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Social responses to sex-selective abortion

Demographic data indicate the proportion of male to female births in Việt Nam has increased over the past two decades, especially since 2003. The Intercensal Population and Housing Survey in 2014 conducted by the UNFPA provides an estimate of the national SRB as 112.2 male births per 100 female births. Although the government and social organisations have taken a number of measures to try to deal with this matter,¹ the upward trend in the national SRB has not yet been effectively restrained. The rapid increase in the SRB raises questions about the effectiveness of strategies aimed at combating prenatal sex-selection practices. What are the sociopolitical responses to this phenomenon? Why have they had such a limited effect? This chapter reviews current debates about sex-selective abortion, focusing on the social and political responses to the practice and aiming to open discussions about potential avenues for confronting the challenges posed by sex selection in Việt Nam.

1 The Vietnamese Government has attempted to address sex-ratio imbalances, including through laws that prohibit the determination and disclosure of the sex of the foetus and any advertising relating to prenatal sex determination. The laws provide punishment such as fines for anyone contravening them.

Attitudes towards sex-selective abortion: Global debates, local dilemmas

In 1990, Indian economist Amartya Sen published an article titled 'More than 100 million women are missing'. It rang an alarm bell for the world about increasing SRBs. The issue of sex selection was first raised at the ICPD in 1994. Section 4.15 of the ICPD's program of action discusses sex selection as a problem arising from son preference and discrimination against girls from the early stages of their lives—compounded by new technologies that can determine foetal sex and facilitate abortion of female foetuses:

Since in all societies discrimination on the basis of sex often starts at the earliest stages of life, greater equality for the girl child is a necessary first step in ensuring that women realise their full potential and become equal partners in development. In a number of countries, the practice of pre-natal sex selection, higher rates of mortality among very young girls, and lower rates of school enrolment for girls as compared with boys, suggest that 'son preference' is curtailing the access of girl children to food, education and health care. This is often compounded by the increasing use of technologies to determine foetal sex, resulting in abortion of female foetuses. (UNFPA 1994: s. 4.15)

The next year, the Beijing Platform for Action listed practices considered 'violence against women', including prenatal sex selection and female infanticide. It declared that these were:

Violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery and forced pregnancy; forced sterilisation, forced abortion, coerced or forced use of contraceptives; pre-natal sex selection and female infanticide. (UN 1995: paras 115, 116).

These two documents created the foundation for several countries either prohibiting or recommending against the use of various technologies for sex identification and sex-selective abortion. For instance, Article 14 of the Council of Europe's 1997 Convention on Human Rights and Biomedicine states that 'techniques may not be used to choose a future child's sex, except where serious hereditary sex-related disease is to be avoided'.

However, the value of restricting prenatal sex selection has been debated vigorously in reproductive forums. Sex-selective abortion intensifies existing debates and brings out new ethical and sociopolitical challenges. If debates about abortion in general are concerned mainly with women's rights versus foetal rights, the challenges with respect to sex-selective abortion include the morality of abortion, the clash of values, the persistence of gender discrimination against women, the meaning of procreation, the boundaries of individual liberty and choice, individual and collective responsibility in the technological age, the importance of the 'common good' and the power and limits of the state to prevent harm and promote social wellbeing (Jing-Bao 2010). The essential question is whether prenatal sex selection should be restricted. The notion of reproductive liberty is the most common argument made against proscribing sex selection. Two articles in the journal *Human Reproduction* capture the spirit of the debate: Claude Sureau's 'Gender selection: A crime against humanity or the exercise of a fundamental right?' (1999) and Giuseppe Benagiano and Paola Bianchi, 'Sex pre-selection: An aid to couples or a threat to humanity?' (1999). The 'liberal' argument for sex selection supposes that the rights of parents are paramount (Dahl 2003). In the meantime, there is widespread opposition to sex selection.

Opponents argue that enacting legislation banning the practice of sex selection will create tensions between the discourses about abortion rights and those about gender equality. Daniel Goodkind (1999b: 52) writes:

Restricting the practice would seem to interfere with reproductive freedoms and maternal empowerment, the twin goals adopted at the recent Cairo conference. The restrictions may also increase human suffering if sex discrimination is then shifted into the postnatal period.

Goodkind (1999b) raises five ethical issues related to legislative restrictions on sex selection. First, what is the effectiveness of government legislation in reducing sex-selective abortion where a culture of son preference remains untested? Second, the liberal interpretation of reproductive rights is that parents may choose the sex of their children—preferably, one boy and one girl in low-fertility societies. Third, even if a ban on sex-selective abortion was effective, human suffering may be increased if parents substitute postnatal for prenatal discrimination. Fourth, the restriction of sex-selective

abortion might undermine individuals' rights to reproductive freedom and could lead to a decline in the availability of abortion services. Fifth, there is no solid evidence that a shortage of females will have a detrimental effect on women's wellbeing.

Drawing on the ethical and sociopolitical debates surrounding the proscription of sex-selective abortion, Nie Jing-Bao (2010) discusses practical problems inherent in state-centred and coercion-oriented approaches to preventing sex-selective abortion: the neglect of reproductive liberty and reproductive rights; overlooking the hidden dangers of state power; inconsistency with existing abortion policies; ineffectiveness in practice; underestimating the costs and resistance involved; simplifying and misrepresenting the key problems to be solved; a lack of sufficient public discussion; and ignoring indigenous moral and political wisdom.

Opponents of sex-selective abortion argue that the issue of reproductive liberty is of little importance because the problem of a severely imbalanced sex ratio poses a great threat to society. Jing-Bao (2010) argues that although reproductive liberty matters, it must be sacrificed for the common social good, according to the 'two concepts of liberty' (Berlin 1969). Meanwhile, some observers discuss the consequences of sex-selective abortion. Analysing the short-term and long-term implications of sex-selective abortion, Danièle Bélanger (2002) indicates that, by terminating a pregnancy because the foetus is female, many women can gain legitimacy, earn recognition and acquire status in their family and community. Sex-selective abortion can therefore help women avoid having more children than they want and allow them to limit the size of their family. Therefore, sex-selective abortion is empowering for women who face pressure to produce a male heir. However, Bélanger (2002: 194) also supposes:

viewing sex-selective abortion as strictly empowering is unquestionably short-sighted ... Sex-selective abortion, while empowering women in the short term, will most likely continue to further threaten their position in the long term.

