Rights, Social Policy and

Reproductive Well-being: The Vietnam Situation

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Rights, Social Policy and Reproductive Well-being: The Vietnam Situation[1]

Since the 1994 International Conference on Population and Development the language of reproductive rights has gained prominence in international social policy forums. The overarching international human rights framework defends universal rights but recognises that the means for realising those rights need to be locally specified. In practice, though, rights-based approaches to reproduction have generally offered a fairly uniform, expanded and improved constellation of reproductive health services that take little account of the embedded nature of reproductive rights issues. For Vietnam, we link an understanding of rights with an assessment of the shifting identities and diverse reproductive health needs of women. Through identifying a number of contextualised challenges for a rights-based approach to reproduction in the country, we demonstrate that engagement with the wider realities of women's lives and incorporation of notions of social differences is necessary to *effectively broaden the scope of reproductive freedoms and entitlements.*

Introduction

The 1990s have seen a major shift in international social policy affecting reproduction: decades of population policy focused on reducing societal fertility have given way to rights-based approaches to reproductive wellbeing. The Cairo agreement has been hailed as a critical turning point but certain problematic continuities between these policy discourses are being neglected. The inevitable gap between idealistic international commitments and local practice has, of course, been widely discussed and the main challenge has been constructed as one of encouraging and enabling the implementation of rights-based approaches. However, the problematic continuities to which we want to draw attention suggest that the notion of implementing a rights-based approach to reproduction is fraught with three different sets of very old concerns: the first group of concerns is about universalism, insensitivity to different cultural contexts and non-engagement with varying socio-economic realities; the second set is about a rights-discourse that purports to prioritise social justice but by its very language conceals social difference; the third set is about the way in which rights discourse both obscures the contingent and socially-constructed nature of obligations and entitlements and is naive about the potential achievements of social policy interventions. Our objective in recognising these tensions, which are discussed in detail in Locke (forthcoming), is not to dismiss reproductive rights but to gain clearer insight into the political potential for rights-based approaches to play a role in the meaningful advance of reproductive wellbeing.

Taking these themes seriously invites us to look much more closely at the reality of reproductive behaviour, well-being and policy in 'other' contexts. To date analyses of country situations for rights-based approaches to reproductive policy have tended towards audits of rights status that often rather simplistically deduce a failure of reproductive rights from aggregate statistics (such as high levels of maternal mortality) and laying the blame for these at the door of government. We would argue that this kind of analysis does not help much in providing an insightful understanding. It neglects to analyse the

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causes of reproductive ill-being, it dismisses the way in which different societies, organisations and governments value and balance the legitimate scope for individual freedom for action with societal priorities and constraints, and fails to understand the realistic scope of social policy and why national reproductive policy has evolved in the way it has. There is a real danger that these audits identify a litany of what are termed 'abuses' whose only practical use is as a cudgel for demonising 'other' governments. We argue that a more sensitive and meaningful analysis of reproductive behaviour, wellbeing and policy can inform constructive negotiation at several levels (civil society – government, government – bilaterals, government – international organisations) about future policy directions.

Here we investigate the Vietnamese situation in order to demonstrate and make explicit the kind of analysis we feel may be more useful for those interested in advancing reproductive wellbeing. We are not concerned with 'judging' a rights record but with understanding how reproductive entitlements and needs are variously perceived in Vietnam and how policy affecting reproductive behaviour and wellbeing has come to be what it is. Following Sen (Sen, 1985a, 1985b) we employ a notion of wellbeing that is located within the three spheres of capabilities, functionings and entitlements thereby drawing attention to the extent to which people are able to choose and achieve a range of reproductive aspirations rather than focussing solely on reproductive outcomes. We are concerned to draw out the embedded nature of reproductive behaviour and entitlements in order to highlight salient aspects of social differentiation and to engage with debates about the way in which changing social capital and processes of social inclusion/exclusion shape reproductive wellbeing in Vietnam. Our research is largely based on secondary materials, unpublished documents, reports and census data but is also informed by 13 interviews conducted in November 1999 with key personnel in national and international NGOs, academics and professionals working in the area of sexual and reproductive health and rights in Vietnam.

The Vietnam Context

Vietnam is a tropical country in the Southeast Asian region. It occupies a long strip of land, bordering China in the north, Laos and Cambodia in the west, and the South China Sea on the east and the south. The area of Vietnam is about 330,000 km^2, of which approximately 80 percent are plateaux and mountains, and the remainder well cultivated and densely inhabited plains along the eastern coast. Historically and contemporarily, economic, political and cultural activities have concentrated in two core regions: the Red River Delta in the North centring around Hanoi and the Mekong River Delta in the South surrounding Ho Chi Minh City, or Saigon.[2] Administratively the country has 57 provinces and four municipalities,[3] which are grouped into eight geographical regions.[4] Each province consists of districts, which are then composed of communes. In 1993, there were 560 districts and nearly 10,000 communes (CCSC, 1999; GSO, 1995b: 1).

According to the latest Vietnamese census results, population in Vietnam was around 76 million in

[2] Population residing in the two deltas accounted for 57 percent of Vietnam's entire population in 1999 (CCSC, 1999).
[3] The four cities are: Hanoi and Hai Phong in the North, Da Nang in the Central Coast and Ho Chi Minh City in the South.
[4] These are Red River Delta, Northeast, Northwest, North Central, Central Coast, Central Highlands, Southeast and Mekong River Delta.

1999. The majority, who account for some 90 percent of the population, are Viet (*kinh*), and the remaining 10 percent are composed of 56 ethnic minority groups, who are most often found in upland areas (CCSC, 1999; Dodd & Lewis, 1998). Economically and socially, Vietnam is largely an agrarian society. In 1999 some 76 percent of its population lived in rural areas, and agriculture was still the largest sector in the country's economy accounting for about a quarter of its GDP in 1998 (CCSC, 1999; CIEM, 1999).[5]

The contemporary history of Vietnam was featured by national resistance to foreign invasions and civil wars triggered by serious domestic political divisions. Vietnam proclaimed independence from the French colonial occupation in 1945 when the Democratic Republic of Vietnam (DRV) was founded following the August Revolution in that year. However, the formal international recognition of DRV and the country's regain of national sovereignty only came almost a decade later when the communist-led resistant forces won a decisive military victory in Dien Bien Phu in 1954, which ended the nearly a century's French colonial rule (EIU, 1997). This was followed by a civil war between the Communist-led northern government and the US-backed southern regime. In the historical backdrop of the cold war, the Americans became heavily involved in Vietnam politically and militarily from the early 1960s till the mid-1970s. The American military presence in the country escalated at the peak of the Vietnam War, reaching half a million by the late 1960s and early 1970s, and the US forces dropped more than a dozen million tons of munitions in the country, killing one million people and wounding hundreds and thousands of others (Hirschman, Preston, & Loi, 1995; Jamieson, 1993; Kolko, 1997).[6] The legacy of the war, particularly the casualty and trauma it inflicted upon the nation has produced profound and long-lasting impact on the composition of its population in terms of sex ratios, etc., shaped and reshaped the nation's fertility patterns, and affected many aspects of the sexual and reproductive needs for people at specific life stages.

