Asia-Pacific Population Journal

Vol. 13, No. 2, June 1998

Young Single Women Using Abortion in Hanoi, Viet Nam

If unmarried youth had better reproductive health information and skills, their use of pregnancy termination could be reduced

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Data on legal induced abortion in Viet Nam suggest that the number of abortions has dramatically increased between 1975 and the early 1990s. Between 1990 and 1993, the annual number of abortions reached 1.2 million (Ministry of Health, 1990-1993). For 1992, the total abortion rate was estimated at 2.5 abortions per woman, the highest rate in Asia and one of the highest in the world (Goodkind, 1994). One of the reasons for Viet Nam's rising abortion rate may be the increase in premarital sexuality, leading to more unwanted pregnancies and hence an increasing demand for abortion. A number of factors confirm this hypothesis.

First, demographic analyses show that more young women than older ones are having premarital conceptions and a shorter interval between marriage and their first birth (Bélanger, 1997; Johansson and others, 1996b). As suggested by Rindfuss and Morgan (1983) for other Asian countries where they had observed the same trends, a "quiet sexual revolution" appears to be under way currently in Viet Nam. Second, the transition from a socialist, planned economy to a market economy initiated in the mid-1980s was accompanied by an opening of the country to cultural influences from Western and other Asian countries, such as movies, magazines and television programmes. These imports expose Vietnamese youth to different values and life-styles and may well affect behaviour in areas such as dating and sexual activity (Khuat, 1998; Le, 1997; Marr, 1997). Third, marriage changes indicate an intensification of premarital relations. That marriage patterns are changing is indicated by the fact that arranged marriage by the parental generation has given way to more freedom of choice by young people themselves (Bélanger and Khuat, 1996; Goodkind, 1996; Nguyen, 1997). Premarital relations today are more intimate than in the past and young people no longer need parental supervision to meet each other and enjoy activities together. These changes associated with rising premarital sexuality have also been observed in other Asian countries (Xenos, 1990).

This evidence, coupled with reports of low contraceptive use by unmarried youth (National Committee for Population and Family Planning [NCPFP], 1996; NCPFP and Vietnamese-German Technical Cooperation, 1995), suggests that the demand for abortion from single women indeed might have contributed to the overall increase in the number of abortions performed yearly in the country. However, the proportion of

single women among all women having an abortion is difficult to estimate since those using abortion services are guaranteed anonymity from providers. As a result, false declarations of age and marital status are common, as no identification documents are required, except in cases of complicated or late abortions. Rough estimates from the service providers published in newspapers in 1995 and collected by the World Health Organization (WHO) in 1997 range from 25 to 30 per cent (Le, 1995; WHO, 1997). This proportion suggests that a growing number of single women are facing unwanted pregnancies. Since NCPFP has the objective of reducing the use of abortion in Viet Nam (WHO, 1997), studying unmarried youth using abortion services should provide insights as to how to plan policies aimed at fulfiling this objective.

This article presents the results of an exploratory study conducted during the period 1995-1996 in Hanoi involving single women having abortions. The main objective of our study was to explore the context and process of abortion use for single women. We wished to identify paths leading to abortion use in relation to dating, sexual and contraceptive behaviour. Four gynecologists performing abortions surveyed a total of 259 single women who had an abortion in two hospitals and one district health centre in Hanoi. In addition to the women surveyed by questionnaire, 20 other women participated in in-depth interviews, 10 of which took place at the district health centre and 10 at a private clinic.

The quantitative survey provides mainly descriptive information about our sample. Results suggest that few women used a contraceptive method before having an abortion. A pattern of low contraceptive use also prevails among women who had repeat abortions, although the likelihood of use is higher among them than among first users. We argue that this low contraceptive use among all the women concerned is due mainly to a lack of information, skills and post-abortion counseling and services. Results on information sources and support networks about sexuality and contraception, as well as on the self-perceived need for information, clearly suggest that policy makers should take into account the needs of unmarried youth.

The qualitative interviews clarify results generated from the quantitative data and provide information as to what are the obstacles to contraceptive use. The analysis points to barriers linked to poor knowledge and misconceptions about family planning methods. Communication barriers between women and their boyfriends about sexuality and contraceptives also reduce contraceptive use. Results show a clear distinction made by the women between menstrual regulation and abortion, the former being considered minor and used as a post-gestation contraceptive method and the latter, as a more severe intervention.