The long-term consequences of sex-selective abortion include an imbalance in the sex structure of populations, with a shortage of women leading to their detriment through increased violence (or even war due to a shortage of brides) and a decline in women's political power because of fewer women voters (Bélanger 2002).

The Vietnamese Government has been warned that the imbalance in its SRB could lead to a number of social problems in coming years. Former deputy prime minister Nguyễn Thiện Nhân told state media in 2010 that the government was concerned about the increase in the SRB and its consequences. However, despite such statements, effective policies to address this trend have yet to be developed. More fundamentally lacking in the policy response is a clear understanding of the factors behind this trend and of the links between it and the phenomenon of sex-selective abortion. In particular, a better understanding of the relationship between sex-selective abortion and state policies is critical for the formulation of an effective policy response.

How the state and social organisations have responded to the vexed phenomenon of sex-selective abortion is one of the issues with which this chapter is concerned. However, first I consider another question—the extent to which this reproductive practice is itself a response to state policy settings. To situate sex selection within Việt Nam’s political context, I review the country’s policies on population and abortion. I contend that recent policy changes in these two areas have impacted on sex selection in several unforeseen ways.

Social responses to population and abortion policy

Population policy

The first of these state policies relates to population control. The Vietnamese Government launched the one-or-two-child policy in the 1960s. After *Đổi Mới* in 1986, the government began urgently promoting a norm of one or two children for each couple. In the 1990s, the one-or-two-child policy strongly focused on limiting family size through the provision of family planning services, including abortion (Johansson et al. 1998). The government’s population programs were effective in reducing the total fertility rate, from 3.1 in 1994 to 2.3 in 1999 (UNFPA 2007).

The impact of the change in policy on population outcomes, including on the SRB, has been discussed by stakeholders, policymakers and social scientists. Annika Johansson et al. (1998) indicated the need for

sons was still strongly felt in North Vietnamese culture. In addition, the one-or-two-child policy introduced new and potentially contradictory pressures on women. On the one hand, women who did not have a son were worried about not producing a male heir. On the other hand, they felt pressure from the authorities to stay within the two-child limit. Daniel Goodkind (1999b) and other authors have argued that contemporary manifestations of son preference are accentuated under the small family policy because, with fewer children, parents have a lower probability of having a son (Das Gupta 1987; Gu and Roy 1995; Das Gupta and Bhat 1997). As documented in this book, sex-selective abortion gives expression to the contemporary preference for sons, representing an attempt by women to reconcile the conflicting pressures they face. Such outcomes may not have been envisaged by population planning authorities and can be seen as an unintended consequence of the population control they espoused.

A second shift in policy settings, the consequences of which were also unforeseen, concerns reproductive autonomy. Influenced by the 1994 ICPD, Việt Nam's population policies advocated self-determination for families regarding family size and other reproductive health matters (Bélanger and Khuat 2009). The emphasis on women's rights in reproductive decision-making was made even more explicit in the subsequent population conference held in Beijing the following year. Reflecting these concerns, the 2003 Population Ordinance issued by the Vietnamese National Assembly states as its goal for citizens:

To decide the timing, number and spacing of births in accordance with the age, health, education, employment and working, income and child-rearing conditions of every individual and on the basis of equality between the couple. (National Assembly of Vietnam 2003: Art. 10, cited in Bang et al. 2008: 178)

Policies of this kind, which advocate self-determination over reproductive decision-making, reflect global concern about overly prescriptive family planning policies that create dilemmas for individuals whose needs, obligations and/or circumstances conflict with the reproductive agenda deemed desirable by state population planners. In a way that is responsive to these concerns, Việt Nam's 2003 Population Ordinance shifted the responsibility for reproductive decisions on to individuals and families, giving them a greater degree of discretion than before. This emphasis on reproductive

self-determination can also be placed within a broader set of changes in Việt Nam, away from centralised or command-style decision-making in social and economic affairs towards a more liberal governance approach. Since the late 1980s, individual households have had the right to make their own production decisions and have had increased responsibility for the consequences of those decisions. The 2003 Population Ordinance reflected this new model of devolved decision-making, in the sense that it accorded families rather than state planners more autonomy over their reproductive decision-making.

Article 10 of the ordinance has been construed as allowing couples to have as many children as they wish. However, it has also provoked internal criticism that free choice is leading to an increase in fertility. The increase in the fertility rate in 2003 (from 2.12 in 2002 to 2.23) created great concern among policymakers. Although the UNFPA (2005, 2006) determined that the fertility increase in 2003 had been caused by the popular desire to give birth during the Year of the Goat—believed to be a favourable birth year—the unexpected development prompted new calls for the enforcement of the one-to-two-child policy. Resolution 47, ‘Further Strengthening the Implementation of Population and Family Planning Policy’, issued in March 2005, expressed the Vietnamese Government’s concerns:

The surge in population would ruin what has been achieved, reduce socio-economic development and efforts to improve the quality of the population, slow down the country’s industrialisation and modernisation process, and make the country further lag behind ... The Population Ordinance and existing policies and regulations, which are not consistent with the two child campaign, should soon be revised. Policies on encouragement and incentives to communities, families and individuals with good records on population and family planning should be reviewed and revised accordingly. (Cited in Bang et al. 2008: 179)

One population policymaker said of these issues:

Some people misunderstood the 2003 Population Ordinance. Article 10 of this ordinance includes two items: 10a and 10b. Item 10a says couples have a right to have their desired number of children. But Item 10b regulates couples’ responsibility to comply with the population planning of the state. People, especially cadres and government workers, took advantage of the relaxation of the ordinance to have another child with the hope that it would be a son. (Population policymaker, interviewed in 2009)

This phenomenon reflects a trend of families taking advantage of the more relaxed population policies to achieve their desired reproductive outcomes. While giving individuals—particularly women—greater say over their reproductive lives, the ordinance also inadvertently provides scope for the expression of son preference. Certainly, the impact of different policy options on population outcomes is an issue requiring discussion among concerned stakeholders.

