

# Abortion in Context: Women's Experience In Two Villages in Thai Binh Province, Vietnam

By Annika Johansson, Le Thi Nham Tuyet, Nguyen The Lap and Kajsa Sundström

*The government of Vietnam adopted a two-child policy in the 1980s to curb population growth; Vietnam now has one of the highest abortion rates in the world. In rural Thai Binh Province, where some local authorities strictly enforce the national population policy through a system of financial incentives and disincentives, 114 abortions occurred for every 100 births in 1991. A survey in two villages in Thai Binh among 228 women who had abortions that year revealed that contraceptive choice was limited; the IUD was essentially the only modern method used, and many women had given it up because of side effects. On average, the women had had 2.4 live births and 1.5 abortions, most of which took place before eight weeks of gestation. The most frequent reasons for choosing an abortion were wanting to save money and to avoid being fined for exceeding the two-child limit. Husbands were the most important persons in sharing the abortion decision; parents and parents-in law often did not agree with the decision. Postabortion counseling was absent or inadequate. The village where the national population policy guidelines were more stringently enforced had twice the abortion ratio of the village where enforcement was more lenient.*

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In many countries, rapid fertility decline has been accompanied by extensive reliance on induced abortion.<sup>1</sup> In Vietnam, the transition to lower fertility rates has been attributed partly to rising abortion rates, which are among the highest in the world.<sup>2</sup> Data are available on trends and regional variations in abortion patterns in Vietnam,<sup>3</sup> but the family and social context in which abortions occur and women's experiences with abortion have not been documented. In this study, we explore the circumstances of abortions from women's perspectives.

## Background

### *Induced Abortion in Vietnam*

In traditional Vietnamese society, induced abortion was considered a sin, and a woman undergoing such a procedure was severely condemned.<sup>4</sup> According to Bud-

dhist ethics, "the pregnant woman and her relatives had the duty to protect the foetus until the day of delivery even if it was the outcome of illegitimate relations or if the future child would be a heavy burden to the family."<sup>5</sup>

Abortion was legalized in 1945, when Vietnam gained independence, but it did not become widely accepted for many years. Since the early 1980s, abortion has been available, at no charge and upon a woman's request, as part of the family planning services delivered at all levels of the public health network.<sup>6</sup> The number of officially reported abortions in 1980 was about 170,000, corresponding to a rate of 15 per 1,000 women aged 15–44.<sup>7</sup> This rate was considerably lower than the rates of 40–100 per 1,000 women of reproductive age reported for China and Eastern Europe.<sup>8</sup> In 1992, the abortion rate in Vietnam had increased to approximately 100 per 1,000 women, making it third in the world only to rates reported for Romania and the former Soviet Union (199 per 1,000 and 112 per 1,000, respectively).<sup>9</sup>

During the 1980s, Vietnam also experienced a decline in total fertility, from 4.7 births per woman in the period 1980–1984 to 3.9 births per woman in 1985–1989.<sup>10</sup> Birthrates declined most rapidly in the main cities, where the highest rates of abortions were also reported. In rural areas, abortion rates are, on average, about one-third of those in the cities. An excep-

tion to the rural pattern is Thai Binh, an agricultural province in the Red River Delta in the northern part of the country, where abortion rates are comparable to those in urban areas.<sup>11</sup>

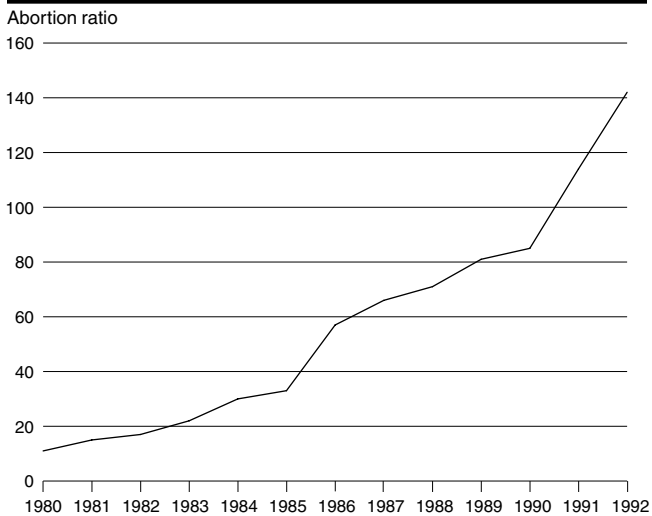
### *The Thai Binh Context*

With a population of 1.7 million and more than 1,000 inhabitants per square kilometer, Thai Binh is among the most densely populated provinces in Vietnam.<sup>12</sup> In response to the national two-child policy (which was promulgated in the early 1980s, officially established in 1988 and reinforced in a decree of 1993<sup>13</sup>), family planning campaigns have been vigorously pursued in the province and services expanded. Following provincial guidelines, each village is responsible for developing regulations aimed at keeping its population within the limits of the national targets.