With reunification of the country in 1975 and the birth of a new Socialist Republic of Vietnam (SRV) the following year, a centrally planned economy based on the Soviet model was comprehensively introduced, extending from its base in the North to the newly integrated South in the official post-war reconstruction efforts.[7] However, the adoption of this ill-adapted economic system proved to be highly unsuccessful, encountering resistance from the South and inducing economic crises nation-wide. During the second half of the 1970s, the country saw an unimpressive annual growth rate of merely 0.4%. In consequence, there was a severe material shortage and limited improvement in people's living conditions (EIU, 1995; Dodd & Lewis, 1998). This situation was further exacerbated by the American-led economic embargo in the wake of the Vietnam War and the dwindling of the Soviet aid in the 1980s. In this context, Vietnam was forced to think about alternative approaches to development. The outcome has been a strategic shift of emphasis from central planning to "socialist market" realised

[5] Vietnam has experienced rapid industrialisation and urbanisation in the last decade, as indicated by the contrast between these data and their earlier counterparts. In the early 1990s, rural population accounted for about 80 percent of the total population, and the agricultural sector represented 40 percent of the GDP (CIEM, 1999; EIU, 1997).

[6] There have been varied estimates of the Vietnamese mortality during the peak period of the Vietnam War. Here the figure of about one million deaths comes from a more recent demographic study which is based on the 1991 Vietnam Life History Survey (Hirschman et al., 1995).

[7] The Soviet model started rooting in North Vietnam since 1954, but its imposition on the southern part of the country only began with reunification in 1975 (EIU, 1997).

through a large-scale economic restructuring programme known as *doi moi* since 1986. The *doi moi* programme, which in Vietnamese means reform and renovation, has seen Vietnam opening to the outside world and achieving rapid economic growth, which has averaged about 8% per annum during the last decade of the 20th century (CIEM, 1999; EIU, 1997).

Although *doi moi* has brought about considerable improvement in people's lives and created new opportunities for people in Vietnam, it has also witnessed many problems emerging with the economic transition and market. There have been growing economic and social inequalities produced particularly by greater regional and sectoral divisions, and declining social services such as education and healthcare. Vietnam's social services, which were established and provided publicly under the central-planning structure, have been experiencing varied degrees of difficulty in terms of funding, capacity and management. A combination of factors during the economic restructuring, such as introduction of users' fees, shrinking of the government budget and the dissolution of rural co-operatives have contributed to the gradual erosion of the country's social, particularly public health, services (EIU, 1997; Bloom, 1997; Ensor & San, 1996). The reduced role of the state in social provision, together with the increased risks and uncertainty associated with market, the undermining of traditional safety nets and social support systems in the transitional context, has raised new health and equity issues, especially with respect to reproductive and sexual health and wellbeing.

Dynamics of Family Structure and Gender Relations

The biological ability of women to bear children, the social and cultural construction of gender roles and the gender hierarchy observed in almost every aspect of life have all rendered gender issues prominent in political and academic discourses on sexual and reproductive health and rights. It is almost self-evident that sexual and reproductive health and rights mean more to women than to men, although men's role in reproduction and reproductive decision-making should not be neglected. Based on the above understanding, we first examine gender relations, family structure and cultural traditions, as well as their dynamics in Vietnam before turning attention to issues of sexual and reproductive rights and wellbeing.

Historically, Vietnamese culture was significantly influenced by its big and powerful neighbour China through trade, immigration, and cultural and religious exchanges. Confucianism, which has been the dominant ideology in many parts of East Asia including China has also held a predominant ideological position in Vietnam. However, compared with China, Vietnam has displayed greater cultural diversity thanks to its proximity to the Southeast Asian region, the variety of its ethnic makeup and its relatively late adoption of Confucianism as an official ideology.[8] In fact, a combination of East and Southeast Asian religions of Confucianism, Taoism, Buddhism and its own indigenous cultural systems has featured Vietnamese culture and tradition from ancient times till present. This cultural difference in the weight of Confucianism on Chinese and Vietnamese societies has been seen by many as the main

[8] Confucianism had emerged during the Spring and Autumn Period (770-476 BC) and became the official ideology since the Han Dynasty (206-220 BC) in China, whereas it was adopted by the Vietnamese elites only from the 10th century AD, and by society at large even later (Frenier & Mancini, 1996).

reason for the relatively high status of women in Vietnamese history compared with women's position in Chinese (Frenier & Mancini, 1996; Jamieson, 1993; Le & Mai, 1978; Whyte & Whyte, 1982). In Vietnamese legends female-led uprisings against foreign invasions are quite common and their names kept prominent in the annals of history. In parts of Vietnam daughters and wives enjoyed equal inheritance rights with sons and husbands; and among the variety of local cultures some ethnic minority groups inhabiting the uplands have had women-centred culture, practising a matriarchal way of life or maintaining matrilineal social relations (VWU & Centre for Women's Studies, 1989; Fairbank, Edwin, & Graig, 1973; Tran & Allen, 1992).

In spite of its cultural diversity and divergence from the more orthodox Chinese Confucianism, the mainstream Vietnamese society has, nevertheless, been dominated by Confucian ideology. The most salient features of the Confucian domination in the country have been the central role of the family and kinship institutions in society and the general system of values and mores. As in traditional China, the extended household with several generations living under the same roof and its individual members being hierarchically positioned on the basis of age and sex within it used to be the ideal form of the familial structure in Vietnam. In the family, parents held absolute authority over adult children and marriages were largely arranged as transactions between two families and patrilineages other than being perceived as a matter of the individual man and woman concerned. Kinship ties as well as the ownership and inheritance regimes were, and still are, basically patrilineal, which was backed by the custom of patrilocal marriage (Fairbank et al., 1973) (Jamieson, 1993; Keyes, 1977).

Gender roles and women's status were defined within this traditional familial and kinship structure. Membership in the family and the immediate community, which was attached with a range of privileges and entitlements, was assigned in accordance with a set of ascriptive criteria including sex. Except for a few exceptions, the majority of women in the traditional family and kinship system were made subordinate to men and deprived of their equal membership rights. Confucian moral emphasis on filial piety combined with the practice of patrilocal marriage and patrilineal inheritance established sons' superior, privileged position in the family and lineage – They were regarded as the sole roots of the family and patrilineage since only sons were seen as eligible for performing the rites of ancestor worship and continuing the family and lineage line in both material and symbolic senses. Women, in contrast, were perceived and treated as outsiders of either their natal or own married families. They were also expected to follow the Confucian moral code of "three obediences": Obedience to father before marriage, to husband when married, and to the eldest son when widowed (VWU & Studies, 1989; Tran & Allen, 1992).

Society also demanded women's premarital virginity and one-sided fidelity to their husbands after marriage, but permitted polygyny, especially for men from upper-class families. This double moral standard functioned to control women's sexuality, about which the constant apprehension of a patriarchal society underlay the exclusion of women from socio-economic and political lives outside home, particularly for women in better-off or noble families. Most women were barred from formal education and participation in civil service. Women's primary duties then fell within the narrow domain of reproduction, including domestic labour, and bearing and rearing male offspring for their husbands' families and lineages. Failure to achieve the latter would result in constant anxiety on the

part of the wives, which could render them even lower status in the family and community (Barry, 1996; Eisen, 1984). Moreover, sons were deemed important as an old-age security for both husband and wife in traditional society, where the elderly had to reply on their sons for meeting emotional, material and welfare needs within the familial and kinship structure based on patrilineal and patrilocal principles. As we shall see from the analysis below, the legacy of the traditional society and the multi-dimensional and highly relational nature of the reproductive process have played a marked role in influencing and shaping reproductive patterns, behaviours and experiences in contemporary Vietnam.

The Confucian tradition of valuing men but debasing women has encountered serious challenge with the emergence of women's movement since the early 20th century. The women's movement in Vietnam was initially incorporated into the country's prolonged struggle for national independence and its tenacious resistance to foreign occupations. Women in both the South and North played an active role in the national liberation movements against foreign invasions by either direct involvement in military actions like guerrilla warfare or indirect participation, such as intelligence gathering, community mobilisation, provision of rear services, and production and reproduction. During the war time, many men went away from home to join the armed forces and fought in the battlefields, while women became the backbone of the productive and supportive forces, more independent, and acted as household heads making decisions on family matters in both urban and rural areas (VWU & Studies, 1989; Du, 1996; Tetreault, 1996).

