

Introduction

On a rainy day in the summer of 2003, I met Hương¹ and her husband in an obstetrics and gynaecology hospital in Hà Nội sitting on a bench outside the ultrasound room. I was in the hospital undertaking a research project on prenatal screening in Việt Nam.² The couple looked anxious as they waited for a three-dimensional ultrasound scan. Hương borrowed my pen to fill in her medical admissions form. I took this opportunity to ask her about her pregnancy. I learnt that the couple were doctors who worked for a provincial hospital about 100 kilometres from Hà Nội. They already had one daughter and Hương was 14 weeks pregnant. ‘I will only fulfil my obligations to my husband’s family if I have a son,’ she said. ‘If I have no son, my husband’s lineage will be considered extinct.’ The couple’s worries began when a two-dimensional ultrasound scan at the provincial hospital where they worked revealed Hương’s foetus was female. If they proceeded with this pregnancy and then later tried for a son, they would violate the country’s two-child policy. So, they had come to Hà Nội for a three-dimensional scan³ to obtain a more accurate diagnosis of the sex of the foetus. Hương confided to me tearfully that she would have an abortion if the ultrasound showed conclusively that she was carrying a female baby.

1 All personal names given in this book are pseudonyms.

2 Funded by the Danish International Development Agency, the project’s title was ‘Population, Development and New Reproductive Health Technology: Pre-natal screening in Việt Nam’.

3 Prenatal ultrasonography is the use of high-frequency soundwaves, which pass through the abdomen with the aid of a transducer to generate a video or image of the foetus. Three-dimensional ultrasonography is equivalent to two-dimensional ultrasound, but it also releases soundwaves from different directions and consequently makes a life-like image that plainly shows the characteristics of the foetus.

My conversation with Hương has stayed with me to this day. She was just one among a number of women I met in that hospital who were using ultrasonography to diagnose the sex of their foetus. Her story offered a glimpse into how new reproductive technologies were being utilised in Việt Nam, and it was my first evidence that some women were using them to prepare the way for, and obtain, a sex-selective abortion. Meeting Hương made me eager to learn more about such contemporary forms of reproductive agency and to better understand the motives, circumstances and experiences of women who use technology to change their reproductive destiny.

In the early 2000s, there was a dispute about whether the sex ratio at birth (SRB)—the ratio of males to females at birth—was increasing in Việt Nam. Hospital data on the SRB suggested that some Vietnamese families might have been resorting to sex-selective abortion. Data collected on all births at two major hospitals in 2001—one in Hà Nội (9,924 cases) and the other in Hồ Chí Minh City (29,437 cases)—indicated that mothers who were government employees tended to have a higher SRB for third-born or higher birth order children (Bélanger et al. 2003). The National Census of Population and Housing in 1999, however, recorded Việt Nam's SRB as 107, which was not far above the global standard (105 boys to 100 girls),⁴ and demographers had no evidence on the use of sex-selective abortion in the country (Bélanger et al. 2003; UNFPA 2007). In a discussion of the issue, Danièle Bélanger and Khuat Thi Hai Oanh (2009) concluded that it remained an open question whether or not sex selection was occurring in Việt Nam.

Despite mounting evidence of an imbalanced SRB in Việt Nam (Guilmoto et al. 2009; UNFPA 2012, 2015), whether or not sex-selective abortions are occurring is in dispute. When I began research for this book in 2009, I believed an ethnographic study could provide a definitive answer to this question, while also offering insights into the circumstances of those involved in sex-selection practices and the meaning sex-selective abortion held for them. The research was driven by several questions: What factors drive sex-selective abortions? How have such abortions been able to take place? What do women feel about their abortions? And how does society respond to this phenomenon?

4 The average value of the SRB in human populations is 105. An SRB of between 104 and 107 is still considered a normal/balanced ratio.

While undertaking research in a hospital in Hà Nội between January 2009 and February 2010, I had the opportunity to meet 35 women who were in the process of having a sex-selective abortion. Thanks to the rapport I built with these women, I was able to explore their experiences in depth and gain insights into the circumstances and decision-making processes that led them to seek an abortion. I learnt about the methods used to determine the sex of the foetus and how the women elicited the assistance of doctors and other health professionals to procure an abortion. I came to understand the difficult emotional experiences that all parties to these procedures went through—before, during and after the abortion—and gained increased awareness of the complexities of the social response to such abortions.

As the first ethnographic study of sex-selective abortion in Việt Nam, this research sheds light on the social, cultural, institutional and personal contexts in which sex-selective abortion takes place. Focusing on the experiences of women who had sex-selective abortions and describing the role of abortion providers and others involved in these practices, the study illuminates the relationships and processes that enable these abortions to occur. Adopting an approach to ethnographic analysis inspired by phenomenological anthropology, the research provides insights into the lived experiences of those involved in sex-selective abortion. By locating women at the centre of this study and situating their actions within social and political contexts, the research examines why and how women undertake sex-selective abortions, and what they feel about their involvement in this practice. By exploring how regulations have impacted on the practice in both the public and the private sectors, I reveal how sex-selective abortion has been perceived, portrayed and acted on by significant state, quasi-state and civil society entities. Through an in-depth and multistranded analysis of sex-selective abortion in Việt Nam, the study contributes to the global and local debates about the factors that shape the phenomenon of sex selection.

