home and wait until the Monday of the next week because of the 15th-day celebrations. Doctors do not want to perform abortions, especially late-term abortions, on this day.

To explain the differing numbers of clients on different days and the decline during ceremonial days and months, one nurse told me:

Women want to have their abortion on a Friday because they have two days off on the weekend. People do not want to do something immoral on the days of sacrifice or during Tết because they are afraid that sinfulness is more serious at such times, and unlucky things will happen to them. (Nurse, 50 years old)

Abortion in private clinics: Illegal and unsafe, but profitable and convenient

I met Hoa, who was 15 weeks pregnant, and her husband on a hot summer day in the public hospital. The couple was wet with sweat and confused about finding the abortion clinic. They had come from a province about 70 kilometres from Hà Nội. Although they had left home early in the morning, it was nearly lunchtime when they arrived at the hospital. They had to wait a long time to complete the administrative procedures, which cost VND320,000, by which time it was late afternoon. Hoa had an appointment for an abortion the following day. The counsellor advised her that it would in fact take three or four days for a late-term abortion. The couple did not have relatives in Hà Nội and could not afford accommodation near the hospital. Their small children were at home without a carer, so the couple had to return home by motorbike. In the end, they decided to have an abortion at a private clinic near their home without any tests. Hoa said:

I was introduced to a private clinic. The price was VND2 million. The fee for an abortion in public hospitals is VND1.2 million. The expenses for food and travel for me and my husband are very high. Abortion in a hospital is safer and cheaper than in a private clinic; however, the administrative process in hospital is complicated and takes a long time, waiting in crowded conditions. Abortion in a private clinic is conducted quickly and secretly, so I decided to have an abortion in a private clinic near my home. (Hoa, 14 weeks pregnant)

Like Hoa, many women chose to have an abortion at a private clinic, where they were at risk of unsafe practices. They were often poor rural women who lacked access to the safer abortion services offered by public hospitals or lacked awareness of the alternatives available to them. Some found out about the private clinics through acquaintances:

I have never gone to hospital to have an abortion, but I was told that the administrative procedure in the hospital is complicated. I would have to go through many doors to complete the administrative procedures and to have blood and uterine tests as well. It is crowded in hospital and I would have to queue up for a long time ... I decided to have an abortion in a private clinic for quickness, although I have to pay more money. My friend told me about a reliable clinic and I went there. I had never had a late-term abortion, so I knew nothing. In the private clinic, I had no test before the abortion. They said they would do an abortion for me immediately for the price of VND2 million. (Tân, 16 weeks pregnant)

Like Tân, many women chose the private and semiprivate sectors because of the convenient operating hours and shorter waiting times, but many also did so because of real or perceived obstacles to gaining admission to a public hospital where the standard of treatment was higher. While wealthy women in the city have more options for accessing an abortion by a trained practitioner, poor women in rural areas have fewer options. Differences in economic resources, geographic location and levels of awareness make for inequality of access to safe abortion.

Recently, a 'sex-selection package' has appeared at some private clinics. Some of the women in my core case group admitted they were offered an abortion after having foetal sex determination by ultrasonography.

When the doctor said it is a girl, I was very sad. She told me that if I wanted to have an abortion, she could help me. Her clinic also provides abortion services. She consoled me when I worried about the safety. She said she had regularly done abortions at 15–16 weeks pregnancy. (Phương, 15 weeks pregnant)

Assessing the abortion situation in private clinics, a provincial health manager said:

Illicit abortion in private clinics creates difficulties for evaluating the abortion situation and making policies on this issue. The medical facilities and the skill of abortion practitioners lead to complications.

However, women who want to have abortions have limited knowledge about them. They usually want to have an abortion at any gestation stage in a short time. (Manager, 54 years old)

The WHO (2003b) estimates that almost 20 million unsafe abortions are carried out globally every year. At the 1994 International Conference on Population and Development (ICPD) in Cairo, the international community recognised the pressing need to address unsafe abortion and called on governments to act:

All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services ... In all cases, women should have access to quality services for the management of complications arising from abortion. (UNFPA 1994: para. 8.25)

In Việt Nam, since 1989, the private sector has been allowed to provide abortions up to 49 days of pregnancy. Recently, semiprivate services provided by public sector employees working after hours are becoming more common in urban as well as rural areas. The judgement of the WHO (1999: 53) on abortion services in Việt Nam's private sector is as follows:

The number of private sector abortion service providers, with or without official sanction, is unknown but is believed to be growing rapidly in Vietnam's largest cities and towns, particularly in the south of the country.