The national liberation movements as such saw significant changes in women's position in the family and society, which was also due to both government actions and modernisation process. Constitutional recognition of the general principle of gender equality has been provided since 1946 soon after the establishment of DRV in the North, guaranteeing in legal terms women's equal rights with men in both public and private domains.[9] The Marriage and Family Law promulgated in 1959 and revised in 1986 with the commencement of *doi moi* has emphasised free choice of marriage partners, equal property and inheritance rights between husband and wife and equal treatment of sons and daughters by parents, and women's rights to divorce and the custody of children. It has also recognised domestic work as "productive" contributions to the common property of the family. Arranged and early marriages (under 18 for women and 20 for men) and polygyny have been outlawed and legal provisions stress husband's responsibility in bringing up children either in marriage or after divorce (VWU & Centre for Women's Studies, 1989). In addition, various labour protection policies and regulations aimed at providing women with improved working conditions have been formulated, which have granted female employees in state sectors entitlements to maternity leave and exempted them from heavy and noxious work (Croll, 1998; Fong, 1994).

Although considerable gaps have existed between legislation and reality, the effects of laws and policies on promoting gender equality should not be underestimated. Besides, changes in these respects have been catalysed by broader economic and social changes taking place in the country for the past

[9] The Constitution was revised in 1959, 1980 and 1992, and with each revision the principle of gender equality was reiterated and further expanded to include sexual equality in both

decade or so, particularly in areas of female education and employment. Gender discrepancy in education in Vietnam has been relatively small compared with other East Asian societies dominated by Confucianism. Thanks to official attention paid to education, Vietnamese people have enjoyed a high literacy level relative to the country's low per capita GDP. In 1992-93, the literacy rate was 93% for males and 86% for females, although gender differentiation was more obvious in terms of the average years of schooling, which was 5.8 for men but only 3.4 for women (GSO, 1996b).

Vietnamese women have been especially active in economic life, making significant contributions to the national liberation movements in the wartime, and to the income and welfare of the family and community during the post-war reconstruction and the current transitional periods. According to official statistics, the country's female labour force participation rate was 76.8% in 1992-93, a rate which was higher than that of males for many years (NCFAW, 1995). The economic restructuring in rural and urban Vietnam since the late 1980s have seen the dissolution of agricultural co-operatives and the revitalisation of the private sector and market. On the one hand, this structural change has offered women more choice and employment opportunities, greater flexibility in arranging productive and reproductive tasks, as well as improved income and living standards. On the other hand, new gender issues such as sex discrimination in workplace and feminisation of agriculture have emerged, and many existing problems with respect to gender equity, e.g. sexual division of labour and sex differentiation in remuneration, have assumed new forms under the operation of the market (Croll, 1998; Fong, 1994).

Industrialisation and urbanisation have occurred rapidly in Vietnam for the past decade and more, which has fundamentally affected the Vietnamese family structure and marriage practice. Traditional extended families are giving way to modern nuclear families, and more liberal attitudes towards love, marriage and cohabitation are gaining greater prevalence in urban areas. The rate of divorce, particularly female-initiated divorces, has been rising saliently as well as the number of female-headed (usually single-parent) households (Du, 1996; Hirschman & Loi, 1996; Nguyen, 1996). In the meantime, greater social differentiation by gender, sexual exploitation in the form of pornography and prostitution, as well as sexual and domestic violence such as rape and wife-battering, are increasingly visible, which are drawing more public attention to issues of women's rights and their sexual and reproductive needs and wellbeing (Le, 1996; UNFPA, 1997). Below, we examine the history of healthcare provision and population policy and consider the impact of transition on both.

Social Policies Affecting Reproduction

A key distinction has been drawn between rights-based and needs-based approaches to social policy including policies affecting societal fertility on the grounds that competing ideas about the definition and content of social policy reflect different visions of society. The recent history of Western social policy has revolved around two conflicting ideas of the person either as an "active choice making agent" commensurate with a rights-based approach or as a "site of wants that need satisfaction" commensurate with a needs-based approach (Ferguson, 1999). However, some analysts argue that "rights may also be seen to arise from unfulfilled needs" (Gloppen & Rakner, 1993: 3), suggesting that

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production and reproduction (Tran & Allen, 1992)

identifying and meeting people's basic needs including women's sexual and reproductive health needs are not necessarily contradictory to claiming or protecting people's basic rights.

In Vietnam, individual rights have not been widely applied either historically or contemporarily. During the country's protracted struggles against foreign occupations, individuals were expected to fight for the "collective right" of the nation to independence and self-determination. After the war, Vietnam's adoption of the economic and political model of the former Soviet Union meant that the system was based on a rationale which was fundamentally different from the political and philosophical assumptions underlying Western liberal democratic systems but which placed a strong emphasis on meeting the basic needs of the majority. The notion of rights has been recognised in both political and academic discourses as originating from and being deeply rooted in Western cultural traditions of individualism, whereas many non-Western cultures are more communal-oriented and based on different perceptions of people's rights and duties in relation to the family, community and the state (Gloppen & Rakner, 1993).

In spite of the specific Vietnamese context in which the applicability of a rights notion and a "rights-based approach" to social policy and reproductive health may have more or less been limited, the recent implementation of the *doi moi* programme with concomitant economic liberalisation and political relaxation has given rise to ordinary citizens' increased awareness of and claims on their individual rights. Despite the decline of social services, the government remains politically committed to universal access to basic education and health and is a signatory to the Cairo Programme of Action (PoA). However, the adoption of a "rights-based approach" to social policy, including those influencing reproduction, in Vietnam has largely been indirect and implicit, focusing on economic and social rights, rather than explicitly developing political and human rights. As such, social policy has placed more emphasis on concrete issues in relation to sexual and reproductive health instead of on more abstract concepts of "individual rights".[10]

Family planning has been promoted in Vietnam since the early 1960s. The communist-led northern government advocated a small family norm with 2-3 children in 1963 although the ensuing escalation of the Vietnam War hampered the implementation of the policy (GSO, 1995b; Vu, 1992). This policy initiative by the northern government in an overwhelmingly agrarian society with a pro-natal Confucian cultural tradition has been viewed by some as being out of concerns with the sharp population growth, the unusually high population density and the associated chronic food shortage in the area surrounding the Red River Delta in the late 1950s (Goodkind, 1995; Nguyen, Knodel, Mai, & Hoang, 1996). According to official statistics, at the end of the l950s the annual population growth rate approached 4% in the Red River Delta, where population density was historically much higher than any other areas in the country (GSO, 1991).[11] In contrast, the Mekong River Delta in the South had a far

[10] Interview with Dr. Birgit W. Victor, Danish Red Cross Field Representative in Vietnam, Hanoi, 16 November 1999.

[11] It is estimated that in the early 1930s, the Red River Delta was among the most populous areas in the entire Southeast Asian region, with a population density of about 430 people/km^2 in contrast to the average density in Indochina of around 31 people/km^2 (Jones, 1982).This high density of the Red River Delta has remained fairly unchanged since then despite the Vietnamese official attempts to reduce the demographic pressure on the Delta area through population redistribution schemes after 1975 (Desbarats, 1987) and the sharp decline in

less population density, and the US-backed southern regime promulgated a conservative Family Law in 1959 with the effects of strengthening parental authority over children, and reinforced Confucian morality and rites of ancestral worship. Divorce and the use of contraception were also temporarily banned in the South (Goodkind, 1996; Jamieson, 1993). The divergent legal and policy positions on family planning, marriage and population issues adopted by the northern and southern regimes reflected the different ideological orientations and political cultures, as well as varied demographic pressures experienced by the two distinct regions.