The birthrate in Thai Binh declined during the 1980s and into the early 1990s, and is among the lowest in the country.<sup>14</sup> During the same period, however, the prevalence of abortion climbed steeply (see Figure 1, page 104). In 1992, little was known about the dramatic increase in abortions in Thai Binh, and even less about the consequences for women. The aim of this study, therefore, was to describe the abortion pattern in a local community and women's contraceptive use prior to abortion, explore women's experiences with abortion decision-making at the family level and with the procedure itself, and investigate the possible reasons for the rapid increase in abortion.

Two neighboring agricultural villages, typical for Thai Binh and with a combined population of approximately 17,000, were chosen for the study. Each has a health center, where family planning and abortion services are provided on a weekly basis by a team from the district hospital; the same team covers both villages. At the time of the fieldwork for this study, the IUD was virtually the only modern contraceptive method offered to the women. Condom and pill supplies were erratic, and service providers did not encourage women to use these methods. Male and female sterilization were being introduced, but were used very little.

Annika Johansson is a sociologist, and Kajsa Sundström is a professor of gynecology, Department of International Health and Social Medicine, Unit of International Health Care Research (IHCAR), Karolinska Institute, Stockholm, Sweden. Le Thi Nham Tuyet is a professor of anthropology, and Nguyen The Lap is a gynecologist, Centre for Research on Gender, Family and Environment in Development, Hanoi, Vietnam. The authors thank colleagues from Thai Binh Medical College and Thai Binh Population and Family Planning Commission who collaborated closely in fieldwork. Vu Qui Nhan at the National Committee for Population and Family Planning, Hanoi, and several colleagues at IHCAR offered valuable comments on the manuscript. The study was funded by the Swedish Agency for Research Cooperation with Developing Countries.

**Figure 1. Number of induced abortions per 100 live births (abortion ratio), Thai Binh, 1980–1992**

Source: Unpublished data from the Statistical Office, Commission for Population and Family Planning, Thai Binh, 1992.

In written regulations issued in May 1991, the People's Committee in Village 1 specified sanctions for exceeding the two-child limit and rewards for staying within it. According to these regulations, couples having a third or higher order birth had to pay a fine of 200–250 kg of paddy rice, which represented about 3–4 months' production. In addition, they were expected to contribute in rice or workdays to the village public utility fund, they received low priority in the allocation of land or new housing and they were not entitled to the same social benefits as couples with only one or two children.

On the other hand, couples in Village 1 keeping within the two-child limit were entitled to an annual reward of 20 kg of rice until the mother reached the age of 45. Women who had an IUD inserted or an abortion performed after the first or second birth were rewarded with 20 kg of rice.

In Village 2, there were no written regulations at that time, and women's responses to questions about rewards and fines were rather vague. However, they indicated that the village leaders were lenient with couples who exceeded the two-child limit; for example, fines were sometimes waived for poorer families.

Recent demographic statistics and abortion data from the villages reveal notable differences between them. In 1991, there were 110 abortions per 100 live births in Village 1, compared with 54 per 100 in Village 2 (see Table 1). That same year, both the birthrate and the proportion of births that were of third or higher order were considerably higher in Village 2 than in Village 1.

## Study Design

The study population consisted of all women in the two villages who had had an abortion during 1991. The women were identified from lists provided by the village health centers of those who had had an abortion in the village or had been referred to the district hospital for the procedure. These lists were cross-checked with district hospital files, and the data were complemented with information from health workers.

Of the 249 women who had had an abortion, 20 could not be contacted because they

had moved from the village or had given wrong names, and one woman declined to participate. The 228 remaining women were interviewed in their homes by teams of medical and social scientists from Thai Binh and Hanoi during two weeks in spring 1992. A semistructured questionnaire was used to elicit information on the women's socioeconomic characteristics, reproductive history and contraceptive use prior to the abortion; the interview also included open-ended questions on decision-making and health problems in connection with the abortion. Socioeconomic and some reproductive data are presented separately for the two villages, but in other instances, the results are combined.

