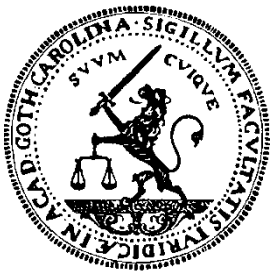

FACULTY OF LAW

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A minor field study on abortion legislation and practice in Vietnam

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Contents

Summary

Abortion was legalized in Vietnam in 1945. Vietnam has for decades had among the highest abortion rates in the world. Due to the lack of reliable numbers on abortion and a lack of collected information on abortion a comprehensive picture of the current legislation and situation is well needed. No overview of the abortion legislation in Vietnam has been provided earlier. This thesis, partly conducted in Vietnam, offers an overview of the Vietnamese abortion legislation and the practice of abortion by using social science methods such as interviews, review of literature, surveys and statistics.

Vietnam does not have a specific abortion law, but rather regulations concerning abortion incorporated in different legislative texts. Currently there are issues with the implementation and understanding of the abortion legislation. This is especially apparent in the legislation on prohibition of sex selective abortions and fetal sex determination.

The population growth in Vietnam was from the 1960s and onwards seen as a problem for the development of the country and therefore different measures has been taken to slow down the population growth. The family planning program and population policies implemented for the last 50 years are failing in some issues. Only recently did the family planning program provide contraceptives to unmarried women and it did not provide counselling in connection with abortion. In addition, Vietnam faces an increase of abortion services performed by private providers. These providers offer an opportunity for women to get a quick and anonymous abortion, but possibly on the expense on their health.

Vietnam is in the process of drafting a new population law which will have an impact on the possibility for women to have an abortion.

Sammanfattning

Abort är lagligt i Vietnam sedan 1945. Vietnam har under flera årtioden haft bland de högsta aborttalen i världen. Avsaknaden av trovärdiga siffror på abort och samlad information på abort talar för ett behov av en övergripande beskrivning av nuvarande lagstiftning och situation. Inget övergripande arbete har tidigare gjorts kring abortlagstiftningen. Denna uppsats, till viss del utförd i Vietnam, erbjuder en översikt av Vietnams abortlagstiftning och användningen av abort genom samhällsvetenskapliga metoder såsom intervjuer, litteraturstudier, enkäter och statistik.

Vietnam har ingen specifik abortlag utan abort regleras i olika lagtexter. Det finns problem med implementeringen och förståelsen av nuvarande abortlagstiftning. Detta är framförallt tydligt i den lagstiftning som förbjuder könsselektiva aborter och identifiering av fostrets kön.

Befolkningstillväxten har sedan 1960-talet setts som ett problem för landets utveckling och därför har olika åtgärder tagits för att minska tillväxten. Familjeplanerings och befolknings policys som har funnits de senaste 50 åren har misslyckats på några områden. Erbjudande av preventivmedel till ogifta kvinnor har dröjt tills nyligen och det har ej erbjudits rådgivning i samband med abort. Utöver detta så har Vietnam en uppskattad ökning av aborter på den privata marknaden. Dessa privata tjänster erbjuder en möjlighet för kvinnor att få en snabb och anonym abort men möjligtvis på bekostnad av deras hälsa.

Vietnam håller för närvarande på att skapa en ny befolkningslag som kommer att innebära förändrade möjligheter för kvinnor att göra en abort.

Preface

I would like to first and foremost thank the Swedish International Development Agency (SIDA) for approving a Minor Field Study grant. Thanks to the grant, I was able to carry out a field study in Ho Chi Minh and Hanoi in the period October to December 2013. The data from the Minor Field Study provided the background for my MA thesis.

I appreciate the guidance and recommendations I have received from my supervisors Bengt Lundell and Helle Rydström.

I am thankful for all the help that was provided to me in Vietnam. My Quynh Luong, Tu Thanh Nguyen, Van Hoa To, Dao Le Thu I appreciate that you introduced me to Vietnam and got me in touch with relevant persons and offered me useful information.

I would also like to thank for the support which I received from family and friends. Mehdi, Huy and John have been particularly supportive and of practical help during my work with this thesis.

Charlotta Sjösten,

Lund, March 2014

Abbreviations

CEDAW- The Convention on the Elimination of All Forms of Discrimination against Women

CPR- Contraceptive Prevalence Rate

CRC- Convention on the Rights of the Child

CREPHA- Center for Research on Environment Health and Population Activities

D&C- Dilation and Curettage

D&E- Dilation and Evacuation

ECHR- European Convention on Human Rights

ECtHR- European Court of Human Rights

GSO- General Statistics Office (Vietnam)

ICCPR- International Covenant on Civil and Political Rights

ICPD- International Conference on Population and Development

ICRW- International Center for Research on Women

ISDS - Institute for Social Development Studies

IUD- Intrauterine Device

MA- Medication Abortion

MOH- Ministry of Health

MOJ- Ministry of Justice

MVA- Manual Vacuum Aspiration

NCPFP- National Council of Population and Family Planning

NSG- National Standards and Guidelines

SAVY - Survey Assessment on Vietnamese Youth

SRB- Sex Ratio at Birth

UNFPA- United Nation's Population Fund

VCP- Vietnamese Communist Party

VND- Vietnamese Dong

The currency in Vietnam is Vietnamese Dong (VND), 100.000 VND is about 37 SEK.

1 Introduction

Even though Vietnam has among the highest rate of abortion[1] in the world, there are few available studies on the legal aspects. There are studies on issues of abortion, such as abortion methods or sex selection, but virtually no research on abortion legislation per se. Hence, we need more knowledge about the ways in which abortion is defined legally in the Vietnamese context. There is still much to explore as regards abortion and family planning in Vietnam and with this study I hope to contribute insights about the legal dimensions of abortion in Vietnam.

My interest for human rights and especially women's rights as well as reproductive rights, decided my thesis topic. The study attempts to give an overview of the legislation regulating abortion services in Vietnam and how they are followed in practice. The point of departure for the thesis is the fact that Vietnam has one of the highest abortion rates in the world, a two-child policy enforced by the state and a political will to decrease the abortion rates. I am interested in how this is reflected in the legal texts and in the practice of abortion. During the work with this thesis it came to my knowledge that Vietnam is currently in the midst of a drafting process of a new population law. The population law is suggested to affect the possibility and requirements to perform an abortion. This thesis thus is able to include recent material and facts regarding the drafting process and how it impacts the current legislation on abortion.

1.1 Purpose of study and research questions

The purpose of the study is to investigate the current abortion legislation and how it is implemented and followed in practice. A major question is thus if the practice of abortion accords with the legal texts as well as which factors that might influence a woman's choice to make an abortion. In addition, a concern of the study is the effects of the family planning program in regard to abortion.

Research questions:

- **Does the practice of abortion accord with the legal texts?**
- **Which factors influence the practice of abortion?**
- **What effects do the family planning programs have on the practice of abortion?**

[1] Throughout this thesis the term abortion is used to refer to all methods for inducing abortion brought on intentionally by medication or instrumentation, regardless of the length of gestation.

1.2 Method and material

The methods chosen for this thesis were social science methods such as interviews, use of literature, surveys and statistics. These methods correspond well with the focus and purpose of the study. I initially had planned to use a legal dogmatic method, which would mean to follow a Swedish legal dogmatic method, i.e. exhaust the legislation through public preparatory work, doctrine and jurisprudence. This was not possible with the Vietnamese abortion legislation, due to lack of public preparatory work and doctrine in English and no access to court cases on abortion or interpretations of the legislation.

The material on abortion on which this thesis draws is limited. Though, I have managed to get access to relevant legislation, interviewed relevant persons and read reports on abortion in Vietnam. Sources have been found by using search engines online, by recommendations from my supervisors and contacts in Vietnam as well as by using a broad set of references. Of the reports which I have used I found that Annika Johansson et al. (1996), Danièle Bélanger (1999, 2004, 2009), Tine Gammeltoft (1999, 2001, 2007, 2014) and Daniel Goodkind (1994, 1995) usually are cited by other scholars. Hence, I will also use those as important sources to the topic of the thesis. I have also used reports from organizations and institutes, especially the United Nation's Population fund (UNFPA) which has conducted extensive research on sex selection and attitudes concerning family planning in Vietnam and elsewhere. Due to the scarce literature which does not cover aspects such as the implementation of legislation and the drafting of the population law, much emphasis was put on the interviews I conducted in Vietnam. Consequently the legislation and practice regulating abortion will be explained and understood by drawing on literature and up to date information provided by interviews which I carried out with ministry staff, professors, directors and project managers.

Statistics in Vietnam is difficult to gather and not always completely reliable. One interviewee, for instance, explained that the international community reacted to Vietnam's high abortion rates in the 1990s and Vietnam therefore decided to make the figures less transparent.[2] In addition, private abortion providers do not report number of abortions performed.[3] The public provider's data is reported to the Ministry of Health (MOH) from the different levels of providers at province, district and village level. Numbers of abortions are filled in on a standard form. Daniel M. Goodkind (1994) shows hesitance towards the reliability of these figures since the process of providing the date is going through the different administration levels which may cause confusion. Moreover providers might not be accurate with the numbers.[4] A minority of the statistics is from self-reported

[2] Interview with Director 2, 29/11.
[3] Daniel M. Goodkind, *Abortion in Vietnam: Measurements, Puzzles, and Concerns*, pp. 342-352, Studies in Family Planning, vol. 25, no. 6, 1994, p. 343.
[4] Ibid p. 344.

data.[5] This method is not completely reliable when it concerns sensitive topics such as abortion. Goodkind (1994), Nguyen Anh Chi (2009) and also one of the persons whom I interviewed told that people might not be entirely honest when reporting about abortions. They may also report a fictive age and marital status to remain anonymous and avoid any public shame and embarrassment. One director, whom I interviewed, thought that such tendencies are reflected in the SAVY 2 study.[6]

I interviewed 7 people including 3 law professors, 2 directors of research institutes, 1 project manager at the UNFPA and 1 employee at the Ministry of Justice (MOJ). The professors interviewed were approached by the aid of Vietnamese professors who have been associated with the Faculty of Law in Lund. I contacted the directors of the research institutes and the project manager at the UNFPA through email and phone calls. The employee at MOJ was approached by Tu Thanh Nguyen who works at the Ministry of Justice. I was promised an interview with staff at Ministry of Health (MOH), unfortunately no such meeting ever took place. I approached 8 additional organizations and research institutes that did not respond or were unable to meet for an interview. The selection was made by recommendations from my supervisors as well as from Vietnamese professors in law. I also researched online for organizations based in Vietnam working with reproductive health and women's and children's rights. The interviewed were all seniors, except the MOJ employee who was a junior (approximately 2 year experience). 3 men and 4 women were interviewed. 5 of the interviews were conducted in a private room at the offices where the interviewed persons were working, 2 of the interviews were conducted in a café close by on the suggestion of the interviewed. One interview was made by the aid of Dao Le Thu who kindly interpreted for me. The length of each interview was about 1 hour. 4 interviews were not recorded but I took careful notes and a control copy of my notes was sent to the interviewees for admittance if in doubt or on request.

An interview differs from a conversation in the sense that the interviewer is there to gather information and has a purpose with the questions. The interviewer directs the conversation. The researcher will only receive the information that the interviewed can and wants to share. Three criteria are listed by Annika Lantz (2007) for when an interview can be considered useful. First, reliability which means -that the method must give confident results. Second, validity which concerns that the results are valid. Finally it should be possible for others to critically check the conclusions being drawn.[7] Steinar Kvale and Svend Brinkmann (2009) elaborate on these criteria and suggest that reliability refers to the consistency of the results. This is important because it should be possible to reproduce the

[5] Self-reported studies include SAVY 1 and SAVY 2.
[6] Goodkind, 1994, p. 349., Director 2., Nguyen Anh Chi, *Public Opinion in Vietnam about Adolescent Sexuality, Sex Education and Abortion,* 2009, p. 6., SAVY 2 from 2009 is the Second Survey Assessment on Vietnamese Youth. The first one was conducted in 2003. SAVY 2 is a research study under the project "Prevention HIV/AIDS among Youth" by the Ministry of Health funded by the Asian Development Bank.
[7] Annika Lantz, *Intervjumetodik,* 2007, pp. 7-10.

study another time by other researchers. Validity, they argue, is about the accuracy and strength of the statements developed.[8]

An interview can be designed with different degrees of structure, as open, semi structured or structured questions.[9] I choose the semi-structured interview, since I wanted the respondents to be able to elaborate on their answers. The semi structured interview is defined as an interview with the purpose of receiving descriptions from the interviewed in order to interpret the described phenomenon.[10] Semi structured interviews are conducted through an interview guide consisting of a set of themes and suggestions for questions to ask.[11] The semi structured interview gives a chance for the respondents in their answer to consider various dimensions and reason for their statement. The interviewer can follow up the replies given and ask the respondent to specify their answer. Thereby it is possible for the interviewer to try to understand the reasons stated and even receive additional information.[12] Since this research is about the laws and its implementation and factors influencing the use of the law I want to know about the different agents opinion's on the matter. The questions asked were overall the same, some interviewees could not answer to some questions, while some were experts in some aspects. The structure of the interview guide, themes and questions was by large followed, yet opening for the possibility of additional and explanatory questions. The themes addressed in the interviews included legislation, family planning, drafting of the population law and sex selection.[13] Naturally (follow up) questions came up as the interview proceeded, questions that it would have been impossible to prepare for before the interview.

Language barrier is a problem that can arise in interview situations, especially when neither part is speaking their mother tongue. This is important to be aware of as an interviewer, to make sure the person responding despite language barrier feel comfortable and confident to share their view.[14] I initially introduced myself and my research and that I was interested to get their views on the topics. The interviewees were luckily speaking English well and at moments of confusions in the language we sorted it out by repeating or asking again until the confusion was solved.

Data was processed by listening to the 3 interviews recorded and going through my notes several times. I sorted the answers collected in accordance with the themes of the interview guide including implementation of abortion legislation, family planning, sex selection and the drafting of the population law. Only one of the interviewed persons specifically asked to remain anonymous, but I will guarantee the anonymity of all those who participated in my study due to the sensitivity of the topic. I will refer to the

[8] Steinar Kvale, Svend Brinkmann, *Den kvalitativa forskningsintervjun* , 2009, p. 263.
[9] Lantz, 2007, p. 29.
[10] Kvale, Brinkmann, 2009, p.19.
[11] Ibid. p. 43.
[12] Ibid. pp. 19-23.
[13] See Supplement B for the interview guide.
[14] Heléne Thomsson, *Reflexiva intervjuer,* 2002, p. 99.

interviewed persons as Director 1, 2, Professor 1, 2, 3, Employee at MOJ and Manager at UNFPA.

1.3 Delimitations and difficulties

Abortion legislation has to some extent been addressed by various scholars, but there is, to the best of my knowledge, no extensive material in English with an explicit focus on the abortion legislation.

The thesis limitations are limited by the legislation suggested by the Vietnamese professors and the legislation that I could find. This thesis is also limited by the material I could find in literature. The family planning policies are described in this thesis, however I cannot explain the implementation or regional differences of family planning services, due to lack of recent material on the subject and because it goes beyond the purpose of the study. The aftercare on abortion in a pure medical sense is not covered here since it belongs more to medical studies. Other consequences from abortions such as maternal mortality rate, which is a decreasing problem since the last decade, has a sharp decrease[15] and complications that might appear after an abortion are not covered in this thesis. There has been quite an amount of research done on the awareness of HIV-positive status and its correlation with an increased tendency to have an abortion. Though, the HIV prevalence among pregnant women was at a relative low rate of 0,37% in 2006, consequently this thesis will not investigate the situation on HIV.[16]

I am aware that there are differences in abortion services and the practice of abortion in urban and rural areas of Vietnamese society. The thesis does not, however, elaborate on these differences to any further extent as it would go beyond the resources I had for this study.

Since I also was aware that court judgments are difficult to get access to in Vietnam and to a large extent not jurisprudence I am not presenting such sources. As mentioned already I did not find literature or information about cases on abortion. Hence, no such material will be discussed in the thesis.

As for limitations, I do not go into depth as regards the situation of adolescents[17] but nevertheless address the issue. I take my point of departure

[15] UNFPA, *Compendium of Research on Reproductive Health in Vietnam for the period of 2006-2010*, 2012a, p. 9.
[16] Bui Kim Chi et al., I*nduced abortion among HIV-positive women in Quang Ninh and Hai Phong, Vietnam*, pp. 1172-1178, Tropical Medicine & International Health, vol. 15, 2010, p. 1173.
[17] Unless otherwise specified, throughout this thesis the term adolescents refer to individuals aged 10–24 years. Interviewees and literature might use the WHO 10-19 year's old range or another scope. I believe the exact ages are not of utmost importance. The Vietnamese Youth Law, Law no. 53/2005/QH11 article 1 defines youth as 16–30 years.

in a predominant heterosexual matrix in Vietnam informed by a patrilineal way of structuring the family and society more widely.[18]

The scarce literature on the subject of abortion legislation was expected. Though, I had hoped to find some reports on abortion legislation, but could not despite an intensive search. The legislation in itself was surprisingly hard to find, since I could not find any textbooks on the legislation regulating abortion almost all legislation had to be found online. I have used the database "Vietnam laws online" available through the Faculty of Law in Lund University to identify relevant legislation. Some legislation has been found through the homepages of the Ministry of Justice and the Ministry of Health[19]. The legislation that could not be found on these pages I accessed through search engines by the aid of the file number of the act or by using keywords such as health and abortion. Translation has been provided by a translation agency. Lists of abortion related legislation provided to me by Van Hoa To and My Quynh Luong were helpful.

I was aware that there exists a culture of hierarchy in Vietnam and that it is of importance as a researcher to be in contact with the "right" person in the hierarchy. It was not easy to figure out whom to approach or how insistent to be towards them once in contact. Several NGOs were approached, many of them never responded despite emails, phone calls and visits. Other were not interested in being interviewed as they did not feel they knew enough about the topic. Though, I am grateful for the help I received by my contacts in Vietnam, even though it was difficult to arrange interviews with persons whom I preferred to get in touch with from NGOs, or professors and ministries.

1.4 Thesis outline

By introducing the reader to the current and historic Vietnamese legal system as well as current international regulations on abortion the reader is offered information about the context. Chapter 4 is a historical overview of the abortion legislation and population policies.

In chapter 5 the current abortion situation, such as the legislation and explanation of topics related to the practice of abortion is described.

The following chapters explain in broader picture also family planning services, sex selection and the situation for adolescents. A chapter on the new suggested population law follows. The discussion part following consists of interviews and scholars opinions regarding mainly the abortion legislation. Conclusions and recommendation are thereafter made. The last chapter is a short note on further studies that can be undertaken.

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[18] See Rydström 2003, 2006, 2010., UNFPA, *Son Preference in Vietnam: Ancient Desires, Advancing Technologies*, 2011, p. 9. "In a patrilineal system, descent is reckoned through males: The patriline is a line of descent from a male ancestor to a descendant (either male or female) which is continued only through sons."

[19] See moj.gov.vn and moh.gov.vn.

2 Vietnam's legal system

To understand the current legal system and abortion legislation it is of importance to get an understanding of the feudal and colonial laws that preceded it.