To set the stage for my findings, I discuss recent research in a number of key areas that provides a preliminary basis for this investigation.

The context of sex-selective abortion in Việt Nam

The imbalance in the SRB appeared later in Việt Nam than in some other Asian countries, such as South Korea, India and China. Within a short period, however, Việt Nam's SRB rose from an estimated 106 male births per 100 female births in the year 2000, to 110.5 in 2009 and 112.6 in 2013. The SRB imbalance has increased in both rural and urban areas, but the rise has been most dramatic in the latter (UNFPA 2015). My ethnographic study was conducted in Hà Nội and the surrounding provinces. The registered population of Việt Nam's capital is approximately 7 million, but in fact is much greater because of a large number of unregistered migrants. Hà Nội is located in the centre of the Red River Delta, the most heavily populated region in Việt Nam, with a total population of 19,577,944 persons. The Red River Delta has recorded the highest SRB in the country—115.3 in 2009 and 122.4 in 2011. The high SRB and number of sex-selective abortions in Hà Nội and the Red River Delta occurred in the context of the transformation in the country's healthcare system and the provision of abortion services—changes discussed in the sections below.

In the 1980s, the government launched reforms that were highly successful at rejuvenating the economy. This process, known as *Đổi Mới* ('Renovation'), formally began in 1986. At the time of my research, Việt Nam's healthcare system—along with all other sectors of the economy—was in the midst of a dramatic transformation. This transformation has significantly affected people's lives nationwide, and especially in big cities such as Hà Nội. After the beginning of *Đổi Mới*, the implementation of a series of neoliberal health policy reform measures in 1989 affected the delivery and financing of Việt Nam's healthcare services. Private sector provision was first officially approved by the government in 1989, although it had undoubtedly existed before this. Private health services were often provided by traditional healers and government health workers operating after hours. The reforms have brought about a rapid commercialisation of health services. The private sector has evolved rapidly, particularly in urban areas. Private health clinics may have poorer equipment and higher fees than public ones, but they are usually more conveniently located, more flexible and offer a better care environment for their clients (Tipping et al. 1994).

Together with the economic and healthcare reforms, policies on population and abortion were reinforced. Although the Vietnamese Government's one-or-two-child policy was launched in the 1960s, after *Đổi Mới* the government began actively promoting a small-family norm of one or two children for each couple. In the 1990s, Việt Nam's one-or-two-child policy strongly focused on limiting family size through the provision of family planning services, including abortion (Johansson et al. 1998). Abortion has been legal in Việt Nam since 1954. Abortions were rare until the beginning of the 1980s, when they began to increase—first slowly and then rapidly during the late 1980s—at the same time as the reinforcement of the 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 in their lifetime (WHO 1999). There were 37.5 abortions per 100 live births in 2004 and 35 in 2005 (MOH 2005, 2006).

In 2003, the Ministry of Health (MOH) published the National Standards and Guidelines for Reproductive Health Services (NSGs), which included a chapter on safe abortion. The NSGs stated that trained obstetricians, assistant doctors in obstetrics, paediatric specialists or trained midwives could legally perform abortions and that abortion services could be provided at three administrative levels of the health system: 1) abortion at six to 22 weeks gestation at central and provincial hospitals; 2) abortion at six to 12 weeks gestation at district health stations; and 3) abortion up to six weeks gestation at communal health centres. Private clinics were allowed to perform abortions up to six weeks gestation if they met criteria set out by the provincial health services. The revised guidelines in 2009 permitted medical abortion using a combination of mifepristone and misoprostol for gestation up to 63 days (gestation was limited at the district level to 49 days; the provincial level, 56 days; and central level, 63 days), and second-trimester abortion using a combination of mifepristone and misoprostol or misoprostol only for gestation of 13–22 weeks. According to the guidelines, first-trimester abortion by manual vacuum aspiration could be provided at central, provincial and district levels and communal health centres, while medical abortion was to be provided only at central and provincial levels. Dilatation and evacuation (D&E) have been introduced at two central and seven provincial hospitals. The cost of abortion services varies according to the period of gestation, the abortion method and the provider. In 2009, in public hospitals,

a manual vacuum aspiration cost approximately US\$4–7, a medication-induced abortion cost US\$20–25 and D&E cost US\$80–100. The cost of abortion services in the private sector also differed according to the gestation period and individual clinics, ranging from US\$18 to US\$100.

Việt Nam's transition from a planned to a market economy in the *Đổi Mới* process somewhat unexpectedly brought a renewed emphasis on the family in socioeconomic life and an expectation that households would take responsibility for their own socioeconomic wellbeing (van Praag et al. 2003; Nguyễn 2008). Culturally, the reforms ushered in a restoration of patrilineage and the reinvention of ancestor worship as part of the religious revival that swept the country. Such unexpected 're-traditionalising' has been documented by anthropologists (Werner and Bélanger 2002; Luong 2003; Taylor 2007). It is possible that such political, social and cultural changes create conditions that shape the sex-selective abortion phenomenon in the country.