In addition to the survey, open interviews were conducted with six women who had had at least two abortions. These interviews were tape-recorded, transcribed and translated into English, and have been used in the analysis to explore issues related to women's contraceptive and abortion-related experiences and to family support.

## Results

### Socioeconomic Characteristics

As Table 2 shows, 52% of the women were in their 30s; education was virtually universal, and 23% of the women had a secondary or higher education. Farming was the predominant occupation (87%), and 8% of the women were employed in non-agricultural work.

With two exceptions, the women were married, and in most cases, the husbands lived permanently at home. The majority

of the women were nonreligious or were Buddhist; about 10% were Catholic. Whereas 90% reported that their family had enough food throughout the year, 10% said that they had an insufficient food supply for about two months out of each year. Differences in socioeconomic characteristics between the villages were not statistically significant.

### Reproductive and Contraceptive History

Over their lifetime, the women had had a total of 928 pregnancies; on average, each woman had had 2.4 live births and 1.5 induced abortions (see Table 3).

For 64% of the women, their abortion in 1991 was their first abortion, for 25% it was their second and for 11% it was at least their third. At the time of the abortion, 79% of the women had two or more children, 20% had one child and 1% had no children. Almost all of the women who had undergone two or more abortions (including this one) were older than 30.

About 80% of the abortions were performed before the eighth week of pregnancy (counted from the first day of the last menstrual period). None were reported after the 12th week. Women in the two villages did not differ significantly with regard to age, parity or gestational age at abortion.

In all, 44% of the women had been using some method of contraception when they became pregnant. Some 11% had been using an IUD, 2% had been using condoms and 31% had been using a traditional method (usually rhythm or withdrawal) or had been breastfeeding.

Women who had not been using any contraceptive method when they became pregnant gave a variety of reasons for their nonuse. A few women reported that the pregnancy was intended, but that they had decided on abortion for health reasons. The majority of the nonusers had previously used the IUD, but had stopped because of side effects, including increased bleeding, backache, headache, abdominal pains and weakness.

In the open interviews, some women

**Table 1. Selected demographic measures, Thai Binh and study villages, 1991**

Measure	Thai Binh	Village 1	Village 2
Population (000s)	1,700	9.7	7.2
Birthrate	1.8	1.5	2.3
% of births of order $\geq 3$	u	18	28
Abortions per 100 live births	114	110	54

Note: u=unavailable.

**Table 2. Percentage distribution of women who had an abortion, by selected characteristics, according to village of residence, 1991**

Characteristic	Total (N=228)	Village 1 (N=148)	Village 2 (N=80)
<b>Age</b>			
<20	0	0	1
20-29	29	30	28
30-39	52	54	49
≥40	19	16	22
<b>Education (yrs.)</b>			
None	0	1	0
Primary (1-8)	76	71	86
Secondary (9-12)	15	16	14
Higher education	8	12	0
<b>Occupation</b>			
Farmer	87	80	92
Nonagricultural worker	8	15	4
Other	5	5	4
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>

said they had tried over the years to use modern and traditional methods in various combinations. For example, a 34-year-old woman who had just had her fifth abortion in four years recounted that she and her husband had decided after having their second child that they wanted no more. She used an IUD but became pregnant three times and ended each pregnancy with an abortion. She then began using rhythm, but became pregnant again after another year and had her fourth abortion. On her doctor's advice, she began to use the pill, but stopped after some months because she felt that it gave her backaches. She related:

I went to the health center to have the backache treated by acupuncture. It became all right, and I started taking pills again. But the backache resumed, and I decided to give up the pills. My husband brought home some condoms that he had been given at the health center. We tried to use them, but they caused me inflammations. We took up the rhythm method, but as my menstrual cycle was not so regular, I must have miscalculated and I became pregnant again. Since I was too busy, I had to wait until after the harvest to have the abortion. I don't know how to deal with contraceptives now.

**Table 3. Percentage distribution of lifetime pregnancies, and average number of lifetime pregnancies per woman, by outcome (N=928)**

Outcome	% dist.	Avg. no. per woman
Abortion	37	1.5
Live birth	59	2.4
Stillbirth or miscarriage	4	0.2
<b>Total</b>	<b>100</b>	<b>4.1</b>

### The Abortion Experience

Some women said they had had their abortion because they wished to space births, and a few cited health reasons. The most common reasons given, however, were financial, such as wishing to save money to build a house or wanting to avoid being fined for having too many children. One woman recalled:

My husband was even more concerned than me. He was afraid of having to pay the fine if we had a fifth child. He complained that the family was not rich enough to feed so many mouths.... He wanted me to have an abortion, and finally I complied with his request.