The final population policy I discuss relates to the emphasis on population quality. After achieving state population reduction targets, Việt Nam's population programs have shifted from birth control to the quality of reproductive outcomes. Several studies discuss this shift in focus (Johansson et al. 1998; Gammeltoft 2008). Population quality control programs have focused on the early detection of foetal anomalies with a view to minimising the number of children born with deformities and disabilities. These measures reflect a certain view of what constitutes a 'normal' population as well as a desire to reduce the potential burden on families and the wider economy posed by children requiring extremely high levels of care. The key measures in this program have been the use of prenatal ultrasonography to identify the health status of the foetus and the use of abortion services to abort any deformed, diseased or otherwise 'abnormal' foetuses.

One implication of this concern with population quality is that it is not restricted to central government authorities, but is also widely shared by parents. Clearly, education campaigns and the advice of medical professionals have transmitted the official population quality agenda to society at large, while also authorising and enabling strong interventions in reproductive processes in the interests of obtaining 'quality' outcomes. However, quality does not necessarily mean the same thing to all concerned. For instance, parents who strongly desire a son might regard a perfectly healthy female foetus to be a 'poor-quality' outcome or an all-girl family as 'abnormal' according to their notion of what a normal family should be. At the same time, one can see how parents might feel emboldened by official public health strategies that consider it acceptable to intervene in reproductive processes to achieve desired 'quality' outcomes. They may be similarly enabled to achieve their reproductive goals by the availability of scanning technology and abortion services. In short, one might posit a link between 'public' population quality policies and 'private' sex-selection practices.

Reproductive technologies and modes of intervention that have been made widely available to serve the normalisation of population quality policies are being used by individuals in ways unforeseen by state planners in pursuit of desired reproductive outcomes that are at odds with those of the state.

Abortion policies

Abortion has been legal in Việt Nam since 1954; however, the procedure was still rare until the beginning of the 1980s, when it started to increase, first slowly and then rapidly during the late 1980s, with the reinforcement of the one-or-two-child policy (Johansson et al. 1998). Việt Nam has one of the highest abortion rates in the world (more than 1 million each year), with many women undergoing multiple abortions (WHO 1999). In 2004 and 2005, there were 37.5 and 35 abortions for every 100 live births, respectively (MOH 2005, 2006).

Table 1. Abortion policies and induced abortion statistics for Việt Nam and selected countries, 2009–10

Countries	Government support for family planning	Year	Abortion rate*
Australia	Indirect ¹	2010	14.2
China	Direct ²	2009	19.2
Canada	Indirect	2009	13.7
Denmark	Direct	2010	15.2
Singapore	Direct	2010	10.8
Việt Nam	Direct	2010	19.0**

* Number of legally induced abortions per 1,000 women aged 15 to 44 years.

** The figure does not include abortions in the private sector.

¹ Indirect support is where the government does not provide family planning services through official outlets, but instead supports the private sector, including non-governmental organisations, in the provision of these services.

² Direct support is when family planning information, guidance and services are provided through government-run facilities.

Sources: Data for Việt Nam from MOH (2010); all other data from UN (2013).

Việt Nam's abortion rate of 19 per 1,000 women aged 15 to 44 years represents abortions provided by the public sector only (Table 1). A more recent study (Hoàng et al. 2008) suggests the number of abortions provided in the private sector equals that in public hospitals. The recent very high abortion rate in Việt Nam is an issue about which there has been relatively little public debate.

Since sex selection occurs largely by means of abortion, the two issues are clearly linked. One might consider the ease of access to abortion in Việt Nam, its prevalence and its routinisation to be among the key preconditions enabling sex selection to take place. Abortion services are inexpensive and widely available through public and private providers (Gammeltoft 2002). A great many clinics and specialists provide these services, making inspection and regulation extremely difficult. The high incidence of abortion also makes it difficult for health providers and regulators to determine why an abortion is being sought. Finally, the recourse to abortion as a way for parents to deal with pregnancies that fail to conform to state population planning guidelines also leads to the normalisation of abortion as a family planning measure. When families routinely use abortion to meet the state's reproductive goals, it is a short step to use abortion to secure the reproductive outcomes families themselves deem desirable.

In fact, this is one aspect of Việt Nam's abortion policies that has been debated. Different views exist about how to deal with this matter—for instance, most healthcare managers and population policymakers believe abortion regulations are too open. The conditions for having an abortion in Việt Nam are very simple; according to regulations, pregnancies of less than 22 weeks can be terminated if there is no medical contraindication. Managers and policymakers with whom I spoke proposed tightening regulations on abortion:

Perhaps it is necessary to reconsider the abortion policy. If abortion is too easy to access, people will take advantage of this in combination with sex determination by ultrasound technology to have sex-selective abortions. If abortion is managed closely, sex-selective abortions may decrease. (Population policymaker, male, 57 years old)

Meanwhile, others had contrasting views:

Recently, international organisations have required having a simple administration to create good conditions for women to access abortion services easily. If we tighten abortion policy, the number of illegal and unsafe abortions will increase. In some countries such as Romania and South Africa, the abortion fatality rate increased rapidly after a stricter policy on abortion was implemented. The number of sex-selective abortions is a very small number compared to abortions in general—just a few per cent. (Reproductive health policymaker, male, 54 years old)²

Legislation is a central part of the political framework around sex selection. However, the managers and policymakers with whom I spoke were conflicted about the right steps to take. The dilemmas are multiple: balancing women's rights, reproductive rights and customary rights; building adequate legislation for the use of new reproductive technology while preventing the misuse of that technology to detect the sex of a foetus; and making safe abortion accessible versus enforcing stricter regulation of abortion. In fact, strict law enforcement could create difficulties in accessing reproductive services and increase the fee for using them, and illegal abortions conducted by unregistered and untrained providers could increase the serious potential health consequences for women. There is a lower incidence of unsafe abortion and a much lower mortality rate in countries where legislation allows abortion on broad indications than in countries where abortion is heavily restricted (Berer 2008).