The factors that shape the sex-selective abortion phenomenon

To situate the issue of sex-selective abortion in context, it is useful to think about the factors that shape such practices. Demographers and health researchers have used demographic data to speculate that the imbalanced SRB results from a number of factors, including the traditional preference for sons, the policy emphasis on small family size and the availability of new reproductive technologies (Bélanger 2002; Guilmoto 2007a, 2009; Phạm et al. 2008). However, it is necessary to find out more about the factors behind this trend and the experiences of those engaged in these practices. Microlevel ethnographic studies, therefore, are needed for a closer understanding of this complex issue and to situate the phenomenon within the context of people's everyday lives. In this section, I review research into the factors believed to be behind sex-selective abortion, highlighting calls to rethink the interaction of such factors in a multidimensional context.

Son preference

Preference for sons is considered one of the main causes leading to sex-selection practices (Croll 2000; Bélanger 2002; van Balen and Inhorn 2003). Son preference tends to be strongest in patrilineal and patrilocal societies (Goodkind 1999a), in which kinship, residence and customary inheritance practices, backed by religious and legal norms and institutional biases, accord men a central place in cultural, ritual and political roles, while devaluing or minimising the cultural, social and economic contributions of women (Ortner and Whitehead 1981; Croll 2000; Das 2007). In studying Vietnamese families, some authors have noted that son preference is a salient feature of the culture (Johansson et al. 1998; Phạm Văn Bích 1999). The main drivers of son preference are a need for familial labour, the value placed on the maintenance of patrilineages, regulations on the inheritance of family property and residence after marriage and social norms about the roles of sons and daughters in supporting their parents. In Việt Nam's traditional agricultural society, labour was at a premium. Farming families needed males for heavy work in their fields, and sons were considered necessary to maintain and extend the lineage. Worship of the ancestors was very important and only men could perform these rituals. If a man died without a son, his lineage was considered broken.⁵ In their old age, parents lived with their oldest son; therefore, the son inherited the family property. In return, the son supported his elderly parents. In contrast, a daughter would be married early and live in her husband's house after marriage. She henceforth would provide little or no support for her original family; hence, any 'investment' in a daughter would be lost to the family. Daughters were considered 'flying ducks' because they were lost to their parents after marriage (Johansson et al. 1998; Phạm Văn Bích 1999; Tran 1999).

Such traditional values may no longer be relevant in the contemporary era. For instance, urban households have no need for labour for heavy agricultural work. Cadres who obtain the old-age pension do not need to depend on their children economically. Socialist reforms and, more recently, globalisation have led to a reevaluation of traditions and the

5 The minimum requirement for the observation of patrilineal ancestor worship is that a family must have at least one son, who is required to perform the rites. This suggests the priority accorded to sons in ancestor worship should be described as a 'son requirement' rather than a 'son preference'.

introduction of new norms and values. One may therefore wonder what role traditional norms and the value of son preference play in contemporary Việt Nam, and whether there has been a change in the value placed on sons.

Population policy and low fertility rates

Contemporary manifestations of son preference are also activated in part by the modern phenomenon of declining family size (Goodkind 1999a). Demographers assert that rapid fertility decline has created a new demographic environment and a demand for proactive sex selection (Löfstedt et al. 2004; Guilмото 2009). However, some researchers emphasise that prenatal sex selection is rooted not simply in son preference and/or low levels of fertility; they argue that prenatal discrimination against daughters is also augmented by population policies. Under government pressure, parents' reproductive options are constrained, leading many to try to ensure they have at least one son among the limited number of children they are allowed (Goodkind 1999a; Jing-Bao 2010). The impact of changing policy on population outcomes, including on the SRB, has been discussed by international organisations, policymakers and social scientists. Daniel Goodkind (1999a) and others argue that contemporary manifestations of son preference are accentuated in the modern context of small families because the fewer children parents have, the lower is their probability of having a son (Das Gupta 1987; Gu and Roy 1995; Das Gupta and Bhat 1997). Analysing the SRB in Việt Nam, Christophe Guilмото (2009) believes the rapid decline in fertility has undoubtedly created a new demographic environment for sex selection. Although demographers have hypothesised that low fertility encourages people to seek sex-selective abortion instead of having additional births, they often have no empirical evidence to support this argument. Moreover, our understanding of how the decline in fertility or in the allowable number of children in Việt Nam is perceived by parents and articulated in their reproductive decision-making and behaviour is still very limited.

The available evidence suggests that the interaction between population policy and what might be termed traditional reproductive preferences is quite complex. Annika Johansson et al. (1998) indicate that the need for sons is still strongly felt in North Vietnamese culture. In addition, they note, the one-or-two-child policy created potentially

contradictory pressures on women. On the one hand, women who had not had a son were distressed about not producing a male heir. On the other hand, they felt pressure from local authorities to stay within the two-child limit (Johansson et al. 1998). What remains to be ascertained is whether this combination of factors is inducing parents in Việt Nam to seek sex-selective abortion. Also crucial is shedding light on the interaction between these different factors and how they are weighed by individuals as they make their reproductive decisions.