2.1 Vietnamese historic legal system

The Hong Duc code promulgated by the Le kings in the 15th century remained in force until the beginning of the 19th century. The basis of the social system was the clan composed of a small number of families which generally included man, wife and their children. The family was patriarchal, all authority was in the hands of the father. He enjoyed an absolute right of life and death over the members of the family i.e. he could sell or hire out his children or wife. If another family was deprived of their father, the father of another household could become the head of that household as well. In that capacity he took charge of the distribution of the patrimony[20], e.g. in the first half of the 16th century the father distributed the land available if no testament was found.[21] Filial devotion after the death of the parents continued, by prohibition of distribution of inheritance and dissolution of the family or marriage.[22] The parent-child relationship was at the core of Vietnamese culture, dominating everything else. Children were taught filial piety, to obey, respect and honor their parents, any obvious breach of filial piety was illegal and was severely punished by the authorities if it came to their attention.[23] Marriage was regarded as a family matter and the main purpose was to have children to continue the patrilineage and perpetuate the cult of the ancestors, the parents usually married their son or daughter when they were still young. Polygamy was legal. The Hong Duc Code was replaced with Gia Long code 1812, Hung Doc Code was in many points less rigorous and more humane than the Gia Long Code. Both were though feudal laws.[24] When Vietnam was colonialized by France in 1862, the Gia Long Code was still valid with the exception of one part of Vietnam where French Civil Code was ruling. In 1931, the French Civil Code was enforced upon North Vietnam and in 1936 also Central Vietnam complied to the Code. Polygamy remained legal, the marital power was maintained, the married woman remained an incapable person and by marriage she entered her husband's family. Thus, in old Vietnamese law the family was marked by exploitation of women and children.[25]

The 1946 Constitution, together with the 1945 declaration of Independence was the first foundation of the new civil law. It was the first

[20] *An Outline of Institution of the Democratic Republic of Viet Nam,* 1974, pp. 157-158.
[21] George E. Dutton, Jayne S. Werner, John K. Whitmore, *Sources of Vietnamese Tradition,* 2012, p. 136.
[22] *An Outline of Institution of the Democratic Republic of Viet Nam,* 1974, p. 158.
[23] Neil L. Jamieson, *Understanding Vietnam,* 1993, pp. 16-17.
[24] *An Outline of Institution of the Democratic Republic of Viet Nam,* 1974, pp. 158-161.
[25] Ibid. pp. 162-165.

time in Vietnam's history that the equality of rights and obligations of the citizens and between the two genders was written into a constitutional text. By the end of 1959 a new constitution was adopted by the National Assembly. The new constitution laid the foundation of socialist civil law in Vietnam.[26]

In 1986, Vietnam adopted the doi moi policy i.e. renovation policy, which referred to a policy of controlled economic reforms aimed at stimulating a transition from a fully subsidized economy to a partially subsidized, partial market economy and greater private sector growth.[27]

2.2 Current legal system

The legal system is based on communist legal theory and the French civil law system. The Civil Code is a comprehensive codification of Vietnamese laws, including a separate codification for family law. The Vietnamese legal system is a civil law jurisdiction in that its only source of law is written legislation.[28] Court judges do not have the power to interpret the law and court judgments are not binding in subsequent cases.[29] The mandate to interpret the law belongs to the National Assembly's Standing Committee. However, this committee can only interpret the constitution, laws and ordinances. The major part of Vietnamese legislation is lower statutory law such as resolutions, decrees, regulations, directives, circulars and decisions and these are not officially subject to any authority's interpretation. In practice the authority which adopts a regulation is entitled to its interpretation.[30] Different bodies within the Vietnamese system have the authority to issue different legal instruments. Higher ranking legal instruments set out more general rules, while lower-ranking legal instruments provide details for implementing the higher-ranking ones.[31]

The president is the head of state in Vietnam. The president promulgates the constitution, laws and ordinances as well as negotiates and ratifies treaties in the name of the state. Vietnam is party to a number of international treaties, such as CEDAW, CRC and ICPPR. Under Vietnamese law international treaties take precedence over domestic legislation.[32]

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[26] Ibid. pp. 146-151.
[27] Jennifer Kidwell Drake et al., *Stakeholder perceptions of a total market approach to family planning in Viet Nam*, pp. 1-17, Reproductive Health Matters, vol. 18, issue 36, 2010, p. 3.
[28] http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf, 2010, p. 210.
[29] Van Hoa To, *Judicial independence: a legal research on its theoretical aspects, practices from Germany, The United States of America, France, Vietnam and recommendation for Vietnam*, 2006, p. 458.,
http://www.vietnamlaws.com/pdf/LegalGuidetoInvestmentinVietNam.pdf, 2012, p. 10.
[30] Van, 2006, p. 420.
[31] http://www.vietnamlaws.com/pdf/LegalGuidetoInvestmentinVietNam.pdf, 2012, p. 11.
[32] Ibid. pp. 10-11.

Vietnam is an authoritarian one party state. The Vietnam Communist Party (VCP) has ruled in North Vietnam since 1954 and throughout Vietnam since the unification in 1975. VCP monopolizes all economic and political decision making. Vietnam, as other socialist states, is featured by interacting directorates where every government unit has a party component all way down to the village level. The state bureaucratic apparatus is controlled by the party through membership, appointments and policy directives. The power within the party is centered to the Central Committee. The Politiburo is the highest body of the VCP between the Central Committee's twice annual meetings. Article 4 of the constitution gives the party the role to fulfill its leading role within the law. Zachary Abuza (2001) notes however, that a great deal of state matters are conducted secretly by a party hierarchy which is self-justifying and self-regulating.[33] David Koh (2004) stresses that VCP political structure is top-down and highly controlled.[34]

Vietnam's political system is underpinned by the principle of centralized democracy. There is no separation of powers.[35] All state powers are centralized in one supreme body, The National Assembly, and are then delegated to lower bodies in the hierarchy. The National Assembly is the only body with the power to make the constitution and laws. The National Assembly has two sittings each year and between these sittings the Standing Committee of the National Assembly is empowered to act. They can pass ordinances on matters for which it is not yet possible for a law to be passed by the National Assembly The Standing Committee can also pass resolutions. They also review and draft law in preparation for the National Assembly's meetings. Hierarchical order of the legislation follows first the government's decrees, regulations and resolutions and then the prime minister's decisions and directives. Lowest in the hierarchy on central level is the ministries circulars and decisions. The central-level state apparatus is mirrored at local level. Each province or city is administered by a Provincial People's Council, an elected body similar to the National Assembly, and the People's Committee, an executive body similar to the government. The People's Councils have the authority to pass resolutions; however, in practice, most regulation at the local level comes from the People's Committees. [36]

[33] Zachary Abuza, *Renovating politics in contemporary Vietnam,* 2001, pp. 1,18-19.
[34] David Koh, *Vietnam's recent political developments*, pp. 41- 62, *Social Inequality in Vietnam and the Challenges to Reform,* ed. Taylor, P., 2004, p. 52. Compare section 9.1. that discusses the meaning of a top down process in legislation.
[35] The Vietnam Constitution article 2, 1992 as amended 2001.
[36] http://www.vietnamlaws.com/pdf/LegalGuidetoInvestmentinVietNam.pdf, 2012, pp.8-11.

2.3 Legal Traditions: Confucianism

Confucianism dominated Vietnamese society from 1075-1919.[37] Per Bergling (1999) argues that the concept of political Confucianism is still influencing Vietnamese politics and to be able to understand the political and legal organization it is necessary to consider Confucianism. Historically political Confucianism was the support of a hierarchical system of social relations with an emperor at top. The Vietnamese system of party rule can therefore be seen as a "superfamily", where the party and the government is a father to the people (the children). The ideal citizen shall possess the skills to behave in accordance with the laws and customs.[38] Another consequence of this way of legal thinking is that the courts keep strict to the law.[39]

[37] Helle Rydström, *Gendered Inequalities in Asia Configuring, Contesting and Recognizing Women and Men*, 2010, p. 71.
[38] Per Bergling, *Legal Reform and Private Enterprise: The Vietnamese Experience*, 1999, p. 47.
[39] Ibid. p. 73.

3 Defining abortion

In this thesis abortion refers to all methods for inducing abortion brought on intentionally by medication or instrumentation, regardless of the length of gestation. This chapter will introduce arguments and international documents on the right to abortion.

The human rights argument used by anti-abortionists activists can simply be stated as viewing the start of life at moment of conception. At that moment a human being comes into existence. This human being has the same human rights as all other people, including the right to life, according to this view. Therefore, society cannot accept abortion and per se denying this person its right to life.[40]

The human rights arguments used by pro-choice advocates can shortly be described as a view of giving a woman the possibility to have a legal abortion if she wishes so. James Kingston (1996) states that it can also include the right to positive measures as to regulate the fertility and measures such as contraception to ensure that the women has a real choice about the future of her pregnancy.[41]

3.1 International documents

This section will introduce international documents that attempts to seek for a right to life and a right to abortion.

The International Covenant on Civil and Political Rights (ICCPR)[42] does not state clearly when life begins, while article 6 regulates right to life. The Human Rights Committee, responsible for the monitoring, has not dealt with the question of any state abortion laws conformity to the article. Neither does the article 24, on the right of the child, give any definite answers. The Convention on the Rights of the Child (CRC) does not give any clear indications if the term child includes time as a fetus. A child is defined as a human being, without human being defined. Regional treaties, such as the International Convention on Human Rights (ECHR) also protect the right to life, without taking any specific standpoint on abortion. ECHR article 2 regulates the right to life. In the case Paton v United Kingdom, the European Court of Human Rights (ECtHR) held that article 2 did not prevent states from permitting abortion in a wide range of circumstances such as in the Abortion Act 1967 (United Kingdom). ECtHR rejected the possibility that the ECHR guaranteed the unborn an absolute right to life, since this could lead to a serious risk for the woman's life and therefore

[40] James Kingston, *Human Rights: The Solution to the Abortion Question*?, pp. 455-479, *Understanding Human Rights*, eds. Gearty, C., Tomkins, A., 1996, p. 456.
[41] Ibid. p.457.
[42] All international documents in this section, except ECHR are ratified by Vietnam.

threaten her right to life. Thus it seems like international treaty law does not provide any legal basis right for an unborn to live.[43]

The Convention on Elimination of All Forms of Discrimination against Women (CEDAW) article 12 protects women's and men's equal right to health care services. However, the right to abortion cannot be said to be included as part of the reproductive freedom. Ireland which has one of the toughest abortion laws in Europe also has one of the lowest rates of maternal mortality, which implies that sophisticated alternative methods are used for birth control. The right to live a healthy (female) life therefore does not automatically incorporate a right to abortion, and is only consequential or derivative. If the state can provide adequate health care by other means it may do so, Kingston concludes.[44]

Kingston compares cases in ECtHR and draws the conclusion that if not even the judges from a quite homogenous part of the world can find much common ground, it indicates that it would be even more unlikely to find common ground worldwide for the interpretation to include a comprehensive right to abortion. Kingston argues that only the most extreme cases would warrant intervention by the ECtHR on the ground that denial of abortion could constitute an infringement of the pregnant women's right to life or to freedom from inhuman and degrading treatment.[45]

Kingston refers to Berta E. Hernandez who argues that the right to abortion is part of customary international law or in general principles of law based on the fact that about 90% of the countries in the world, covering 96% of the population do allow abortion on the ground of saving the women's life. Beyond this minimum threshold there seem to be little agreement however between states.[46]

To sum up there is no definitive right to abortion in international legal documents, but in extreme circumstances such as in a case of a threat to the women's life there might be an opening as a right to abortion.[47]

3.2 Understandings of the fetus

Pregnancy termination was considered to be a sin in traditional Vietnamese society and a woman undergoing an abortion was severely condemned. This was due to the Buddhist ethics of viewing the women and her relatives as responsible of protecting the fetus until it was born, nonetheless it was the result of illegitimate relation or a heavy (financial)

[43] Kingston, 1996, pp. 458-461.
[44] Ibid. pp. 465-466.
[45] Ibid. p. 465.
[46] Ibid. p. 467. That 90% of the countries in the world allow abortion is also recognized in ICPD Programme of Action, article 8.19.
[47] Ibid p. 466.

burden to the family with a child.[48] Tine Gammeltoft (1999, 2007) notes that the fetus until about 50 years ago was seen as belonging to the domain of nature and an early abortion was therefore seen as a morally neutral act while late abortions were considered morally wrong. An early abortion can be referred to as menstrual regulation, which in Vietnamese language means to draw out, to regulate your menstruation. While the Vietnamese words for abortions at a later stage mean to scrape out the fetus. They were both considered as pregnancy terminations, but the former was performed at such early stage that the fetus was not yet formed, but was considered to be a blood clot or bean seed.[49]

In the 1950s, 1960s the view of a fetus as something more than a fetus faded out, thanks to the family planning campaigns and the abortion providers which distributed the message of the fetus not being formed yet. Whereas claiming an abortion at the early stage of gestation is like a menstrual regulation, the campaigns avoided the women to blame themselves. Director 2 noted that today among medical practioneers the term menstrual regulation is not as common, the term abortion is used among them regardless of length of gestation.[50] Some women continue to make a moral differentiation between early menstrual regulation and abortions in a later stage. Women therefore want an early abortion, when still not considering themselves as being pregnant.[51] A few of the people that I interviewed suggested that many who search for an abortion consider the issue from a practical perspective. When a young women gets pregnant she is not concerned about the character of the fetus the interviewees pointed out to me she is rather logical/practical and wants to dispose of the fetus, without focusing on the fetus as such.[52] Director 1 even said that amongst women in general, abortion is perceived as a technique and an easy measure, not particularly technical, problematic or as something which is involving much moral reasoning. She noted that women are not aware of the side effects or complications that might occur in connection with an abortion. Abortion is therefore, according to the interviewee, often perceived as a simple thing and an easy choice by the women obtaining it. Women know that they do not want the baby and do what is necessary to get rid of it.[53] Professor 3 supported such ideas by stating that especially in rural areas abortion is currently seen as something natural.[54] Gammeltoft (2014) notes that abortions has been a moral dilemma for many women, especially since the family planning programs has been a key political priority for

[48] Annika Johansson et al., *Abortion in Context : Women's Experience in Two Villages in Thai Binh Province, Vietnam* , pp 103-107, International Family Planning Perspectives, vol. 22, no 3, 1996, p. 103.
[49] Tine Gammeltoft in UNFPA, *Research on Reproductive Health in Vietnam A Review for the Period 2000*-2005, 2007, p. 23., Tine Gammeltoft, *Women's bodies, women's worries* 1999, pp. 89-90., Tine Gammeltoft, *Between "Science" and "Superstition": Moral Perceptions of Induced Abortion Among Youth Adults in Vietnam*, pp. 313-338, Culture, Medicine and Psychiatry, vol. 26, 2001, pp. 316-317.
[50] Director 2.
[51] Tine Gammeltoft in UNFPA, 2007, p. 23., Gammeltoft, 1999, pp. 89-90.
[52] Interview with Director 1 28/11, Interview with Professor 3 19/11.
[53] Director 1.
[54] Professor 3.

many years, while women did not dare to discuss their dilemmas openly and instead kept their concerns for themselves. Abortion on the basis of fetal malformation is easier to handle for the women since childhood disability is seen as a threat to the family and society, as implied in several governmental reports and population policy documents.[55]

[55] Tine M. Gammeltoft, *Haunting Images A Cultural Account of Selective Reproduction in Vietnam*, 2014, chapter 1. Due to the recent release of the book I have only been able to find the book online and access the first chapter, hence, the reference to chapter 1.

4 History of abortion legislation and population policies

4.1 Historical overview

This section explains the development of laws and policies of significance for abortion services and family planning in Vietnam from the independence in 1945 and onwards.

In pre-revolutionary Vietnam abortion was forbidden by law and considered an immoral act. Abortion was legalized in 1945 when Vietnam gained independence. The communist government strived to create a new enlightened society where modern scientific methods, such as abortions and contraceptives, for fertility and reproduction would be introduced.[56] From the 1960s onwards the Ministry of Health has ensured abortion services to women upon request at public clinics by trained physicians and midwives.[57]

In the 1960s the Law on Marriage and Family was adopted, it was based on the four principles, freedom of marriage, gender equality, monogamy and the protection of women's and children's rights. The law includes stipulations on marital age and monogamy which are considered to be the corner stones for the ideal of building happy families, the education of children and the prevention of large families as in the time of polygamy.[58] Family planning thus became a political priority and abortion services and contraceptives became available to some extent in public health facilities. Birth control was introduced as a method to create a modern socialist society and the intent from the government was to abolish the former gender inequalities and kinship hierarchies.[59] Vietnam was still not a united country, but divided in North and South Vietnam. From the results of the 1960 census the Government of North Vietnam realized that a large and growing population created a problem of pressures on the land and decided to introduce a population policy.[60] It was known that specific areas (e.g. the

[56] Gammeltoft, 2001, p. 316., See section 3.2. how the family planning programs in the 1950s and 1960s changed the view of abortion, which is an explanation on why abortion was not used widely until the 1960s. Director 1 stated that before the 1960s a woman needed a reason to be allowed to have an abortion .Unfortunately she did not mention what such a reason could be.

[57] http://www.asap-asia.org/country-profile-vietnam.html

[58] Ibid.

[59] Gammeltoft, 2014, chapter 1., Daniel M. Goodkind, *Vietnam's One-or-Two-Child Policy in Action*, pp. 85-111, Population and Development Review 21, no. 1, 1995, p 89 notes that intrauterine device (IUD) was introduced as the main contraceptive.

[60] Nguyen, 2012, p. 57., Marie Klingberg- Allvin, *Pregnant Adolescent's in Vietnam Social Context and Health Care Needs*, 2007, p.14., Goodkind, 1995, p. 87 notes that the North Vietnam government emphasized the promotion of gender equality in the 1960s regulations and encouraged independence and revolutionary consciousness among previously disadvantaged social groups to facilitate agricultural collectivization. In contrast, South Vietnam promoted the traditional patriarchal cult of the ancestors as its family ideal.