2 This statement indicates the policymaker's limited knowledge. First, the 'simple administration' that international organisations require corresponds to good clinical governance—for example, ensuring doctors and nurses follow rules of best practice—which does not always occur in Việt Nam. This is evident in accounts of abortion practices. The policymaker here has misunderstood the statement as a request to 'tighten up abortion policy', which is not the intention of international organisations. It is interesting that, because there is so little discourse around clinical governance and regulation for good practice among health practitioners in Việt Nam, this speaker, who works in reproductive health policy, has not understood the importance of the push from international organisations for the health system to function in a way that is more resonant with norms of best practice. Second, the example from South Africa is factually incorrect. South Africa moved from a prohibitive stance to a more liberal stance, with legislation that allowed abortion, in 1996. After South Africa legislated the introduction of safe abortion, the mortality rate due to abortion sepsis dropped a little; however, this reflected the poor state of the health system, which was slow to make safe abortion readily available (Coovadia et al. 2009).

Some researchers (Goodkind 1994; Bang et al. 2008; Bélanger and Khuat 2009) argue that parental discrimination against a female foetus is exacerbated by population policy. In this view, ‘sex-selective abortions are interpreted as a “public” act, in that they reflect contemporary government pressure, constrained reproductive choices, and lack of political will to stop such acts’ (Goodkind 1994: 351). However, in light of the preceding discussion, one might refine this observation to note that, in a context of decentralisation and increasing reproductive autonomy, measures such as family planning and abortion—which were once used to prosecute a state’s population and public health agenda—are now increasingly being used by the population at large to advance reproductive agendas that differ significantly from those endorsed by the state. It is in this sense, too, that sex-selective abortion might be considered a ‘public’ act, enabled as much as constrained by the public policy context in which it occurs.

The response of local and national authorities to sex-selective abortion

Nie Jing-Bao (2010) concludes that the one-child policy, together with greater economic and civil freedoms, contributed to an increased SRB in China. He argues that the problem of distorted sex ratios might not have become so serious if there had been public debate about the issue from the outset. Although they have known about the distorted sex ratio since the late 1990s and early 2000s, Chinese officials have denied the existence of the problem by underreporting the number of female deaths (Peng 1997). They have tried to show that China’s SRB is not unbalanced. Of course, free public discussion is not a complete solution in itself, but it would help to identify the problem and to suggest effective measures to deal with it before it becomes serious. Similarly, Việt Nam has responded slowly to the rise in its SRB, which may have been occurring since 1999, when there were 107 boys born for every 100 girls, with an average annual increase of 1 point. However, responding to voters’ questions at the 10th meeting of the 9th National Assembly in 2006, the Vice-Director of the Reproductive Health Department of the MOH gave a written reply: ‘There is no indicator to confirm the imbalance of sex ratio at birth’ (‘The imbalance of sex ratio at birth has been an apprehensive issue,’ Response to the dispatch 740/VP1, 06/11/2006, MOH). Although the Standing Committee of

the National Assembly passed its Population Ordinance in January 2003 prohibiting sex-selection by any means, and the government promulgated the 'implementation decree' for this ordinance in October 2006, government officials only began paying attention to the rise in the SRB when the UNFPA released the results of the 2006 Population Change Survey in Việt Nam. The report warned:

When inferential analysis (i.e. conclusions deduced from sample data) is added, along with information on the number of deliveries in 2006 coming from health facilities, it can now be confidently stated that the sex ratio of births at the national level is slightly skewed toward boys. However, provinces/cities with high SRB (above 110) need close monitoring and immediate attention. (UNFPA 2007: 4)

In 2006, the Vietnamese Government adopted a series of regulations and policies prohibiting prenatal sex determination and sex-selective abortion. All organisations and individuals were strictly forbidden from performing nonmedical foetal sex determination and sex-selective abortion. To respond to the increase in sex selection and public concern about this issue, the government issued Decree No. 114/2006/ND-CP in October 2006, which stipulated fines of between VND500,000 and VND15 million for people using traditional practices to determine the sex of a foetus or promoting or practising abortion for the purpose of sex selection. However, prohibition of sex-selective abortion is not simple for number of reasons. As we have seen in previous chapters, abortion of foetuses of the undesired sex can be concealed easily by the parent providing other reasons for the abortion. It is also difficult to prohibit diagnosis of foetal sex because the services for foetal sex determination are widely available. And it is hard to procure evidence and prosecute violations of the regulations on foetal sex determination. The feasibility and the enforcement of this decree show some shortcomings that will be considered in the next section of this chapter.

The increase in the SRB in Việt Nam came at a late stage compared with other countries, such as South Korea, China and India, where imbalances in the SRB started to appear in the early 1980s. The increase in the SRB in Việt Nam did not occur before the late 1990s; however, from then on it increased rapidly, gaining 1 point per year. This rate of increase is higher than that measured in South Korea and China during the 1980s (Guilmoto et al. 2009). This phenomenon is commonly explained by the lack of adequate medical facilities and equipment in Việt Nam in the 1980s, such as private clinics and modern ultrasound

machines (UNFPA 2009a). Ultrasound technology first appeared in some major hospitals in the mid-1990s and has since become widely available in the private health clinics that have been springing up in urban and semi-urban areas.