Availability of new reproductive technologies

In its guideline note on prenatal sex selection, the United Nations Population Fund (UNFPA) enumerates the various stages and strategies of sex selection: preconception (for instance, sperm sorting); reimplantation (for instance, in-vitro preimplantation genetic diagnosis, followed by implantation of an embryo of the desired sex); sex selection during pregnancy (for instance, using ultrasound, followed by sex-selective abortion); and postnatal methods (for instance, feticide, infanticide or neglect—with respect to nutrition, vaccination, curative care, abandonment and so on) (UNFPA 2009b). The new prenatal diagnostic techniques involve the use of two main technologies, amniocentesis and ultrasound. New reproductive technologies, especially ultrasound, are often considered one of the main causes for the rise in the SRB. Sex-determination tests became big business shortly after being introduced in India in the 1970s. As the number of clinics providing tests grew, competition pushed down the price of these services, making them more affordable to the lower middle class. In China, starting in the 1980s, ultrasound machines became widely available throughout the country for checking intrauterine contraceptive devices (IUDs) and access was free as part of the country's family planning program. New reproductive technologies for sex selection are now widely available in many countries.

Demographers suggest the rise in the SRB is closely linked to the increase of sex-selective abortion and the introduction of ultrasound and amniocentesis in the late 1970s (Hull 1990; Guilimoto 2007b). For instance, Terry Hull (1990: 74) notes the possible use of ultrasound to determine the sex of a foetus, leading to subsequent abortion if it is of the unwanted sex:

Ultrasound technology for monitoring foetal development can also be used to determine the gender of a foetus ... Despite the technical difficulties of the procedure and the regulations against its use for the purpose under discussion, the growing availability of ultrasound technology makes it easier for women to determine the gender of second and higher parity births and to obtain gender-specific abortions.

Ultrasound is one of the most common new reproductive technologies in Việt Nam.⁶ Most district health centres and provincial and central-level hospitals have ultrasound machines and, in urban areas, most private clinics have a machine. At present, the price for a two-dimensional ultrasound scan is VND50,000–100,000 (US\$2.5–5),⁷ and for a three-dimensional ultrasound scan, VND200,000–300,000 (US\$10–15). These prices are reasonable for most urban women, although they are prohibitive for the rural poor. Recent studies in Việt Nam have found that ultrasound is routinely being overused in pregnancy. One study found that, on average, women undergo six to seven scans during each pregnancy (Gammeltoft and Nguyễn 2007). In most European countries, it is national policy to conduct one or two scans during pregnancy (Marinac-Dabic et al. 2002). The World Health Organization (WHO 2002) has noted that the use of ultrasonography in pregnancy is not warranted in developing countries.

The practice of sex determination raises a number of ethical questions. Studying new reproductive technologies in China, Lisa Handwerker (2002) concluded that sex determination through prenatal diagnosis followed by abortion of a female foetus became widespread in that country, resulting in millions of girls never being born. She warns of the serious bioethical issues related to the use of new reproductive technologies such as the right to life, the right of free choice and equality of rights for male and female children (Handwerker 2002). Despite the disturbing ethical questions raised by these uses of technology, some believe these technologies could benefit women and their foetuses. Medical professionals consider ultrasonography a revolution for obstetrics. New reproductive technologies have the capacity to not

6 When I refer to new reproductive technologies used in sex selection in Việt Nam, I focus on ultrasonography in particular. Other new technologies such as amniocentesis, chorionic villus sampling (CVS) and in-vitro fertilisation (IVF) are rarely used because of their high cost and the high level of technical skill needed to administer them.

7 The exchange rate for Vietnamese Dong (VND) to United States Dollar (USD) is around VND20,000 to US\$1.

only subordinate women, but also give them control over their own bodies (Sedlenieks 1999). Others argue that the availability of new technologies for sex selection, including abortion, could replace older and less 'humane' methods of sex selection, including infanticide and infant neglect (van Balen and Inhorn 2003). The ethics of sex selection and the use of ultrasound have been intensely debated by scholars, but often absent from these debates are the voices of the people who are undertaking these practices.

New reproductive technologies, especially ultrasonography, are often considered to be among the main causes for the rise in the SRB (Patel 2007; Hvistendahl 2011). Demographers suggest the rise in the SRB is closely linked to sex-selective abortion and the development of ultrasonography and amniocentesis in the late 1970s (Hull 1990; Guilmoto 2007b). These technologies were introduced to Việt Nam in the late 1980s and have become widespread in provincial hospitals since the mid-1990s. The use of ultrasonography in obstetrics and gynaecology is booming in Việt Nam; however, very little is known about how women use such scanning and how this technology is involved in the decision to have a sex-selective abortion.

In the global context, the role of reproductive technologies in sex selection has been widely debated. Some authors suppose that the rapid progress of SRB imbalances in Asia is most commonly related to the progress of ultrasound technology (Guilmoto 2007b; Patel 2007; Hvistendahl 2011). For example, Mara Hvistendahl's (2011) insistence on the global context of sex selection and the responsibilities of those supplying the ultrasound technology that facilitates it adds a vital contribution to this debate. However, she pays less attention to the local or 'demand-side' dimensions of the proliferation of new reproductive technologies in the countries where sex selection is occurring. Many questions remain unanswered. What are the responsibilities of the various governments, healthcare managers, private businesses, clinics and sonographers involved in utilising these imported technologies? In postsocialist countries such as Việt Nam, how does the rapid adoption of technology relate to the decline of the state's once central role in economic and social management, and to the devolution to households of the responsibility for their material wellbeing and their own reproductive decision-making? How does this modern technology fit within a preexisting spectrum of traditional techniques and practices for achieving desired reproductive outcomes, and do they

coexist? My study examines one use of ultrasonography as part of a new reproductive trend: sex selection. Studying the role of ultrasonography in sex determination and sex-selective abortion, my case studies contribute to an understanding of the impacts of the transfer of new medical technologies to developing countries.