Regulation of the private sector varies by province, and in some cases includes periodic inspection, short-term training courses and punitive fines. In provinces where the private sector is prohibited from providing abortions, services are provided covertly and are far more difficult to regulate.

The MOH's circular letter guiding Ordinance 07/2007/TT-BYT on private clinics decrees that private obstetrics and gynaecology clinics only conduct 'menstrual regulation' for women who are less than 49 days pregnant (less than seven weeks). Clinics that violate this ordinance are to be fined VND3–8 million and their permits to practice revoked. An official in the Hà Nội health department confirmed that 'private clinics are not allowed to practice abortion, only "menstrual regulation". Billboards advertising the provision of abortion violate the regulation

on abortion' (personal communication, 21 October 2009). Despite this, private obstetrics and gynaecology clinics are booming around public hospitals, especially well-known hospitals such as Bạch Mai Hospital, Army Hospital, National Hospital for Obstetrics and Gynaecology and Hà Nội Obstetrics and Gynaecology Hospital. Outside the gate of the Hà Nội Obstetrics and Gynaecology Hospital, I counted more than 20 private obstetrics and gynaecology clinics. Most of these had billboards advertising abortion services. The situation was similar around Bạch Mai Hospital, where there was an 'abortion market' in a nearby street crowded with private clinics offering abortion. Potential clients are invited to have an abortion regardless of the stage of their pregnancy. Describing such a private clinic, a woman told me:

My friend introduced me to a private clinic to have an abortion. When I went there, I was frightened by the facilities in this clinic. The clinic was simple and untidy; it was in a small alley. It took 30–40 minutes from the road to walk to the clinic. I did not see any equipment or professional tools. If I had excessive bleeding, I would have died before receiving emergency aid. (Cúc, 13 weeks pregnant, Vĩnh Phúc province)

Although private clinics are not supposed to provide second-trimester abortions, these procedures are conducted with inadequate facilities by unskilled providers. Women use private clinics because of their convenient operating hours and shorter waiting times and the wider range of services they offer, including those that are illicit.

Perceptions of sex-selective abortion

Women's perceptions

As I outlined in Chapter 2, termination of pregnancy is seen as a sin in Việt Nam, but there is a moral differentiation between early and late-term abortions. Several of the women in my study who had a sex-selective abortion told me that abortion early in the second trimester was acceptable, but they would not have an abortion late in the second trimester because the foetus was too big and had the completed shape of a baby. Sex-selective abortion is very often the result of a planned pregnancy, which makes it difficult for women to decide to have an abortion. A woman who had an abortion when 14 weeks pregnant told

me it was very common for women to have an abortion if a pregnancy was unplanned, but to go ahead with an abortion when the pregnancy was planned just because the foetus was female was a regrettable act.

The two things women were worried about before an abortion were the moral issues and, in particular, the degree of pain. The most common question I heard women ask was, 'Is it painful?' According to some authors, the degree of pain experienced during abortion varies with the age of the woman, the stage of pregnancy, the amount of cervical dilatation and the individual's level of fear (Smith et al. 1979). Helping women relax before and during the abortion procedure can help reduce pain, and adequate counselling can lessen a woman's fear.

A cervical preparation procedure is performed usually three or four hours before an abortion. Prostaglandins may be administered orally or inserted into the woman's vagina.⁴ From that point, women have to stay in the waiting room, where the tension is palpable. This is the most stressful time for them. I saw one woman crying before going to the operating room, and she said, 'Mummy doesn't want to do this, but I have no choice. Forgive me.' Some women were still asking themselves, 'Am I doing the right thing?' Clearly, even at this late stage, many were still ambivalent about abortion.

Women in this situation experience 'not only physical pain and trauma, but also moral anguish and emotional turmoil' (Gammeltoft 2002: 313). The emotional wrench is particularly poignant, because abortion is the end of the life of the foetus, the end of a pregnancy that may have lasted for months and a separation of the foetus from the mother. As we have also seen in the sex-selective abortion decision-making process, the perception that abortion is sinful weighs particularly heavily on mothers as they wrestle with their choice. In my study, women had to cope with the anxiety, fear and grief that accompany abortion and the moral pain of shame and guilt without the psychological support of adequate counselling. In these circumstances, ritual activity serves as one means of coping. On the threshold of proceeding with their abortion, women usually seek help and compassion from spiritual beings and powers. The case of one couple, Hài and Huê, offers an illustration.

4 Prostaglandins are locally acting messenger molecules. Prostaglandin-induced abortion is a method for terminating pregnancy in the second trimester in which prostaglandins are administered to induce uterine contractions, followed by cervical dilation.