In the decade from 2010, Việt Nam was in almost exactly the same position as China had been in the late 1990s. In this regard, it is necessary to reiterate comments by Ian Howie, UNFPA's representative to Việt Nam, in 2006:

Việt Nam's population dynamics have changed rapidly over the past decade, accompanying swift developments in the country's social and economic structures. There is some evidence that the national sex ratio at birth is currently tilted toward a higher-than-expected number of boys. It is imperative Việt Nam pays close attention to this phenomenon, to ensure it continues on a positive development path and avoids the numerous problems that arise from a skewed gender balance. (Institute for Social Development Studies 2007: 18)

The Vietnamese Government is conscious of the importance of controlling the SRB. In its national gender equality strategies for 2011–20, approved on 14 November 2011, the SRB was one of the indicators targeted. In trying to control the rapid increase, the government has set a target for the SRB to be lower than 113 by 2015 and 115 by 2020.

The Vietnamese Government has provided strong support to reduce the SRB by introducing various regulations banning sex selection. However, it is far from certain how effective the implementation of regulations prohibiting prenatal sex determination and sex-selective abortion has been. The legislative approach that has been adopted in Việt Nam needs further evaluation and discussion to determine whether it is capable of achieving its aims. It is necessary to have comprehensive strategies that involve healthcare providers, social organisations, community members and mass media as agents of change.

The General Office for Population and Family Planning of Việt Nam (GOPFP) initiated an intervention project to reduce the SRB in 18 provinces with a high SRB rate in 2009 and 2010. The specific objectives of the project were to: 1) provide information on the imbalance in the SRB for couples of childbearing age, sonographers, abortion service providers and people who had prestige in the community, to reduce the activities leading to the imbalance in the SRB; 2) implement and

enforce regulations relating to the SRB; and 3) encourage and support women and girls through education, reproductive health care and economic development.

Improved knowledge about the incidence of sex-selective abortion in Việt Nam is an essential precondition for effective government action to manage this problem. Evidence from other countries in the region suggests that the rapid increase in the SRB occurs mainly through sex-selective abortion. This study has also confirmed that sex-selective abortions are being conducted routinely in Việt Nam in a covert and tacit manner. However, in a workshop titled ‘Creating a Shared Vision to Address the Imbalanced Sex Ratio at Birth in Việt Nam’, organised by the UNFPA in collaboration with the GOPFP in November 2010, many Vietnamese government officials in attendance revealed they believed the rise in the SRB was a result of ‘traditional methods’ of preconception sex selection, such as the timing of sexual intercourse and the use of traditional medicine, and not the use of ultrasonography and abortion. A colleague of mine, who for many years has studied abortion in Việt Nam, attended this conference and was disappointed by this stance. The question is why government officials did not admit that sex-selective abortion was the main cause of the increase in the SRB in Việt Nam. Were they lacking in information about the incidence of sex-selective abortion or were they trying to find alternative explanations to deflect social criticism of their slow and insufficient response to the problem? As the Indian prime minister has noted of his country, sex-selective abortion and high rates of female infant mortality are a national shame. Việt Nam’s policies on sex-selective abortion have been copied from countries with an imbalanced SRB, rather than being modified to account for the motives, methods and experiences of those who undergo sex-selective abortion in Việt Nam. Perhaps official acknowledgement of the existence of sex-selective abortion in Việt Nam will require the same measures that led to the earlier government acknowledgement of the increase in the SRB—an admission made only after the 2006 Population Change Survey. The statistical data the survey produced played a crucial role in changing the government’s perspective. In a similar way, research on sex-selective abortion in Việt Nam is likely to improve public knowledge of the phenomenon and prompt the formulation of policy to address it.

Healthcare system responses

Prenatal sex selection and health sector reforms

In Việt Nam, the proliferation of ultrasonography—a popular obstetric technology—coincided with economic and comprehensive health sector reforms initiated in the late 1980s. Ultrasound services—especially prenatal scanning—have increased rapidly and have become an important source of revenue for public and private healthcare providers. However, the introduction of ultrasonography in antenatal care is occurring in an ad hoc manner, driven by market forces rather than health policy, which is leading to its overuse (Gammeltoft and Nguyễn 2007; Gammeltoft 2014). In addition, a lack of control over the practice of foetal diagnosis—particularly foetal sex determination—has social implications such as the increase in sex selection.

The *Đổi Mới* reforms that began in 1986 and ushered in economic liberalisation and privatisation have created dramatic changes in social service delivery systems. Renovation of Việt Nam's health sector began in 1989 with the introduction of user fees, private drug sales and gradual legalisation of private service providers (WHO 2003b). Two major changes in the institutional arrangements for the public health sector, driven by state-imposed fiscal constraints and management of health services, were the 'socialisation' of service provision (the encouragement of user-pays) and decentralisation of state budgeting and organisation of public services. Privatisation and commercialisation of the healthcare system have created conditions conducive to the use and abuse of technology for sex determination in Việt Nam. This phenomenon—combined with the weak supervision of abortion—has allowed sex selection to increase. The improved accessibility of private sector health services provides women with greater choice in reproductive health care, but, in this context, it also creates new pressures and avenues for women to achieve desired pregnancy outcomes.

Health system responses

In response to the increase in sex selection, the MOH issued Official Document No. 3121/BYT-BMTE, dated 21 May 2009, prohibiting the use of medical technology for sex selection, to limit the factors driving

the imbalance in the SRB. The MOH required all health facilities that offer prenatal screening and reproductive health services to abstain from using technology for sex-selection purposes.

Since this ban was issued, sex determination is no longer conducted openly. In public hospitals, notifications by medical staff to patients about the sex of their foetus have been limited; however, this does not mean they have been eliminated altogether. Compared with public hospitals, private clinics offer numerous services for sex determination. Together with ultrasonography, sex-determination capabilities are now available in most localities, spreading from the large cities to market towns, where villagers can access such technology at an affordable price. Ultrasonography is a relatively easy technique to administer and does not require highly trained staff or much additional operational expenditure. Costs have been reduced largely by competition as the private health sector has developed.

Dr Dương Quốc Trọng, the head of the GOPFP, provided the following solutions to deal with the situation of the SRB imbalance: first, the legal prohibition on dissemination of knowledge on sex selection and implementation of foetal sex determinations and sex-selective abortion services need to be reviewed, amended and supplemented. Second, the power of authorities to prevent, inspect and take responsibility for sex-selection activities should be enhanced. Third, individuals and organisations violating the regulations need to be strictly fined (Dương Quốc Trọng 2012).