After reunification, small family norms were officially re-emphasised during the mid-late 1970s, which was followed by a nation-wide concerted family planning effort since the early 1980s. In 1984, the National Committee of Population and Family Planning (NCPFP) was formally established to co-ordinate family planning and health care services. In 1988 shortly after the inception of *doi moi*, Vietnam's cabinet, the Council of Ministers, pronounced an enhanced family planning programme, vigorously promoting a small family norm of one or two children for each Viet couple with the exception of certain ethnic minority groups. The family planning policy was reiterated and reinforced in 1993 when the government announced Vietnam's population and family planning strategy to the year 2000. Specific guidelines embodying the principle of "fewer-later-longer" have been lain down to direct family planning work, which include minimum child-bearing ages for women in urban areas at 22 and rural areas at 19, and for men at 24 and 21, respectively; and 3-5 years' spacing between the first and second births (GSRV, 1989; Goodkind, 1995). Abortion has been made legal and widely available. Material and non-material incentives and disincentives have been adopted to enforce policy implementation. These include free or heavily subsidised contraception provision, such as IUD insertion and condoms, and material benefits offered to couples who receive sterilisation to compensate for the time taken off from work and transportation expenses.[12]

Health Care Reforms

Vietnam has possessed an extensive national health care network providing basic curative and preventative medical services for its population. Before the *doi moi* period, the government financed such social services as health care and education. This public provision, however, was largely confined to the urban, state sectors. In rural areas, social provisions were mainly the responsibility of agricultural co-operatives. Health workers in commune health care centres were not employed by the state, but by the agricultural co-operatives, which remunerated the health personnel in kind (Vu, 1994). Like the centrally planned economic structure, the public health system was adapted from the former Soviet Union in North Vietnam before the mid-1970s, which was featured by highly centralised decision-making and free health care provided in either state or collective medical facilities. Health care services were delivered at four basic levels: Central, provincial and district hospitals, and commune health stations. In South Vietnam, in contrast, such a public health system was non-existent during the war. Following reunification in 1975, the northern system was rapidly extended to the South. Within a short

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population growth therein. The latest census results indicate that the population density of the Red River Delta was 1,180 persons/km^2 and that of the Mekong River Delta was 408/km^2 in 1999 (CCSC, 1999).

[12] Personal conversation with Dr. Nguyen Kim Cuc, Vice President of Vietnam Family Planning Association, Hanoi, 18

period, grassroots commune health stations increased from some 5,000 to more than 10,000 nation-wide (Ensor & San, 1996; Pham & Nguyen, 1998: 295).

Under the command economy, this national public health network had difficulties such as limited resources, severe shortage of drugs and unsatisfactory quality of services. Nevertheless, it provided primary health care to the entire population in a less developed economy, and demonstrated the political commitment of the government to the health of its people (Tipping & Truong, 1997). Following the introduction of the market mechanism during the *doi moi* period, however, financing of this public health system has been eroded, especially in the countryside and at the initial stage of the economic transition. Agricultural co-operatives have been dissolved and thus no longer provided collective fund for commune health care stations. The private sector has been legalised in both urban and rural areas, and user fees have been charged in the public sector for drugs and treatments since the late 1980s. There has been a paralleled development of an expanding private sector, gradually rising user fees and continued government subsidies for the public sector. Official health care subsidies have largely been directed towards the disadvantaged remote and mountainous areas, and its prioritised programmes such as family planning services (Behrman & Knowles, 1998; Tipping & Truong, 1997). Pluralised health care financing and decentralised decision-making are among the major changes in the country's health care system during the transition period.

The more recent health care reforms have seen increased choices for service users. However, the choices and options do have their costs. The proliferation of private practices and the introduction of user fees have emerged hand in hand with enlarged regional and sectoral disparities in income, and growing inequalities in personal wealth in conjunction with a market economy. According to some recent studies, considerable disparities have been observed among different regions and between rural and urban areas in respect of health and quality of life. In 1995, for instance, per capita health expenditure in Vietnamese cities was 30 percent higher than that of rural areas. Health expenditures in the relatively disadvantaged North Mountain and Midland regions represented only 35 percent of those in the more prosperous Mekong River Delta region (Pham & Nguyen, 1998: 301). The practice of fee charging, particularly the relatively high charges for inpatient treatment and medical operations may also deter low-income groups or those residing in poorer regions from gaining access to health care services. User fees charged by public health facilities, furthermore, have become a significant financial burden for rural households, especially for the poor ones. A recent study has discovered that among the rural households in debt, nearly 30 percent have identified paying for medical services as the principal reason for borrowing (Ensor & San, 1996: 78). It has become increasingly evident that well-being and health outcomes of the nation are further affected and differentiated by region, sector, poverty and gender during the transitional period.

The Vietnamese government responses to the emerging challenges faced by the health sector during the economic transition have been, among other things, to add a number of medical personnel in each grassroots commune health station on the government payroll. This has partially filled the health care

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vacuum created by the decollectivisation process in rural areas. Varied medical insurance schemes have also been introduced since the early 1990s. However, their implementation has been rather patchy at the current stage, covering only about nine percent of the population. Most of those being covered by the health insurance schemes, furthermore, are working in state, urban sectors, whereas in the non-state or agricultural sector, people still rely on informal risk-sharing mechanisms such as familial and kinship ties, and community linkages (Bloom, 1997; Ensor & San, 1996). A further problem with the restructured health care system is the inadequate regulation and monitoring of the emerging private sector, which has exposed the public to possible malpractices, negligence, overcharge or substandard quality services provided by incompetent or unregistered health care workers (Tipping & Truong, 1997).

Reproductive and Sexual Health Services

Family planning and reproductive and sexual health services have been incorporated in Vietnam's national health care network and they too have been affected by the undermined financing of that network during the economic transition, especially at the grassroots level in rural settings. It is reported that health facilities in commune health stations saw considerable physical and technical degradation after decollectivisation. For some time before the government took measures to counteract the trend, health workers had to shift to farming or other occupations as they no longer received payment in kind from the non-existent agricultural collectives (Vu, 1994). In the early 1990s Vietnam's Ministry of Health, in assessing the status of health facilities closely associated with family planning and reproductive health services at grassroots, estimated that among the approximately 10,000 communes nation-wide, 600 did not have a health centre, about 3,000 did not have a midwife, and over 6,000 had the urgent need for improved supplies and equipment aimed at providing maternal and child care and family planning services in their health stations (Nguyen, 1993). The official evaluation of FP and reproductive health services conditions seems to have caught attention from the government actors as well as national and international NGOs. Since then different consolidation and training schemes have been initiated, particularly at the grassroots level, to invest in and upgrade facilities, train reproductive and FP service providers and offer mother and child care services (Vu, 1994).

In terms of other related reproductive health indicators, Vietnam has possessed a quite impressive record both in the past and at present, relative to its per capita GDP level of about US $200 in the 1990s and compared with its neighbouring countries. This is largely attributable to its established extensive health care system. Despite the recent trend of growing inequality between regions and sectors during the economic transition, the average indicators for the country as a whole have seen continued improvement thanks to the better living conditions achieved through rapid growth for the past decade and more. From the 1980s till the late 1990s, Vietnam's infant mortality rate dropped from 70 per 1,000 to 45 per thousand; the under five mortality rate decreased from 82 per thousand to about 62 per thousand; the under-five malnutrition rate lowered from 50 percent to some 41 percent; the maternal mortality rate reduced from 200 per 100,000 to around 137 per 100,000 (PCSA, 1999: 38). The following table gives the comparative health indicators between Vietnam and its neighbouring countries in the mid 1990s. Vietnam's performance against these indicators is comparable with that of Thailand where GNP per capita is over ten times higher. Vietnam out performs lower income countries

like Bangladesh and Loas with similar GNPs per capita. It is fair to say that Vietnam performs well against these criteria given its income levels and this must reflect in part the politics of its social policy.