The experience of sex-selective abortion

Understanding sex-selective abortion in Việt Nam involves asking not only why they are occurring, but also how they are practised, and what such practices mean to those who engage in them. Addressing these aspects of the problem entails identifying the people who engage in sex selection and their social characteristics—what motivates them, what procedures they follow and how the practice of sex selection impacts on them physically, psychologically and socially. It also involves an exploration of the social and cultural contexts in which sex-selective abortion takes place and of the health system that both supplies and ostensibly regulates such practices.

Sex-selective abortion is an illicit practice in Việt Nam—and is widely seen as violating ethical and spiritual precepts and engendering considerable emotional turmoil in its participants. One central puzzle this book seeks to solve, therefore, is how a practice that is so heavily proscribed and controversial on so many levels can even occur. One answer to the riddle is compartmentalisation. There is no single actor or set of relationships that can be held solely responsible for sex-selective abortion and no single point at which a sex-selective abortion takes place. Instead, sex-selective abortion can be conceptualised as a set of procedures that unfolds over a number of stages, in different places, using a variety of different technologies and involving a series of discrete decisions taken by a range of actors. I suggest therefore that it is illuminating to adopt a processual approach to analysing sex-selective abortion. Conceptualising sex-selective abortion as a process that unfolds over several distinct stages is useful, I contend, as it has the potential to shed light on how such troubling acts take place, as well as illuminating the circumstances, relationships, experiences and reactions of the key actors involved.

By tracking the experiences of women undergoing sex-selective abortion, I discovered that the process could be divided into four stages: sex determination, decision-making, the abortion procedure and postabortion consequences and care. In the following pages, I discuss each of the phases to situate the case studies that make up the core of this book.

Sex determination

New reproductive technologies such as ultrasonography, amniocentesis and chorionic villus sampling (CVS) have been embraced throughout the world and are appreciated for their many positive applications in reproductive health. However, they have also been deployed in unforeseen ways, including for sex selection on a massive scale in some Asian societies. With its advantages of a high accuracy rate, low expense compared with other methods and ease of access, ultrasonography has become a popular method for determining the sex of a foetus (Hull 1990; Croll 2000; Guilimoto 2007a). A number of studies report that ultrasound machines are being used primarily for sex determination (Das Gupta 1987; Johansson and Nygren 1991; van Balen and Inhorn 2003). According to one survey, one of the main reasons for using ultrasound scanning in Việt Nam is to identify the sex of a foetus (Nguyễn et al. 2005).

One of the salient local factors in the domestication of this 'global' technology is its entrenchment in the Vietnamese public health system. Ultrasonography has become an indispensable technology in all matters relating to maternal and child health. In previous studies, Tine Gammeltoft and her colleagues looked at the use of ultrasonography for checking foetal anomalies (Gammeltoft and Nguyễn 2007; Gammeltoft 2008; Gammeltoft et al. 2008). These studies contend that a shift has occurred in Việt Nam's population health policies, from concerns about the size of the population to an increasing focus on population quality. This shift is informed by concerns about the potential strains on the public health system and on individual families incurred by the birth of excessive numbers of disabled or unhealthy children. Ultrasonography is being used extensively to detect foetal anomalies, and fetuses deemed abnormal are in most cases aborted on the recommendation of medical staff, broadly in keeping with national population health priorities. In short, the technology is being widely used to prosecute

Việt Nam's population health agenda. Considering the technology is already being used in the crafting of a demographically 'high-quality' population, I ask whether its use for sex selection represents a personalisation and privatisation of that public health agenda, as individuals and families seize the initiative and use the technology to craft their desired reproductive outcomes.

Ultrasonography represents an accurate and effective technique for identifying the sex of a foetus, and it is likely that the enthusiastic embrace of it in Việt Nam is in large part related to its perceived efficacy in facilitating desired reproductive outcomes. A survey of preconception and prenatal sex-determination practices, however, reveals that demand for 'traditional' practices has not dimmed, suggesting the new technology has not entirely supplanted traditional methods of sex selection. How are we to account for the existence of a vibrant and pluralistic market for traditional and modern sex-determination techniques? How does ultrasonography interact with preexisting methods to affect birth outcomes? What does this reveal about how women experience sex determination and the local expectations they bring to the new technologies? This research draws a portrait of patterns of sex determination and situates the use of ultrasonography in the context of the lives of the women who use it and other sex-selection practices. In Chapter 1, 'Chasing the gender dream', I explore the 'traditional' and 'modern' methods of sex determination that are being utilised in Việt Nam. In particular, I describe the motivations, circumstances and experiences of those seeking to determine the sex of their foetus. The chapter explores the application of new 'global' reproductive technologies such as ultrasonography to sex determination in Việt Nam.

Sex-selective abortion decision-making

Autonomy is a key concept when looking at decision-making. A number of factors influence women's autonomy in making reproductive choices, including ideology, national and international population policies, the availability of means for fertility regulation, new reproductive technologies and social barriers (Gupta 1996). The differences between women such as ethnicity, class or socioeconomic position and accessibility to resources, including knowledge, contribute to the differences in their levels of autonomy. Els Postel-Coster

(1991) supposes women's reproductive choices take place in, and are dependent on, their social context. Women's choice depends on their specific socioeconomic relations, political environment and culturally determined ideas about women and motherhood. As Jyotsna Gupta (1996: 7) points out, 'to study autonomy means studying ideas and structures of society which have a bearing on the measure of autonomy an individual can exercise'. These insights build on those raised by critical feminist researchers who have analysed how interlocking factors of power, class and ideology delimit the idealised notion of women's autonomy (Petchesky 1987; Rapp 2000; Mitchell 2001).