Like healthcare managers, most abortion providers think public hospitals should create good conditions for women seeking abortion services to reduce the incidence of unsafe abortion, including the simplification of administrative procedures. The following comments by one abortion provider are representative of those of several other providers I interviewed:

Nobody ever tells us they are having an abortion because of the sex of their foetus. We have no real proof that they are having sex-selective abortions. If we refuse to provide abortions for them, they may have unsafe abortions in private clinics. If the administrative procedure is too complicated, they can also find abortion services in private clinics. Private clinics with abortion services are available everywhere. Previously, we required an identity card and family record as part of the pre-abortion procedure; however, these requirements

caused inconvenience to customers. So, we decided to leave off these requirements. If pregnant women want to have an abortion, they will try to do it by any means. (Abortion provider in a public hospital, 57 years old)

Most abortion providers denied taking part in or preventing sex-selective abortion. Some expressed sympathy for women seeking a sex-selective abortion and some arguments were also advanced in favour of sex selection, supporting the freedom and autonomy of patients to make their own reproductive decisions and the family planning aspect of avoiding unwanted births.

Many sonographers believed parents had the right to know the sex of their foetus:

It is not a problem at all to tell mothers about the sex of their foetus as long as they do not have a sex-selective abortion. Wanting to know the sex of their baby is a parental need. Our customers are not satisfied if we do not tell them the sex of their baby. (Male, 54 years old)

One sonographer told me: 'A number of doctors became rich by performing illegal sex diagnoses or sex-selective abortions' (Female, 42 years old). In fact, responsibility is shifted between sonographers and abortion providers, with each blaming the other.

As we saw in Chapter 2, ineffective government management of new reproductive technologies and the private health sector is a major contributor to the prevalence of sex selection. Many other factors influence sex selection, but the popularity of ultrasonography in antenatal care and the boom in private clinics are two of the most important in Việt Nam. Clearly, in the context of reproductive health care in Việt Nam today, doctors and clinic managers have played an active role in the diffusion of sex-selection technology. Health workers and doctors at various levels have thus been the key enablers of sex-selective abortion.

Social organisations' responses

In Việt Nam, international agencies have conducted reproductive health and safe abortion advocacy programs on various scales. For example, WHO and IPAS, a global nonprofit organisation, provide technical support for safe abortion in Việt Nam, while Pathfinder International,

Marie Stopes International and Việt Nam Family Planning Association design and implement reproductive health projects. The UNFPA is an international development agency that assists Việt Nam to collect and analyse population data to better understand demographic trends and plan for future needs. Its activities are aimed at women's empowerment and equality, by supporting intervention projects and improving reproductive health and rights through the promotion of high-quality family planning services. As mentioned earlier, the first scientific evidence of the imbalance in Việt Nam's SRB came from the population surveys supported by the UNFPA.

At a press conference for World Population Day on 2 July 2010, Urmila Singh (2010), the UNFPA's deputy representative, said:

The unusually rapid increase in the sex ratio at birth is a big challenge for Việt Nam ... Though the Government of Việt Nam has clearly ... [decreed] that sex determination of a foetus and abortion for sex selection are illegal, efforts need to be dedicated towards changing couples' traditional preference for male children, as well as towards empowering women's position in the family and society as a whole.

Over the past 20 years, the UNFPA has been engaged in bringing attention to sex selection—starting in China and India, but now also in other countries—and is working with sister agencies such as WHO, the UN International Children's Emergency Fund (UNICEF), the Office of the High Commissioner for Human Rights and the UN Development Fund for Women to address this problem. It is clear from the literature that combatting sex selection is more effective if there is a link between agencies coordinated by an independent governing agency and if a number of different interventions are employed. The lessons learned from South Korea, China and India are valuable for Việt Nam; some of these are outlined below.

At the beginning of 2006, China began national implementation of its 'Care for Girls' campaign, aimed at changing the ideology of son preference and related behaviour by publicising the relevant regulations and providing information on parenthood and reproductive health as well as various incentives. The project has contributed to a reduction in the SRB in China, which stopped increasing in 2006 (Li 2007).

Experiences from India indicate that the most important tool for change is improving the status of women through education and increasing their self-sufficiency. Education measures include a focus at the primary school level on women's rights and building girls' self-esteem, increased literacy and job training programs, improving women's access to higher education and public education campaigns about women's issues. It is believed these are the only ways to begin to effect true reform. In addition to education programs, promotion of credit and loan programs for women is an effective way to increase their self-sufficiency. Such programs provide small loans for the purchase of items such as sewing machines or looms, allowing women to use their skills to contribute to household income and improve their status within the family and community (Patel et al. 2006). The success of these activities in India owes much to the participation of the country's women's union. A 'community vigil' is a popular Indian method for educating community members about the negative consequences of a skewed SRB and placing responsibility on all members of the community to report incidents of sex-selective screening and abortion.

South Korea has also used an awareness campaign, employing young volunteers. Its experience is one that other countries could adopt as an approach to reducing son preference, by focusing on interventions that seek to alter social norms and accelerate the diffusion of new values (Chung and Das Gupta 2007).

Adopting experiences from other countries in the region, Việt Nam's Intervention Project for Reduction of the Sex Ratio at Birth, run in 18 provinces in 2009–10 by the GOPFP, aimed to include social organisations in its activities, such as the creation of associations for women who have only daughters and promise not to have a third child (*Câu lạc bộ phụ nữ sinh con một bé gái không sinh con thứ ba*). The rationale behind this proposal was that these women would help one another develop their household economy. Regrettably, the project's effectiveness has not yet been evaluated.

Việt Nam is building a social support system to counter the increasing imbalance in the SRB and looking for solutions to deal with the problem. One of the lessons from the successful control of population growth in Việt Nam is the necessity for cooperation between government and a multitude of agencies and the involvement of social organisations such as the women's union and youth union. At this stage, social

organisations lack information and are therefore considered outsiders when it comes to responding to the imbalances in the SRB and sex selection. A leader of the local women's union in Thai Binh province told me in 2009:

There may be more boys than girls recently. This phenomenon will have impacts upon marriage and the family. However, the upper levels of the women's union have not provided any official information about this matter.