The social taboo associated with premarital sexuality makes difficult the use of contraceptive methods on a regular basis for some women. We conclude that, although information about and access to contraceptive methods need to be improved, older generations must come to terms with the necessity to inform adequately unmarried youth for the sake of their reproductive health, as most countries have agreed to do at the 1994 International Conference on Population and Development (ICPD). Policy makers should work in concert with unmarried youth, parents and schools to enhance awareness about the potential risks of unprotected sex and repeat abortion.

Background

Abortion has been legal in Viet Nam since the 1960s and currently is widely available. Most pregnancy terminations are performed in public health service centres at the provincial or district level, although the private sector also offers abortion services. In Hanoi, the capital of Viet Nam located in the northern part of the country, many health institutions provide abortion services, the most important ones being the public central hospital and municipal hospitals, maternal and child health care and family planning centres, and district health centres. A number of private centres have opened in recent years, but there are no statistics available on private health services in Viet Nam. Almost all hospitals in Hanoi have an obstetrics department that provides abortions. Among them, the most important ones are the Obstetrical Hospital of Hanoi, and the Institute for the Protection of Mother and Newborn (formerly Hospital C). At the district level, Maternity Hospitals A and B are the institutions performing the greatest number of menstrual

regulations and abortions.

Viet Nam's health providers distinguish between two types of procedure: menstrual regulation and abortion. Menstrual regulation (*hút thai*) is a pregnancy termination performed during the first six weeks of pregnancy, while the term abortion (*nao thai* or *phá thai*) describes abortions done after six weeks of pregnancy. The distinction is used in statistics published by the Ministry of Health. However, menstrual regulation may not be systematically preceded by a pregnancy test in all health facilities. This might be the case for 50 per cent of menstrual regulations (General Statistical Office [GSO], 1996:3). Thus, in these cases, a woman would not know whether or not she was actually pregnant.

As mentioned in the introduction, abortions performed in Viet Nam have increased sharply since the early 1990s. According to the Ministry of Health's statistics, the annual number of abortions rose by a factor of 10 between 1976 and 1986, leading to an average number of menstrual regulations and abortions of 700,000 between 1986 and 1989 (Ministry of Health, 1983-1990). In the late 1980s, abortion rates continued to increase, partly as a result of an increase in the number of institutions providing abortion services. In 1992, 660 abortions were done for every 1,000 births in Viet Nam. Part of this increase was also linked to a relaxation of the requirements for users. Until 1987, abortion services were provided according to a woman's residential sector, and disclosure of her identity was compulsory. This meant that women could request abortion services only at the health centres in the sector where they were registered as residents. In 1988, the system of service delivery according to the place of registration was dismantled. Subsequently, women who wanted menstrual regulation or abortion services could go to any public health institution offering the service and their anonymity would be guaranteed. In November 1996, the cost of a menstrual regulation was 32,000 dong (US$1 = about 10,500 dong) and 52,000 dong for an abortion. All single women must pay the fees for the abortion procedures.

Before the 1990s, research on abortion in Viet Nam was non-existent. Over the last few years, the increase in abortions performed in the country has drawn the attention of research institutions and some initial surveys addressing the question of abortion have been carried out. In 1991, a survey was conducted of 2,088 women in five Hanoi hospitals and nine hospitals in Thai Binh Province, which is also located in the northern part of the country (Do and others, 1993). These hospitals had performed an average of 1,000 abortions in the year preceding the survey. The results show that nearly all the women surveyed had an abortion either because they had not used any contraceptive method or because they had experienced contraceptive failure. Only 20 per cent of the women were using a modern contraceptive method; however, the survey also showed that a high proportion of the women had had two or more abortions. Moreover, 7 per cent of the sample of the women in this survey were unmarried. Johansson and her collaborators (Johansson and others, 1996a) studied the issue of abortion in Thai Binh Province in 1991. For their sample, they calculated a very high total abortion rate and also found that most women chose abortion to save money or avoid being fined for exceeding the two-child limit prescribed by the national population policy. According to their survey, husbands were the most important persons sharing the abortion decision; parents and parents-in-law often did not agree with the decision. In the survey area, post-abortion counseling was either absent or inadequate.