In the women's family and social networks, husbands were the most important persons in sharing the abortion decision. About 90% of the women said that they and their husband had made the decision together. The women's parents or their husband's parents also had a voice in the decision-making, and there were often differing views between the generations. In almost half of the families, the women's parents or parents-in-law had advised against the procedure, generally because they were concerned about the moral and ethical aspects of abortion or, if the couple had only daughters, because they wanted a grandson.

In some cases, the husband had wavered in his opinion and left the woman to make the decision on her own. A 31-year-old woman who had two children and had had three abortions, for example, said that sometimes her husband agreed to the abortion and sometimes he did not, since his parents had told him that abortion is wrong and is harmful to the woman's health. Asked what she did when he did not agree, she explained:

I didn't want another child, so I went to the hospital by myself. I went without the knowledge of either my husband or my parents-in-law. I was afraid that their disagreement would cause a lot of trouble. I thought that they would neither want me to have the third child nor allow me to have an abortion in any form. So I had to leave for the hospital in a quiet and secret way, early in the morning, without the knowledge of anyone.

On the other hand, the women were asked if they felt "pushed" into the decision to have an abortion. Only 5% replied affirmatively, mentioning the Women's Union (a national organization with local branches throughout the country) and friends:

I was advised by my friends who spoke in favor of abortion because there was no other way and no other solution.

Most of the women had become aware

of their pregnancy early on and had gone to the village health center for menstrual regulation (manual vacuum aspiration). In some cases, however, their workload had prevented them from seeking early treatment, as described by a 28-year-old mother of three who had had two abortions:

In May, when I became aware that I was pregnant, I could not go to the health center to suck out the fetus [i.e., have a menstrual regulation] because it was harvest time and my husband was away from home. When I was two and a half months pregnant, I had to go to the district hospital to have the fetus scraped out [curettage]. I did not have to pay for the abortion, and I got medicine and tonic free. But when I got home, I had no nutritive food to eat because we had little money. And I could not rest afterward; the day after, I had to go to the fields. I felt a strong headache and bellyache, and I was dead tired. My health deteriorated, and I had to use antibiotics and bought some medicinal herbs from the herbalist in the market. After some time, I gradually got better.

When asked about their health after the abortion, 20% of the women said that they felt "normal," a concept not without ambiguity, as illustrated in this remark:

My health after the abortion was quite normal. I felt somewhat dizzy and had a backache. I still feel the dizziness and have frequent headaches, so I always have some medicine at home.

The women who said that they did not feel "normal" after the abortion had experienced various problems with their health (see Table 4); most described more than one symptom. The most common complaints were fatigue, headache and backache. Of the 172 women with complaints, 51 reported a decrease or increase in menstrual bleeding, 15 said they had prolonged menstruation and 30 said they

**Table 4. Number of women reporting various health problems related to abortion**

Problem	No.
Fatigue	68
Headache	54
Backache	43
Decreased menstrual bleeding	34
Loss of appetite	32
Vaginal discharge	30
Insomnia	28
Abdominal pains	20
Increased menstrual bleeding	17
Prolonged menstrual bleeding	15
Fever	7

Note: In all, 172 women reported one or more abortion-related health problems.

had had vaginal discharge. The complaints indicated a general state of weakness and feeling of ill health, although fever, indicating the presence of an infection, was rare.

Feelings of worry and fear related to the abortion were more difficult to describe. More than half of the women stated that they had been afraid to have the abortion. One woman described her feelings in this way:

When I knew I was pregnant, I couldn't sleep well. I was very worried all the time about the abortion. I would get my normal sleep back only after the abortion.

One-third of the women had not received any contraceptive counseling or other health advice from the doctor or other health worker after the abortion. The rest had usually been advised to try to use the IUD.

## Discussion

The pattern of induced abortion among the study women was similar to that reported from another survey conducted in Thai Binh in 1992, but different from the pattern revealed in a 1992 survey from Hanoi discussed in the same article.<sup>15</sup> Only 9% of the women undergoing abortion in our study were younger than 25, and fewer than 1% were terminating their first pregnancy, compared with 17% and 14%, respectively, in Hanoi. The Hanoi data may reflect the increase in abortions among teenagers noted in recent years,<sup>16</sup> a trend that has not been evident in data from Thai Binh.