Mass media responses

The mass media can help enrich the debate among the general public, various stakeholders, the medical community, health authorities and policymakers about sex selection and its potential impacts. In Việt Nam, however, a lack of coordination between researchers and the mass media means research results are not being disseminated. So far, few qualitative research projects have been conducted to gain a better understanding of the social and cultural factors underlying sex-selective abortion. Furthermore, there has been no research on the media's response to the issue of sex selection. From the beginning of 2008 to the end of 2010, I accessed the websites of popular newspapers such as *Lao Động (Labour)*, *Gia Đình và Xã Hội (Family and Society)*, *Đời Sống và Pháp luật (Life and Law)*, *Phụ Nữ (Women)* and *Thanh Niên (Youth)* weekly and collected 71 articles related to sex selection. The number and content of these articles tell us something about trends in the media's coverage of the issue. Interestingly, the focus of reporting changed over time. Stories relating to the SRB and son preference were prevalent in 2008 and 2009, while articles about sex-determination methods and policies dominated in 2010. Over three years, these articles focused on six topics: the imbalance in the SRB in Việt Nam, son preference, sex-selection methods, sex-determination methods, Vietnamese policies and regulations on sex selection and sex-selective abortion.

Sex ratio at birth

The newspaper articles related to the SRB were based on results of recent population surveys. The emphasis of these articles changed following the release of statistical data on the imbalance in the SRB in Việt Nam. The titles of articles before the National Population Survey in

2009 often vaguely or sensationally warned about the imbalance in the SRB—for instance, ‘Dangers of an imbalance in the sex ratio at birth’ (*Nguy cơ mất cân bằng giới tính*) (A.T. 2009). After the survey, article titles pointed to more concrete information, such as ‘The sex ratio at birth in Viet Nam is being seriously imbalanced’ (*Mất cân bằng giới tính ở Việt Nam đã ở mức nghiêm trọng*) (Hạnh Thư, 2012) and ‘The sex ratio at birth is increasing’ (*Chênh lệch giới tính khi sinh tiếp tục gia tăng*) (T.H. 2017). These later articles maintained the previous sense of alarm, while providing more information to validate that stance.

Son preference

When providing explanations for son preference and sex-selective abortion, the newspapers tended to emphasise simplistic reasons such as the country’s heritage of Confucianism or feudalism. One article, entitled ‘Having a son: Everyone’s “thirst”?’ (*Con trai ai cũng khát*), reported: ‘One of the reasons leading to the skewed sex ratio is the “backward” conception influenced by Confucianism, and the disregard of women’s roles in their families and in the society’ (Trịnh Trung Hòa 2008). Other explanations—such as those related to contemporary economic and social conditions and the effects of public policy—have not been explored.

Methods of sex-selection

In 2008, a number of newspaper and website articles about methods of sex selection were published, containing instructions for couples on how to conceive a baby of the desired sex; from 2009 to 2010, others expanded this discussion. An article entitled ‘Herbal medicine for giving birth to a son’ (*Bốc thuốc đẻ con trai*) described how herbal medicines for conceiving a son could be easily obtained from healers, while the local authorities did not know about such sex-selection practices and were embarrassed about dealing with this phenomenon (Hà Thu and Lan Phương 2009). Another article, with the title ‘Hunt high and low to find out ovulatory date’ (*Ngược xuôi soi trứng*), also described preconception sex-selection methods, including the recent trend of using ultrasonography. The article concluded:

A number of women have a thirst for having a son from the perspective of valuing men above women. This perspective is considered to be outdated, but it still influences many families' happiness today. (Hương Thu 2008)

Sex-determination methods

Several articles considered sex determination, with titles such as 'Too easy to know the sex of the foetus' (*Quá dễ để biết giới tính thai nhi*) (Hải Hà 2007), 'Foetal sex diagnosis: Doctors and pregnant women in collusion' (*Chẩn đoán giới tính thai nhi: Bác sĩ 'bắt tay' với sản phụ*) (Ngọc Bảo 2012) and 'Sex determination: Prohibited but still practised' (*Xác định giới tính thai nhi: Cấm vẫn cứ làm*) (Thiên Nga and Nguyễn Cẩm 2008). The last article quoted a doctor in a private clinic: 'We answer our customers' inquiries. If we do not meet their demands, they will find other clinics. To keep a pregnancy or to have an abortion is a parent's right.'

Policies and regulations on sex selection

Policies and regulations on sex selection have been disseminated by the mass media in newspaper articles such as 'Violating regulations on sex selection will be dealt with by the law' (*Vi phạm về lựa chọn giới tính sẽ xử lý theo pháp luật*) (Thủy Hà 2017) and 'Work permits will be revoked if doctors perform sex determinations without permission' (*Rút giấy phép hành nghề nếu bác sĩ để lộ giới tính thai nhi*) (VTC News 2009). The articles quoted several regulations relating to sex selection but did not mention their effectiveness or people's perspectives of them.