Methodology and data

The quantitative data for our study come from a hospital-based sample of 259 single women who had an abortion and who were living in Hanoi at the time of the survey. Our sample of women does not represent all single women having an abortion, as the survey was conducted in a few health institutions only and the women interviewed were not selected randomly from a larger population. Four young female gynecologists working in two Hanoi hospitals administered a questionnaire to the 259 women prior to or after the pregnancy termination. The selection of women depended on the gynecologists' ability to take 30-40 minutes to do an interview during their busy work day. In spite of this non-random procedure, these gynecologists did not give preference to women sharing certain characteristics over others. We opted for the collaboration of the medical staff after having tested a self-administered questionnaire which gathered

poor data. A trained interviewer completed 10 questionnaires and 10 in-depth individual interviews in a district health centre. An additional 10 in-depth interviews were done by the same interviewer at a private clinic in Hadong, a Hanoi suburb. These qualitative interviews were not conducted immediately before or after the abortion; instead, the women interviewed had had the abortion between two and six months prior to the interview. This time-lag between the abortion and the interview enabled the interview to be conducted in a more relaxed atmosphere which is often helpful for a long, qualitative interview. The survey took six months to complete and was conducted between November 1995 and May 1996, a time-frame which included the training of interviewers, pretests of the questionnaire and the interview guidelines.

The four survey sites were selected for two reasons. First, we met substantial resistance from the authorities in the conduct of the survey. While some institutions were afraid that young women would not come to their institutions if they knew about this survey, others refused even to discuss the issue of single women seeking an abortion. This resistance, we believe, reflected the difficulties authorities were facing in dealing with the new issue of premarital sexuality and pregnancy in the mid-1990s.[1] Second, our survey sites allowed for a good screening of women according to their marital status. As mentioned previously, it is not uncommon for single women to declare that they are married in order to avoid the stigma associated with premarital pregnancy. However, some institutions are more concerned with collecting accurate information on marital status and the age of the users of this service. During the time of the survey, the Hanoi Obstetrical Hospital was testing the pill known as RU486, which causes an abortion, giving priority to single women in this process. It was thus imperative to distinguish married from single women and to gather information on the women?s identity. In Hospital C, most of the women were being referred by another doctor because they were having a late abortion (more than 12 weeks) and, therefore, the gathering of personal information and medical history was a strict requirement. In the district and private clinics, all of which are small institutions, contacts are more personal, and single women are more at ease to declare their marital status and age. Details on the number of women interviewed in each survey are contained in table 1.

Table 1. Number of women interviewed per institution: greater Hanoi

Institution	Obstetrical Hospital of Hanoi	Institute for Protection of Mother and Newborn	District clinic	Private clinic	Total
Questionnaire	182	57	10	—	259
Qualitative interview	—	—	10	10	20
Total	182	57	20	10	279

The questionnaire used covered the following topics: onset of sexual relations, number of partners, types and duration of relationships, knowledge and use of contraceptive methods, knowledge of sexually transmitted diseases and of the female menstrual cycle, and sources of information about sexuality and contraceptive methods, including family members, peers, boyfriends, the media, school and printed material. In the section of the questionnaire about contraceptive knowledge and use, we collected spontaneous mentions of methods and did not prompt afterwards. Considering the population investigated, prompting of the methods by the interviewer would have led to an overestimation of knowledge and use.

Two questions were aimed at evaluating contraceptive use since the onset of sexual relations. At the beginning of the questioning we asked the young women to name all the contraceptive methods about which they had knowledge and had ever used. Towards the end of the questioning the women were asked if they had ever used any method to avoid pregnancy. If so, they were asked to list the methods. By combining the responses to the two questions (some women answered the second question more thoroughly), a variable was obtained measuring the use at any point of a contraceptive method. Also, a specific question was asked about knowledge and use at first intercourse, and about use with the current boyfriend prior to the unwanted pregnancy.

The qualitative interview included questions about all love episodes and sexual partners, sharing of these experiences with family members and friends, contraceptive use and the decision to have a pregnancy termination. Since these women had had the abortion a few months before the interview, it was possible to investigate sexual and contraceptive behaviour after the abortion. Less than 5 per cent of the women approached refused to participate. All the women interviewed, a total of 279, had undergone pregnancy testing, including those who underwent menstrual regulation.

Study limitations

The study design we had to use in order to reach single women having an abortion has some limitations. The major limitation comes from the fact that the sample is not statistically representative of all women using abortion. For example, the few institutions surveyed may attract women sharing common characteristics. Women from the countryside and living in university dormitories in the city, for instance, may have less financial resources and thus might more often choose public services, which are cheaper than private ones. On the other hand, women from Hanoi may not want to go to a public hospital, for fear of meeting someone they know; thus, they might choose a district health centre far from their residence. In view of the fact that the three institutions surveyed were located in different parts of Hanoi, we thus increased the chances of reaching different sub-populations of single women.