Red River delta) had for centuries been plagued by flooding, shortages of food and since the 1950s experienced a rapid increase in population growth.[61] Therefore the population policy was directed to lower the annual population growth rate by advising couples to limit their family size to two or three children, with 5–6 years spacing between children.[62] Fines were introduced and commonly used, when violation of the regulations occurred. Minimum fine was a normal month salary. In a study conducted by Goodkind (1994), he found a strong association of people who knew someone having had an abortion and who knew someone who had got a fine having a third or higher parity births or not complying with the spacing rule. Goodkind explains that women might have used an early abortion as a pre-emptive measure not certain they were pregnant or not but to avoid a later abortion which might be more complicated or getting fined. Thereby implying a correlation between abortion incidence and the implementation of the policy.[63] The overall success of this policy was still limited due to the ongoing war and scarcity of resources, although the policy increased the availability of contraceptives and abortion services in North Vietnam.[64]

The government expanded family planning services in the south, following the reunification of North and South Vietnam in 1975. The south previously had higher fertility rates than in the north due to pronatalist policies enforced by the French in beginning of the 19th century and again by the Catholic regime after partition of Vietnam in 1954. Both those regimes were disapproving of family planning methods such as contraceptives.[65] Parallel with the population policy family planning was done mainly with propagation but not on a juridical ground. The more children one had the more benefits one received from the state, such as food coupons and more land allocaments. Therefore the family planning campaign could not bring any positive effect on the increasing population growth. The family planning methods intended to slow down population growth were though in use for the 1970s and early 1980s.[66] After the 1979 census which showed that population growth was still high in Vietnam, the Government restated the importance of the family planning program as a part of national population policy and also recognized the program as a social movement to improve the quality of life of the people. The guidelines were still that each couple should have only three children, but the birth intervals were changed to 3 - 5 years or more and married women should give birth only at age 22 years or later.[67] In 1984 the implementation of

[61] Goodkind, 1994, p. 343., Goodkind, 1995, p. 87.
[62] Bussarawan Teerawichitchainan, Samin Amin, *The Role of Abortion in The Last Stage of Fertility Decline in Vietnam*, pp. 80-89, International Perspectives of Reproductive and Sexual Health, vol. 32, no. 2, 2010, p.81.
[63] Goodkind, 1994, p. 350.
[64] Teerawichitchainan, Amin, 2010, p.81.
[65] Ibid. p. 81., Goodkind, 1995, p. 89., Goodkind, 1994, p. 343.
[66] Nham Tuyet Thi, Xuan Tinh Vuong, *Reproductive culture in Vietnam*, 1999, p. 9.
[67] Nguyen 2012, p. 2., Goodkind, 1995, p. 89., Lisa Drummond, *The Modern « Vietnamese woman » : Socialization and Women's magazines* , pp. 158-178, *Gender Practices in Contemporary Vietnam*, eds. Rydström, H. Drummond, L., 2004, p. 161 reports that slogans such as « Have only one or two children in order to bring them up properly » were common, implying that only small families can produce citizens of good quality.

family planning and population policies were united under the responsibility of the newly founded National Council of Population and Family Planning (NCPFP).[68] In 1988, the government implemented a population policy, which called for maximum two children per family and a spacing of 3–5 years between children. This policy also provided free provision of contraceptives and abortion services, cash incentives for sterilization and penalties for violations.[69] The fertility control provided for under this policy lead to abortions becoming routine medical procedures in both urban and rural areas.[70] The government pursued with population policies and followed many of the measures adopted by the Chinese government, the policy measures were less strict though and instead of using coercion as in China the Vietnamese program appeared to be subtly manipulative, studies showing that family planning was not entirely voluntary. Local family planning promoters relied on personal relationships with the population and emphasized economic and normative disincentives toward excessive childbearing to make people feel obligated to have no more than two children.[71]

After the new Population Ordinance in 1989, in addition to the promotion of family planning methods, government campaigns convinced people that having maximum two children could mean children of higher quality and greater family happiness.[72] In 1989, the current Law on Protection of People's Health was affirmed. The law made it possible for all women to obtain an abortion, prior to 1989, a woman needed to be married and have a letter from her husband confirming his consent to the abortion.[73] In the 1990s, the population program strongly promoted the one-to-two-child family. The implementation of the policy which specifically promoted contraception was successful and reached the vast majority of the population and the fertility rate declined.[74] Long et al. (2000) note that medical

[68] Goodkind, 1995, p. 89.
[69] Teerawichitchainan, Amin, 2012, p. 81., Goodkind (1994) notes that after 1988, the NCPFP expanded from provincial to district and village level centers. Small groups of ethnic minorities, which together consisted of 13% of the population were allowed to have three children.
[70] Gammeltoft, 2014, chapter 1.
[71] Teerawichitchainan, Amin, 2012, p. 81, Lisa Eklund, *Rethinking Son Preference – Gender, Population Dynamics and Social Change in the People's Republic of China*, 2010, p. 44. notes that the Chinese population policy in 1979 enforced a one child policy., Goodkind, 1995, pp. 90-92, suggests that the Vietnamese policy is somewhat similar to China, with posters promoting the small family and how family planning was promoted as contributing to national welfare. The violation of the population policy was commonly punished by fines. See also Bélanger, Oanh, 2009, p. 164., how fines enforcement varied between regions, some allowed three children when a couple had two daughters. David Shapiro, *Women's Employment Education, Fertility, and Family Planning in Vietnam: An Economic Perspective*, pp.123-143, ed. Barry, K., *Vietnam's Women in Transition*, 1996, p.138., notes how the policies charged higher land rent for bigger families and prohibition for families with three children or more to move to urban areas.
[72] Danièle Bélanger, Khuat Thi Hai Oanh, *Second-trimester abortions and sex-selection of children in Hanoi, Vietnam*, pp. 163-171, Population Studies, vol. 63, no. 2, 2009, p. 164.
[73] Director 2. See Supplement A for 1989 Law on Protection of People's health.
[74] Pham Nguyen Bang et al., *Analysis of socio-political and health practices influencing sex ratio at birth in Viet Nam,* pp.176-184, Reproductive Health Matters, vol. 16, no 32, 2008,

practitioners and couples increasingly viewed abortion as a method of contraception. The availability and easy access to abortion was a key in reaching family planning and population targets. Thus in the 1990s Vietnam had one of the highest abortion rates per capita in the world.[75]

In 1992, Vietnam's new constitution was approved and two articles are relevant for the family planning and abortion legislation. Article 39 declares that, the state shall invest in people's health, protect, harness and organize all social forces to build and develop prevention oriented Vietnamese medicine. The Constitution also ensures health care insurance and the creation of favorable conditions for all people to enjoy health care. A priority is given to the people living in mountainous areas and ethnic minorities. Article 40 states that it is the state, the society, family and all citizens obligation to give protection and care to mothers and children to implement the population and family planning program.[76]

In the late 1990s the emphasis in Vietnam shifted from birth control to reproductive health. This shift in focus was influenced by the 1994 International Conference on Population and Development, (ICPD),which reoriented the population policies from a narrow focus on family planning to a broader perspective to include reproductive health and rights, as part of population policy.[77] The ICPD 1994 Programme of Action, the final document from the conference, set out the term reproductive health in §7.2. motivating a shift from demographic concerns to emphasis for meeting the needs of individuals for reproductive health information and services.[78] A new approach to family planning was also developed. ICPD advocated that families should make decisions about family size and other reproductive health matters. The conference left it open to the states on how to ensure reproductive rights to its citizens. The Programme of Action contained very little discussion on abortion. The document states that abortion shall be regulated on a national level and never be promoted as a method of family planning. It also recognizes the fact that many abortions are done under unsafe conditions and urges the state's improvements.[79]

Though the ICDP Programme of Action resulting from the discussions and agreements is not binding, Vietnam's adaptation of it was to shift into more of reproductive rights agenda, by introducing a National Strategy on Reproductive Health Care, for 2001-2010. This strategy was the primary

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p. 178., Gammeltoft, 2014, chapter 1, notes that in the 1990s incentives such as fines were mainly applied in the north and the densely populated Red River Delta area, while in the south emphasis was on decentralized contraceptive services.

[75] Lynellyn D. Long et al., *Changing Gender Relations in Vietnam's Post Doi Moi Era,* Policy Research Report on Gender and Development Working Paper Series no. 14, 2000, p. 22.

[76] Constitution of Vietnam 1992 as amended 2001 December 25, Article 39 and 40. See Supplement A.

[77] Hoang Tu Anh, *Gender, women's empowerment and reproductive health Impact of Programme of Action,* 2002, pp. 84-87.

[78] Maja Kirilova Eriksson, *Reproductive freedom in the context of international human rights and humanitarian law,* 2000, p. 170.

[79] Ibid. p. 175.

government policy on reproductive health under this period. In the view of the ministry, Vietnam required a reproductive health strategy to provide health care to the people, particularly to women, mothers, and children, in a broader sense and with a more comprehensive approach.[80] Bang et al. (2008) note that the new focus on reproductive health also was present in the Vietnam Population Strategy 2001-2010. The strategy meant a relaxation to the former one-to-two-child policy. The strategy highlighted the benefits of small family size and voluntary family planning though it was still emphasizing the need to improve the quality of the population. The term "small family size" was however not clearly defined.[81] Both those strategies, The National Strategy on Reproductive Health Care and the Population Strategy 2001-2010, had intentions of decreasing the rate of unintended pregnancies, the abortion rate and abortion complications.[82]

The Vietnam population strategy and the relaxation it involved was considered important as a first step for the development of the Population Ordinance issued by the National Assembly in 2003. This document officially recognized the reproductive rights of all citizens by having specific objectives and policies related to reproductive health included to ensure that women have the right to decide when to have a child, the number of children and the spacing between births and to ensure that women have the freedom to choose contraceptive methods according to individual needs and preferences.[83] The 2003 Population Ordinance article 10 was a reinforcement of the relaxation to the former two-child policy. The ordinance allowed parents to have the number of children they wished to have. However, the legislators never reached a consensus over the abandonment of the two-child policy and internal criticisms were that a rights-based and free choice approach to family size would lead to an increase in fertility and, hence, population growth rate. A slight rise in fertility did follow by the liberalization of population policy. It is though suggested that the slight increase of fertility rates in 2004 may have reflected a desire by many parents to have a child born in 2003 due to the

[80] http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010, pp.216-218. The strategy contained provisions on e.g. raising awareness about reproductive health among the population starting with the leaders at all levels, provide better treatment for HIV and other infections as well as for infertility, provide good quality contraceptives and reduce the unintended pregnancies and abortion complications.

[81] Ibid., Bang et al., 2008, pp. 178-179., the term small family size was considered as a decent choice of wording when the legislators could not agree on how many children to allow, it left it open to the citizens to be wise enough to plan their family accordingly, so the "happy family" could be sustained. A reference to a small family was considered to be clear enough. The lack of a definition of small family size is also affirmed in interviews with Professor 2 (15/11), Professor 3. The term quality was in the strategy meant as an improved quality in terms of physical, intellectual and spiritual terms, in order to meet the requirements of modernization and industrialization. Vietnam's focus was to reach the medium advanced level in the Human Development Index by 2010.

[82] Dao Xuan Hung, *Puberty Reproductive and Sexual Health of Vietnamese Young People: Thematic Report Survey Assessment of Vietnamese Youth*, 2010, pp 35-36.

[83] Bang et al., 2008, p. 178.

Lunar Year of the Goat, widely perceived as a good year for reproduction.[84] Birth rates in following years showed a fall and a similar phenomenon was documented in Korea, implying it would be due to the lunar year rather than the changed legislation. Due to mass media articles on the baby-boom and advocate's protests that saw fertility as a state concern as opposed to an individual one and the slight fertility increase as due to the changed legislation, the new legislation did not last for long. The relaxation of the policy got reversed by a political resolution in 2005.[85] The resolution re-introduced the former two-child policy. It introduced fines for government employees and party members who violated the policy, though it was not clear whether this also extended to ordinary citizens. That the state officials followed the legislation accordingly would have importance for how the rest of the population would reason, it was believed among the legislators. The resolution has strengthened conservative factions in the party and reinforced a social obligation on couples to follow the policy.[86] The two- child policy was once again affirmed in late 2008 by an ordinance amending article 10 of the Population Ordinance 2003. Article 1 in the 2008 Ordinance states that the couples can decide time and spacing for their children, but are only allowed two children, except in cases stipulated by government regulations. Those exceptions are regulated by a decree implementing the article 10 of the Population Ordinance, which e.g. allows for more children for ethnic minorities and if the couple has triplets at first birth.[87]

4.2 Abortion rate and fertility rate over the last decades

Stanley K. Henshaw (1990) argues that in a developing country, which intent to lower the fertility rate while providing both abortion and contraceptives, initially will experience an increase of abortion rates. When the contraceptives eventually are effective and a widespread decrease in abortion rate is to be expected. Therefore a rapid fall in birthrates might demand a high abortion rate at least for a period of time.[88] This theory could account for a possible recent fall in abortion rates when contraceptive methods are more easily available.

[84] Bélanger, Oanh, 2009, pp. 164-165., The Year of the Goat explanation is also noted in my interview with Employee at MOJ (14/11) as a reason for increased fertility rate in the year of 2004.
[85] Ibid. pp. 178-179., Political Bureau's Resolution no. 47/NQ-TW "Further Strengthening the Implementation of Population and Family Planning Policy" issued in March 2005. See Supplement A.
[86] Ibid pp. 178-179.
[87] Population Ordinance 06/2003/PL-UBTVQH11 January 9, 2003 amended by the Ordinance no 08/2008/PL-UBTVQH December 27, 2008. , Decree 20/2010 ND-CP implementing the article 10 of the Population Ordinance. See Supplement A.
[88] Stanley K. Henshaw, *Induced Abortion: A World Review*, pp. 76-89., Family Planning Perspectives, vol. 22, no. 2, 1990, p. 88.

4.2.1 Abortion rates

Abortion prevalence rose rapidly and peaked after the introduction of the population policies from 160,000 abortions in 1979 to 810,000 in 1987 and 1.34 million in 1992. 1992 numbers made Vietnam rank three on highest abortion rates in the world, only outnumbered by Soviet Union and Romania.[89] Johansson et al. (1996) suggest that the rise of abortions also meant that the abortion rate began to exceed the rate of births.[90] The rise in abortion rate is suggested to be due to family planning policies and a relaxation of the documentation as requirements for an abortion.[91] The rise might also have been due to an expansion of private clinics performing abortion services, see section 5.4. Director 2 noted that in the 1980s Vietnam was criticized by the international community for its high abortion rate and the family planning methods. For this reason the abortion rates were treated with certain secrecy. That is an explanation to the difficulty in finding reliable numbers nowadays.[92] Gammeltoft (2014) notes that official reports states significantly declined abortion rates from the 1990s to the 2000s, abortion rate fell from 86/1000 women in 1996 to 26/1000 women in 2003.[93] According to government records, 540,400 abortions were performed in 2003.[94] Gammeltoft (2014) notes that in general it is impossible to assure a declining trend since the private sector abortions are not reported.[95] It is estimated to be about half a million abortions performed in the private sector each year.[96] In 2010 the abortion rate per 100 live births had decreased to 32% among married women 15-49 years old. Though a decrease the rate was not enough to meet the abortion reduction goal of 22.5% stated in the Vietnam Population Strategy 2001-2010. One study revealed that 1/3 of abortions were among women who had no other children, of which 1/5 were unmarried.[97] Estimated abortion rate for the average Vietnamese woman is 2.5 abortions during her lifetime.[98]

[89] Teerawichitchainan, Amin, 2012, p. 81., Johansson et al., 1996, p. 103. This section presents abortion numbers and rates. In this thesis abortion rate refers to the number of abortions per 1000 women between 15-49 years and by percentage of 100 live births. The abortions performed in the private sector are not included in the numbers if not specifically stated.
[90] Johansson et al., 1996, p. 105.
[91] Director 2., Teerawichitchainan, Amin, 2012, p. 81.
[92] Director 2.
[93] Gammeltoft, 2014, chapter 1., UNFPA, *Policies on Reproductive Health Care for Ethnic Minority People in Vietnam*, 2010a, p. 25 notes that MOH statistics yearbook reports falling abortion rates compared to live births. In year 2000 the abortion rate compared to 100 live births was 45%, in 2005 it was at 35% of 100 live births.
[94] Teerawichitchainan, Amin, 2012, p. 82.
[95] Gammeltoft, 2014, chapter 1.
[96] http://www.asap-asia.org/country-profile-vietnam.html
[97] UNFPA, 2012a, p. 53.
[98] http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010, p. 219.

4.2.2 Declining fertility rates

From the 1970s to the 1990s the fertility rate dropped from over 6 children per woman to below four.[99] Birthrates declined most rapidly in the cities, where also highest rate of abortions were registered. Rural areas reported 1/3 of the rate of abortion compared to the cities.[100] The fertility rate has kept dropping in Vietnam, from 2.33 in year 2000 to 2.03 in 2009, though still with local differences up to rates of 5.3 children per woman. The National goal for fertility reduction 2.1 children per woman, set out in the 2001-2010 Vietnam Population Strategy was achieved already in 2005, sooner than expected.[101]

The family planning policies introduced are followed by a declined fertility rate, thereby implying a direct influence of the policy on the fertility rate.[102] Other reasons for a decline in the fertility rate, and especially in the urban areas are the combination of urbanization, high rates of abortion and delayed age of marriage. In contrast, rural areas may be experiencing different and less rapid socio-economic changes.[103] Johansson et al. (1996) argue that the increased abortion rate and decreasing fertility rate can be considered in context with the doi moi policy introduced and how the following economic growth might have affected fertility rates in the sense that to raise a child, e.g. education and health care, got more expensive preventing people from having more children than two.[104]

At ICPD it was decided that abortion should never be promoted as part of family planning. However, this chapter suggests that the family planning policies have affected the amount of children couples decided to have as well as the abortion rates. In the coming chapters the relation between family planning and abortion will be investigated further.

[99] Shapiro, 1996, p. 123.
[100] Johansson et al., 1996, p. 103., In 1996 53 million people lived in rural areas of a total 74 million population in Vietnam. This implies that a relatively small part of the population (urban based) obtained 2/3 of the abortions.
[101] UNFPA, 2012a, pp. 27-29.
[102] Teerawichitchainan, Amin, 2012, p. 81.
[103] Long et al, 2000, p. 22.
[104] Johansson et al., 1996, p. 106.

5 Current state of abortion legislation and practice

As previously described the regulations attributing to abortion are not comprehensive or collected in one law, but are regulated in different legislations. This chapter gives a summary of the legislation concerning abortion. The regulations presented are mentioned by interviewed and cited in literature. Some legislation will be further explained under the chapters of family planning and sex selection. This chapter also present sections on topics related to the practice of abortion such as abortion procedures, health care staff, abortion fees and demographic differences.

5.1 Legislation

Abortion was legalized already in 1945 when Vietnam gained independence. In 1989 the current legislation Law on Protection of People's Health came into force. Article 44 states that abortion is legal and available on request. The Ministry of Health has the duty to consolidate and expand the network of obstetrics to ensure medical care for women. Article 44 also forbids medical institutions and individuals to practice abortions or remove intrauterine devices (IUD's) unless permitted by the health ministry or service. The extension of abortion providers was made in the 1990s as part of the doi moi policy see section 5.4.[105]

All possible grounds for an abortion are allowed, with one exception, making an abortion on the basis of sex selection. This is prohibited in legislation since 2003, by the Population Ordinance article 7.[106] Article 40(7) b of the 2006 Law on Gender Equality reinforces this regulation when it identifies one of the violations on gender equality in the field of public health to choose the sex of the fetus or under all forms of inciting and forcing other people to abort because of the sex of the fetus.[107] The prohibition of sex selection will be further discussed in chapter 7.