Sex-selective abortion

On the whole, media reports reflected the perspectives and knowledge of government officials on sex-selective abortion, while information about women's and health providers' motivations for and experiences of such procedures was absent. The press coverage conveys an attitude of disapproval towards this practice, but without providing explanation or analysis. The media's lack of engagement with women's stories points to the fact that public debate about sex-selective abortion in Việt Nam is almost never about the reality of women's experiences. This perhaps reflects the fact that most women do not want to be involved in that

debate because of the stigma around abortion and sex-selective abortion in particular. Furthermore, this is a 'sensitive' issue, so it is not easy for journalists to write or publish penetrating investigative reports on this subject. I still remember being contacted by a journalist who wanted—but was unable—to write an article about sex-selective abortion:

I certainly went to the hospitals to interview pregnant women who were going to undergo an abortion. But, sadly, the interviewees told me that they would abort for reasons other than because they had female fetuses. (Journalist with *Thanh Niên* online)

Meanwhile, books on traditional and modern methods for preconception and prenatal sex selection were being sold in many bookshops, including that of the obstetrics and gynaecology hospital where I did this research. Some common books are *Sinh con theo ý muốn* (*Having Babies of Desired Gender*) (Đỗ Kính Tùng 2002); *Bí quyết sinh con theo ý muốn* (*The Secret of Having a Baby of the Desired Sex*) (Mai Liên 2008); *Sinh con, nuôi con cần biết: Sinh con theo ý muốn* (*Essential Knowledge about Giving Birth and Raising a Child: Having a Baby of the Desired Sex*) (Minh Quân 2009); *Phương pháp sinh con theo ý muốn* (*How to Conceive a Baby of the Desired Sex*) (Ngọc Lan 2004). These books provided information about what dietary regime to follow, how to calculate the day of ovulation and even ways to weaken the X sperm. In 2009, the government destroyed more than 30,000 copies of such books—27 titles in all—and closed seven websites instructing couples on how to conceive a baby of their desired sex.

Radio and television are immensely popular platforms in Việt Nam and are often more influential with viewers than other mass media. A study of the power of the media to reduce the incidence of sex selection in India indicates that television is the preferred platform for campaigners on this issue. Fictional drama and daily soap operas are the most popular genres among the core target audience (young women), providing a platform from which to focus on issues of gender equality (Naqvi 2006). Việt Nam has not yet taken advantage of radio and television to transmit messages aimed at reducing sex selection and promoting gender equality. A variety of formats could be considered for such communication, including short and full-length feature films, public service advertisements on radio and television and TV drama.

As yet, there has been no research evaluating the impact of mass media messaging on behavioural change in relation to sex selection in Việt Nam. This is also beyond the frame of this study. However, on the basis of comments made by communication experts and others engaged in interventions in this area, some shortcomings of the existing messaging on sex selection are that it tends to be targeted to women—ignoring the fact that sex-selection decisions are not made by women alone—and can have the unintended side effect of promoting misinformation and inducing fear in women seeking abortion services (Naqvi 2006).

Examples of successful messaging elsewhere include China's 'Care for Girls' campaign, which was aimed at changing behaviour around sex selection and which received vigorous support from citizens and social organisations. Meanwhile, India developed a slogan, 'Daughters are not for slaughter'. China's message encourages people to improve the environment for girls' survival and restore the natural SRB. India's slogan seems to imply that sex selection is a sin. At present, the GOPFP is seeking to develop its own messaging around sex selection. Such campaigns must be carefully developed so as not to present as an antiabortion campaign, drive practices further underground, promote simplistic stereotypes, accentuate stigmatisation or further silence and alienate those engaged in these practices. As we have seen in previous chapters, sex selection involves not only women, but also their families and society as a whole. It is necessary for any potential media campaign to consider the multiple layers and participants in the practice of sex selection. An information strategy seeking to change behaviour around sex selection should target a wider audience than just women of reproductive age. Furthermore, to be effective, it should be based on reliable data about the nature of sex-selective abortion in Việt Nam, particularly the circumstances, motivations and experiences of those engaged in the practice.

Conclusion

The debate about sex-selective abortion and the consequences of changes in the SRB in Việt Nam has been driven chiefly by international organisations and feminist researchers, who use India, China and South Korea as comparisons. This debate draws on recent data on macrosocial trends in Việt Nam, such as the SRB, on the experiences

of other countries and on perspectives about ideal social wellbeing. To date, however, the debate has not been based on evidence of the circumstances of Vietnamese women and the contexts in which they make decisions about abortion. The extent to which sex-selective abortion is enabled or encouraged by Việt Nam's specific mix of population and health-sector reform policies has yet to be adequately explored. Furthermore, the debate is entirely lacking information about the motives and experiences of those who undergo sex-selective abortion in Việt Nam, increasing the risk of misunderstanding who engages in it, why they do so and how it is experienced.

At present, the prohibition against sex determination and sex-selective abortion in Việt Nam would appear to be unenforceable. There is a gap between government regulations and the current reality of sex selection. Efforts at prohibition have been ineffective for a number of reasons. First, both the state officials and the healthcare workers whom I interviewed generally shared the opinion held by many Vietnamese women and their families that sons are more important than daughters. This tends to diminish the political will to take any serious action against sex selection. Second, despite the fact the Vietnamese Government has enacted regulations against nonmedical foetal sex identification and sex-selective abortion, those who harbour a strong son preference continue to use illegal channels to access such services. Legislation is designed to deal with the proximate drivers of the rise in the SRB, but it cannot eliminate the fundamental causes of son preference. 'Legislation in these matters does not pay dividends unless accompanied by action/interventions at the community level to bring about a change in attitude', according to Uday Shankar Mishra, associate professor at the Centre for Development Studies in Trivandrum, southern India (cited in Chatterjee 2009: 1410). Third, the responsibilities of sonographers, doctors and nurses, who are the gatekeepers in sex selection, have not been adequately addressed. Fourth, while there are many challenging social, ethical and political issues surrounding sex-selective abortion, there has so far been a lack of involvement of social organisations and a lack of research into and public debate about these issues.

At this stage, international organisations are bringing sex selection to the public's attention, while Vietnamese social organisations are latecomers or outsiders when it comes to responding to this emerging social phenomenon. Although the media conveys information about phenomena such as the imbalance in the SRB and sex-selection

trends in society, the reports lack informed and critical analyses of sex-selective abortion or engagement with the stories of those who undertake the practices. Components crucial for the success of policy responses are further research on sex-selective abortion, dissemination of that research, education, mass communication and public debate. A comprehensive communications strategy to encourage behavioural change is of value, but its success will rely on advances in these policy components. Such a strategy must give voice to and illuminate the circumstances of the central participants in sex-selective abortion in a manner that does not further marginalise, stigmatise or silence them, but rather seeks understanding and allows them to contribute to the public debate.

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