COUNTRY	GNP per capita, 1994 (US $)	Proportion of children immunised against DPT[1] (per cent)	Life expectancy	Infant mortality (per thousand)	Maternal mortality (per a hundred thousand)
Bangladesh	220	74	53	107	>500
China	530	95	71	27	100-249
Indonesia	880	89	63	65	250-499
Laos	320	25	51	96	>500
Thailand	2410	88	69	27	100-249
Vietnam	200	91	65	38	100-249

[1] Diphtheria, Pertussis and Tetanus.

Source: World Health Report 1995, World Development Report 1996 (Cited in Bloom, 1997: 3)

Below we offer a contextualised exploration of three specific reproductive rights challenges. We do not aim to provide an exhaustive analysis. Our purpose is to demonstrate that enlarging the scope for reproductive entitlements must support a commitment to universal wellbeing with a detailed analysis of local issues if it is to be a meaningful guide to social policy.

Unmet Sexual and Reproductive Needs

The priority granted to family planning on the official agenda since the late 1980s, has not been consistently accompanied by appropriate consideration of related healthcare issues, particularly with respect to reproductive and sexual health. Parallel to the single-minded emphasis on economic growth as the sole criterion for assessing development performance in international development thinking and practice of the time, Vietnam's family planning efforts in the early days were characterised by achieving numerical targets, that is, targets of reducing fertility and population growth rates. International donors and national policy makers alike tended to view the attainment of such targets as ends themselves, losing sight of the more fundamental goals of promoting wellbeing of the population in general, and women's sexual and reproductive wellbeing in particular.

The blindness of the family planning programme to the more fundamental human and social aspects led to instrumentalism and neglect of women's sexual and reproductive health needs in policy implementation and service delivery. Indeed, focus on reducing the fertility rate alone rendered many of women's sexual and reproductive needs poorly identified and barely met. A Vietnam demographic and health survey conducted in 1988 indicated that the intrauterine device (IUD) was the most widely adopted contraceptive method in Vietnam, being used by some 86 percent of married women who had ever used a modern method (Do, 1994). Explanations for this, however, tended to be based on the assumption that the IUD was the most popular contraceptive method among Vietnamese women. Contrary to such an assumption, recent studies have indicated that the high rate of IUD use was more

likely due to insufficient information on alternative contraceptive methods provided for women as well as the unavailability of alternatives in many rural health centres that offered family planning services (Do, 1994). Lack of information obviously limited women's choice and prevented them from fully realising their rights to choose the contraceptive methods they preferred. A further obstacle to information dissemination on alternative contraceptives, particularly the pill, arose from the international practices of the earlier decades by the pharmaceutical industry and the world population control agencies of neglecting women's reproductive health issues in both R & D and the quality of products. In consequence, pronounced side-effects of the pill observed in North Vietnam in the early 1960s still functioned to deter its utilisation by women in the country two to three decades later.[13]

Since the mid-1990s, there has been a noticeable shift of stress in the Vietnamese official thinking regarding the family planning programme from a pure demographic perspective towards greater concerns with quality of life for individuals and communities. As a result, there has been a considerable increase in central and local government budgets devoted to family planning, which was previously heavily dependent on external sources such as international donors. Continued efforts have been made in government provisions of support for maternal care services in the form of subsidies and more attention has been paid to nutrition and health of children (Behrman & Knowles, 1998; Vu, 1994). There has been greater diversification in the adoption of contraceptive methods as well with a decline of the IUD dominance among married women in their child-bearing age from 86 percent in 1988 to about 51 percent in 1994 (Do, 1994; GSO, 1995a).

Conventional demographic understanding of the unmet sexual and reproductive needs of women in developing countries tend to focus on the single dimension of contraceptive supply falling short of demand on the part of married women to control their fertility and limit their family size. However, such a simplified, universalised approach often overlooks the aspects that have adversely affected women's health in relation to sexuality and reproduction, as well as the more complicated factors behind them. It also contributes to the type of policies and programmes on sexual and reproductive health, which tend to be based on accepted mores and norms. This often leads to failures in identifying and satisfying women's diverse sexual and reproductive needs arising from their different and shifting identities and standards, and in tackling effectively the real causes of reproductive ill-being. Women's diversified needs tend to be associated with their particular experiences at different life stages, embedded in specific historical and cultural settings and shaped by existing gender power relations. In contrast to the numerical, instrumental or medical approaches which are frequently found in discussions on reproduction and family planning, here we present some examples to illustrate the multiple dimensions of the unmet reproductive needs of Vietnamese women from a life-cycle, societal and gender perspective.

[13] Our research points to the liability of transnational pharmaceutical corporations and international population agencies for the reproductive ill-being suffered by women in many developing countries before the upsurge of international women's health movement, which has raised the awareness of women's health issues in connection with birth control technologies and exerted increasing pressure on such organisations. Most other analyses, however, focus on the problem of outdated information and knowledge of the family planning service providers who offer advice to women of childbearing age. See, for instance, (Vu, 1994).

Single Mothers

As illustrated earlier, the recent history of Vietnam was marked by wars lasting from the 1940s till the 1970s. This, together with increased emigration and migration of young men and the universally observed low life expectancy of males relative to that of females, has led to notable sex imbalance in the Vietnamese population. According to the census results of the past couple of decades, the male to female sex ratio in the country has been below 100 ever since the early 1930s despite that the sex ratio at birth has been similar to or slightly higher than the commonly reported ratio of 105. The lowest sex ratio ever recorded was 94.2 in 1979. Since then the sex ratio began its gradual recovery: It reached 94.7 in 1989 and 96.7 in 1999 (CCSC, 1990, 1999). However, even this latest ratio is well below the normally observed ratio of women only slightly outnumbering men in adult population in many other parts of the world (Saith & Harriss-White, 1999). Further analyses of the sex distributions among the specific age groups from 1979-94 indicate that a growing asymmetry in the sex ratio occurred with the increase in the age of the population starting from the 15-19 cohort. The demographic effects of the war are easily detectable from the greater sex ratio imbalance of the middle-aged cohorts between 35 and 59, which was well below 90 in 1989. The war also produced a much larger number of widowed women (2,417,000, who accounted for 10.8 percent of the female population) than widowed men (402,000 who represented two percent of the male population) in the same year (CCSC, 1990; NCFAW, 1995).[14]

The war ended more than two decades ago, but its aftermath has lingered and unevenly experienced by men and women. One of the gender-specific consequences of the war was that many women became widows at a young age without having children. However, because of the prevailing mores and public opinion against widows' remarriage in the countryside, most of them had to lead the rest of their lives in widowhood alone. In addition, for the past decade and more there have been an increasing number of rural young men leaving their native villages for cities in search of more employment opportunities and better living conditions. This further exacerbated the imbalance of the sex ratio of the population in some rural areas. One research reports that in certain silvicultural farms and agricultural production teams in North Vietnam women have made up of 60-70% of the total labour force (Nguyen, 1996). The salient sex ratio asymmetry in the composition and structure of the population resulting from the combined factors of the war and migration has contributed to the reduced bargaining power of rural women in either the marriage market or relationships with men. It has also caused great difficulty for many women to find satisfactory sexual or marriage partners and narrowed their range of choice in this respect. In a culture in which marriage and family are almost universal, women who cannot or choose not to marry are deemed as "abnormal" or "miserable".[15]