The Labor Code, 2012, article 159 regulates that women are allowed sick leave for abortion according to the regulations in the Law on Social Insurance. Social Insurance Law article 30 provides that when pregnant female workers are having an abortion, experiencing miscarriage or stillbirth they are allowed at least 10 days off.[108]

If a woman has been exposed to domestic violence and immediate forced sexual intercourse she shall be given emergency contraception by

[105] Goodkind, 1995, p. 108. See Supplement A for the Law on Protection of People's Health.
[106] 2003 Population Ordinance article 7. See Supplement A.
[107] Gender Equality Law, no. 73/2006/QH11. See Supplement A.
[108] The Labor Code, Law no. 10/2012/QH13, Law on Social Insurance, no: 71/2006/QH11. See Supplement A.

medical staff. If the woman seeks care later and is pregnant she shall be advised to make an abortion,[109] even if it is her husband who is the offender.[110]

The Penal Code from 1999 article 243 regulates illegal abortions, which refers to all abortions performed except the ones in authorized private clinics and state hospitals. Fines and imprisonment are the punishments without closer stating what illegal abortion is. The legislation targets the provider of the illegal abortion service, not the woman receiving the service. The number of prosecutions regarding this article is impossible to estimate since the court decisions are secret.[111]

5.2 Abortion methods at different stages of gestation

The Employee at MOJ told me that there is a regulation stating abortion is possible until week 12[112], UNFPA and Gammeltoft (2014) note that abortion is legal until week 22[113], Professor 1 states no such regulations exist.[114]

In 2003 Ministry of Health published the National Standards and Guidelines for Reproductive Health Services (NSG) including a chapter on safe abortion. These guidelines decide which type of clinics and provider's that are allowed to provide the different abortion services. Communal health center can only perform abortions up to 6 weeks. District health stations can perform abortions up to 12 weeks, abortion up to 22 weeks gestation are provided at central clinics such as Ho Chi Minh and Hanoi and in provincial hospitals. Private clinics are allowed to perform abortion up to 6 weeks gestation if they meet required criteria set out by the Provincial Health Services.[115]

For the first tri-semester counted from 1-13 weeks of gestation, several procedures of pregnancy termination are available. The most common used method until week 12 is a manual vacuum aspiration (MVA), whether or not pregnancy has been established. The MVA is recommended

[109] Regulated in circular 16/2009/TT-BYT . See Supplement A.
[110] Professor 3.
[111] Correspondence via email with Dao Le Thu, Professor in criminal law at Hanoi Law University, 2014-02-25. See Supplement A for the Penal Code article 243.
[112] Employee at MOJ.
[113] UNFPA, 2011, p. 50., Gammeltoft, 2014, chapter 1., also states that the legal limit for abortion is week 22., Professor 3 noted that inter circular 04/2012/TTLT-BYT-BTC by Ministry of Health and Ministry of Finance states 22 week limit for abortions. I cannot however read out from that circular a 22 week limit. I will though take my departure from a 22 week limit, since several sources state so is the case.
[114] Interview with Professor 1, 15/11.
[115] Bela Ganatra et al., *From Research to Reality: The Challenges of Introducing Medical Abortion into Service Delivery in Vietnam*, pp. 105-113., Reproductive Health Matters, vol. 12, no. 24, 2004, p. 107., http://www.asap-asia.org/country-profile-vietnam.html. Unfortunately I have not been able to find the text of the NSG.

due to few complications. Apart from doctors and assistant doctors, secondary and college level midwives who are trained in MVA are authorized to do MVA up to six weeks.[116] Dilation and curettage (D&C) or dilation and evacuation (D&E) is rare but still prevalent above eight weeks.[117] Medication abortion (MA) is also used during the first tri semester. Medication abortion became more frequent after studies conducted in 2001-2002, i.e. satisfaction with medical abortion was high and the option of home administration was found to be safe and feasible for introduction into the Vietnamese healthcare system. The MA is also done at clinics. Some service providers in the southern part of the country, where religious influence is stronger, note that medical abortion shifted responsibility for the abortion from themselves to the woman. Since the staff did not have to perform any procedure but the woman takes the pill herself.[118]

Second tri-semester abortions start after 13 weeks of gestation. The Ministry of Health restricts second-trimester abortion to central and provincial public health facilities, contending that lower-level public facilities and the private health sector might lack trained health care providers, adequate medical equipment, or necessary emergency support. According to the NSG dilation and curettage followed by medication is the sole method to be used between 12-18 weeks of gestation. Traditionally a Kovac's method was used, but it is associated with serious complications and is restricted to gestation of 16–22 weeks or greater.[119]

MOH does not provide national abortion data by duration of pregnancy.[120] Some estimations have however been done. Johansson et al. (1996) show in their study from the mid-1990s that most abortions are carried out before 8 weeks of gestation. In 1991 4% of the reported abortions nationwide were performed after week 12.[121] Maria F. Gallo and Nguyen C. Nghia (2007) report that second tri semester abortions account for an estimated 10% of total rate of abortions.[122] UNFPA (2012a) states 60% of abortions in health centers were performed in the first tri-semester. Most common reason for not having an early abortion was lack of awareness of pregnancy status.[123] While in some clinics it is reported most of the abortions are being performed on female embryos of between 14 and 22 weeks.[124] This is consistent with results from another study, where

[116] Ganatra et al., 2004, p. 106., http://www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Elements-of-Comprehensive-Abortion-Care/MVA.aspx.
[117] Ganatra et al., 2004, p. 106., UNFPA, 2012a, p.54
[118] Ganatra et al., 2004, pp. 109-110.
[119] Maria F. Gallo, Nguyen C. Nghia, *Real life is different: A qualitative study of why women delay abortion until the second trimester in Vietnam,* pp. 1812-1822, Social Science & Medicine, vol. 64, 2007, pp. 1812-1813.
[120] Bélanger, Oanh, 2009, p. 169.
[121] Johansson et al., 1996, pp. 103-106.
[122] Gallo, Nghia, 2007, p. 1812.
[123] UNFPA, 2012a, pp. 54-55.
[124] http://www.thanhniennews.com/2010/pages/20121212-hanoi-doctor-says-more-women-aborted-girls-in-dragon-year.aspx.

almost half of the abortions, 48%, were performed between weeks 17-20.[125] Even if these are only estimations, it can be suggested that abortions nowadays are being performed on a later stage. The probability of a larger amount of abortions being performed later might be associated with the introduction of sex selection technology such as possibility of ultrasonography that was introduced in the 1990s. Danièle Bélanger and Khuat Thi Hai Oanh (2009) note that health care providers indicate that women seeking sex selective abortions use strategies that hospital data cannot capture, such as visiting a clinic known for not asking detailed questions, or initiate a medical abortion on their own and then rush to the hospital to seek care for a miscarriage. Officially, the private sector can provide only first-term abortion services, but in practice it is possible to obtain a later abortion though at a higher cost.[126]

5.3 Health care staff

According to the NSG trained obstetricians, assistant doctors with obstetric pediatric specialization or trained midwives can legally perform abortions. Marie Klingberg-Allvin (2007) notes that midwives are in some areas conducting early abortions at primary care level. They also assist doctors with abortion procedure, but are not authorized nor trained in counselling in connection with abortion.[127] Klingberg-Allvin suggests there is a problem with the nurse and midwifery education, due to its lack of competent teachers, not being a standardized education yet and limited time of schooling. Adolescent sexual and reproductive health also creates ethical dilemmas for future midwifes, this is of value for program planners to consider, and improvements are needed both in technical procedures and ethical dilemmas.[128] Especially in the rural areas there is a shortage of further training of the nurses and midwifes, leading to a low competence level and refraining women from seeking reproductive health services, this clearly counteracts the client focused reproductive and sexual health services that is wished for.[129] The refraining from seeking help is also reflected in studies made where clients find health care staff to be patronizing and condescending towards the client's issues, stating everything is normal with them. Differences in care depending on how much one paid was shown in a study, especially in the urban areas, where envelopes with money resulted in better care. Technically skilled providers followed by standard equipment were stated as most important factors when it comes to safe abortion services.[130] Director 1 stated that it is very important to educate the health workers. The money incentive is obviously an important factor for the health staff and counselling usually does not provide money for the clinic, therefore they rather see clients coming back

[125] UNFPA, 2007. p. 23.
[126] Bélanger, Oanh, 2009, p. 169.
[127] Klingberg-Allvin, 2007, p.16.
[128] Ibid. p. 44.
[129] Ibid. p. 17.
[130] Ibid pp. 31-32. The study was conducted at public and private clinics, women under the age of 20 were interviewed about their experiences. See further section 5.7 and 6.5.

for another abortion than to supply counselling and alternative contraceptive methods.[131] Time constraints is another reason stated for why counselling is not prioritized, the abortion providers already have too many clients.[132]

5.4 Private abortion providers

Currently private clinics are allowed to perform abortions until week 6. The private clinic need, as all medical facilities performing abortion services, a license.[133]

Private abortion providers have purportedly become increasingly common since it was approved in the 1989 Law on Protection of People's Health. Government subsidies started in 1991, the subsidies were evidently intended less as an incentive to encourage such procedures, than as an attempt to incorporate abortion into the Vietnamese medical delivery system.[134] In 1999 government estimated 12% of the clinics were unlicensed.[135] Professor 2 stated that most of the abortions performed are done in private clinics. The government could find these clinics if they wanted to, but not much effort seems to be made into restricting these clinics performing abortions above the allowed 6 weeks.[136] The proportion of all abortions performed by private providers is uncertain, in the early 1990s one study estimated it at 15% of the total amount of abortions being performed in Vietnam.[137] There are no reliable numbers on the abortions performed in private clinics nowadays, but it is probably an increasing number, since interviewed states there are constantly new clinics opening.[138]

Professor 2 noted that a frequent problem for the private clinics is the difficulty to get the clinic insured. Even if the clinic manage to get an insurance, the owner rather not take responsibility for a consequence occurring from an abortion if it is performed illegal e.g. later than week 6 or in a not certified clinic for abortion services, or by a provider who is not certified for abortion services.[139] The private clinic providers are either full time providers, running their own business or part time providers, also employed by the state hospitals.[140] The latter run their own clinics because they do not earn what they consider to be a decent salary in the public clinics. The state hospitals long waiting list also account for many women turning to a private clinic for an abortion.[141] The legal system wants to

[131] Director 1., UNFPA (2011) also states that the education of health workers regarding the prohibition of sex selection is of utmost importance.
[132] Director 2.
[133] Law on Protection of People's Health article 44.3, Circular 07/2007 TT-BYT. See Supplement A.
[134] Goodkind, 1995, p. 90.
[135] http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010, p 213.
[136] Professor 2.
[137] Teerawichitchainan , Amin, 2012, p. 81.
[138] Professor 2, Professor 3, Interview with Manager at UNFPA, 29/11.
[139] Professor 2.
[140] http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010, p 212.
[141] Professor 2.

protect the individual and that is why it is easy to obtain an abortion, it is by nature a problem with the statistics concerning abortion statistics in general and in particular with the private clinics, since there is no need to even show an ID when asking for an abortion. The ID is only needed if you want to claim support from the health insurance.[142] Director 1 told me that in a private clinic one can obtain an anonymous abortion, there is no need to register one's name or age. Due to the stigmatization of young people who have sex and a young woman getting pregnant many would be interested in remaining anonymity. Director 1 suggested that private clinics mainly are used by younger, single women. Cultural aspects such as giving the family a bad reputation also accounts for young women turning to private clinic and an anonymous abortion.[143] The anonymity that can be kept in a private clinic also serves well for single women getting an abortion after having become pregnant with e.g. a married man. Consequently if no registration is made, it is hard to prosecute the responsible provider for the abortion if something goes wrong.[144] By legislation medical practitioners can be held liable for illegal acts resulting in injury to a patient and may be required to pay compensation.[145]

Private clinics are consequently a good choice for clients who want to remain anonymous and for a quick service. Though with the issue of illegal abortions e.g. performed after week 6 or with a non- qualified provider it can constitute a health risk for women.[146]

The supervision of the clinics is done by the medical agencies of the government quarterly and by instant check if the ministry receives a complaint. Complaints from patients as well as from journalists discovering deficiencies are quite frequent and the agencies then perform an immediate check- up at the clinic in question. The supervision is randomly chosen both in public and private clinics and hospitals. The supervision is for instance focused on if advertised prices are followed, that the correct doctor is performing the procedures and that the qualities of the services are high. The Employee at MOJ, whom I interviewed, had registered a problem with the existing procedures. He suspected that a clinic which gets a complaint returns to old routines after the supervision visit. Since supervision visits in general are so rare the clinic can fail in complying with the regulations.[147]

5.5 Abortion fees

Fees for health services were endorsed as part of the doi moi policy in 1989 and in 1992 mandatory and voluntary health insurance schemes were

[142] Manager at UNFPA.
[143] Director 1. See also Rydström 2006.
[144] Professor 2.
[145] See Supplement A on Ordinance on Private Medical and Pharmaceutical Practice, no: 07/2003/PL-UBTVQH11 article 18.2k.,
http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010, p 218.
[146] Director 1.
[147] Employee at MOJ.

introduced.[148] The fees for abortion services vary, depending on the method used and the quality of the clinic. Medication abortion is usually more expensive than other types of abortion. Director 1 noted that a doctor with good reputation can charge higher fees. For married women who experience method failure and for all women in poor, rural areas it is free of charge.[149] According to Bang et al. (2008) abortion is accessible free of charge in the public health services and at a cost of about 120,000–150,000 VND in private clinic.[150] The fee for an abortion is anyhow rarely stated as a reason by women to not have an abortion.[151]

5.6 Demographic differences in abortion prevalence

UNFPA (2012a) which reviewed studies made during 2006-2010, states that some studies indicate there is no difference in abortion rates between urban and rural regions, while other studies reported abortion rate is higher in urban than rural areas.[152] In some studies there are regional differences stated, such as higher abortion rate in the northern area of Vietnam than in the southern area while the south central area has the lowest abortion rate.[153] Professor 2 believed most abortions are being performed in rural areas by young women.[154] Director 2 disagreed and said that it is easy to blame the high abortion rates on the young women. She admitted increased rates of abortions performed by young, unmarried women. Nevertheless, she noted that most abortions are done by married women as a family planning method.[155]

The possible differences in abortion rates due to geography can be explained by differences in the enforcement of the two- child policy. In the north, and the densely populated Red River delta incentives and fines are more strictly applied than in the southern parts of Vietnam where focus is on decentralized contraceptive services, supply and distribution.[156] The abortion rate of people with low education level is relatively high, but people with elementary school graduation have the lowest rate of abortion. The abortion rate shows differences depending on number of children the couple have. Families with one or two children had the highest abortion rate, whereas families with 3 or more children or no children had lower abortion rate.[157] These facts support the suggestion of abortion being used as a family planning method.

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[148] Drake et al., 2010, p. 3.,
http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010 p 213.
[149] Teerawichitchainan ,Amin, 2012, p. 81., UNFPA, 2012a, p. 57., Director 1.
[150] Bang et al. 2008, p. 181.
[151] Director 1, Director 2, Manager at UNFPA.
[152] UNFPA, 2012a, pp. 53-54.
[153] Nguyen, 2012, pp. 56-61.
[154] Professor 2.
[155] Director 2.
[156] Johansson et al., 1996, p. 105.
[157] Nguyen, 2012, pp. 56-61.

5.7 Specific situation for adolescents

Explanations to increasing abortion rates among adolescents and the specific situation for adolescents are described in this section. There is no specific legislation regarding adolescent's abortions. This section will provide among others, statistics from SAVY 2 which is the largest conducted study on adolescent's reproductive health behavior.[158] The question of adolescent's abortion rates seems to be of great concern for scholars and also well covered by media, as several studies and interviewees mention adolescents' abortion rate as a main concern.[159]

With the rise in the average age of first marriage for both men and women the rates of premarital sexes has increased. In SAVY 2, almost 10% claims they have premarital sex, other studies shows this rate is about 5%. Pre-marital sex might be more widespread, since 25% of youth claims they have a friend who has been sexually active. The age for sex debut has been decreasing last decade and is currently at 18 years both for male and female.[160]

The SAVYs and Nguyen (2009) note that attitudes towards pre - marital sex among adolescents are becoming more open minded. Traditional values, such as importance of the women remaining virgin until the wedding night, are given up upon and premarital sex is now accepted more widely as a part of a modern lifestyle.[161] This can be explained as a change in the perception of love and trust among lovers and a way to demonstrate their commitment to a future marriage. Studies reviewed by UNFPA (2012a) still indicate that respondents have a strong preference for traditional views, such as stressing the importance of a woman being a virgin when getting married. In those studies 75-90% of adolescents and their parents support the traditional views.[162] Klingberg-Allvin (2007) also notes deep rooted Confucian values in Vietnam and strong cultural disapproval of premarital relations.[163] She notes that the Vietnamese society has not found a way to be well prepared for the need of the adolescents, which puts barriers for young women to practice contraception leading to unwanted pregnancies and unwanted abortion.[164]

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[158] SAVY 1 was the first research in its kind on this age group. SAVY 1 was performed in 2003, SAVY 2 in 2009.
[159] Professor 1, Professor 3 Director 1., Studies include e.g. Nguyen, 2009, Nguyen 2012
[160] UNFPA, 2012a, p. 43., Nguyen, 2009, p. 6., The SAVY 2 showed that the rate of male having premarital sex is 13,6% while female is 5,2%. The penal code prohibits adults to have sex with people under 16 years old, breach of this can lead to imprisonment of 5 years.
[161] Vu Quy Nhan, *Emergent issues in reproductive and Sexual Health: Specific Topic Report Survey Assessment of Vietnamese Youth,* 2006, p.11., Nguyen, 2009, p.8., WHO, *Health of Adolescents in Vietnam,* factsheet , http://www.wpro.who.int/topics/adolescent_health/vietnam_fs.pdf?ua=1, p. 4., In SAVY 2 44% stated having "modern values" of premarital sex, among male 58%, among female 30%.
[162] UNFPA, 2012a, p. 43.
[163] Klingberg-Allvin, 2007, p. 34.
[164] Ibid. p. 41.

Professor 1 emphasized the importance of parents talking to their adolescents about reproductive health. She thought parents are hesitant to speak about such matters due to traditions and values as well as there has been a delay of introduction of sexual education in schools due to their generation's hesitance, even though it is commonly known that sexual education is decisive for unplanned pregnancies and abortion. The teachers rely on parents to teach their children about reproductive health and the parents rely on the teachers.[165] It is noted anyhow by some interviewees, that education in schools has improved, because of support from doctors and health providers. The sexual education was introduced in 1984. Family planning methods and abortion is yet to be provided as part of the education. Professor 1 noted that adolescents tend to browse internet for information on sexuality and safe sex, though internet can give a skewed picture of sex and wrong information, positive outcomes can include increased general knowledge on reproductive health and information on e.g. emergency contraceptive pill.[166]

Adolescents' contraceptive knowledge is high, according to SAVY 2, almost all of the respondents can name at least one. To be aware of contraceptives is though only the first step, to use them the next step. Half of those who had been or were sexually active used a condom at first sex.[167]

In SAVY 1 among unmarried youth 80% stated not using contraceptives generally. Unwillingness to use contraceptives was counting for 30% of the respondents and thereby the most common reason stated for not using contraceptives. While 18% says they lack information and do not know how to use contraceptives.[168] Nghia and Gallo (2007) note that the reason for Vietnamese youth not using contraception to any further extent might be that in order to conform to social norms against premarital intercourse they focus on the spontaneity of the act. The spontaneity necessitates contraceptive non-use which allows the adolescents to preserve their socio-moral identity.[169]

According to the SAVY 2 study, 9% of women who are sexually active reported having had an abortion. According to the results almost all (98%) of the women who have had abortion are married.[170] In SAVY 1 among the unmarried group having sexual intercourse, 27% reported having

[165] Professor 1. See Rydström 2006 on how the teachers rely on parents informing the adolescents and vice versa.
[166] Director 1., Professor 1.,
http://reproductiverights.org/sites/default/files/documents/Vietnam.pdf , 2010, p. 220., note that the exclusion of family planning methods and abortions in sexual education is a reference from the latter source and was relevant as to 2010.
[167] WHO, *Health of Adolescents*, p. 5.
[168] Vu, 2006, p. 16.
[169] Nghia, Gallo, 2007, p. 1821.
[170] Hung, 2010, p. 35., WHO, *Health of Adolescents,* p. 6 notes that the number of 98% is not valid " the authors of SAVY 2 have emphasized that this information is not significant and should only be used as a reference and not for official use. Other reports suggest that abortions by unmarried young women made up between 10% and 20% of all abortions in urban areas".

had an induced abortion. Urban females reported higher abortion rates than rural (50% versus 14%).[171] A consequence of the pregnancy in youth identified late, due to young women's inexperience about body changes might be negative effects on their future fertility. There is a lack of understanding of what impact an abortion can have, some choose abortion instead of other contraceptive methods due to fear of side effects of other methods.[172]

There are plenty of contradicting results in the above mentioned surveys, such as the view on premarital sex and the rate of abortion being performed by unmarried women. What is clear though, is that a relative large amount of young sexually active women are experiencing moral dilemmas surrounding their sexual life and use of contraceptives. The young women avoid stigmatization and sign up for an anonymous abortion and might even prefer a cheap clinic which might not be certified or reliable. In this way they are risking to damage their own health. The increased sexual education performed by schools in combination with an improved counselling service could help to inform young women on reproductive health.

[171] Vu, 2006, p. 29.
[172] Ibid. pp. 35-36.

6 Family planning

6.1 Defining family planning

Maja Kirilova Eriksson (2000) notes that no international treaty defines the term family planning. It is though generally agreed, as defined in the spirit of contemporary human rights law that family planning consists of first the right to procreate and second the right not to reproduce, i.e. reflecting the diversity of fertility-related situations which women must cope with.[173] CEDAW article 16 (1) e stipulates that "States parties shall…ensure, on a basis of equality of men and women: the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".[174] The ICPD Programme of action[175] also expanded the family planning term to include women's reproductive health and promotion of women's equality.[176]

Long et al. (2000) argue that family planning in Vietnam can be understood narrowly in terms of the rhetoric of a one- or two-child policy and more broadly in terms of family harmony and happiness which engages both individual households and the state.[177]

6.2 Legislation

It is the responsibility of the state, society, the family, and the citizen to implement the nation's population program and family planning policies. This is regulated in the Population Ordinance (article 4, 5.2, 9.3 and 10.2), in the 1989 Law on Protection of People's Health article 43 and in article 40 of the 1992 Constitution.