The second main limitation pertains to the time and context in which the questionnaire was administered. Young women who answered the questions were interviewed before or shortly after having an abortion, which was a time of stress for some of them. This aspect may have affected the quality of the data. Furthermore, that a medical doctor conducted the interview may have been intimidating for the women. None the less, the medical staff who participated in the survey expressed confidence in the quality of the data collected. According to them, most young women had not had a chance previously to talk about their sexuality and therefore felt relieved to be able to speak in a confidential setting with a knowlegeable person. The fact that all interviewers were themselves young women and did not have a judgmental attitude facilitated the conduct of the interviews. For our study, we purposely selected women gynecologists genuinely concerned about the issue of single women using abortion.

Some limitations also arise from our study of contraceptive use patterns, since the women using abortion could have been less likely to use contraceptives, or alternatively, could have been better informed than other women, since they had had contact with abortion providers. The general population of young women having premarital sex probably features a different pattern of knowledge and use than the women in our

sample. As previously mentioned, the exclusion of prompting about contraceptive methods in our investigation might have under-estimated knowledge. Also, the questionnaire did not include very detailed questions about the depth of knowledge and the regularity of use because our objective was not to focus on knowledge and use but rather on the overall context of abortion use. This lack of information in the questionnaire, however, is compensated by more elaborate data provided in the qualitative interviews.

Finally, we believe that gathering information on unmarried abortion users remains a difficult endeavour since in Vietnamese society the topic of premarital pregnancy is taboo in the extreme and users' anonimity is closely guarded. In this context, personal information about age and marital status declared by users is unreliable anyway and the drawing of a representative sample is therefore not possible.

Results

The survey questionnaire

The characteristics of women surveyed by the questionnaire are shown in table 2. Over 90 per cent of them were teenagers (15-19 years) and young unmarried adults in their early twenties (20-24 years). Three-fourths of the women are natives of Hanoi; the ones not born in the capital had been living there for an average of four years. Most migrants moved to Hanoi to continue their studies and therefore lived either in a university dormitory or with relatives living in the capital city. Many women (over 80 per cent) in the sample, however, lived with their parents or other relatives. Close to 20 per cent lived alone, with friends or in a student dormitory. Among those living with family members, over 60 per cent lived in a privately owned house (as opposed to a state-owned housing unit), which is an indication of a higher socio-economic profile. Those from families with less financial resources were more likely to live in publicly owned housing (26 per cent). Close to 40 per cent of the women had a college or university level of education; almost 50 per cent of them had completed their upper secondary education. The current main activity of most women was either work (46 per cent) or studies (39 per cent), while a small proportion was staying at home. Most employed women worked in a factory or private enterprise, which in many cases was owned by their family. Nearly two-thirds of the women received money from their parents and one-third obtained an income from a monthly salary (results not shown in the table). Their average monthly income was 358,000 dong per month, with some women not receiving anything and others receiving up to 2 million dong a month. The education level of their parents was high, and a significant proportion of the parents comprised government cadres (results not shown).

Table 2. Characteristics of women in the greater Hanoi sample

(Percentage)

Age	
15-19	37.5
20-24	55.6
25-29	5.8
30 and older	1.1
Current main activity	
Working	45.9
Studying	39.0

At home	12.0
Other	3.1
Type of residence	
Private	63.3
Collective	26.3
School dormitory	7.0
Others	3.4
Level of education	
6-9 years of schooling (lower secondary)	8.8
10-12 years of schooling (upper secondary)	53.6
College	19.3
University	17.8
Other	0.4
Living arrangements	
Nuclear family (two parents)	66.8
Nuclear family (one parent)	6.6
Extended family	5.0
Other relative	7.3
Friends (including student dormitory)	11.6
Alone	2.0
No answer	0.7
Father's education	
Upper secondary and lower	27.8
More than upper secondary (college or university)	68.4
No answer	3.8
Mother's education	
Upper secondary and lower	54.5
More than upper secondary (college or university)	41.3
No answer	4.2

In sum, women in our sample came from different socio-economic groups and were at different stages in their life-course; a significant proportion of them, however, lived with their parents, have a high level of education and are from Hanoi.

It is relevant to compare our sample with the general population of women aged 15-24 living in Hanoi. To do so, we generated tabulations from the urban clusters of Hanoi included in the 5 per cent sample of the 1989 census (results not shown here). In comparison with women aged 15-24 living in Hanoi in 1989, our sample of women is more educated and is composed of more working women than found in the general population. Also, a comparison of their parents' characteristics with those of the adult population of Hanoi, by sex (for the corresponding age groups), reveals that the parents of the women surveyed are also more educated, and are more often government workers than indicated by the census for adults of the same age groups.