Unmarried women in the local community are disadvantaged in terms of social capital compared with

[14] The traditional moral disapproval of widows' remarriage may also underlie the salient discrepancy in the numbers of widows and widowers, as there has been much higher chance for the latter to get remarried than that for the former.
[15] In rural Vietnam, most men get married at the age of 22-23. As men tend to marry younger than women, it becomes difficult for women over the age of 23 to find suitable marriage partners. As a result, some rural parents have resorted to arranged marriage and forced their daughters to marry earlier than the legal marital age of 19. This, however, often creates new problems rather than solves the existing ones for young village women (Nguyen, 1999).

men,[16] as the familial and kinship networks in rural areas, which are based on a patrilocal, patrilineal structure, are largely male-centred. They command less social capital than their married counterparts as well, since the latter may develop broader familial and communal linkages indirectly through their husbands and via reproductive activities and outcomes. For unmarried village women, their capability to expand necessary social contact and hence forge valuable social capital may also be undermined by the dissolution of agricultural co-operatives during *doi moi*, as women spend most of their time alone on family farms rather than with co-workers in rural collectives. Furthermore, as Confucian moral standards, especially the double sexual morality, still dominate the sexual norms of local communities and society at large, both unmarried women and young widows are expected to have neither sexual relations nor any children.

Despite such expectations, many of the women have consciously or unconsciously defied the dominant Confucian moral criteria and judgement of their sexuality and morality by having children through "illegitimate" sexual relationships. As evidenced by some studies, single mothers have become a common phenomenon in many parts of Vietnam (Nguyen, 1999; Nguyen, 1996). It is reported, for example, that in a production team of a silvicultural farm in the North, families composed of unmarried women and their children accounted for one fourth of the total number of team families (Nguyen, 1996). Unmarried women's sexual and reproductive behaviours in defiant of the moral demand and social pressure on them can be partly explained by theories of family demography in relation to social capital. As Astone, et al. point out, engagement in sexual relations and, especially birth and rearing of children are individuals' major strategies to command and accumulate social capital (Astone, Nathanson, Schoen , & Kim, 1999). This is particularly the case in rural Vietnam, where social capital is vital for the welfare of individuals, who have to rely on themselves and their families for meeting most emotional and material needs, and for old-age security and welfare.

Indeed, researches have indicated that the determination to cope with unsatisfactory circumstances, ensure old-age security and seek personal wellbeing via realisation of motherhood and investment in social capital has motivated these women to have children and bring the children up on their own (Nguyen, 1999; Nguyen, 1996). For unmarried women, children are valued not only as an old-age support, but also as a source of enjoyment and emotional comfort. Moreover, motherhood is vital in the development of these women's lives and identities at different life stages, as well as in the realisation of their sense of self. Their unorthodox sexual behaviour and reproductive decision-making has been used as a strategy to pursue personal wellbeing. In so doing, single mothers in Vietnam have contested the accepted sexual mores and rules of legitimacy. However, the asymmetry in gender power relations and the lack of paternal financial support have exacerbated the financial strain on unmarried women. Furthermore, single mothers have been faced with social prejudice and discrimination from the family and local communities. It is reported that they tend to be rejected by their families who view their unconventional sexuality and reproduction as a disgrace to the honour of the family. They are also looked down upon in the local community, deprived of equal economic opportunities and formal and

[16] Social capital is defined here as tangible or intangible resources emerging from one's familial and social ties (Portes & Landolt, 1996).

informal rights to statutory and non-statutory social support and social services (Nguyen, 1996).

The coverage of and access to reproductive health and family planning services have been differentiated by sexuality in relation to marital status. The official conceptualisation of reproductive health issues, and hence the corresponding social policy making have not gone much beyond the culturally accepted notions of legitimacy in terms of sexual relations and informal entitlement rights. Mainstream information, education and communication (IEC) campaigns, which are intended to disseminate relevant information and knowledge about reproduction and family planning, have only targeted couples and married women in their child-bearing age. Similarly, reproductive health and family planning services have not been extended to people who fall outside such categories.

Although there have not been explicit rules excluding unmarried women, in reality, these women have been prohibited from realising their rights to information, knowledge, technology and services that are necessary to achieve sexual and reproductive wellbeing. Social taboos on sexuality, the double moral standards for men and women, and the resultant familial and community pressures have deterred the unmarried women from visiting local health clinics and reproductive health facilities for information, advice and services. They fear that to do so would be tantamount to acknowledgement of their nonorthodox sexual and reproductive activities and their deviation from the accepted social norms and traditional standards. Single mothers in such situations have suffered from entitlement failures,[17] which have seen many unmet needs of and even detrimental effects on their reproductive health and wellbeing. Research on single mothers in three communes near Hanoi has found that most of the unmarried women in the area know very little about condoms, other contraceptive methods or the HIV/AIDS threat to the health of women and their children. They do not use any contraception, or practise safe sex. In consequence, most of the unmarried women (52%) suffer from reproductive track infection (RTI) or sexually transmitted diseases (STDs). However, the stigma attached to sexuality and reproduction outside marriage, as well as the social prejudice held by local communities and service providers have prevented the women from seeking medical advice and timely diagnosis and treatment (Nguyen, 1999).

Abortion

Abortion is legal in Vietnam and as a component of the national family planning services, it has been made widely available at various levels of public health facilities from the communal health clinics to the central hospitals' gynaecological and obstetrical departments. Although women in Vietnam have legal abortion rights thanks to the lack of serious religious or moral obstacles, as well as to the official promotion of family planning, what has caused considerable concerns nationally and internationally is the drastic increase and high incidence of abortion in the country during the past decade. According to official statistics, the national incidence of abortion was 760,000 in 1989. It rose to 1.3 million in 1994 and 1.5 million in 1996 (Henshaw, Singh, & Haas, 1999a: S34; MOH, 1997: 33). The abortion rate

[17] Here we adopt Sen's framework, in which entitlements refer to a person's command over commodities and capabilities in the existing legal, political, social and economic structures (Sen, 1990). The idea of extended entitlements goes beyond formal legal forms of command over commodities and includes "more informal types of rights sanctioned by accepted notions of legitimacy" (Drèze & Sen, 1989).

(abortions per 1,000 women aged 15-44) was about 27 in 1988, which increased sharply to 83 in 1996. As such Vietnam's rate of abortion stands as one of the highest in the world (Henshaw, Singh, & Haas, 1999b: 46).

Demographic explanations of high abortion incidence tend to emphasise women's desire to terminate unintended pregnancy combined with insufficient availability of or access to alternative fertility control methods (Henshaw et al., 1999b). However, focusing on such factors alone can exclude other relevant dimensions such as the service delivery aspects of abortion, leading to simplified identification and interpretation of the causes of high abortion rates, and hence inadequate policy responses to other important issues in relation to women's sexual and reproductive experiences and needs.