The 2003 Population Ordinance article 9 regards family planning as a primary measure to readjust the birth rate and as a consequence contribute to ensuring prosperous, equitable, progressive and happy lives. The implementation of this ordinance includes a two- child policy.[178] The National Strategy on Population and Reproductive Health 2011-2020 have target of reducing the abortion rate and basically eliminate unsafe abortion. The vision is to reduce the rate of abortions to 27/100 live births in 2015 and

[173] Kirilova Eriksson, 2000, p. 188.
[174] Ibid. pp. 240-241. See Supplement A.
[175] ICPD 1994 Programme of Action was the resulting document from the International Conference on Population and Development held in 1994. See 4.1. for further information on ICPD. The Programme of Action has served as a guide for international population activities as well as national actions 20 years from 1994. There will be an ICPD conference in April 2014.
[176] Kirilova Eriksson, 2000, p. 281.
[177] Long et al., 2000, p. 23.
[178] Ordinance 08/2008/Pl-UBTVQH amends article 10 of the 2003 Population Ordinance. See Supplement A.

below 25 by 2020. Currently Vietnam is in phase I (2011-2015) where the target is to focus on the model of healthy small families and take initiatives in adjusting birth rates suitably to each region and area so as to maintain the national total fertility rate at around 1.9 by 2015. The strategy also aims to intensify controls on the practice of sex selective abortions and to intensify the dissemination and education of population on reproductive health policies and laws, especially those on control of sex imbalance at birth. Vietnam intends to concentrate on improving population quality through implementing pre-marriage counselling and health-check.[179]

6.3 Issues around family planning

Family planning refers to both modern and traditional methods. The latter consists of abstinence, fertility awareness and withdrawal. Modern family planning methods include IUD, condoms, oral contraceptive pills, female and male contraception, diaphragm, injectable and implants. Contraceptives such as condoms and oral pills are easily available, at least in urban areas and are sold in pharmacies.[180]

In 2013, the contraceptive prevalence rate for married couples was 77%. This is an improvement over the last decade.[181] Provincial differences are noted, where some provinces have a contraceptive prevalence rate (CPR) above 90% among married couples already having two children, whereas some provinces have a CPR under 75%.[182] The most commonly used contraceptive is intrauterine device (IUD) which represents 55% of family planning methods used by married women in Vietnam.[183] Vietnam's family planning strategy tends to favor the IUD over other methods, with the objective for the health staff to perform a target number of IUD insertions. This strategy common in socialist states is driven by a lack of resources.[184] Beyond that, until recently contraceptives were only given to married women.[185] Health problems related to the use of IUDs are experienced by a large amount of women. These problems consist of infections, heavy and prolonged menstruation, feeling of weakness, tiredness.[186] Some women choose to remove it secretly because of the side

[179] See Supplement A.
[180] UNFPA, *Unmet Need for Reproductive Health and HIV/AIDS Services: Evidence based on the analysis of the 2011 MICS data*, 2013, p. 27., UNFPA, 2012a, pp. 29-32 presents the contraceptives available and an overview of the problem with implementation and regional differences of family planning services. This section presents main issues regarding family planning services.
[181] GSO Statistics from 2013, http://www.gso.gov.vn/default.aspx?tabid=622&ItemID=14774., UNFPA, 2012a, p. 1., Bang et al. 2008, p. 177. notes a CPR of 78% in 2008 and 80% in 2009. The CPR includes modern and traditional methods of family planning.
[182] UNFPA, 2012a, p. 28.
[183] Drake et al. 2010, p. 1., 2008 figures, among married women 13% used oral contraceptive pills and 11% condoms.
[184] Teerawichitchainan , Amin, 2012, p. 81.
[185] Director 1.
[186] Phan Thi Thu Ha, Sidney Ruth Schuler, *A qualitative study in southern Vietnam*, 1999, pp. 27-32., Johansson et al., 1996, p. 105.

effects of the IUD. They do it by themselves or in a private clinic without telling their partner, thus facing the risk of an unwanted pregnancy.[187] Differences in usage by age and occupation exist, especially among women aged 20-35 years and among farmers.[188] Long et al. (2000) note a problem with the limited use of condoms due to AIDS campaigns promoting fidelity as a strategy and target drug users, prostitutes and foreigners as risk groups. This strengthen the perception of not needing condom with partners that one trust. As well the sense of shame carrying condoms and not knowing if and when to use it.[189] Studies on family planning failure rate are rare.[190]

Despite the increased availability of a variety of contraceptive methods and the official attitude and campaigns promoting men participating in family planning and taking a greater responsibility, the use of male contraceptive methods rarely seem to be considered. As noted, IUD has been the most prevalent method among females for many years, making it a standard method or a natural choice rather than one alternative among many. In a study that Phan Thi Thu Ha and Sidney Ruth Schuler (1999) conducted it was shown that couples discuss family planning and contraception. However, the responsibility to plan and practice family planning measures still lies with a woman. Reasons for this responsibility were based on opinions expressed by women such as that the man has to work hard, stay healthy and not worry about contraceptives. In addition, it was expressed that since the women bear children it is natural she gets responsible for the family planning. Men are described as supporters rather than as key persons when it comes to family planning.[191] Women are therefore, taking initiative to seek information and make certain that suitable contraceptive methods are used. Often frightened by giving birth or having an abortion, women are having a direct interest in preventing pregnancy.[192] The ISDS, ICRW, CREPHA study (2012) concluded that men's perception and attitudes toward abortion are considered to affect their partners' access to safe abortion services and as a help to promote women's reproductive health and rights. Overall, the data revealed a relatively high acceptance of abortion among men in the study.[193]

UNFPA (2012a) notes that rates of CPR for young and unmarried couple are not available, neither are the adolescent unmet needs for family planning. UNFPA suggest that the high rate of abortion implies a low CPR among adolescents.[194] The fact that the Vietnamese state does not gather CPR rates among unmarried and young women makes family planning

[187] Director 2.
[188] UNFPA, 2012a, p. 29.
[189] Long et al., 2000, p. 22.
[190] UNFPA, 2012a, p. 30, states that contraceptive method change is addressed in a few studies, where 55% of users changed their method due to side-effects and health issues.
[191] Phan, Schuler, 1999, pp. 34-36.
[192] Anh, 2002, pp. 84-87.
[193] ISDS, ICRW, CREPHA, *Study on gender, masculinity and son preference in Nepal and Vietnam*, 2012, pp. 63-66. The study was conducted in July 2011 through interviewing 1000 men in the age group 18-49, mean age 35.
[194] UNFPA, 2012a, p. 1.

strategies difficult to fulfill for this group of women. When there is not a measurement tool to grasp the complexity of the reproductive health among adolescents and unmarried women, family planning cannot be precisely directed.

The discourse on population control can serve as an example of a contradiction in the Vietnamese society. From the government's side it is wished for a slower population growth, which is highlighted by campaigns promoting the small happy family[195]. Women who do not bear children are though stigmatized in spite of their contribution to slower population growth. Lisa Handwerker who has researched about infertility in China concluded that "overly reproductive female bodies threaten national security and economic development, while non-reproducing female bodies threaten moral values or patriarchal control over women's reproduction and sexuality.[196] Even if this statement refers to infertile women, the only recent focus on unmarried women shows that the sexuality and reproductive rights of a woman are not targeted, but her ability to reproduce can be an issue.

Goodkind (1994) notes that Vietnam's population policies, although not directly encouraging abortion, raise the marginal cost of childbearing to such an extent that disrupting pregnancy becomes more accepted. In addition, the modernization and development of the society contributes to increase of premarital sex and unwanted pregnancies and hence, demand of abortion services.[197]

6.4 Unmet need of family planning

Unmet need for family planning is referring to the proportion of married women of reproductive age 15-49 with a preference to avoid pregnancy although not using any form of family planning. Initially the unmet need only targeted married women, but recently also extends to unmarried women in determining need for e.g. abortion services. Unmet need for family planning can lead to e.g. unintended pregnancies and unsafe abortion practice.[198] UNFPA (2013) concluded in an analysis of the Multi-Indicator Cluster Survey[199] that overall Vietnam has relatively low unmet need for family planning, though disturbing trends include unmarried and young women not in a union, this group tends to be urban based and consists of well educated women. The most vulnerable group however UNFPA states are the ones with low education level and low living standard, from ethnic communities in specific regions. According to

[195] See notes 67 and 71 about the campaigns promoting small families.
[196] Lisa Handwerker in Danièle Bélanger, *Single and Childless women of Vietnam: Contesting and Negotiating Female Identity* , pp. 96-116, *Gender Practices in Contemporary Vietnam,* eds. Rydström, H., Drummond, L., 2004, p. 99.
[197] Goodkind, 1994, p. 350.
[198] UNFPA, 2013, pp. 7-9.
[199] Ibid. pp. 2, 19. Multi-Indicator Cluster Survey conducted by the General Statistics Office (GSO) of Vietnam in 2010 and 2011. The results were also compared with previous surveys conducted in 2000 and 2006. MICS asked women aged 15-49 on contraception, sample size 11614 households.

UNFPA there is a common misassumption that women want to bear a child soon after marriage, which often leads to neglect for these women in family planning program activities. The unmet need for family planning among married women is 11% and among unmarried single sexually active women 34%.[200] The unmet need for modern methods is 29% among married and 43,5% among unmarried single sexually active women.[201]

A consequence of unmet need of modern contraceptives is that traditional methods get more common, thereby creating a requirement of improving effectiveness of such methods and to encourage better use of modern contraceptives.[202] In 2013 about 10% of the couples use traditional methods such as abstinence, fertility awareness and withdrawal.[203] Nghia and Gallo (2007) note that women who experience problem with contraceptives may rely on traditional methods such as abstinence or withdrawal with abortion as a backup.[204]

6.5 After care on abortion

With aftercare it implies the care being provided after an abortion such as counselling and medical care given. As after care is not a legislative question[205] it will be considered as an issue of lack of counselling and affecting the abortion prevalence.

The Employee at MOJ whom I interviewed argued that since after care is not regulated by law the responsibility lies on the clinics and the patient. He argued that the doctors shall guarantee that their clinic supply enough counselling and advice before and after performing an abortion.[206] The NSG points out that women seeking abortion shall be given information on contraceptive methods by a counsellor with an expertise in counselling in questions concerning contraception. However, midwifes are not authorized to give such counselling, but there is a desire among health service planners to increase the competence and strengthen the role midwifes can have for reproductive health services such as counselling.[207] Several interviewees told that there are severe problem with the aftercare on abortion. There is not enough medical care, neither in private or public clinics.[208] The midwives and doctors are not used to counselling. From the clients view, it is stigmatizing with the counselling, especially if it is situated, as an interviewed explain in a corner of the hospital where everyone can see you

[200] Ibid. pp. 24-26.
[201] Ibid. pp. 29-30., see also UNFPA, *Advocacy brief Unmet need for contraception and implications for Vietnam,* 2010b, p. 1.
[202] Ibid. pp. 62-63.
[203] http://www.gso.gov.vn/default.aspx?tabid=622&ItemID=14774., UNFPA, 2012a, p. 30 states that in mid 2000s the rate among couples for using traditional methods was 14%.
[204] Nghia, Gallo, 2007, p. 1821.
[205] Employee at MOJ
[206] Ibid.
[207] Klingberg-Allvin, 2007, pp. 16-22, UNFPA, 2007, p. 23
[208] Professor 2, Director 1, Director 2.

seeking counselling.[209] Danièle Bélanger and Khuat Thu Hong (1999) show that only few women who had abortions get information on how to avoid pregnancy again, although they have indicated they would like to have such information. Some manage to find information elsewhere others are left knowing as little as they did before their abortions.[210] It has been shown in a study that when providing counselling on abortion consisting of e.g. discussion on risks and severity of abortion, reduced rates of abortion and increased use of contraceptives are the outcomes.[211] Studies of interventions aimed at reducing abortion rates are apart from that one surprisingly rare.

6.6 Abortion as a method of family planning

Previously in this thesis the rates of abortion and fertility have been described as following the population planning policies introduced. In this section it will be discussed if abortion *is* a family planning method in Vietnam or if abortion is rather an alternative method when *other* family planning methods are not used.

Abortion can be described as a measurement of the capacity to meet the need of using contraceptive methods and the quality of family planning services.[212] UNFPA (2012a) stresses that more than 10% of women consider abortion as a family planning method thus highlighting the need to expand access to contraceptive choices and deter abortion as a method for family planning.[213] Long et al. (2000) note that medical practitioners and couples have increasingly viewed abortion as a method of contraception.[214] Bussarawan Teerawichitchainan and Samin Amin (2012) suggest that Vietnamese women use abortion to achieve the desired family size, based on the inadequate availability and inefficient use of contraceptives. Contributing factors are also that abortion is subsidized by the government and several family planning campaigns still list abortion as a method of birth control.[215] Abortion as a family planning method is not intended by the government according to professor 3.[216]

[209] Director 2., WHO, *Factsheet on Adolescents Health*, p. 7. reports that corners are an initiative from 2004 covering 22 communes in 7 provinces, targeting 10-24 year olds, with an emphasis on reproductive health services and gender equality, numbers in 2006 show that approximately 10-15 youth would visit the corner each day.
[210] Danièle Bélanger, Khuat Thu Hong, *Single women's experiences of sexual relationships and abortion in Hanoi, Vietnam*, pp. 71-82, Reproductive Health Matters, vol. 7, issue 14, 1999, p. 79.
[211] UNFPA, 2007, p. 25.
[212] Hung, 2010, p. 35.
[213] UNFPA, 2012a, p. 55.
[214] Long et al., 2000, p. 22.
[215] Teerawichitchainan , Amin, 2012, p. 82., Director 2 also stresses that women use abortion as a birth control method.
[216] Professor 3.

According to Johansson et al. (1996) data, most women do not use abortion as a means of family planning.[217] Johansson et al. argue, as does Kristin Luker (1975), that women are not irrational as regards contraception. Women engage in contraceptive risk taking and conscious decision making by viewing abortion as less costly for their health than if they were using contraceptives, i.e. women who experience side effects of using contraceptives and would rather use traditional methods such as withdrawal and taking the risk of facing an abortion. Luker pushes this explanation by arguing that women consider and weigh the costs of contraception including acknowledging and planning their sexual activities as more costly then to have an unwanted pregnancy. Thus, Luker challenges family planning managers who tend to support the contraceptive ignorance theory, a theory which holds out women's lack of knowledge about contraception and irrational contraceptive behavior as the reasons for abortion.[218]

[217] Johansson et al. 1996, p. 105.
[218] Kristin Luker, *Taking Chances: Abortion and the Decision Not to Contracept*, 1975, pp.18-21, 64. See also section 5.7. where Nghia and Gallo (2007) argue that adolescents might not use contraceptives due to spontaneity of the sexual act.

7 Sex selection

This chapter will introduce the legislation on prohibition of sex selection and sex determination and thereafter list different theories and facts on son preference, gender equality, sex determination and use of such services as well as skewedness of sex ratio at birth.

7.1 Legislation

As previously mentioned (see current state of abortion section 5.1), the 2003 Population Ordinance article 7 prohibits sex selection in any form. Bang et al. (2008) state that there is no evidence of action being taken under this article. Decree 104/2003 ND-CP came shortly after the Population Ordinance as an implementation of the ordinance i.e. in article 10 the decree prohibits sex selective abortions and the use of ultrasound technology for sex determination and selection purposes. In response to public concern about sex selection, the Vietnamese Government issued Decree 114/2006/ND-CP in October 2006, since November 2013 replaced with 176/2013/NĐ-CP, which imposes sanctions on people who promote or practice abortions on the basis of fetal sex or who use practices to determine fetal sex. Bang et al. (2008) argue that the decree imposing sanctions does not specify how the regulation would be enforced in a situation where there is access to ultrasound and abortion service.[219] The legislation is thus clear, however the issue with the current legislation on sex selection and sex determination is the enforcement and implementation, which will be discussed in this chapter as well as further discussed in chapter 9.

7.2 Son preference

Bélanger (2004) suggests a theory on the necessity for women in Vietnam to produce children in general and sons in particular. She reasons that the status of women highly relies on the ability to reproduce, particularly to have a son. Fertility stands as a fundamental marker of femininity. Women who give birth are thought to be more beautiful, complete and feminine than childless women. Young couples might therefore attempt to have a first child as soon as they can after their marriage and any delay raises doubts as to the woman's physical ability to bear a child.[220]

UNFPA (2009) suggests that reproductive choices made by the Vietnamese population today are guided by the principles of low fertility and son preference. Sex selective abortions thus become an option to satisfy both needs. UNFPA also notes however that a large majority of the Vietnamese population is gender-neutral with respect to fertility choices.[221]

[219] Bang et al., 2008, p. 181. See Supplement A.
[220] Bélanger, 2004, p. 108, see also Rydström 2003.
[221] UNFPA, *Recent change in the sex ratio at birth in Vietnam*, 2009, p. 9.

This approach is supported by Professor 2. He argued that the reason for choosing boys in the past related to ideas about reproducing the patrilineage and to carry out the necessary farm work. Many urban families care less about the ancestors today and about having a son. They do not necessarily see the boy as being the responsible for particular rituals. However, Professor 2 noted that the elderly still have a preference for boys and might want to influence their offspring's view on daughters and sons.[222] UNFPA notes that the strong son preference is rooted in a largely patrilineal and patrilocal kinship system that tends to place a normative pressure on couples to have at least one son.[223]Rydström (2002, 2003) has argued that the idea of patrilineality refers to the ways in which a son due to his body and blood is considered a link between the deceased and the alive members of the patrilineage. Boy's bodies are inscribed with symbolic meaning such as morality, honor and reputation which gives them a unique position in the family and society. The boy's body is considered to be a materialization of patrilineal history according to Rydström.[224]

In one of the largest surveys (ISDS, ICRW, CREPHA 2012) being performed in Vietnam on men's attitudes towards abortion and son preference, most men supported statements that revealed a son preference, but fewer men supported sex selection abortions. The highest proportion of men in Vietnam agreed with the statements that sons are important to carry on the family lineage and for parental support.[225] About 2% agreed with the views related to aborting a female fetus, putting a daughter up for adoption or abandoning a wife who does not bear at least one son.[226]

Men's views about the importance of sons and daughters are highly influenced by traditional customs, gender roles and expectations, as also shown by Rydström (2002).[227] The most common reason stated for having a son was the need to carry on the family name, the proportion of Vietnamese men citing this reason was overwhelming large (at 71 percent). The second and third most important reasons were to show support in old age, followed by the performance of religious rituals such as the ancestor worship.[228]

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[222] Professor 2. See Rydström, 2002, 2003.

[223] UNFPA, 2011, pp. 9.,"In a patrilineal system, descent is reckoned through males: The patriline is a line of descent from a male ancestor to a descendant (either male or female) which is continued only through sons. The term patrilocal refers to a kinship system in which a married couple resides with the husband's family." UNFPA, 2011, p. 23 notes that matrilineal and bilineal kinship systems also exist in a small extent in Vietnam, mainly among smaller groups of ethnic minorities. Matrilineal referring to a system where descent is reckoned through mothers and in bilineal system through both mothers and fathers.

[224] Helle Rydström, *Sexed Bodies, Gendered Bodies : Children and the Body in Vietnam*, pp. 359-372, Women's Studies International Forum, vol. 25, no. 3,2002, pp. 360-361.

[225] ISDS, ICRW, CREPHA, 2012, p.3.

[226] Ibid. p. 45.

[227] Ibid. p. 3., Rydström, 2002., See also Eklund (2010) who elaborates on son preference in China.

[228] ISDS, ICRW, CREPHA, 2012, pp. 52-53., UNFPA, 2011, p. 25 states that with ancestor worship comes also responsibility for ancestral graves. Considering the wars that been fought quite recent in Vietnam, many people tend to put a priority in keeping those family graves.

