

Conclusion

As mentioned in the introduction, one of the reasons for conducting this project is that women's experiences of sex-selective abortion are still largely missing from dialogues about reproductive rights and health. My research has explored the motivations, circumstances and experiences of women in Việt Nam who make use of new reproductive technologies to determine the sex of their foetus and undertake a sex-selective abortion. The analysis is based on specific cases of women who have undergone sex-selective abortion, tracing their passage through the sex determination and abortion decision-making phases, and investigating their experiences during and after the abortion. The research has explored the women's interactions with the range of social actors and health institutions implicated in the process of sex selection, as well as examining social responses to sex-selective abortion. The crucial themes of this book are the notions of women's choice, health and suffering, and the moral and ethical dilemmas of sex-selective abortion.

Women's choice

Rosalind Petchesky emphasises two dimensions of reproductive decision-making: the individual and the social. The emphasis of the first is on the individual's control over their own body in accordance with a general principle of the 'right to bodily self-determination' (Petchesky 1980: 691). In this perspective, women should be allowed to make decisions about their own bodies and reproductive capacities. The second dimension emphasises the social construction of women's reproductive experiences. Women's social context influences (directly or indirectly) the choices they make. 'Women's reproductive situation is never the result of biology alone, but of biology mediated by social and cultural organisation' (Petchesky 1980: 667). My research sheds light

on the sociocultural contexts in which women decide to proceed with a sex-selective abortion. As we have seen, the decision to have a sex-selective abortion is structured according to socioeconomic, cultural and political conditions. In the Vietnamese context, various factors influence this decision-making.

First, this research shows that son preference persists in Việt Nam for a number of mutually reinforcing reasons, and differs according to a woman's social position. Rural women are usually pressured by their family and kin to provide a male heir, while parents lacking access to state-provided aged care value sons as future providers for their old age. But urban women—especially professional women—are also influenced by social norms and ideologies that structure women's position within their family and society. Women who are more 'empowered' have greater opportunities to access information about sex-selection and related services. As Elizabeth Croll (2000) argues, gender equality among adults does not necessarily lead to gender equality among children. In the current era of low fertility, son preference puts more pressure on couples—and especially on women—to do what is necessary to produce a son. This research confirms that cadres and government workers are under simultaneous pressures to have at least one son and to stick to the one-or-two-child policy. Thus, the desire for sons continues to drive the family-building process in Việt Nam today.

Second, while women are victims of oppressive systems, they are also social actors who use resources (reproductive technology, in this case) to challenge or resist the patriarchal social system. Women are often pressured by others to seek foetal sex determination and sex-selective abortion, but many are also interested in knowing the sex of their unborn child and themselves initiate a sex-selective abortion. Having a son may improve the wellbeing of a woman's family and can be empowering for individual women. Therefore, women themselves find ways to improve or guarantee their status within their family and community. Rather than challenging and changing the dominant cultural stereotype, Vietnamese women accept and tend to perpetuate the existing social and moral orders. Women both suffer from and resist patriarchal expectations, and both passively endure and actively shape their reproductive destiny. These phenomena have been observed in the application of reproductive technologies for contraception (Gammeltoft 1999) and in circumstances where abortion is illegal and considered sinful (Whittaker 2004).

Third, rapid socioeconomic transformation and the global circulation of new reproductive technologies have influenced women's abortion choices. Not long after it was introduced to Việt Nam, ultrasound technology was being used in a range of prenatal health services. Its use today is booming and escaping legal controls. It is interesting that the increasing use of ultrasonography for sex selection coincides with a revival of traditional sex-selection methods, rather than replacing them, as we might have expected according to standard scenarios of modernisation and technology transfer. The practice of sex selection in Việt Nam is an aspect of the complex and dynamic market for reproductive health services and demonstrates that women's traditional desire to influence their reproductive destiny remains particularly strong. The failure to regulate the private health sector and the lack of government response to the spread of new sex-determination practices have allowed sex-selective abortions to occur relatively unchecked.

Son preference has been reinforced by the advances in the new reproductive technology. The global circulation of ultrasound technology has permitted couples to reliably produce offspring of the desired sex through prenatal sex diagnosis, thus changing gendered relations at local sites such as Việt Nam. These developments pose major challenges for the management of reproductive health services that are part of a globalised market. The responses of women to new reproductive technologies are attributable not just to 'tradition' and local hegemonies, but also to the effects of globally circulating knowledge and practices on their lives. New reproductive technologies suggest possibilities for increased freedom and innovative change, but they also frequently open the door to new forms of domination or neocolonial expansion.

Fourth, women's reproductive choices are made against official policies limiting the number of children per family and prohibiting sex-selective abortion. There are a number of studies suggesting the link between the government's efforts to control population growth and sex-selective abortion. This research provides evidence of the policy implications of sex-selective abortion. The case of Việt Nam indicates that state intervention in relation to abortion—legalising abortion and prohibiting sex-selective abortion—represents a complex and sometimes contradictory policy. State policies on sex selection and population control are attempts not only to contain women's abortion

practices, but also to control the size and composition of the population. In other words, in the politics of fertility control, the practice of sex-selective abortion represents a fusion of control.