Most abortions among women in the study villages were performed quite early in the pregnancy, and none were reported after the 12th week. By contrast, 4% of abortions nationwide in 1991 reportedly were performed after the 12th week.<sup>17</sup>

### *Abortion—A Substitute for Contraception?*

In another abortion study in Thai Binh, the researchers suggested that “a substantial proportion of women are using pregnancy terminations as a substitute for modern and traditional family planning.”<sup>18</sup> Our data do not support this statement. We have no evidence showing that the women decided to rely on abortion in advance of needing it or considered it a better alternative. In fact, there was much apprehension about abortion among these women; the decision to undergo the procedure was one they made only when there was no alternative.

Similarly, other researchers have observed that if women have a real choice, they would rather prevent an unwanted pregnancy by practicing contraception than have an abortion.<sup>19</sup> One researcher has argued against what she calls the “contra-

ceptive ignorance theory,” which blames abortion on women's lack of knowledge about contraception and irrationality in their contraceptive behavior.<sup>20</sup> Against this theory, which she holds to be the most prevalent one among family planning managers, the investigator suggests that unwanted pregnancies result from contraceptive risk-taking, based on conscious decision-making. When women assess the costs and benefits of using contraceptives, she contends, they may judge the risk of getting pregnant and having an abortion as less “costly” than contraception.

This reasoning seems highly applicable to our data. The majority of the women in the survey had previously used the IUD, but had given it up because of side effects. Instead, they tried a traditional method or used no method at all. Open interviews from this and a previous study in Thai Binh<sup>21</sup> revealed that many women considered the use of the IUD a constant burden, causing them pain and fatigue. Under such circumstances, the decision not to use a method is a rational one, based on the perception that contraceptive use is more “costly” in terms of health risks than nonuse.

### *Why Is Abortion on the Rise?*

Abortions started to become more common in Thai Binh in the early 1980s as abortion services expanded. Initially, the services probably met a previously unmet need. In the first half of the 1980s, the increase was modest; after 1985 however, the climb was very rapid, and it was accentuated in the early 1990s, when the annual number of abortions began to exceed the number of births. During this period, enforcement of the national two-child family policy became increasingly stringent, and authorities imposed stricter demographic and service performance targets.

A recent study discusses variations in enforcement of the two-child policy in Vietnam.<sup>22</sup> The system of incentives and fines is applied mainly in the north, predominantly in the densely populated Red River Delta; in the south, the emphasis is on decentralized contraceptive services, supply and distribution. In the north, there is also considerable local variation in the application of the national guidelines, as shown by our study and a previous study in Thai Binh.<sup>23</sup> In Village 1, the financial penalties were quite severe and entailed both immediate fines and long-term consequences, such as impaired opportunities for employment, promotion and allocation of land. By contrast, in Village 2, the enforcement of the two-child policy reportedly was more lenient, probably re-

flecting different strengths and ambitions of local leaders.

Although the two villages had similar socioeconomic profiles and were served by the same family planning team, Village 1 had a considerably lower birthrate and a smaller proportion of births in 1991 that were of third or higher order, suggesting that enforcement of the national population policy was more “effective” in Village 1 than in Village 2. However, the women there paid the price, with an abortion ratio that was twice that of their counterparts in Village 2.

The abortion increase should also be seen in its wider socioeconomic context. Since 1986, when the *doi moi* (renovation) open-door policy and market reforms were introduced in Vietnam, the country has experienced unprecedented economic growth. The effect of the reforms on fertility behavior is still a matter of debate. On the one hand, one may expect a higher “demand” for children with the return to a family-based economy; on the other hand, the cost of education and health care has increased, making children an economic burden for the family.<sup>24</sup> As we have seen, financial motives often underlay the abortion decision among the women in our study.