Birth, family name and homeland of one's child can be registered in accordance with any parent anyhow.[229] Hence, the law is not the issue, since family name can be passed by the daughter as well.[230] That the practice, and belief of regulations, is not in accordance with the law is also the case for the second most important stated reason. The parental support in old age might be due to the customs regulating housing, couples tend to stay with the man's parents[231], even though article 20 of the Law on Marriage and Family stipulates that couples can choose their own place to live. In the past it was common if a couple only had daughters to find another heir such as the father's brother's son. In present time however it is rare with inheritance forms like that. If a couple have no sons the inheritance will be transferred to one of the couple's daughters.[232]

The results from the survey also demonstrated that girls were considered important for emotional support (by 76% of the respondents), support in old age, when the parents were sick and the daily share of the workload the daughters did.[233] This is consistent with Kristina Göransson (2010) findings from Singapore, where she observed that caring for the elderly is a way for daughters in a patrilineal society to prove their value in the family. Since girls are born without symbolic value they need to prove their filiality through deeds.[234] Lisa Eklund (2010) notes with reference to a Chinese context that son preference is not only related to gender relations in the family but also as a reflection of unequal gender relations in society at large. Eklund continues stating that people might not even know why they prefer a son, when asked they might answer accordingly to what they believe the person asking wants to hear.[235]

Son preference is deeply rooted in Vietnamese culture and society and has despite recent socio-economic development and political interventions, such as a prohibition of sex selection prevailed.[236] The son preference appears to have been integrated into modern perceptions of small family

[229] Decree 158/2005/ND-CP article 15 and Circular 01/2008/tt-BTP chapter 2 article 1e. See Supplement A.
[230] UNFPA, 2011, p. 10.
[231] UNFPA, 2011, p. 27 states that according to the 1999 census, 77% of the people aged 60+ co-reside with their adult children. The percentage living with a son is about 50% higher than the percentage living with a daughter. However it is not an insignificant part, 20%, who resides with a daughter even though a son is alive. People in the survey suggest elderly living without a son is not miserable but well taken care of by their daughters.
[232] UNFPA, 2011, p. 30., See Supplement A for Law on Marriage and Family.
[233] ISDS, ICRW, CREPHA 2012, pp. 52-53.
[234] Kristina Göransson, *Gendered Expectations and Intergenerational Support among Chinese Singaporeans,* pp. 191-220, *Gendered inequalities in Asia Configuring, Contesting and Recognizing Women and Men,* ed., Rydström, H., 2010, p. 209., Helle Rydström, Paul Horton, *Heterosexual Masculinity in Contemporary Vietnam: Privileges, Pleasures, and Protests,* pp.542-564, Men and Masculinities, vol. 14, no 5, 2011, p. 549 argue that female bodies are considered blank in terms of not incorporating the morality and honor of their father's lineage. A son is defined as inside the lineage, while a girl is outside the lineage.
[235]Eklund, 2010, p. 19,40.
[236] Ibid. Eklund notes that the ways in which son preference change over time is only guesses since there is no way to measure it.

size, with the two- child family as an increasingly acceptable norm. Given this context, there may be unintended negative synergies between the son preference, two- child policy, and easy available access to abortion and diagnostic ultrasound services, which together may lead to an increase in sex selection. Bélanger and Oanh (2009) argue that policymakers should address the root causes of the elimination of female fetuses such as the gender inequality and the preference for male children rather than be focused on the abortion rate. They continue by arguing for a better implementation and enforcement of existing laws promoting gender equality. The law on inheritance grants equal inheritance to sons and daughters, in practice however, women do not have access to parental inheritance in many rural communities of Vietnam.[237] Social security schemes and financial incentives for elderly sonless parents should be introduced.[238]

7.3 Gender equality

Gender equality was first mentioned in the 1960 Marriage and Family Law. More recent the concept has been emphasized in Vietnam by policies and legislation, e.g. through Gender Equality Law 2006, as well as reinforced by the Decision no. 2351/QD-TTg of December 24, 2010, approving the 2011-2020 National Strategy for Gender Equality.[239] Director 2 argued that the core issue in Vietnamese society is the inequality of gender.[240] Kirilova Eriksson (2000) refers to CEDAW art 16 (1) e which stipulates the right not to have children at a certain point of time as well as to choose to remain childless. She argues that whether women will be able or not to exercise their right to make a free choice of a fertility regulation method is related to gender relations as well as with women's ability to exercise other human rights. Social pressures, religious beliefs as well as concern about health complications are mentioned as further reasons. The burden of contraception falls disproportionately on women. There are many more means of contraception methods for women than for men. A related issue is therefore women's health. Women are exposed to more health risks than men are, e.g. using hormonal pills and IUD. For family planning services to succeed they must be available and consist of balanced and objective information about method options, so the women can make a free and informed choice.[241] Nandini Oomman and Bela R. Ganatra (2002) question if there can be an individual choice on e.g. reproductive rights in a gender-biased society. They argue that women make choices about their reproductive lives in the context of their families and communities. If

[237] Bélanger, Oanh, 2009, p.169
[238] ISDS, ICRW, CREPHA, 2012, p. 60. Social security schemes for couples with only daughters are supported by 74% of respondents. Director 2 commented that the majority of the Vietnamese population live in the countryside and are farmers with no pension. They therefore lack financial support in old age. A social security system for them would be beneficial and their reliance on their children decrease.
[239] See Supplement A.
[240] Director 2.
[241] Kirilova Eriksson, 2000, p. 242. See Supplement A for reference on CEDAW.

women live within the structures of a patriarchal system that does not favor the birth of a female child, their choices are not really free and volitional rather a response to the pressures of a society that systematically discriminates against girls and women.[242]

7.4 Sex determination and the use of such services

In this section sex determination techniques such as ultrasonography services will be presented. This will be linked to surveys performed on attitudes and usage of such services. As initially stated, the use of ultrasound is prohibited for purposes of sex selection and sex determination.

Since the early 1990s ultrasonography scanning services have developed rapidly and become a lucrative business in Vietnam. Even though the NSG do not recommend routine use of ultrasound in pregnancy, ultrasound has due to its availability, accessibility and affordability been increasingly used by pregnant women as part of routine pregnancy care.[243] UNFPA (2012b) notes that the legislation on prohibition of sex selection and sex determination is difficult to enforce due to limited cooperation from parents and practitioners as well as due to the risk that it may limit access to legal abortion.[244]

The ISDS, ICRW, CREPHA (2012) report investigated the male attitudes to use of ultrasonography services. In their report they found that the wife of 64% of the respondent men had undergone an ultra sound test, 4% reported that the reason was a desire for having a son. The main reason for obtaining an ultrasonography was otherwise stated as a matter of a concern for health conditions of the fetus and a concern for the health of the woman carrying the fetus. The survey states that 86% of the ultrasonography scannings are done after week 13, 45% after week 28.[245] The last number indicates it would not be for determining the sex of the fetus and possibly have an abortion, since that is usually considered too late in week 28.[246] Even though it is prohibited in Vietnam for the provider to disclose the sex of the fetus the survey results indicate that these regulations were not followed. In the sample of the survey performed, the vast majority (75%) of the men reported that the sex of the fetus was disclosed by the service providers while undergoing an ultrasound test. This finding resembles the results of a General Statistics Office (GSO) 2010 Population

[242] Nandini Oomman, Bela R. Ganatra, *Sex selection: the systematic elimination of girls,* pp. 1-10, Reproductive Health Matters, vol. 10, issue 19, 2002, p.3. See also Rydström 2010.
[243] Tine Gammeltoft, Hanh Thi Thuy Nguyen, *The Commodification of Obstetric Ultrasound Scanning in Hanoi, Viet Nam*, pp. 163-171, Reproductive Health Matters, vol.15, issue 29, 2007, pp. 165-166.
[244] UNFPA, *Sex Imbalances at Birth: Current trends, consequences and policy implications*, 2012b, p. 11.
[245] ISDS, ICRW, CREPHA, 2012, pp. 57-58., Oomman, Ganatra 2002, p. 2 note that ultrasound imaging can determine the fetal sex at around 13-14 weeks as earliest.
[246] As earlier noted no legislation has been found stating that week 22 is the limit.

Change and Family Planning Survey where 75% of women aged 15-49 who gave birth from April 2008 to March 2010 knew the sex of the fetus before delivery.[247] The high proportion of health providers disclosing the sex of the fetus to their clients was in a study attributed to the fierce competition among clinics, the client's pressure to disclose the information and the very loose enforcement of the regulations on the use of ultrasound tests for sex identification. Private clinics lacks government subsidies and are more willing to attract clients by offering to let them know the fetal sex which is one of the primary aims for undergoing ultrasound test. If they do not disclose the information, they might lose their business. The study also showed a consensus amongst from ordinary people in Vietnam, health providers and officials that ultrasound scanning is overused. This study also highlighted the need to educate health workers on the negative social consequences of a skewed SRB, because if they are not aware of the problem, all measures and supervision is taken in vain, it was concluded.[248] The high number of ultrasounds being performed after week 28 hints that these scannings are not made on the purpose of determining the fetal sex due to wish to abort if not the preferred sex. Though, many women are informed about the fetus sex at a time while abortion is still an option.

7.5 Sex ratio at birth

The sex ratio at birth (SRB) in a country is at a normal level somewhere between 100-106 male on 100 female. So naturally there are more boys being born. When rates increase to level of 110 or more it can have serious demographic, socioeconomic and political problems such as male singlehood, many men will have to delay their marriage, increased violence, forced marriages especially at young ages, rape, trafficking of girls and women and civil unrest.[249]

The results of the Vietnamese census in 1999 failed to identify any significant SRB imbalance. Thereafter a slight excess in the SRB has gradually been detected in sample surveys performed by GSO.[250] Similarly as 2003 was the year of the goat, 2012 was the year of the dragon. This year was in East and Southeast Asia considered being a good year to have a son. That could be one explanation to why Vietnam's sex ratio at birth worsened from 109.8 in 2006 to 113.8 in 2013.[251] There are regional as well as

[247] ISDS, ICRW, CREPHA, 2012, p. 68.
[248] UNFPA, 2011, pp. 47-50.
[249] Kirilova Eriksson, 2000, p. 272., Bélanger, Oanh, 2009, p. 169., GSO, UNFPA, *Vietnam Population and Housing Census 2009 Sex Ratio at Birth in Vietnam: New Evidence on Patterns, Trends and Differentials,* 2011, p. 46 note that » Male singlehood is a rather paradoxical outcome of the current trends : it would potentially lead to a severe disruption of the functioning of the patriarchal structures that rely on men to perpetuate the family line. The quest for sons through modern sex selection might indeed endanger the very system that gave rise to it ».
[250] GSO, UNFPA, 2011, p. 9.
[251] Bélanger, Oanh, 2009, p.163., http://www.thanhniennews.com/2010/pages/20121212-hanoi-doctor-says-more-women-aborted-girls-in-dragon-year.aspx , http://www.gso.gov.vn/default.aspx?tabid=622&ItemID=14774.

sizeable differences among ethnic groups of sex ratio at birth. The north part of Vietnam has generally higher SRB. There has also been a stronger influence of Confucianism in the north, a strong characteristic of Confucianism is the preference for sons, justified by the fact that a son is the only way to continue the family line. The explanation to sex ratio cannot be explained by income, since sex ratio at birth among the poorest socioeconomic class often is at a normal level.[252] There is coherence in the view of the SRB worsening, both from governmental side, since the targets are 115/100 in 2015 and 117/100 in 2020 and from officials who believes the expected increase in SRB will result in an estimated shortfall of 2.3-4.3 million women by 2050.[253] Eklund (2010) notes that SRB imbalance only exists where fertility rates are low, son preference prevails and reproductive technologies and services which enable prenatal sex selection are available. If there is no limitation on fertility couples will continue childbearing until the desired amount of sons and daughters is achieved.[254]

In late 2006 on a seminar on the issue of sex ratios at birth some speakers clearly linked increasing sex ratios to sex-selective abortion, particularly in the case of late abortions. Government representatives at this seminar suggested that abortion rates should be reduced in order to address the issue of increasing sex ratios at birth.[255] Bang et al. (2008) state that policymakers need to recognize that the restriction of reproductive rights and the political drive to lower population are themselves contributors to the increasing sex ratio at birth in Vietnam. They stress the need of providing appropriate information for women, their partners and families who seek for abortion beyond the 12th week of pregnancy, especially those with girl children. Women tend to view their abortion behavior only as personal issues with individual benefits but may change their views if they understand that son preference and sex selection may have harmful consequences for society as a whole, including for their sons.[256] UNFPA (2011) refers to studies which states that a variety of factors play a role in recent rise of SRB, including a son preference, ability to afford and access sex selection technology (a supply factor) and the specific effect of fertility decline, where a pressure on including at least one son in a small family. These factors together in a particular context, such as Vietnam allows the SRB to increase, since Vietnam has a long standing son preference, rapid fertility decline imposed by the family planning programs and a recent emergence of modern sex selection technology.[257]

[252] Bang et al., 2008, pp. 178-179., UNFPA, 2012b, p. 9.
[253] http://www.thanhniennews.com/2010/pages/20121212-hanoi-doctor-says-more-women-aborted-girls-in-dragon-year.aspx.
[254] Eklund, 2010, p. 43.
[255] Bélanger, Oanh, 2009, p. 7. There is concern for this response from interviewed and in literature see chapter 8 on drafting of new population law.
[256] Bang et al., 2008, p. 181.
[257] UNFPA, 2011, p. 7.

7.6 Discussion on sex selection

Kirilova Eriksson (2000) argues that the freedom of choice compatible with international norms on human rights cannot comprise a freedom of the parents to decide on their child's sex if that would result in total devaluation of one of the sexes (as seen in China and India). Nevertheless, she stresses, since there is a demand for sex selection, freedom of choice includes freedom to have a child of one's own choice. Choosing the sex of a child is in that view a logical extension of the right to family planning.[258] GSO and UNFPA (2011) note how South Korea by enforcement of the legislation on prohibiting sex selective abortions, introduced family and employment laws and having rising proportions of women attending higher education, better jobs and higher incomes managed to lower the sex ratio to normal levels.[259] Attempts to regulate by legislation ultrasound and sex selective abortions in India and China have been ineffective and unenforceable. Although they appear to be easy options, they often limit access to safe abortion services. They may encourage doctors and patients to fabricate reasons for termination, constrain an otherwise socially accepted practice, and create a profitable underground market for illegal sex selective abortion, with all the associated health problems.[260] Oomman and Ganatra (2002) argue that laws are not likely to be effective in society where son preference is strong and deeply embedded in patriarchal structures. They argue that laws are difficult to implement and the laws even allow for a sense of complacency and encourage corruption. Practices, if they move underground, also expose women to unsafe medical conditions and monetary exploitation. Oomman and Ganatra adds that they remain concerned about the possibility that legislative responses to this practice threaten to victimize further the female sex i.e. by the family of the woman if she does not produce a male heir and by the law if she seek the means to do so.[261] It is difficult to ensure compliance of the current legislation prohibiting sex selection abortions. UNFPA (2011) report how an official notes that it is impossible to detect the violations of the legislation since women can state any reason for an abortion.[262] This is also emphasized in my interview with the Employee at MOJ who argued that it is impossible for a provider to know why a woman wants to have an abortion. He argued that responsibility however lies with the doctor and the patient. He stated "Legislation cannot do all. Education has to play a more important role. Legislation puts the foundation. Responsibility lies somewhere else".[263]

This chapter has explained that the practice of abortion is not in accordance with the legislation, such as the regulations prohibiting sex selective abortions and sex determination. Deep laying traditions and beliefs make the customs not adaptable to the laws and regulations. Advocacy and

[258] Kirilova Eriksson, 2000, p. 268.
[259] GSO, UNFPA, 2011, p. 46.
[260] Bang et al., 2008, p.181.
[261] Oomman, Ganatra, 2002, p. 5.
[262] UNFPA, 2011, p. 48.
[263] Employee at MOJ.

behavior change communication campaigns are needed to stress the fact that daughters can inherit, pass on the family name, as well as the laws are providing for couples to reside wherever they want and not necessarily with the man's family. More efforts could also be placed on a change of dominant attitudes regarding women's role in the family and in the society. The prohibition of sex selective abortions is a standpoint from the government's side, but in practice difficult to enforce since the state lacks the means to ensure compliance. A woman can state any reason, such as cannot afford another child, and get an abortion. Economic incentives are the foundation of the private clinics and the providers can perform an abortion without questioning the client if they desire an abortion based on a sex selection. For some families a third child (or even more children) may be desirable and although allowing this may lead to an increase in the total fertility rate it could also prevent rising sex ratio at birth. Director 2 suggested that a relaxation of the population policies regarding the number of children one can have would decrease sex selective abortions.[264] Although a relaxation of population policies might lead to an increase in fertility rate, it is a measure that could decrease the skewedness of SRB.

[264] Director 2.

8 Drafting of new population legislation

As earlier described in the method section, while I was conducting research for this thesis the drafting of the new population law came to my knowledge. In this chapter the suggested changes of the law and some concerns raised by doctrine and interviewed will be described.

Already in 2008, there were suggestions of a law on population since currently there is "only" an ordinance. The foundation for this desire of a new legislation was founded in the governmental concern for the increased sex ratio at birth that had been detected.[265] The 2003 Population Ordinance is regarded as outdated compared to the development of today's society. Many of the provisions in the current ordinance are general, of principle and difficult to apply in practice. The new law is by Professor 1 seen as a requirement for the objective to meet the needs of society, the family and the individual.[266] The legislation has been prolonged. The reason is due to the legal system construction. The new population law is intended to concretize the recently changed Law on Marriage and Family as well as the Civil Code. The person whom I interviewed at the MOJ explained that the authorities want to restrict sex selection which is seen as the most common reason for having an abortion. The new law this will condition the abortion possibilities. The suggested changes to the population law are i.e. stricter regulations on abortion and conditioning abortion. The Employee at MOJ notes that the current legislation was designed with respect to women's rights.[267] The reasoning in regard to the new law is that stricter regulations will protect women's health and maintain a balanced sex ratio at birth. The draft law specifies conditions for an abortion to be permissible, i.e. an abortion can only be conducted in order to save the woman's life, if the pregnancy occurs as a result of rape, if the fetus suffers congenial malformation or if the woman is young and unable to afford the cost of raising the child. The woman must also have an agreement from her husband or parents and receive consultancy before the abortion to ensure the woman's health.[268] The Employee at MOJ explained that since the law is still being drafted it is due to changes. The population law is expected to be brought to the National Assembly in 2014 but neither he nor professor 3 considers this to be realistic.[269] Professor 1 noted that key issues as outlined above will help to improve the health of women. Women's health has, according to her, always been a concern for the state and to improve women's health as the suggested intent of the legislation is, there need to be

[265] Bang et al., 2008, p. 179.
[266] Professor 1.
[267] Employee at MOJ. I have not been able to access the new Law on Marriage and Family.
[268] http://english.vietnamnet.vn/fms/society/77113/draft-law-tightens-rules-on-abortions.html.
[269] Employee at MOJ, Professor 3. Professor 3 has by email 2014-03-04 updated me that the law is planned to be submitted to the National Assembly in May 2014.

a tightened regulation regarding possibilities to perform an abortion. She raised concern though for how the new law might not be able to integrate a gender perspective on the development of specific regulations.[270] Director 2 expressed concern for a change in the legislation performing abortions. She suggested that since the gender power relations in Vietnam still are so strong and men are so privileged, a change in legislation will result in an increase in unsafe abortions. If the total numbers of abortions decreases the government will get the impression that the problem with the sex selection abortions have been solved but it has not.[271] Professor 2 is currently working with the upgrade of the law and thought that there are some legal problem with the current Population Ordinance from 2003, such as the language, the wording and how to implement it in practice. He suggested that currently the ordinance is only implemented for officials, but the law is supposed to be valid for everyone. He told that the ordinance has no "teeth", since there are no sanctions for (normal) people who breach, but there are some sanctions, in the political resolution from 2005.[272] The Employee at MOJ suggested that it is of utmost importance to sustain the supervision measures done by state agencies. He raises the issue of a changing population distribution, with fewer babies being born and an aging population. He fears that Vietnam would become another China, with an unbalanced ratio of the sexes, where men would outnumber the women.[273] Regarding the prohibition of sex selection and the suggested changes in the new population law restricting the right to abortion, Professor 2 referred to the Vietnamese saying "If the state cannot manage or cure something, they forbid it". He argued that rather than solving the issue of why Vietnam has high abortion rate in general and sex selective abortions in particular, the state wants to forbid the practice of abortion.[274]

[270] Professor 1.
[271] Director 2.
[272] Professor 2.
[273] Employee at MOJ. That Vietnam would become another China is also a concern for Director 1.
[274] Professor 2.