While feminists argue about the individual 'choices' and 'rights' assumed by Western liberal thought, this framework has found little favour in Asian cultural contexts (Lock and Nguyen 2010). One might ask whether the notion of individual autonomy assumed in feminist discourses on the 'right to choose' is appropriate for the cultural setting in Việt Nam. Looking at social shaping of abortion choices among Vietnamese women who had an abortion because their foetus were malformed, Gammeltoft (2014) argues that such choices were less a question of what an individual preferred to do than a matter of with whom they belonged, and a question of what demands were placed on them. She concludes by linking abortion choice to social belonging—belonging as state discourse, belonging as social practices and belonging as loss (Gammeltoft 2014). I wonder whether these findings hold true in the case of sex-selective abortion. In this research, I try to explore the social circumstances of individual women who are undergoing the process of sex-selective abortion decision-making to understand how these factors affect them. I also attempt to understand how women balance the different expectations and advice they receive when deciding to abort a female foetus. The structural factors—such as the distribution of economic, political and institutional resources—that are fundamental to the level of control women have over their decision-making and how cultural processes shape the contexts and meanings of their reproductive decisions are considered in Chapter 2, 'Sex-selective abortion decision-making: Beyond "a woman's right to choose"'.

Abortion procedures

Sex-selective abortion is usually conducted in the second trimester of pregnancy. Globally, there are often greater restrictions on abortion in the second trimester than on those in the first. Women confront a number of barriers to accessing such abortions—for instance, laws and regulations, lack of services and trained providers, high cost and extensive time demands (Comendant and Berer 2008). Hoàng Tuyết et al. (2008) indicate other barriers to Vietnamese women accessing second-trimester abortions, such as complicated administrative procedures and unfriendly abortion providers. I assume that women having a sex-selective abortion meet even more barriers in light of the fact that such a procedure is illegal. These suppositions are verified by this research.

Also, in terms of personal ethics, many abortion providers believe that sex-selective abortions are unethical. There are psychological consequences of terminating a pregnancy that are seldom reported, relating to the conflicting feelings experienced by abortion rights advocates and by healthcare practitioners themselves. This research gives an ethnographic account of how sex-selective abortion is conducted, and how its providers balance their potentially conflicting position as suppliers of medical care, as cultural consociates of abortion-seeking women and as professionals and citizens bound by the regulations prohibiting sex-selective abortion. The moral dilemmas of abortion are understood through the abortion practitioners' views, as well as by considering the limitations that their rights, duties and obligations impose on the receipt of healthcare services and sex-selective abortion procedures. This book covers interactions with the spectrum of social actors and health institutions implicated in sex-selective abortion. Chapter 3, 'Sex-selective abortion: Dilemmas in the silence', helps us understand the dilemmas faced by women having sex-selective abortion and the other people involved, and points us towards deeply grounded sociocultural tensions within contemporary Việt Nam.

Postabortion consequences and care

Understanding how personhood is conceived in Việt Nam's specific cultural circumstances is a precondition for unravelling and understanding the moral conflicts that infuse the process of sex-selective abortion in the country. Gammeltoft (2010) has

demonstrated that abortion in Việt Nam is constructed as a sin and that it often poses intense moral quandaries for parents, many of whom address their feelings of guilt by making ritual offerings of forgiveness to the aborted foetus. Sex-selective abortion is potentially even more morally fraught, pitting acts conducted in deference to Confucian concepts of filial piety and state family planning guidelines against Buddhist conceptions of such acts as sinful. What cultural or religious ideologies exist in Việt Nam to frame or constrain the practice of sex-selective abortion? In what ways might women who undertake such abortions negotiate the social sanctions and moral proscriptions against such practices? Also relevant is an exploration of Vietnamese notions of foetal personhood, agency and identity. What relationships with and obligations to the foetus are engaged or violated by the practice of sex-selective abortion? Is a mother's relationship with the foetus influenced by traditional Vietnamese spiritual beliefs that construe that relationship as ongoing—or indeed that accord posthumous agency to the aborted foetus?

In keeping with its emphasis on the processual and experiential dimensions of sex-selective abortion, and its methodological focus on women as reproductive agents, this research is concerned with the effects on the mother of undergoing a sex-selective abortion. In addition to the moral dilemmas potentially thrown up by such procedures, the emotional complications are likely to be acute. Relevant to this question are several studies that discuss the emotional impacts of undergoing an abortion. For instance, Joanne Angelo (1994) found that grief after abortion was often hidden and remained undiagnosed for years. The psychological consequences seem more serious for women having an abortion in situations where abortion is considered sinful or is illegal. For example, women in Thailand who abort a pregnancy are considered to have committed a sin that is difficult to cleanse oneself of and that has consequences for their current life and future reincarnation. They are stigmatised and can never really cancel out such a serious sin (Whittaker 2004). In keeping with these findings and considering the illicit nature of sex-selective abortion, some of the additional potential consequences I anticipated encountering in this study were stigmatisation, loneliness and private suffering.