Hải looked very tired after nearly two weeks of following his wife to a series of clinics to check the sex of her foetus and two days in hospital to complete the administrative requirements for an abortion. It was nearly lunchtime when his wife, Huệ, took a drug to prepare for her abortion. It would be another four hours before she could have the procedure. She felt pity for her husband, so she urged him to go home to rest as their house was not far from the hospital. Before her husband left, Huệ reminded him to burn incense and pray for her safe abortion. After he left, she told me she had not slept well the previous night. She had woken at four in the morning and burnt incense to ask the spirit of her foetus to forgive her. She said to me:

There is so much fear that I became ill. I do not want to do this, but I am in a difficult situation. It [her foetus] is too big, with a face and body.

I asked her how these ritual activities helped her. She said: 'To worship is to have sanctity; to abstain is to have goodness [*Có thờ có thiêng; có kiêng có lành*].'

As she prepared for the termination, Huệ sought forgiveness from the spirit of her foetus, for whom she felt attachment, pity and obligation. Her personal anguish was compounded by the private, hidden nature of her act and her perception that what she was about to do was immoral. Her feelings of responsibility and foreboding were reinforced by the formal undertaking imposed on her by the hospital to accept responsibility in case of complications.

My research shows that in thinking about abortion, women confront a dilemma when weighing up the moral and the personal issues while also considering social norms. Having an abortion is a very personal decision, but these findings suggest that, in this context, women's decisions also reflect the collective opinions of those around them and/or the social conventions within which women have to defend their decision.

Providers' perceptions

Doctors in the public hospital I studied did not want to perform late-term abortions because, like their patients, they were aware of the morally problematic nature of such procedures. More importantly, they felt a keen sense of professional responsibility because of the increased risk of complications when pregnancies were terminated in the late

stages of gestation. Complicating all this is the fact that the hospital provides late-term abortion because it meets the demand from women for such a service, it boosts the hospital's profits and it meets the aims of the country's population policies. One doctor said:

Late-term abortion is dangerous, but it has been conducted because it helps women deal with their undesired pregnancies, and the hospital can have more profits by setting a high abortion fee. Abortion also contributes to reducing the population growth rate. (Doctor, 55 years old)

A doctor specialising in abortion described the late-term abortion process as follows: 'To conduct a late-term abortion, the foetus is dismembered, crushed, destroyed, and torn apart.' She considered this savage act to be murder. She said sex-selective abortion was different from termination of unplanned pregnancies because sex-selective abortion was intentional. She said doctors did not want to do this job, but they had to. She has sought psychological balance by undertaking ritual customs. She confided:

I always think about the moral issues when I conduct this job, but I try to stay in balance between 'materialism' [*duy vật*] and 'spiritualism' [*duy tâm*] in order to avoid mental suffering. I do not want to do this job forever. After I have had to perform a late-term abortion, I go to the pagoda for prayers to balance my psyche. Most women have abortions following unplanned pregnancies, and I think that is normal. What happens if women have to give birth if their pregnancy is unplanned? Who will help them deal with this matter? However, it is different when they have the pregnancy intentionally and have an abortion only because the little one is a girl. Killing a girl to have a boy is a savage action. (Doctor, 47 years old)

Like this doctor, others also found it traumatic to conduct a late-term abortion. They wished there was a method of killing the foetus before it was removed through abortion. A doctor expressed her thoughts:

I feel less anxious when I conduct abortions for stillbirth cases. I wish there were an abortion method that made the foetus die before the abortion. It would help doctors feel less anxious and less stressful when we have to do this job. It would make me think I am conducting an abortion for a stillborn baby, not a live one. I do not want to kill live babies. (Doctor, 43 years old)

Obstetrics and gynaecology experts in Việt Nam suppose that killing the foetus before abortion is possible; however, this method can be dangerous for the mother's health. In this situation, the mother's health must take priority.

Nurses also did not want to assist doctors in late-term abortion procedures, and were afraid of the moral and spiritual issues involved. A nurse told me:

I do not want to do this job, but I have to do so. I always feel a chill when I have to perform a late-term abortion. I feel great pity for the unfortunate babies. Their figures are formed, but they have been eliminated. Sometimes, I cannot sleep thinking about the babies' images. I burn incense and pray for the little souls on the 1st and the 15th of the lunar month to relieve anxiety or go to the pagoda to restore peace of mind. (Nurse, 35 years old)

Abortion providers had a range of views about sex-selective abortion. Some supported it. According to these people, women who had two daughters should be allowed to have an abortion. A nurse/counsellor said:

Many women are in a miserable situation because they have only daughters. If we do not provide a safe abortion for them then they will find other clinics to have an unsafe abortion. However, they should be counselled on health problems related to abortion and they should not have repeated abortions. If they want to have a boy, they should apply preconception sex-selection methods such as detecting ovulation. (Nurse, 38 years old)

A doctor expressed his opinion:

Nobody would admit that they are having a sex-selective abortion. We have no reason to say they are having a sex-selective abortion either. If we do not provide abortion services for them, they will find the service in private clinics. Private clinics providing abortion services are sprouting like mushrooms. The facilities and sterilisation conditions in private clinics do not meet the standards. It is dangerous [for] patients. (Doctor, 54 years old)

Others opposed sex-selective abortion because they thought it was immoral and should be condemned. Some counsellors tried to persuade women against it by explaining the potential complications and/or highlighting the moral or religious sanctions against abortion. A nurse

shared her experiences: ‘Some women insisted on having an abortion. I have tried to dissuade them by asking if they would suffer torment or would be condemned by their unborn children’ (Nurse, 52 years old).

All doctors and nurses mentioned the dilemma related to abortion regulations. On the one hand, abortion is legal and women have the right to access it. Providers cannot refuse to provide abortion services. On the other hand, sex-selective abortion is illegal. Most women do not give the real reason for wanting an abortion—that is, because of the foetal sex. The usual reasons given include having enough children already, their last child is still too young or they have been using antibiotics during pregnancy. When a reason other than sex selection is given, providers cannot refuse to provide the service. ‘If we refuse to provide an abortion for them, they can find other places with unsafe abortions’ (Doctor, 56 years old).

Managers’ and policymakers’ perceptions

The ICPD in Cairo advocated for prochoice policies to promote reproductive rights. Is there any contradiction between the prochoice stance and ‘illegal’ sex-selective abortion? The question is whether the right to choose is reduced when both strategies—legal abortion and illegal sex-selective abortion—are implemented through legislation. Therefore the core issue is how to distinguish between a ‘sex-selective abortion’ and a ‘non-sex-selective abortion’ if the real reason for the abortion—sex selection—is concealed.

Managers and policymakers therefore face a dilemma between enforcing women’s rights to access abortion and forbidding sex-selective abortion. As in China and India, the Vietnamese Government faces the difficult issue of how to supervise sex-selective abortion in a context in which abortion is legal. The manager of a public hospital shared his opinions on the disjunction between population and abortion policies and practices:

Abortion is a woman’s right. Women have a great many reasons for abortion. They can provide any reason. Only women know the reason for their abortion. If they do not tell the truth, nobody knows. We have disseminated the regulations and policies to the health staff. If we catch a case of sex-selective abortion, we will deal with it according to the regulations. However, nobody says they want to have a sex-selective abortion, and no doctors write on the medical record that their case is a sex-selective abortion. (Public hospital manager, 52 years old)

The manager of the family planning department also spoke of the dilemma between the right to abortion and the prohibition on sex-selective abortion. He said:

Having more children or not is a woman's right. If they give reasons such as having enough children, we cannot refuse. If we refuse, they will sue us. We have no evidence to say that they are having a sex-selective abortion. I suppose the prohibition on sex-selective abortion would be unfeasible and impractical if we only based it on the law and regulations. (Family planning department manager, 54 years old)

The ability of managers and policymakers to deter illegal sex-selective abortion is constrained by their legal obligation to provide abortion for other reasons. A manager said:

Population policy regulates that each couple should have the number of children they want and have the right to abortion. If we refuse to provide abortion services for them, they will sue the doctor for preventing women from implementing family planning. (Public hospital manager, 57 years old)

Policymakers are aware of the disjunction between public policies and practices.

We have had the Population Ordinance prohibiting foetal sex selection by any methods (Item 2, Article 7). However, it is not enforced strictly. Nobody has been punished so far. To supervise and identify a case of sex-selective abortion is like finding a sewing needle in the ocean. We cannot do it. Instead of prohibition, we should deal with this matter by addressing the root causes, such as providing social security for elderly people. (Policymaker, 58 years old)

The conflict health officials face between their responsibilities as providers of safe abortion and as enforcers of population regulations is a thorny governance challenge that is primarily of concern to policymakers. However, equally profound conflicts trouble all those who are involved with the practice of sex-selective abortion. Women who undergo these abortions are torn between the pressure they are under to have a son and the emotional stress and ethical doubts they experience. Counsellors and other medical staff are divided between their responsibilities as health professionals and the compassion they feel for their patients. Doctors in the public health system know the practice is illicit, but they feel constrained by the need to offer abortion for the sake of the mother's health. Almost every person I met found

sex-selective abortion ethically troublesome. One can see that, although all of these actors participated in the practice in one way or another, for all of them, sex-selective abortion is a peculiarly troubling practice.