9 Discussion and analysis of the abortion legislation

9.1 Issues with the current legislation and its process-making

This section presents different views of the current legislation and how appropriate the preparatory work for a law is. Professor 1 noted problem with current legislation since it allows abortion on any ground, except on the basis of sex selection. She condemns the use of abortion on any chosen ground and suggests that it should not be legal to have an abortion e.g. as revenge on family members or having an abortion due to the wish to keep one's body in shape. Professor 1 thinks that it is rather a duty to give birth than a right to choose.[275] The Employee at MOJ thought that the current laws are theoretically good and has a good impact on people.[276] Professor 2 pointed out to me that the impact of the laws is due to other reasons such as in change in thinking, and not related to the laws, i.e. the legislation on a two- child policy is functioning well because people do not want more than two children due to financial reasons. To raise a child is costly especially for the poorer part of the population mainly residing in the rural areas. The land allocations where people got money according to how large family one had are no longer in force. [277]

Both of the directors, whom I interviewed noted that the issue of abortion services and the usage of such services are not related to the law. The law is by them described as formal and nonsense. The laws are not seen as making any change in practice.[278] I assume they mean this in a positive way, since laws apparently has an implication in a negative way, e.g. forcing people to following the population policy. Professor 2 noted that in theory it is good how the state try to manage the abortion rate by restricting the conditions. However, in practice an individual do not care much about the law, they care about their real situation and they will consider benefit and cost.[279] The Employee at MOJ explained that the legislation on prohibition of sex selection is not supported by the population, since many still prefer to choose the sex of the child.[280] Thereby he confirmed that the change of thinking regarding sex selection is still limited.

Professor 2 believed that there is no effort from the drafters of a new law on the real situation but rather on their own convenience. He explained that the National Assembly politicians do not work on a fulltime basis so

[275] Professor 1.
[276] Employee at MOJ.
[277] Professor 2.
[278] Director 1, Director 2.
[279] Professor 2.
[280] Employee at MOJ.

when they are to pass legislation, not enough efforts and time are spent on considering it, leading to that much of the proposed legislation is being passed without any changes. If changes are made to the legislation, it is often detailed ones such as about the language rather than the content. Legislations are passed to gain the favors of the executives rather than for the sake of the population. Efforts are done to try to raise this question of politicians being closer to the population and to consider their opinions and inputs.[281] Director 1 notes that the lack of knowledge from the legislator's side and unwillingness to either do more research or trust organizations research are reasons for the legislation not being close to the need of the population.[282] Matthieu Salomon (2007) agrees that the National Assembly decisions are commonly based on technical questions rather than major national policy issues, important questions are commonly debated in other rooms and sensitive legal issues are submitted for discussion and decision making to the political bureau or other party offices. A key step in improving the efficiency of the national assembly would be to improve both the conditions for the position, such as higher pay, make all full time employees as well as the qualifications such as professional experience of the people chosen. To legislate in a system where enforcement can be exceptional mottled and to which the public often has little confidence, provides obstacles for the national assembly to fully succeed in its mission to legislate, Salomon argues.[283]

A current problem with the law making progress according to Professor 2 is that it is a top-down process. He argued that in order for the legislation to be generally understood and followed accordingly to its regulations, the law preparation process must be changed to a bottom up process. He explained that this could be done by inviting people to comment on a draft law. Currently the legislation in his view has been introduced without first carefully investigating what the actual needs are. Professor 2 thus stressed the importance of addressing the causes of the high abortion rates and asks for information throughout the country. Currently it is optional to let the population have a saying in the suggested drafting of a law. There is no official referral sent out to the e.g. universities to examine the opinions on suggested legislation. Scholars and NGOs can however, on their own initiative make comments and suggestions, though there is no assurance that those suggestions are taken into account in the revision work.[284] Salomon (2007) notes that public participation of the preparation of legislation started in 1979 with the redrafting of the constitution. It is though difficult to evaluate the impact of the citizens' opinions, since the citizens' changes might be changes that were already planned or discussed by the legislator.[285] Professor 2 considered the revision of the constitution as a

[281] Professor 2.
[282] Director 1.
[283] Matthieu Salomon, *Power and representation at the Vietnamese National Assembly: The scope and limits of political doi moi*, pp. 198-216, *Vietnam's new order International perspective on the state and reform in Vietnam,* eds. Balme, S., Sidel, M., 2007, pp. 207-209.
[284] Professor 2.
[285] Salomon, 2007, pp. 204-205.

successful project, where the government invited comments from the public online on the proposed changes of the constitution. He stressed that the state lacks funds to support research initiatives and pilot studies about law processes and the inclusion of the public. Some ministries have bureaus or departments which take research initiatives but even those ministries lack the proper funding. According to Professor 2 "Ideas always come from inside a room with AC". He referred to the fact that in the legislative process a preparation commission with high ranking officials from different ministries meet up and discuss the proposed legislation without, in his mind, any evidence or research to base their decisions upon. He claimed that these meetings have no input from the outside and consequently not facing the reality.[286]

9.2 Implementation of legislation

Professor 2 stated that a main issue in Vietnam is to coordinate legislations in regard to many and very different problems and to implement the laws throughout the country. He believes that institutional arrangements, mechanisms, tools and schemes are underdeveloped or not efficient. The "mechanisms" consist of the responsible agencies and the capacity of these agencies. He argued that there are two problems, the lack of funds and the lack of knowledge. Even if an agent or an official would be specialized in a matter it would not make much difference because then the lack of financial support to implement a law would still be a problem. The lack of knowledge, he explained is among the responsible person's for implementing the legislation. The legislation gives rights and responsibilities to the citizens, but the citizens do not know how to ensure their rights since the responsible person's for implementing are lacking the knowledge to ensure those rights. Professor 2 argued that due to this lack of knowledge, the legislation end up not being implemented accordingly. Therefore he argued it exist a big gap between the law and the practice of the law.[287] The Employee at MOJ whom I interviewed, noted that due to unequal distribution of resources among the supervision agencies responsible for implementation, some agencies are facing issues of implementation of the legislation.[288]

The Employee at MOJ agreed that due to the unclear regulations concerning e.g. the two- child policy, there is a problem with the implementation of the 2005 resolution, not stating clearly if this extended to ordinary citizens or not.[289] No one of the interviewed mentioned the 2008 Ordinance enforcing a two child policy, which is valid for all Vietnamese (with the exceptions stated in the decree 20/2010 ND-CP). That scholars are not aware of this legislation might be a reflection of the difficulty with enforcement of the legislation.

[286] Professor 2. Rydström, through personal communication, notes that colleagues of hers continuously are invited to share their research information for the law preparation work.
[287] Professor 2.
[288] Employee at MOJ.
[289] Employee at MOJ.

9.3 Lack of a coherent legislation

The current legislation can be described as hard to get a good overview of, with the Employee at MOJ admitting that it is difficult to know the legislation since it is regulated in so many different legal instruments. The interviewees noted that they did not consider Vietnam to have a specific abortion law before I asked them the question.[290] The Manager at UNFPA whom I interviewed said that he did not see a need of a specific law on abortion since there is a consensus towards the right to abortion.[291]

Professor 1 noted that the implications of currently not having a specific abortion law are that the clinics performing abortions do not know the legislation properly.[292] This can lead to defaults in the care for the women seeking the abortion services. The Employee at MOJ whom I interviewed, emphasized that soon there will be a new population law, due to which the state prefers to relate all issues regarding population in one law. Consequently abortion will be included under population issues, which is correct according to the interviewed. All matters related to population will be within the scope of the population law such as the regulations of gender equality, health care of mothers and babies as well as ensuring the quality of a clinic.[293]

[290] Director 1, Director 2, Professor 2.
[291] Manager at UNFPA.
[292] Professor 1.
[293] Employee at MOJ.

10 Conclusions and recommendations

This chapter will combine conclusions and recommendations. I believe there are several measures that Vietnam can take to lower the abortion rate, ensure safe abortions and improve the family planning.

It can be argued that abortion is a non-question in Vietnam with the exception of worries concerning adolescents' abortion habits and the worries of sex selective abortions. The legislators have, until today, not dedicated a single legal instrument only to abortion.

There are several trends regarding abortion in contemporary Vietnam, both in legislation and in practice. There is an estimated decreasing trend of abortion prevalence in the public sector, though it is still a high rate of abortion compared to the rest of the world and an estimated increase of abortions in the private sector. The decrease of abortion rates in public sector since the 1990s is accounted to improved family planning such as availability of contraceptives. The adolescent's abortion rate is though a great concern for the interviewed as well as in literature. When compared with the 1990s, abortion is performed at a later state of gestation in present time. Abortion at a later stage means an increased risk for the woman's health. It is not certain which percentage the adolescents' abortions account for, but what is sure is that many young women are not aware they are pregnant until late and at that time, they realize they cannot bear a child, are too young or need to finish school and therefore abortion is perceived as the only solution for them. The legislation has for the last decade focused on reproductive rights, through policies and legislation measures such as relaxing the population policy (before tightening it again). Instead of women's reproductive health being at the center, as suggested in strategies, the peripheral questions become the focus for women. A woman is rarely able to consider or prioritize her own reproductive health but can be a victim of values that dictate to her a choice even though it may be at her own expense. A woman's reproductive health is torn apart from expectations of reproducing (as a traditional value) but within a two-child framework (currently enforced by the state) and socially implied by family and colleagues. Women also need to produce a son (son preference by family and society) and carry the main responsibility for making sure to perform a family planning method that lowers the risk of unwanted pregnancy with few personal considerations in the choice. Women are also responsible for solving issues in case the family planning is not well functioning. Men in Vietnam seem to be subject to conflicting moralities. In surveys they support women and their health but in reality men seem to hold a relative distance and low responsibility in the women's repeated abortions and health risk behavior.

The main emphasis by the legislators and its agencies has been to enforce the population policies, including the two-child policy. However, the smaller family size nowadays may be not only due to the strict enforcement of population policy and the social pressure to keep a small family but also due to an increase in cost for raising children and an increased urbanization, before children were a labor and safety measure in different ways than today. The pressure to keep to a small family however has resulted in an increased skewed sex ratio at birth.

I believe that the legislation shall reflect the dynamics of the society and therefore a relaxation of the population policies could be an advantage for Vietnam. Suggestions made by an interviewee include a relaxation of the population policy as a way to deal with sex selection and as a way of dealing with a high abortion rate. It might increase the fertility rate slightly, but would release the burden of women to perform an abortion due to keeping within a two- child limit.

A tendency in Vietnamese legislation is as noted, a repetition of goals in plenty of legislations instead of collecting all legislation in one law, e.g. family planning responsibilities, prohibition of sex selective abortions and sex determination. The current strategies, policies and legislation are not followed or implemented efficient, they rather come out as visions then as useful tools. The legislation is theoretically well but the implementation measures are lacking, as well as an understanding of the root causes to the high prevalence of abortions. The enforcement of legislation is currently not well prioritized, which makes the act of abortion not at the center of the legislation. The state and independent organs can with research on the root causes of abortion get a good understanding of how the legislation is best implemented. This could include a broader perspective of investigating the motives of women to have an abortion. Luker's theory on conscious decision making may be relevant for some women.

The practice of abortion appears to me after conducting this study, to be due to several reasons and usually within a complicated structure of historical reasons as described in this thesis, such as cheap and wide access to abortion, the woman's burden of responsibility of family planning, limited access to family planning methods such as counselling and good quality contraceptives leading to an unmet need of family planning. Stigmatization and lack of knowledge among young and/or unmarried women having premarital sex leads to denial of contraceptives and the view of abortion as a technique or a pre-emptive measure when not certain if pregnant or not.

The current legislation is difficult to have a good overview of. Simplicity in the legislation and clear regulations and enforcement methods can reduce the complexity of the practice of abortion. Better regulations could include that Vietnam coordinate all abortion texts into one law, even though the thought is not apparent among scholars, the suggestion made by the author was well received among interviewees. One abortion law would not necessarily have short-term implications, but it would be efficient to

regulate abortion in one law on a long-term basis, both for providers and users of the services. One law on abortion would facilitate a more widely understanding of the regulations because it is easier to overview one law and search for relevant information if necessary for instance for a clinic. This could lead to better awareness about the legislation and the practice of abortion.

This study indicates that the practice of abortion is only rarely related directly to the current legislation, with the exception of the two- child limit. An example of how the practice of abortion and the legislation is not synchronized is found in the prohibition of sex selection. The prohibiting legislation has already before proved to not be of much relevance since it is easy to claim abortion for any reason. When visiting a private clinic for an abortion it is feasible to be completely anonymous and not state a reason for the abortion, hence, it is impossible to know if the abortion is due to sex selection. The private provider has a financial incentive for having as many patients and procedures as possible, so therefore not concerned about the purpose of the clients' abortion nor to provide counselling. After the partial liberalization of the Vietnamese market in 1986, abortion has become a commodity and the state has lost some of its ability to monitor abortion within private clinics. The state opened up for private providers, and though it has proved necessary for some of the providers to run their own clinics to be able to survive on their public clinic salary, this has been made on the expense of the safety and public health concern. Abortions are being performed in a later stage than the legislative regulation state, counselling is rarely provided, insurance has proved to be a problem for the private clinics and anonymous abortions are possible. Monitoring practices are unclear, if the state is concerned about public health and the abortion rates stricter controls on private clinics could be implemented. Stricter and more regular supervision of the clinics could mean that abortions were performed accordingly to the legislation, e.g. not after week 6 in private clinics as well as ensure that the provider is qualified. The improved supervision can include a more frequent and extended monitoring. These measures would require funds, but that could be solved by raising the fines for violations of the legislation.[294]

Historically there has been a lack of family planning services. In literature and as interviewees noted an increased availability and better quality of contraceptives which could benefit all women and men are needed. The family planning services still prioritize married women. There is no contraceptive prevalence rate available for the group of unmarried women. The unmet need for family planning is relatively low but with worrying tendencies. The state, I will argue, has not fully succeeded in the

[294] If a clinic got increased costs for supervision, due to the received fines, they might increase the prize for the services. That would though only be a concern for the clinics which would violate the regulations. Increased supervision and higher fines would hopefully motivate clinics to follow the regulations. I choose not to go further into the question of lack of funds that several interviewees has mentioned, it might be that the state in general lacks funds, but I believe it is about prioritizing the funds one have.

family planning services when traditional methods account for 10% of respondents' methods, though according to official statistics the rate has decreased the last decade. In addition the family planning programs has not been fully voluntary, causing yet another stress to women.

A legislative regulation on mandatory counselling for the clients, when visiting a clinic for an abortion can be introduced. The counselling would lead to higher knowledge and informed choices on contraceptives and thereby reducing rates of abortion. A mandate for midwives to perform counselling could be introduced. The education for midwifes could include chances to discuss moral dilemmas and how to handle clients' repeated abortions. Educative measures can also include a male perspective in reproductive health. Men also need contraceptive advice and counselling, so they can step out of the supporting role in family planning and take a more active role. Including males in reproductive health strategies would release the burden of responsibilities carried by women. Hence, this would reduce the rates of abortion made on a basis of traditional gender role of the woman carrying the responsibility of family planning but would rather be based on a personal basis.

The state does not officially view abortion as a family planning method. However, the current reality for women has turned abortion into a family planning method for the Vietnamese population not least women. The suggested restrictions on possibility to have an abortion show that the state is willing to further distance abortion from family planning. The reform of a new legislation is based on high abortion rates and the willingness to eradicate sex selective abortions. However, currently the official statistics are not grasping the full reality of the abortion situation. The state does not have access to tools such as CPR of unmarried and young women to analyze the complexity and causes of abortion, making its reform for limiting abortion acts in the new law incomplete. An improvement of the statistical and measurement tools on abortion and family planning methods could be imposed before making any reform in the legislation. Concerning the suggested changes in the population law, the changes that make it more complicated and difficult to obtain an abortion would not necessarily improve women's health as expected. Further, it is unclear if it would decrease the abortion rates in general since the suggested law does not prevent the causes that motivate abortion but focuses on reducing the rates of registered abortions. Limiting abortion rights without a consideration of the actual causes behind the practice of abortion may lead to a rise in unsafe and unauthorized abortion, thereby risking women's health rather that protecting it. As scholars and interviewees have suggested, and as this study has shown, it is critical that the new population law keeps the right to abortion intact.

11 Further studies

Suggested research may include counselling and its effects on abortion rates, follow up studies of the new population law and how the new law affects the practice of abortion. Research that can be undertaken also include adolescent abortion behavior and how premarital sex contradicts traditional values, and how that might lead young women turning to unsafe practice of abortion. Studies of intervention in decreasing abortion rates are rare and would be useful for Vietnam.

12 Supplement A

Appendix for legislation and international documents

In order:
Constitution
Laws
Ordinances
Decrees
Circulars
Political Resolution
Decisions on implementation of strategies
International documents

1992 Constitution of the Socialist Republic of Vietnam (as amended on December 25th, 2001)

Article 2
The State of the Socialist Republic of Vietnam is a State of the people, by the people, for the people. All State power belongs to the people whose foundation is the alliance between the working class and the peasantry and the intelligentsia. State power is unity with delegation of power to, and co-ordination among State bodies in exercising legislative, executive and judicial rights.

Article 4
The Communist Party of Vietnam, the vanguard of the Vietnamese working class and loyal representative of the interests of the working class, the working people and the whole nation, who adheres to Marxism-Leninism and Ho Chi Minh's thought, is the force assuming leadership of the State and society. All organizations of the Party shall operate within the framework of the Constitution and the law.

Article 39
The State invests in, develops and ensures the unified administration of people's health protection, harnesses and organizes all social forces to build and develop a prevention-oriented Vietnamese medicine; combines disease prevention with treatment; develops and combines modern with traditional medicine and pharmacology; combines the development of public along with popular health care; ensures health care insurance and creates favorable conditions for all people to enjoy health care.

The State grants priority to the implementation of the health care program for mountain inhabitants and ethnic minority people.

Illegal medical treatment production and sale of medicines detrimental to the people's health by organizations of individuals are prohibited.

Article 40
The State, society, the family and all citizens have the obligation to give protection and care to mothers and children and to implement the population and family planning program.

Law on Protection of People's Health of June 30th, 1989

Article 43
1. Everyone is responsible for implementing the family planning, have the option of birth control and measures planned to expectations. Each couple should have only one or two children.

Article 44
1. Women have the right to have abortion if they so desire, to have medical examinations and treatment for gynecologic diseases, to have prenatal care, and medical service during delivery at medical institutions.

2. The Ministry of Public Health has the duty to consolidate and expand the network of obstetrics and new-born health care down to the grassroots in order to ensure medical care for women.

3. Medical institutions and individuals are forbidden to practice abortions or remove IUD's unless permitted by the health ministry or service.

Penal Code, no. 15/1999/QH10 of December 21st, 1999

Article 243
1. Those who perform illegal abortions for other persons, causing loss of lives or serious damage to the health of such persons, or who have already been disciplined or administratively sanctioned for such act or already sentenced for such offense, not yet entitled to criminal record remission but continue to commit it, shall be sentenced to non-custodial reform for up to three years or between one and five years of imprisonment.