Research indicates that women's experiences of abortion are situationally specific. Several studies have addressed the relationship between experiences of abortion and social, cultural and political

factors (McIntyre et al. 2001; Whittaker 2002; Andrews and Boyle 2003). Henry David (1992) finds the incidence of abortion-related mental problems is negligible in countries where abortion is legal and available. Mary Boyle and Jane McEvoy (1998) conclude that women's perceptions of abortion and their ways of coping with stigma and guilt are affected by the anti-abortion climate around them. Jean Peterman (1996), in a qualitative narrative analysis, demonstrates that women's abortion experiences are affected by their support systems, religious beliefs, desire for motherhood, opportunities and financial situation. Andrea Whittaker (2004) argues that the religious and institutional proscriptions against abortion in Thailand and the clash between biomedical and religious world views combine to make the experience of abortion in that country particularly traumatic and stigmatising.

Another consideration is whether late-term abortion is potentially more conflict-ridden and/or traumatic than others. In medical journals, abortions after the first 12 weeks of pregnancy are often described as late term. From a medical point of view, it is generally agreed that early abortions are preferable to late abortions, for, as the weeks go by, abortion becomes a riskier and more traumatic business for all concerned. Janet Hadley (1996) argues that late-term abortions require more soul-searching than those performed early in pregnancy. A number of studies have investigated women's emotions after late-term abortion (Rapp 2000; Gross 1999; Mitchell 2001; Gammeltoft 2002; Gammeltoft et al. 2008) and find that women and their partners have various emotional reactions to the procedure, including negative feelings typically associated with general psychological trauma, such as anxiety, grief, anger, loneliness, hopelessness, prostration and guilt. Looking at Vietnamese women's experiences after late-term abortion for foetal anomaly, Gammeltoft et al. (2008) observed that the women usually felt very sad, cried a lot and thought constantly about the child they had lost. They had doubts about their way of life, their reproductive capacity, their worth as wives and mothers, and their present and future positions in their kin group.

In short, existing research provides valuable insights into the moral dilemmas, psychological conflicts and social tensions experienced by women who undergo an abortion. It also addresses the effects on women's abortion experiences of prevailing ideological, institutional and cultural structures. As yet, women's feelings after a sex-selective abortion and the ways they cope remain largely unknown. In Việt

Nam, what political, moral, cultural and religious frameworks shape sex-selective abortion? What moral and emotional dilemmas do women experience? To what extent do they experience shame, stigma, loneliness and other forms of social suffering? How do women cope with these tensions and what forms of support are available to them? In addressing these questions, this research provides the first account of women's experiences of the consequences of sex-selective abortion. Chapter 4, 'After the abortion: Suffering, silence and spiritual relief', describes the range of emotions women experience during their journey through sex-selective abortion and provides a comprehensive understanding of women's experiences in dealing with physical and psychological recovery.

Social and political implications of sex-selective abortion

The issue of sex ratio imbalance and sex selection has received increasing attention from international and social organisations and governments. The UNFPA has been addressing this issue with its *Programme of Action Adopted at the International Conference on Population and Development* (UNFPA 1994), urging governments to prohibit female genital mutilation and prevent infanticide, sex-selective abortion and prenatal sex selection.

The politics of abortion are very controversial and focus largely on either a woman's right to choose or a child's right to life, and raise questions about rights to individual privacy. The principal controversy revolves around questions of who makes the decision concerning abortion—the individual or the state—and under what circumstances it may be done. Some believe the government has taken away the unalienable rights of the child by questioning at what point a foetus actually becomes a person and by recognising the rights of the mother over those of the unborn child.

Induced abortion is officially sanctioned in Việt Nam as a reproductive health service and an element of the government's efforts to provide reproductive choice and secure women's reproductive rights (MOH 2003). The Vietnamese Government's population policy aims to normalise abortion as a family planning measure. However, sex-

selective abortion has been prohibited to reduce the imbalance of the SRB. Việt Nam has instituted a number of regulations on sex selection—for example, Decree No. 114, released in 2006, forbidding prebirth sex selection and the MOH's Decision No. 3698, also from 2006, forbidding prebirth sex selection using ultrasonography and abortion. While legalising abortion but prohibiting sex-selective abortion, the government faces a dilemma in striking the balance between women's rights, reproductive rights and customary rights. It must also balance making safe abortion accessible by enforcing stricter regulations on the procedure. In this book, I gather detailed information regarding the strengths and weaknesses of current policies and explore how regulations have impacted on the practice in both the public and the private sectors.

The experience of successful efforts to eliminate sex-selective abortion indicates that broad, integrated and systematic approaches need to be taken. Such approaches should involve governmental actors, social organisations and advocates to ensure that the social norms and structural issues underlying gender discrimination are addressed using the mass media and other social measures to encourage behavioural change (WHO 2011). Therefore, more research is needed to determine the drivers of sex selection and which policies and interventions work best in specific contexts.