Conclusion

In short, the issues surrounding abortion highlight the tensions between notions of equality and authority, freedom and necessity, individuality and collectivity, ethical and legal rights, and the duties and obligations of women, abortion providers, policymakers and others. However, one of the most striking aspects of sex-selective abortion in Việt Nam is that it is largely not spoken about. The silence itself is the result of multiple factors; any single explanation will distort its complexity. The public and private silences surrounding sex-selective abortion have personal, sociocultural and political meanings; people remain silent in different ways and for different reasons. According to Nie Jing-Bao (2005), silence about abortion might signify self-protection, fear, helplessness, self-censorship, anger, shame, anxiety, bitterness, acceptance, embarrassment, indifference, resistance, disagreement, a desire for secrecy, privacy or escape or simply having nothing to say. Looking at the silence around sex-selective abortion from an anthropological approach, I offer some conclusions.

Most of the women in my study who had a sex-selective abortion were 12–16 weeks pregnant. Owing to the time it takes to ascertain the sex of a foetus, sex-selective abortion is usually conducted in the second trimester of pregnancy. Therefore, although the reasons for these abortions were almost never given, we can conclude that sex selection was a factor contributing to late-term terminations. Second-trimester abortions cost more, are more time-consuming and are a burden both to women and to an already overloaded health system. Women suffer mental health problems when they terminate a planned pregnancy late in their term, when their foetus is considered ‘normal’ and when it is so large that it has the appearance of a fully formed child. This sacrifice is extremely painful and further deepens the silence.

Women who undergo a sex-selective abortion remain silent because they are in a state of confusion, fear and anxiety about the medical, legal and moral dangers of late-term abortion. Undertaking sex-selective abortion almost always under other pretexts, they are unable to obtain

adequate advice about their situation from health providers, vent their complex emotions or discuss the alternatives. Women in this situation are faced with the bitter moral issue of ‘killing’ their own child. Despite its prevalence, abortion is condemned in contemporary Việt Nam (Bélanger and Hong 1998, 1999; Gammeltoft 2002) and is negatively defined in public life as an individual moral failure (Gammeltoft 2003).

Second-trimester abortion entails a traumatic experience for abortion providers as well. Counsellors usually are aware of being involved in a sex-selective abortion and often express their frustrations openly, yet they are constrained in what they can do to help the woman or deter her from having the abortion. Doctors also find late-term abortion difficult, considering the human-like form of the foetus they have to remove. From a cultural and psychological perspective, counsellors and doctors share the values that bring women to hospital. They feel pity for women who have only daughters and want to help them. Counsellors and doctors—who can be considered gatekeepers in the sex-selective abortion process—remain silent about their involvement because they sympathise with the women. Sharing the same moral and religious framework as their patients, many handle their complex emotional and ethical reactions to the abortion process through ritual. From an ethical perspective, public hospital providers also feel constrained by their concern that women who are refused late-term abortion may undertake unsafe procedures in private clinics.

The silence surrounding abortion can be interpreted as being not only rooted in the sociocultural context, but also reflecting current public policies. Women and healthcare providers confront disjunctive regulations that are yet to be debated in public. Public sector abortion providers remain silent about sex-selective abortion because of the dilemma they face between their obligation to provide legal and safe abortion and the ban on sex-selective abortion. The regulation forbidding sex-selective abortion, of course, makes sex-selective abortion seekers and providers fearful of revealing their activities. Therefore, the silence in this context is simply to avoid trouble.

One of the difficulties in prohibiting sex-selective abortion is the lack of public debate on policies and regulatory systems governing professional health practices. In practice, the Population Ordinance is clearly perceived as difficult to enforce because there are no other forms of regulation of healthcare professionals’ work. We know that

the SRB—an indicator of sex-selective abortion—has been rising rapidly in recent years even though the government prohibited sex-selective abortion in 2003. Policymakers know it is very difficult to prohibit prenatal diagnosis of sex because ultrasonography is so widely available. It is also extremely difficult to prove and prosecute any violation of the relevant legislation. Health managers are aware that the abortion services offered through the booming private sector in urban and semi-urban areas create not only a high risk for women's health, but also the conditions for sex-selective abortion. However, social and academic debates about the negative effects of these policies and to propose effective alternatives are yet to occur. Free public discussion is not a complete solution in itself, of course, but it constitutes an essential social mechanism for understanding the nature of the problem and devising effective solutions.

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