Frequent abortions are undesirable on grounds of both mental and physical health. In Vietnam, the national family planning programme has been vigorously implemented, which has raised awareness about the possibility and potential benefits of having smaller families. However, the failure to conceptualise women's reproductive wellbeing as the goal of family planning tends to result in neglecting women's health issues in the provision and quality of family planning services. Such neglect is manifest, to some extent, in certain current practices of some family planning, especially abortion services. At present, pregnancy terminations in Vietnam are performed mainly through induced abortion and menstrual regulation (MR),[18] of which the latter accounted for 45-60 percent of the 1.4 million pregnancy terminations carried out in the country in 1995 (GSO, 1996a: 21). Recent researches indicate that a considerable percentage of the high incidence of abortion through MR is, in effect, unnecessary, as many of the women undergoing MR are not pregnant in the first place. It has been reported, for instance, that the rate of unnecessary MR by non-pregnant women is between 17-25 percent in different districts of Thai Binh Province in North Vietnam. It is estimated that this proportion of unnecessary abortion may be extended to the country as a whole (Trinh et al., 1998; Trinh, 1995).

The most obvious factor underlying the high incidence of unnecessary abortion has been identified as the unavailability or omission of pregnancy testing before decisions on MR are made. It is reported that pregnancy testing, which is a low-cost, routine procedure for confirming pregnant status elsewhere, has not been widely instated in Vietnam as an essential part of abortion services offered at different levels from commune health centres to district hospitals, particularly in rural settings (Trinh et al., 1998). Although local resource constraints in rural areas are deemed as partly attributable to such a practice, this alone cannot explain why the lower-cost facilities for pregnancy testing are unavailable, but not the more expensive facilities for performing MR. It seems to us that the high priority granted to attaining numerical targets of reducing fertility rate rather than improving sexual and reproductive health in national and international social policy making on family planning and healthcare provision is a factor contributing to the observed high incidence of unnecessary abortion in Vietnam.

The high incidence of unnecessary MR is also related to the health sector reforms that began in the *doi*

[18] MR is a procedure of inducing menstruation following a missed period, and usually performed within six weeks after the beginning of a woman's last menstrual period.

moi period. The globalisation of social policy has led to greater residualism in social service provisions, which has seen gradual decline in the importance of health in the government social sector expenditure since the early 1990s. Commercialisation and decentralisation of healthcare services is the common trend. One of the measures taken during the restructuring of the country's healthcare system has been the introduction of user fees in medical facilities managed by central, regional and local governments. Accompanying this change is the emergence of and increase in non-governmental financing of healthcare facilities, such as those run by communal and private sectors. However, limited government regulatory mechanisms have been put in place to guarantee the quality of services and monitor the practices of both the private and public service providers in an increasingly decentralised and pluralised sector (Bloom, 1997; Pham & Nguyen, 1998).

Family planning services, which have been offered through the existing public health network, are not exceptional from this trend. Theoretically, family planning services such as abortion and MR should be provided free of charge in accordance with both official policies encouraging family planning practices and state subsidies to public service providers at various levels, and this was true in the 1980s (Le, Johansson, & Nguyen, 1996). In reality, however, decentralisation and marketing of reproductive health and family planning services have started since the early 1990s, which has seen, among other things, increased autonomy of service providers in the management of healthcare institutions.[19] The combined effects of government resource constraints and decentralisation have helped produce a scenario where even with state subsidies, many public healthcare providers charge formally or informally for services. It is reported, for example, that the fees charged for pregnancy testing are about 15,000 VND ($1.25), and for MR 16,400 VND ($1.40) plus "off-the-book" payment to underpaid medical staff for a better MR service (Trinh et al., 1998).

It is possible that the current practice of fee charging, particularly for such basic check-ups as pregnancy testing, has prevented many rural women in relatively poor areas from taking a prior test before an MR operation. Access to quality family planning services and the related reproductive health outcomes may be further differentiated by sectors, regions and income levels, with rural women on lower incomes from poorer regions being increasingly disadvantaged. Furthermore, women may not be fully informed of the potential benefits of prior confirmation of pregnancy status, as the little regulated healthcare sector does not have much motivation to recommend this course of action. In addition to higher charges, offering MR may have an extra incentive for service deliverers. It is suspected that government subsidies provided for medical institutions in light of the numbers and types of operations including MR and abortion performed therein may unwittingly serve to encourage healthcare workers to prioritise MR to pregnancy testing (Trinh et al., 1998).[20]

[19] Personal conversation with Dr. Nguyen Kim Cuc, Vice President of Vietnam Family Planning Association, Hanoi, 18 November 1999.
[20] Such government subsidies function as a supplement to the inadequate salaries of the medical personnel in the public sector.

Adolescents

Adolescents', particularly girls' sexual and reproductive activities and needs were largely invisible in Vietnam before the *doi moi* period owing to the predominant Confucian ethics emphasising women's virginity and chastity, social disapproval of premarital sexuality, and the tight and rigid ideological and social control under the Soviet-style governance. Market reforms and ideological liberalisation over more than a decade have brought about rapid social changes, which have been accompanied by increased individual freedom and greater tolerance for different life styles. A growing generation gap with respect to sexual and reproductive attitudes has also emerged with the young and unmarried possessing more liberal ideas about sexuality and sexual relations compared with the older generations (Khuat, 1998). In the meantime, as changes occur rapidly, parents, educators, sexual and reproductive health providers, as well as society at large seem to be ill-prepared to recognise and deal with a reality in which many of the adolescents are maturing earlier and thus have special sexual and reproductive needs.

In recent years what has caught the attention of parents and social workers is the sharp rise in the abortion rate of adolescent girls aged 15-24. A recent study estimates, for instance, that young unmarried women have comprised 20-30 percent of the total number of women seeking abortion in major Vietnamese cities (WHO, 1997: 30). Furthermore, as data currently available on abortions performed in private clinics are extremely limited, it is suspected that the actual number of adolescent abortions may be even greater (PC, 1998). Several researches have shown that the increase in the use of abortion by unmarried girls is largely caused by the marked rise in premarital sex, poor knowledge and skills of contraceptive use and reluctance to adopt modern contraceptive methods by the young people concerned (Gammeltoft & Nguyen, 1999; Goodkind, 1994; Khuat, 1998).

Unlike their grandparents and parents, who lived in a largely homogeneous society dominated by Confucian ethics or revolutionary asceticism, young people in today's Vietnam are exposed to the overwhelming influence of Western culture through modern mass media, such as television, films, magazines, newspapers and books. Increased cultural pluralism has considerably affected young people with respect to values, norms, sexual behaviour and orientations. The greater earning ability of the young enhanced with better educational and employment opportunities has helped reduce their dependence on parents, who in turn, are gradually losing control over the lives of their children and unable to closely monitor the children's social and sexual contacts. It is in this context of rapid economic and social changes that premarital sexual relations become increasingly common during the *doi moi* period in Vietnam. Some research estimates that between 30-70 percent of unmarried young people in Vietnam have sexual experiences before marriage (CARE & MOH, 1997: 13). It is also found that adolescents engaging in premarital sexuality are from diverse background in terms of education, occupation and parental socio-economic positioning rather than being confined to any particular social stratum (Khuat, 1998).

In spite of the drastic changes in adolescents' sexual attitudes and behaviour as well as an officially promoted national family planning programme actively disseminating reproductive health knowledge and providing relevant services, Vietnamese adolescents today are poorly equipped with information

and knowledge about contraception and safe sex. This is partly attributable to the lack of institutionalised sex education in the country. A related research by Belanger and Khuat conducted in Hanoi in 1996 found that almost half of the unmarried young women undergoing abortion in their research sample never discussed sexuality with anybody, and their knowledge on the matter was very limited (Belanger & Khuat, 1996). The responsibility of disseminating sexual and reproductive knowledge as well as providing necessary advice and counselling for young people has been perceived divergently by different agencies, including educational institutions, public health providers, social workers and parents. The large generation gap has prevented parents from becoming an adequate source of information and counselling on sexual and reproductive health issues. Teachers at school and community social workers have either found it hard to explain to young people delicate and sensitive matters like love and sex or been poorly informed and trained on such subjects themselves. Hospital reproductive health personnel tend to perceive their duty as treating patients instead of offering advice, and believe that the responsibility of sex education lies with schools and parents (Khuat & Belanger, 1998). The lack of consensus on the issue, combined with other cultural and social barriers, has led to a scenario where there has been neither an appropriate assumption of responsibilities by any party nor a sharing of responsibilities among them. Some potential actors even believe that sex education may encourage sexual experimentation and lead to riskier sexual behaviours by the young, and thus should not be advocated (PC, 1998; Huynh, 1997).