In short, women negotiate various contradictory forces within which their lives and their reproductive agency are embedded. Considering women's position in reproductive decision-making, this study shows that significant pressure is placed on women to have a son. Women often have to choose a sex-selective abortion because of the pressure of social norms and official policies. Although this research challenges the portrayal of women as passive victims of patriarchal institutions that grant them little choice, it nonetheless observes that the reproductive agency they display is significantly constrained. As Petchesky (1980: 675) argues:

[W]omen make their own reproductive choices, but they do not make them under conditions which they themselves create but under social conditions and constraints which they, as mere individuals, are powerless to change.

Women's health

Sex-selective abortion is usually conducted in the second trimester of pregnancy. While the WHO is trying to decrease the proportion of abortions in the population, especially those in the second trimester of pregnancy, the popularity of sex-selective abortion is a crucial factor impeding the realisation of this aim. Safe techniques for second-trimester abortion were introduced in Việt Nam in the early 2000s at the same time that the introduction of new reproductive technologies was leading to an increase in sex-selective abortions. A newly introduced abortion technique—dilation and evacuation—has allowed women to terminate their second-trimester pregnancies more safely and easily compared with the older method of saline distillation. Advances in new reproductive technologies and obstetrics techniques that hold such promise for improving women's health have been used for non-medical purposes and, because of insufficient management and supervision, have contributed to the rapid increase in sex-selective abortions in the country. As in other developing countries, in Việt Nam, health regulators have been unable to keep up with the development and utilisation of new reproductive technologies.

In Việt Nam, the difficulty in restricting abortions for sex selection is that the ultrasonography and abortion procedures may be undertaken at separate clinics. Women sometimes use public clinics for an abortion after having a sex-detection scan at a private hospital. Abortion services are inexpensive and widely available, provided by public as well as private health services (Gammeltoft 2002). The ease with which determined people can evade the ban on sex-selective abortion by drawing selectively on specialists and services in different sites poses a major challenge for public health regulators. The strong demand for and supply of sex-selection technologies, the multitude of private service providers and the plurality of pathways that those seeking sex-selective abortion can take to achieve their aim combine to make these practices particularly difficult to regulate.

Counsellors and abortion providers in the hospital where I conducted most of my research were confident they could identify a case of sex-selective abortion according to the number and sex of children of the woman seeking an abortion. The majority of abortion providers were aware of the ban on sex-selective abortion; however, they conducted such procedures—for a number of reasons. They sympathised with sonless women in a patriarchal society. Doctors worried about the effects on women's health if they were unable to access a safe abortion. And second-trimester abortions are also profitable for abortion providers. More importantly, health staff cannot refuse an abortion request since, in Việt Nam, abortion is a woman's right. It should be remembered that sex-selective abortion-seekers often conceal the real reason they are seeking an abortion, claiming that they already have enough children or they face difficult economic circumstances. Sex-selective abortion can therefore be easily hidden from the relevant authorities. Some policymakers blame the accessibility of abortion in Việt Nam for sex-selective abortion and propose tightening regulations on abortion and restricting access. However, regulations regarding sex-selective abortion are tied up with other laws on reproductive health. We should remember that restricting access to abortion can have adverse consequences on women's health.

Clearly, counselling can play an important role in the abortion process, especially sex-selective abortion. The quality of counselling in cases of sex-selective abortion in Việt Nam is affected not only by the poor clinical conditions (lack of staff, overworked staff, untrained counsellors), but also by the perceptions of counsellors, influenced

by larger sociocultural and political circumstances. As a consequence of inadequate counselling, women face a multitude of anxieties and psychological issues and are not given adequate opportunities to reflect on their decision. Although women may present to a hospital intending to have a sex-selective abortion, not all will decide to proceed. The provision of more effective counselling at this critical stage could sway more of those who are ambivalent.

This study demonstrates that women having a sex-selective abortion experience a great number of conflicting emotions before, during and after the procedure. Emotional attachment to the foetus, lack of social support and moral attitudes towards abortion increase the likelihood of women experiencing negative feelings post abortion. To reduce poor post-abortion outcomes for women, women's mental health should receive more attention from families and healthcare providers.

In relation to illegal sex-selective abortion, the physical complications can be more dangerous than the psychological ones for women, and the burden may not rest solely with the individual women, but also with medical institutions and society as a whole. Most of the abortion providers I met believed illegal abortions could lead to serious medical complications, and they expressed concern for women's health if they did not access safe abortion services. Therefore, bans on abortion alone cannot resolve this issue. Counselling together with legislative and social action aimed at promoting gender equality and women's human rights are needed to reduce the cultural, emotional and psychological pressures driving the demand for sex-selective abortion.