2. Committing the crime and causing very serious consequences, the offenders shall be sentenced to between three and ten years of imprisonment.

3. Committing the crime and causing particularly serious consequences, the offenders shall be sentenced to between seven and fifteen years of imprisonment.

4. The offenders may also be subject to a fine of between five million dong and fifty million dong, a ban from holding certain posts, practicing certain occupations or doing certain jobs for one to five years.

The Law on Marriage and Family, no. 22/2000/QH10 of June 9th, 2000

Article 1. Missions and scope of application of the Law on Marriage and Family
The Law on Marriage and Family has the missions to contribute to building, perfecting and protecting the progressive marriage and family regime, formulate legal standards for the conducts of family members; protect the legitimate rights and interests of family members; inherit and promote the fine ethical traditions of the Vietnamese families in order to build prosperous, equal, progressive, happy and lasting families.

The Law on Marriage and Family provides for the marriage and family regime, responsibilities of citizens, the State and society in the building and consolidation of the Vietnamese marriage and family regime.

Article 2. Basic principles of the marriage and family regime
1. Voluntary, progressive and monogamous marriage in which husband and wife are equal.

2. Marriage between Vietnamese citizens of different nationalities and/or different religions, between religious and non-religious people, and between Vietnamese citizens and foreigners is respected and protected by law.

3. Husband and wife are obliged to implement the population and family planning policy.

Article 20. Selection of the domicile of husband and wife
The domicile of husband and wife is selected by themselves without being bound by customs, practices and/or administrative boundaries.

Gender Equality Law, no. 73/2006/ QH11 of November 29th, 2006

Article 40 (7) b
Violations of the law on gender equality in the field of public health include: Choosing sex of the fetus under all forms or inciting and forcing other people to abort because of the fetal sex.

The Labor Code, Law no. 10/2012/QH13 of June 18th, 2012

Article 159
Allowance upon leave to care for sick children, prenatal care, implementation of contraceptive methods, prenatal care, miscarriage, abortion, stillbirth, pathological abortion, care of sick child under the age of 7, fostering adopted child under the age of 6, the female employee is entitled to social insurance allowances in accordance with the law on social insurance.

Law on Social Insurance, no. 71/2006/QH11 of April 29th, 2006

Article 30
Period of leave when having miscarriage, abortion, fetocytosis or stillbirth
When getting miscarriage, abortion, fetocytosis or stillbirth, female laborers are entitled to ten-day leave, for pregnancy of under one month; twenty-day leave, for pregnancy of between one month and three months; forty-day leave, for pregnancy of between three months and under six months; or fifty-day leave, for pregnancy of six months or older. The period of leave for enjoying the maternity regime specified in this article includes public holidays, New Year holidays and weekends.

Ordinance on Private Medical and Pharmaceutical Practice, no. 07/2003/PL-UBTVQH11 of February 25th, 2003

Article 18.2. k
Private medical practitioners being individuals or organizations shall have the following obligations:
To be held responsible before law for their acts of law violation; if causing damage, to pay compensation therefore according to law provisions.

Population Ordinance, no. 06/2003/PL-UBTVQH11 of January 9th, 2003

Article 4 Rights and obligations of citizens regarding the population work
1. Citizens shall have the following rights:
a/ To be supplied with information on population;
b/ To be provided with quality, convenient, safe and secret population services as prescribed by law;
c/ To select measures to take care of reproductive health, practice family planning, and raise the population quality;
d/ To select appropriate residential places according to law provisions;

2. Citizens shall have the following obligations:
a/ To practice family planning; build families with few children which are prosperous, equal, progressive, happy and sustainable;
b/ To take appropriate measures to raise the physical, intellectual and spiritual abilities of their own and of their family members;
c/ To respect the interests of the State, society and community in readjusting the population size, population structure, population distribution, and raising the population quality;
d/ To abide by the provisions of this Ordinance and other law provisions pertaining to the population work.

Article 5 Responsibilities of the State, agencies and organizations in the population work

1. The State shall adopt policies and measures to carry out the population work, socialize the population work, ensure favorable conditions for the population work in compatibility with the national socio-economic development.

2. The State shall adopt policies to encourage organizations and individuals to invest in, cooperate on, assist and support the reproductive health care and family planning and population quality improvement programs, give priority to the poor, ethnic minority people as well as areas with exceptionally difficult socio-economic conditions and areas with difficult socio-economic conditions.

3. The State management agencies in charge of population shall have to direct the implementation of the population work, coordinate with Vietnam Fatherland Front and its member organizations in implementing the population work, inspecting and supervising the implementation of the population legislation.

4. Agencies and organizations shall, within the scope of their respective tasks and powers, have to:
a/ Integrate population elements into the socio-economic development planning, plans and policies;
b/ Propagate and campaign for the implementation of the population work;
c/ Provide various population services;
d/ Organize the implementation of the population legislation within their own agencies and organizations.

Article 7 Prohibited acts
The following acts are strictly prohibited:
1. Obstructing or forcing the practice of family planning;
2. Selecting the sex of unborn babies in any form.

Article 9 Family planning
1. Family planning constitutes a prime measure to readjust the birthrate, contributing to ensuring a prosperous, equitable, progressive and happy life.

2. Family planning-practicing measures include:
a/ Propagating, mobilizing and assisting, ensuring that each individual and couple to apply family planning actively and voluntarily;
b/ Providing quality, convenient and safe family planning services directly for people;
c/ Offering material and moral incentives, implementing insurance policies so as to create a motive force for pushing up extensive and intensive application of family planning among people.

3. The State shall support and create favorable conditions for the implementation of family planning programs and projects, giving priority to areas with exceptionally difficult socio-economic conditions or with

difficult socio-economic conditions, to the poor, persons meeting with difficulties, and minors.

Article 10 Rights and obligations of each couple or individual in the practice of family planning
1. Each couple or individual shall have the rights to:
a/ Decide on the time to have babies, the number of children and the duration between child births suitable to their age, health, study, laboring or working conditions, incomes, and raise their children on the basis of equality;
b/ Select and apply family planning measures.

2. Each couple and individual shall have the obligations to:
a/ Use methods of contraception;
b/ Protect their health, apply measures to prevent and avoid reproductively infectious diseases as well as sexually transmitted diseases, HIV/AIDS;
c/ Fulfill other obligations related to reproductive health care and family planning.

Article 11 Propagating and counselling on family planning
1. The State management agencies in charge of population shall have to work out programs for, and contents of, propagation and counselling on family planning; coordinate with other agencies, organizations and individuals in organizing the propagation and counselling on family planning.

2. Agencies, organizations and individuals shall be entitled to receive information on, participate in, propagating and counselling on the practice of family planning.

3. The information and propagation agencies shall have to propagate and disseminate the legislation on population and family planning. The contents and forms of propagation must be suitable and easily understandable to each target group.

Article 12 Provision of family planning services
1. The State shall encourage organizations and individuals to participate in producing, importing and supplying contraceptive devices and providing family planning services according to law provisions.

2. Organizations and individuals supplying contraceptive devices and providing family planning services shall have to ensure the quality of devices and services using safe and convenient techniques; monitor and remedy side-effects and undesirable incidents (if any) for users.

Ordinance 08/2008/PL-UBTVQH of December 27th, 2008

Article 1

Amend Article 10 of the 2003 Population Ordinance as follows: "Article 10. Rights and obligations of each couple, individuals in the implementation of population movement and family planning, reproductive health care:

1. Decision time and spacing of children; 2. Have one or two children, except in special cases stipulated by government regulations; 3. Health protection, implementation of measures to prevent reproductive tract infections, sexually transmitted disease education, HIV / AIDS and perform other duties related to reproductive health.

Article 2. Enforcement. This Ordinance shall take effect from 01 May 2009

Decree 20/2010 ND-CP of March 8th, 2010 implementing the article 10 of the Population Ordinance

Article 2. Cases in which the limit of having one child or two children is not violated
1. A couple where one or both belongs to an ethnic minority group with a population of under 10,000 or in danger of population decline (the birthrate is lower than or equal to the mortality rate) as officially announced by the Ministry of Planning and Investment, give birth to their third child.

2. A couple who have three or more children at their first birth.

3. A couple who already have one natural child and then have two or more children at their second birth.

4. A couple who have only one alive natural child, including a child already adopted by others at the time of giving birth to their third or subsequent child.

5. A couple with two children where one or both of the children suffers from a non-hereditary malformation or fatal disease certified by a provincial or central level medical assessment council, give birth to their third child.

6. A couple where one or both already have their own natural children and together have one, two or more children at the same birth. This provision is not applicable to a remarried couple with two or more common children who are currently alive.

7. An unmarried woman who gives birth to one child or two or more children at the same birth.

Decree no. 104/2003/ND-CP of May 9th, 2003 Detailing and guiding the implementation of the Population Ordinance

Article 10 To strictly prohibit acts of selecting fetus sex, including:
1. Propagating, disseminating methods of fetus sex selection in forms of organized talks, writings, translation, photocopying of books, newspapers,

documents, pictures, photos, recorded videos, recorded audio tapes, storing, circulating documents and other forms of propagation and dissemination of fetus sex selection methods.

2. Diagnosing to select fetus sex by methods of determination thereof via symptoms, pulse feeling, blood, gene, amniotic fluid, cell tests, ultrasonography.

3. Getting rid of the fetus on the reason of sex selection by methods of abortion, supply and use of assorted chemicals, drugs and other measures.

Decree 176/2013/NĐ-CP of November 14th, 2013 issued by the Government on administrative fines in the health protection area

Article 82 Act of fetal sex determination
1. A fine of VND 3,000,000 to VND 5,000,000 is applied to act of divination for the pregnant woman to determine the sex of the fetus.

2. A fine of VND 5,000,000 to VND 10,000,000 is applied to acts of using sphygmomanometer, ultrasonography or test for the pregnant woman to diagnose, disclosure or provide information about fetal sex unless otherwise provided by law.

3. Additional forms of fine:
Stripping the right to use business license, certificate from 1-3 months to acts defined in the clause number 2 of this article.

Article 83 Violation of the provisions of fetal sex selection

1. A fine of between VND 3,000,000 and 5,000,000 for acts of threat of physical force or mental intimidation to coerce others to apply the method to obtain fetal sex at will.

2. A fine of between VND 7,000,000 and 10,000,000 shall be imposed for using force to coerce others to adopt methods to get the sex of the fetus at will.

3. A fine of between VND 10,000,000 and 15,000,000 shall be imposed for any of the following acts:

a) Specify a manual or drugs to get the sex of the fetus at will;

b) Supply of drugs to get the sex of the fetus at will;

c) Research methods to get the sex of the fetus at will, unless otherwise permitted by law.

Article 84 Violation of having the fetus removed due to sex selection reasons

1. A fine of between VND 3,000,000 and 5,000,000 is applied in cases where the reason for the abortion is sex selection and the woman is not forced to abort.

2. A fine of between VND 5,000,000 and 7,000,000 for acts to seduce or entice pregnant women to have the fetus removed due to reasons of sex selection.

3. A fine of between VND 7,000,000 and 10,000,000 shall be imposed for threatening to use force or mental intimidation to force the removal of the fetus because of fetal sex selection.

4. A fine of between VND 10,000,000 and 12,000,000 shall be imposed for use of force to coerce a pregnant woman to have the fetus removed due to reasons of sex selection.

5. A fine of between VND 12,000,000 and 15,000,000 shall be imposed for one of the following acts:

a) Supply of chemicals or drugs to remove the fetus knowing that the pregnant woman wants to remove the fetus for reasons of sex selection;

b) Specify a manual, chemicals, drugs or other measures to remove the fetus knowing that the pregnant woman wish to remove the fetus for sex selection reasons.

6. A fine of between VND 15,000,000 and 20,000,000 shall be imposed for someone that supplies abortion knowing that the pregnant women wish to remove the fetus for sex selection reasons.

7. Additional sanctions:

a) Confiscation of material evidences used to perform acts prescribed at Point a, Clause 5 of this Article;

b) Stripping of operating licenses, professional practice certificates for a period from 3-6 months for acts specified at Point b, Clause 5 of this Article;

c) Stripping of operating licenses, professional practice certificates for a period from 6-12 months for the offense referred to in clause 6 of this Article.

Decree 158/2005/ND-CP of December 27th, 2005 about registration and civil status management

Article 15 Procedures for birth certificate registration
1. The subscriber for birth certificate must apply for birth proof certificate (in the prescribed form) and show the marriage certificate of the child's parents (if the child's parents registered for marriage).
The birth proof certificate is issued by the health service; if the child is born outside of health service, birth proof certificate is replaced by an assertion text of the witness. In the absence of witness, the subscriber must make a birth registration.

In case the civil status judicial officer knows well the marriage relationship of the child's parents, there is no need to show the marriage certificate.

2. After checking legal documents, civil status judicial officer will record the birth registration copies and the birth certificate form to the Chairman of Commune People's Committee, who signs and issues an original birth certificate to the subscriber. Copies of the original birth certificate is issued on request of the subscriber.

3. In case of non-marriage birth registration, if the father is not defined, the part of father information in birth registration book and original of birth certificate stays blank. If at the time of birth registration, the child is recognized, The People Committee of the Commune solves the recognition and registration.

Circular no. 01/2008/tt-BTP of June 2nd, 2008 guiding the implementation of a number of provisions of the government's Decree no.158/2005/ND-CP of December 27th, 2005 on civil status registration and management

Chapter 2, article 1e
If children are born overseas and brought back by their mothers, who are Vietnamese citizens, to live in Vietnam, the provisions on birth registration for out-of-wedlock children in Section I. Chapter II of Decree no. 158/2005/ND-CP and the guidance in this Section will also apply when:
- Birth registration for such children has not been carried out overseas:
- The mothers of such children have not registered their marriages.
If the mothers make declarations about the children's fathers, the fathers shall carry out procedures to recognize their children according to law.
The "notes" column of the birth registration books must be inscribed with "children born overseas and their birth registration has not been carried out overseas".

Circular 07/2007/TT-BYT of May 25th, 2007 Guidelines for medical practice, traditional medicine and medical private equipment

5.1. Conditions of personnel and facilities:
a) The head of a clinic must be a registered and certificated healthcare obstetric - family planning provider.

5.2. Scope of practice:
a) Consultancy for health education, family planning;
k) Internal medicine abortion for 6 week fetus (from 36 to 42 days since the first day of the last menstrual period).

Circular 16/2009/TT-BYT of September 22nd, 2009 Guiding the reception, medical care and statistical reports for patients

Article 4 Examination and treatment for patients who are victims of domestic violence
3. Requirements for the treatment of patients who are victims of domestic violence:
b/ In case the patients were forced to have sexual intercourse, the patient should be advised and provided with emergency contraception medication at the earliest time. If possible female victims should be treated by female physicians. If the patient had unintended pregnancy, physicians should advise patients to appropriate medical facilities, give counselling and option of safe abortion services.

Political Resolution no. 47/NQ/TW of March 22nd, 2005 on continuation of policy implementation on promoting the population and family planning

Party members and people shall stick to implement the guideline that every married couple has 1 or 2 children in order to bring a good condition for raising and teaching their children.

1. Quickly reach the replacement birth rate (every married couple in reproductive age have in average 2 children), in order to stabilize our population scale at 115 -120 million of people in the middle of the 21st century.

2. Enhancing quality of Vietnam population in physical, intellectual, spiritual structure in order to meet the human resources needed to attend to national industrialization and modernization.

Promote communication, advocacy and education
Continue to promote propaganda and education in order to make profound changes in cognitive and psychological, reproductive practices in the society. Mobilize and encourage the whole society to accept and follow that every married couple only have 1 or 2 children and to consider stopping at two children is an obligation of every citizen to reduce the country's population burden. Spreading and encouraging must be done clearly, carefully and suitably to each one. It is necessary to pay attention to families which already have 2 children to prevent them from having a third child.

Prime Minister Decision no. 2351/QD-TTg of December 24th, 2010 approving the 2011-2020 national strategy for gender equality

Objective 4: To ensure gender equality in access to and benefit from healthcare services

-Target 4: To reduce the abortion rate to 27/100 live births by 2015 and below 25/100 by 2020.

Group of solutions for achieving Objective 4:
- To further provide reproductive and sexual healthcare services for women and men. Especially to provide flexible, accessible and free-of-charge reproductive healthcare services for women and men in ethnic minority regions.
- To expand networks of reproductive healthcare counselling for men. To intensify the training of specialized andrology physicians at provincial-level hospitals.
- To intensify communications activities, aiming to raise the awareness of reproductive health and sexual health for women and men. To intensify men's participation in the implementation of family planning measures. To expand communication activities for minors about sexual health and safe contraception.
- To incorporate gender issues in policies, programs and plans of the health sector.

In Phase 2011-2015
- To build a number of pilot gender equality models. To establish databases of gender equality; to formulate sets of indicators on supervision and evaluation of the implementation of the Law on Gender Equality.

Prime Minister Decision no. 2013/QD-TTg of November 14th, 2011 Approving Vietnam's strategy for population and reproductive health during 2011-2020

- Target 5: To maintain a rational low birth rate, fully meet people's family planning needs and improve access to high-quality assisted reproductive services.
+ Norm 1: The total fertility rate (the average number of children of a couple of reproductive age) will reduce to 1.9 by 2015 and 1.8 by 2020.
+ Norm 2: The population will not exceed 93 million by 2015 and 98 million by 2020.

- Target 6: To reduce the abortion rate and basically eliminate unsafe abortion.
+ Norm: To reduce the rate of abortions per 100 live births to 27 by 2015 and below 25 by 2020.

- Target 8: To improve reproductive health of teenagers and the youth.
+ Norm 1: To increase the proportion of points providing teenage- and youth-friendly reproductive health services to the total number of service delivery points to 50% by 2015 and 75% by 2020.
+ Norm 2: To reduce the number of teenagers getting unwillingly pregnant by 20% and 50% by 2015 and 2020, respectively.

International documents

1950 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights)

Article 2
Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

1966 International Covenant on Civil and Political Rights

Article 6
1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

2. In countries which have not abolished the death penalty, sentence of death may be imposed only for the most serious crimes in accordance with the law in force at the time of the commission of the crime and not contrary to the provisions of the present Covenant and to the Convention on the Prevention and Punishment of the Crime of Genocide. This penalty can only be carried out pursuant to a final judgment rendered by a competent court.

3. When deprivation of life constitutes the crime of genocide, it is understood that nothing in this article shall authorize any State Party to the present Covenant to derogate in any way from any obligation assumed under the provisions of the Convention on the Prevention and Punishment of the Crime of Genocide.

4. Anyone sentenced to death shall have the right to seek pardon or commutation of the sentence. Amnesty, pardon or commutation of the sentence of death may be granted in all cases.

5. Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women.

6. Nothing in this article shall be invoked to delay or to prevent the abolition of capital punishment by any State Party to the present Covenant.

Article 24
1. Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State.

2. Every child shall be registered immediately after birth and shall have a name.

3. Every child has the right to acquire a nationality

1979 Convention on the Elimination of all Forms of Discrimination against Women

Article 12
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 16 (1) e
The same rights to freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise their rights.

1989 Convention on the Rights of the Child

Article 1
For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

ICPD Programme of Action

§ 8.25
In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from

abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions.

13 Supplement B

Interview guide

As explained in the method section an interview guide was used for the interviews. This is the interview guide I followed.

Legislation
What are the advantages and disadvantages with the current legislation on abortion?
How is the abortion legislation implemented?
Why is there not a specific law on abortion in Vietnam?

Population law drafting
What is the main reasoning behind the new law on population?
What are the potential advantages and disadvantages with the new law?
How can the new law improve women's health as suggested intent is?

Family planning
How has the two child policy influenced the population's perception of family planning?
How is the situation on counselling in relation to abortion?

Sex selection
What is the best way to limit sex ratio at birth?
Is there currently a skewed sex ratio at birth?
How can the attitudes concerning son preference be changed?

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