Researchers have demonstrated that the majority of young people in Vietnam today obtain their sexual knowledge mainly from mass media, and some through peer groups. However, information and knowledge acquired this way tends to be superficial and fragmented, and many young people are misinformed by their equally ignorant peers (Khuat & Belanger, 1998; Samuelson, Do, & Khong, 1995). It is reported, for example, that a common perception held by adolescent girls about contraception is that contraceptives are only suitable for older, married women and that they may harm unmarried girls, making them infertile or causing brown marks in their faces. Another widespread perception even amongst reproductive health workers is that modern contraceptive methods including condoms and emergency contraception are for the purpose of family planning, and hence should be adopted only by married people of childbearing age. Moreover, some adolescents believe that “safe sex” merely means preventing unwanted pregnancy. Many of them either are unaware of sexually transmitted diseases such as STD/HIV/AIDS, or see themselves as immune to such risks. However, it has been found that many young males, regardless of their socio-economic background, have visited commercial sex workers as part of their premarital sexual experiences (PC, 1998; Khuat & Belanger, 1998). Greater sexual activity together with the lack of institutional sex education have increasingly exposed adolescents to risks of sexual and reproductive ill-being in the face of the rapid spread of STD/HIV/AIDS epidemic in the region.

In spite of the more tolerant public opinion on the issue of adolescents’ changing sexual behaviour, premarital sex, especially by young women, is still culturally disapproved and hence socially stigmatised. Health policies in general, sexual and reproductive health policies in particular tend to be based on such a conceptualisation of sexuality and culturally accepted legitimacy of sexual behaviours. This has informed the implicit exclusive/inclusive rules with respect to eligibility for sexual and

reproductive health information and services. Accordingly, most contraceptive methods and reproductive health services have only targeted older married women and married couples, neglecting the sexual and reproductive health needs of adolescents, especially unmarried girls. In addition, even if adolescents know something about contraception, they often find it difficult to gain access to such services, or are unaware of how to obtain them, and feel too afraid and embarrassed to make enquiries.

The institutionalised neglect of the sexual and reproductive health needs of adolescents including needs for sex education, information and knowledge on contraception and safe sex and a wide range of relevant services has especially disadvantaged young unmarried women in varied ways. Premarital pregnancy may force the young women to drop out of school, get married and give birth earlier than they originally planned to. This, in turn, can jeopardise their educational opportunities and future career prospects. Sexually active unmarried girls often have to bear the negative emotional, social and physical consequences of unprotected sex initiated in most cases by their boyfriends or lovers. Unlike the assumption sometimes made by health workers that abortion tends to be used readily by unmarried girls as an easy solution to unwanted pregnancy, in-depth researches have found that young unmarried women undergoing abortion perceive the experience as burdensome and highly stressful. These girls are worried about the ethical aspects of the procedure, public opinion affecting their families' and their own "reputation", as well as possible post-abortion complications and negative effects on their health (Gammeltoft & Nguyen, 1999). Unprotected sex and the increased reliance on abortion as a major contraceptive method rather than a backup for contraceptive failures thus expose the girls to a variety of sexual and reproductive health risks.

A recent study conducted in Ho Chi Minh City's Family Planning Centre shows that almost 60 percent of all the abortion-seeking unmarried girls interviewed therein have experienced two or more abortions by the time of the interviewing (Khuat & Belanger, 1998: 11). This indicates that it is quite common for unmarried girls to undergo multiple abortions, a procedure that repeatedly exposes these girls to sexual and reproductive health risks associated with abortion such as infection and complications. It also suggests a lack of post-abortion counselling provided for adolescent girls on safe sex and contraceptive usage as a safer and more effective means to avoid unwanted pregnancy.

Social pressure and the stigma attached to premarital sexuality and pregnancy are another important factor contributing to the practice of unsafe sex and multiple or late-stage abortions by the unmarried girls. Housing shortage and the lack of private space for young women when living under the same roof with their parents have rendered it difficult for them to keep contraceptive devices at home, as they fear that their parents may discover their "illicit" relationships (Khuat & Belanger, 1998). In some cases, unmarried girls are too afraid to talk to anybody about their pregnancy, and so wait for a long time before seeking medical advice and check-ups. It is reported by a study on abortion in Ho Chi Minh City that among the young unmarried girls seeking an abortion, 68% are at a rather late stage (over 12 weeks of pregnancy) (Huynh, 1997: 74). Abortions at a later stage of pregnancy by young unmarried women further increase the risks to their sexual and reproductive wellbeing in both physical and

psychological senses.[21]

Conclusion

A rights-based approach to development has been increasingly gaining currency in development discourse in the recent decade, particularly in the area of global social policy making. Sexual and reproductive rights and rights-based approaches are interpreted and implemented diversely within this broad international context by different international and national actors at various levels. We have argued in this paper that the enabling potentials of a rights-based approach to sexuality and reproduction in developing countries can only be realised when sensitivity to specific cultural and political contexts, as well as to varied and shifting socio-economic realities are taken into account.

We have demonstrated, through our analysis of the specific situation of Vietnam, how historic legacy, political culture, as well as demographic characteristics and socio-economic conditions can shape and reshape notions of rights, particularly sexual and reproductive rights and needs, and their translation into social policies, e.g. healthcare services and family planning programmes. We have shown that national policies intervening in the most intimate human relationships of sexuality and reproduction, have been increasingly affected by the process of globalisation and the shifting international debates on relations between population and development. In accord with the Cairo consensus, a shift of attention in the arena has been observed in Vietnam in recent years. There has been a reorientation from the single-minded emphasis on reducing societal fertility to a more sophisticated approach in terms of meeting people's sexual and reproductive health needs through improving quality of care in social provisions.

Despite such a shift, however, other measures, which have been simultaneously taken with the process of globalisation and economic transition, such as healthcare reforms and the introduction of user fees, have tended to enlarge the existing inequalities in access to sexual and reproductive health services, hence adversely affect women's sexual and reproductive rights and wellbeing. We have illustrated this with respect to the high incidence of unnecessary abortion in Vietnam, which reflects continuities of opportunism and instrumentalism in the international and national population policy making and service delivery leading to the neglect of women's reproductive wellbeing. We have demonstrated as well that coverage of and access to sexual and reproductive health services are frequently informed by certain exclusive rules based on the socially and culturally accepted legitimacy of sexuality and reproduction, as in the case of single mothers and adolescents in Vietnam. This may well result in entitlement failure for some groups, e.g. unmarried women and girls, causing sexual and reproductive ill-being, especially in the face of the serious threat of HIV/AIDS to development and human wellbeing. We argue that a better-conceived rights-based approach should engage with societal differences, such as gender power relations and women's life-cycle-related needs, as well as the way in which the way that particular historical and cultural legacies and social institutions interact with official

[21] It is generally recognised that the fatal risk associated with abortion is 1/400,000 when pregnancy is less than 9 weeks. It rises by four folds when pregnancy is between 13-16 weeks. The risk further quadruples if pregnancy is more than 16 weeks. The degree of risks is also true for abortion complications (Huynh, 1997: 74-75).

policy and reproductive health services.

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