Women's suffering

The high prevalence of abortion in Việt Nam does not mean there are no emotional or ethical concerns about the procedure. In this research, I discovered that sex-selective abortions are traumatic for women in a number of ways. Women who had a sex-selective abortion experienced anxiety, depression, grief, guilt, sorrow and shame. A number of women experienced nightmares. Despite this, some women also experienced relief, believing abortion was the best option in the circumstances. All women in this study who had a sex-selective abortion left the remains of their foetus at the hospital. The main reason for this was a desire to keep their abortion a secret. However, many women were deeply

concerned that the remains of the foetus be disposed of with proper dignity. Information about the deceased foetus is very important to women's psychological state after abortion and this should be addressed in counselling.

The generally poor quality of medical care, social understanding and public health policy regarding post-abortion care contribute to a high risk of complications for women. Women who have a sex-selective abortion are also at high risk of negative outcomes because of the stigma of abortion in society and the legislation prohibiting sex-selective abortion. Women who experienced physical pain and anxiety post abortion were often reluctant to seek follow-up medical care because of the illicit nature of the procedure and fear of being criticised for committing an immoral act. They also were unable to share their experiences and alleviate their anxiety by discussing their experiences with family, friends or others in their social network, instead preferring to keep their experiences secret. This silence also makes understanding the incidence and effects of sex-selective abortion particularly difficult for researchers and health professionals.

When women do not have psychological support from their family and institutional organisations, rituals such as making offerings, prayer and requiems for the souls of the aborted fetuses form part of the healing process. This research indicates that rituals not only help women resolve their complex feelings towards the child they lost, as Tine Gammeltoft (2010) observes; they are also a way of obtaining personal relief and healing for their suffering. The trauma, guilt and other forms of psychological suffering women experience can be expressed and recognised during such rituals. Rituals, therefore, help women seek moral forgiveness and understanding. By undertaking rituals, often in conjunction with others, women transform from passively suffering to actively healing their psychological wounds after an abortion.

The policy challenge

Statistics for SRB are not always available at the national level. Therefore, addressing the phenomenon of an imbalanced SRB is a key opportunity for the government to examine its current legislative framework and the extent to which laws and policies are in line with ideals of gender equality. The data on the SRB should be collected and disseminated to the wider public. Further analysis based on more complete and

better-quality data is urgently needed to aid our understanding of this phenomenon and its trends. The government should also fully support the development of innovative activities that stimulate discussion of sex-selection issues.

One of the most contentious debates around sex-selective abortion is whether it should be prohibited. On the one hand, an official ban on prenatal sex selection has value because the knowledge that they are breaking the law may provide people scope to reflect on the pros and cons of having an abortion. On the other hand, one could argue that sex-selective abortion is a logical extension of existing state policies, including family planning and the insistence on small families; public health policies that make abortions safe and readily accessible; the state's emphasis on the maintenance of traditional Vietnamese cultural identity in the context of globalisation; the support of the state for market-based mechanisms in all aspects of healthcare provision; and the devolution to individual families of the rights and responsibilities of making their own reproductive decisions. Women undergo sex-selective abortion to comply with state regulations and/or because of bullying from their family, while at the same time being encouraged to utilise market-based health services and take responsibility for their own wellbeing. Sex-selective abortion therefore raises challenging questions about the regulation of legal abortion and illegal sex-selective abortion.

Ineffective attempts to regulate ultrasonography and ban sex-selective abortion indicate that bans alone will not stop sex determination and sex-selective abortion. Sex selection must be tackled at more fundamental and comprehensive social, economic, political and legal levels. Better regulation of private clinics that offer sex determination and the enhancement of abortion counselling services are among the interventions in the public health field that, according to my findings, might make a difference. The creation of professional bodies supporting responsible practices among doctors and nurses, including education and the review of credentials, is another aspect of what must be a multifaceted strategy of dealing with sex-selective abortion. Rather than simply banning sex-selective abortion, Việt Nam should also address the root causes of son preference and gender inequality. For example, solutions could include improving social security and financial support for elderly people, especially those without sons, providing better education and more employment opportunities for

women and creating space for the evolution of alternative traditions and cultural conceptions that confer recognition and status on women irrespective of whether they have a son.

The challenges for women's reproductive health

In this research, women were situated at the centre of reproductive behaviour within their families, their communities and the wider society. The research builds a profile of sex-selective abortion in Việt Nam, as a resource to enable governments, professionals and social organisations to establish social policies, interventions and support services. It has to be said that there are no immediately identifiable or simple solutions to the problem of sex-selective abortion. Moreover, in working on reproductive health rights in Việt Nam, the government and international and local organisations should be aware and respectful of women's individual rights. A need also exists to understand the terrible dilemmas and the silent suffering experienced by women who undertake such abortions. So far, women have remained marginal to most national and international debates about and policies on sex selection. We should bring women's needs, interests and experiences into these debates and make their wellbeing the focus of policies aimed at tackling sex-selective abortion. The silence surrounding sex-selective abortion remains a major challenge for individuals and society. Ending this silence would help women who undergo sex-selective abortion and involve the whole society in forging positive responses to this phenomenon.

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