In agreement with other authors,<sup>25</sup> we suggest that the rapid increase in abortions in recent years is the combined effect of stricter population policies and a wish for smaller families, while contraceptive services are still inadequate. One researcher has described a typical pattern in Third World countries when an anti-natalist population policy is introduced and both contraceptive and abortion services are provided: Initially, both contraceptive prevalence and abortion rates increase. Eventually, when contraceptive use becomes more effective and widespread, abortion rates decrease. It may be that a rapid fall in birthrates cannot be achieved without a high abortion rate.<sup>26</sup>

Vietnam's high abortion rate, however, not only is very costly for health services, but can pose a serious threat to women's health. Improved quality of family planning services and expanded contraceptive choice are necessary but not sufficient measures to reduce women's heavy reliance on abortion. At the local and provincial levels, indicators of “success” are still measured in terms of demographic targets and contraceptive prevalence rates, and rewards and punishments are applied accordingly. Voices in the international debate have suggested that a shift in emphasis from demographic targets to indicators of quality of family planning and reproductive health services is bene-

ficial both to women's health and, in the longer run, to population growth.<sup>27</sup> We believe that such a shift is vital for a reduction of the high abortion rate in Vietnam.

### Research Needs

The service and social context for women having an abortion should be carefully studied in each local setting when program planners are developing abortion and counseling services. Women's heavy workload, the lack of opportunity to rest and lack of support after the abortion, and contradictory views and advice from family members were some of the factors that had made the abortion experience more difficult than necessary for the women in our study. Limited contraceptive choice and inadequate counseling, including postabortion counseling, probably lead to many repeat abortions.

Research that will help increase the involvement of husbands and other family members in the abortion decision and in supporting women who have had an abortion is crucial, as are efforts aimed at developing socially and culturally appropriate counseling and education, and easing the psychological stress for women seeking abortion.

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### Resumen

Durante la década de los años ochenta, el gobierno de Vietnam adoptó la política de natalidad de dos hijos por pareja para controlar el crecimiento demográfico; actualmente, este país presenta una de las tasas de aborto más elevadas del mundo. En la zona rural de la provincia Thai Binh, donde las autoridades locales exigen la observancia estricta de esta política demográfica nacional a través de un sistema de incentivos y desincentivos económicos, se

realizaron 114 abortos por cada 100 nacimientos registrados en 1991. Una encuesta realizada en dos pueblos de la provincia Thai Binh, entre 228 mujeres que se habían sometido a abortos ese año, reveló que era muy limitada la opción de anticonceptivos; básicamente, el único método moderno disponible era el DIU y muchas mujeres lo habían abandonado debido a los efectos secundarios. En promedio, las mujeres presentaban un índice de 2,4 nacimientos vivos y 1,5 abortos, la mayoría de los cuales se realizaron antes de cumplirse la octava semana de gestación. Las razones más comunes para recurrir al aborto fueron que querían ahorrar dinero y evitar las multas por exceder el límite de los dos hijos. Los maridos eran las personas a quienes se atribuía mayor importancia para adoptar esta decisión; con frecuencia los padres y suegros no estaban de acuerdo con esta decisión. La consejería después del aborto no existía o era inadecuado. En el pueblo donde se aplican con mayor rigor las políticas demográficas nacionales, la razón de abortos asciende al doble de la del otro pueblo.

### Résumé

Le gouvernement du Viet Nam ayant adopté, dans les années 80, une politique destinée à juguler la croissance démographique par la limitation du nombre d'enfants à deux par famille, le pays présente aujourd'hui l'un des taux d'avortement les plus élevés du monde. Dans la province rurale de Thai Binh, où les autorités locales appliquent parfois strictement la politique démographique nationale par un système de primes et de pénalités financières, 114 avortements ont été dénombrés par centaine de naissances en 1991. Une enquête menée dans deux villages de Thai Binh, parmi 228 femmes qui s'étaient fait avorter pendant cette année, a révélé un choix contraceptif limité: le stérilet était, essentiellement, la seule méthode moderne utilisée, et beaucoup de femmes l'avaient abandonnée à cause de ses effets secondaires. En moyenne, les femmes avaient eu 2,4 naissances vivantes et 1,5 avortement. La plupart des avortements avaient été pratiqués avant la huitième semaine de gestation. Les raisons les plus fréquentes de l'avortement étaient le désir de s'épargner les frais d'une nouvelle naissance et d'éviter les amendes imposées en cas de dépassement de la limite de deux enfants. Les maris jouaient le rôle le plus important dans le partage de la décision d'interrompre la grossesse; les parents et les beaux-parents y étaient souvent opposés. Aucun service de conseil n'était généralement offert après la procédure, ou les services existants étaient inadéquats. Le village où les consignes de la politique nationale étaient appliquées avec le plus de rigueur présentait un taux d'avortement deux fois celui de l'autre village.