The effects of sex selection are already considered a serious problem in some countries, such as China and India. Some experts—pointing to the association between an imbalanced sex ratio and violence—theorise that increasing numbers of poor, single men may lead to a rise in crime and social unrest (Gilles and Feldman-Jacobs 2012). My interest in this research is whether those involved in sex-selective abortion are concerned about the implications of these practices. I also address wider societal responses to these practices, discussing how sex-selective abortion has been perceived, portrayed and acted on by a number of quasi-state and civil society entities. Chapter 5, 'Social responses to sex-selective abortion', examines the social and political dilemmas surrounding sex-selective abortion and builds a profile of sex-selective abortion in Việt Nam, as a resource to enable governments, professionals and social organisations to establish policies, interventions and support services and contribute to the ongoing debate on sex-selective abortion.

Fieldwork

When I chose this topic for my doctoral research project in 2008, a number of my colleagues in Việt Nam advised me that sex-selective abortion was a sensitive issue. In other words, it would not be easy to conduct this research given the issue was not openly discussed and was illegal. Before starting this study in a Vietnamese hospital, I met the hospital manager to get his approval for my research proposal. After reading my application, he seemed anxious and stayed silent for a few moments. He told me the issue was a very sensitive one and studying abortion was never easy. I reassured him by telling him about the necessity of studying sex-selective abortion and my commitment to confidentiality. I had conducted previous research projects in this hospital and had some years of experience working with this manager; he trusted me, and I had always seen him as open-minded. At the end of the meeting, he signed my application, but reminded me of the sensitivity of this research. My research certainly is sensitive, considering that sex-selective abortion is a legally and morally transgressive practice, psychologically upsetting for those involved and fraught with public policy dilemmas.

The account presented in this book is based mainly on my ethnographic fieldwork in a hospital in Hà Nội from January 2009 to February 2010. It is based on interviews with 35 women who had a sex-selective abortion in this hospital and with the people around them. The ethnographic sample was developed gradually by following women I met in the hospital who identified themselves as seeking or having had a sex-selective abortion.

The most difficult obstacle to this research was how to approach these women and others involved in sex-selective abortion. I spent the first days of my fieldwork learning about the hospital's administrative procedures for abortion. I discovered the counselling room was a good starting point for connecting with women seeking an abortion (my core cases). In this room, women went through the preparatory administrative procedures, received abortion counselling and gave their written consent. The main data of this research are based on my observations and conversations with the women who identified themselves as having a sex-selective abortion and with their relatives when I accompanied them during their procedures in the hospital and

made home visits. In September 2010, I spent two weeks following up with the women in my core cases. Together with the above activities, I accompanied relatives, colleagues and my core respondents when they used reproductive health services in private clinics. I took advantage of these visits to find out about the foetal sex determination and abortion services provided by private clinics. My understanding and knowledge have been gained from routine and repeated observations. I learned my way around the clinics and the homes of pregnant women, their families and other people around them. I adopted a proactive approach to participant observation by spending as much time with my core cases as possible to learn more about their decision-making, as well as their experiences after the abortion. Through my conversations with women's family members, I gained insights into how the social environment and kinship relations influenced the ways in which women exerted their agency in making reproductive decisions.

Other important components of this research were my observations of medical practitioners in public and private health facilities and formal and informal interviews with medical practitioners involved in sex-selective abortion. I also conducted interviews with doctors, nurses and sonographers working for the public hospital. I had frequent conversations with nurses in the counselling room and doctors in the Department of Family Planning, where abortions were performed. The purpose of working with these interlocutors was to gain insights into the experiences and perspectives of this group of key actors. I sought to ascertain their awareness of what they were involved in and to understand their motives.

In search of wider social perceptions of and responses to sex-selective abortion, I also conducted interviews with healthcare managers and regulators, policymakers and social workers. My purpose was to better understand the nature and impact of population and health policies, how government regulators perceive and respond to sex-selective abortion, how population health policies and regulations are monitored and whether there is any disjuncture between policy and practice. I also attended workshops on the SRB and sex-selective abortion in Việt Nam to observe the terms of the debate and approached managers, policymakers and social workers in the fields of population and health. Also, since March 2008, when I commenced this PhD research, I have

accessed the websites of popular newspapers in Việt Nam and collected published materials on sex selection from bookstores and other outlets, both in print and online.

I have prepared this study convinced of the need to illuminate a practice that is rarely discussed openly and to spark informed debate on a matter of wide social relevance. At the same time, I am mindful that the experiences described are sensitive and emotionally fraught for many of those involved. I took a nonintrusive approach to this research, which was based on established relations of mutual trust, respect and openness with respondents. Honesty, openness and respect in my dealings with respondents were the essential prerequisites of gaining findings of any value into their world views and experiences. Pseudonyms have been used throughout the study in keeping with the undertakings of confidentiality made to my interlocutors. This strategy has been used to bring into the public sphere matters for informed debate without violating the privacy and wellbeing of the respondents who trusted and collaborated with me in this study.

This book represents a holistic account of the phenomenon of sex-selective abortion in Việt Nam. It describes in detail the technologies, procedures and settings that facilitate sex-selective abortion. Women are at the centre of my investigation of reproductive behaviour and the analysis situates their decision-making and experiences within the context of their families, communities and society. The study adopts an ethnographic and interpretative approach, paying close attention to the circumstances of those involved in sex-selection practices and the meaning sex-selective abortion holds for them. These findings are embedded in an analysis of contemporary values, policies and institutions that shows that the private dilemmas and forms of social suffering that constitute the experience of sex-selective abortion are matters of far-reaching political and social significance.

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