To explore the path to an unwanted pregnancy in relation to dating and sexual behaviour, we collected information on the timing of three events: age at having their first boyfriend, age at first sexual intercourse and age at first abortion. For the sub-sample of women who had two abortions, the questionnaire also provided information on the age at the second abortion. These data enabled the construction of life tables for each "transition": from first boyfriend to first sexual intercourse, from first sexual intercourse to first abortion, and from the first to the second abortion. The timing of these transitions is relevant to our understanding of when and how dating and the onset of sexual intercourse affect subsequent unwanted pregnancies. Cumulative proportions of women who experienced the transition at different time intervals are shown in table 3.

Table 3. Cumulative proportions of single Vietnamese women experiencing first intercourse, first abortion and second abortion

(Percentage)

Interval in years	First boyfriend to first intercourse	First intercourse to first abortion	First abortion to second abortion (N=59)
0	37	50	5
1	67	92	75
2	87	96	85
3	93	98	94
4 or more	100	100	100
Average duration between the two events	15.5 months	6 months	17 months

The study of the onset of dating is important because most women in our sample engaged in sex in the context of a committed relationship. Over 95 per cent of the women in our sample had a boyfriend at the time of the survey. Clearly, women defined a boyfriend as a male friend with whom they had a committed relationship, and in most cases, a person with whom they had sexual intercourse.[2] Once dating was initiated, one-third of the women had had their first sexual experience in less than a year (table 3). After a year, two-thirds were no longer virgins. The average duration between the two events was about 15 months. Between their first relationship and their first sexual experience, 33 per cent of the women had more than one romantic episode. If we calculate the average interval only for women who had their first intercourse with their first boyfriend, we obtain an average of seven months. This average indicates that sexual relations do not follow dating until the relationship is well established. We also observed this behaviour from a direct question on their current relationship: *For how long did you have a relationship with your current boyfriend before you started having sexual relations with him?* In responding, 45 per cent said after six months of dating, and 38 per cent said that they waited one year. These results show that the women in our sample did not engage in sex unless they knew their boyfriend for some time; however, dating and sexuality are strongly associated, as most relationships involved sexual relations.

The second column of table 3 shows that once women started having sexual intercourse, the first abortion occurred rapidly: for 50 per cent of the women, it took less than a year to occur; by one year after the start of their sexual activity, 92 per cent of the women in our sample had had their first abortion. It took an average of six months for the women to have an abortion after their first sexual experience.[3] This relatively short period of time is indicative of the contraceptive behaviour of women before their first pregnancy. First, if we look at the proportion of women who ever used a contraceptive method, we find that only one-fourth of the women did (table 4). Among first abortion users, less than 20 per cent had ever used a contraceptive method. Among those who mentioned having used a method, the condom, withdrawal, the oral pill and periodic abstinence were the methods most commonly used. Two women in the sample had previously had an IUD inserted. A comparison of knowledge and use shows that knowledge is much higher than use, particularly for modern methods. A question on use of a contraceptive method with the current boyfriend prior to the abortion revealed that only 22 per cent of the women had used a method, and that most of these had used the condom or withdrawal methods. Among the women who mentioned having used periodic abstinence (16), only two of them had a correct sense of when a woman was most likely to get pregnant during her menstrual cycle. These results indicate that, between the onset of sexual intercourse and the first unwanted pregnancy, few couples used a contraceptive method, and of those who did, they used it either ineffectively or irregularly.[4] Women who had their first abortion more than one year after their first sexual intercourse did not tend to use contraception more than the ones who had an abortion earlier.

Table 4. Knowledge and use of contraceptive methods among single women in greater Hanoi

(Percentage)

Method	Knowledge	Use
Any method	78.0	26.0
Condom	76.0	13.5
Pill	42.5	7.7
IUD	4.0	0.7
Sterilization (female)	10.0	0.0
Withdrawal	12.4	11.2

Periodic abstinence	12.3	6.2

To explore why few couples attempted to prevent a premarital pregnancy, we conducted bivariate analyses to evaluate which variables are significant in relation to having used or not used a contraceptive method (table 5). While having ever used a contraceptive method is a rough measure of contraceptive behaviour, it does indicate that a woman and her boyfriend had attempted to avoid a pregnancy. Age, number of boyfriends, number of abortions, education, current activity and knowledge of methods are all statistically significant with contraceptive use. More experienced women are more likely to have used a method than less experienced ones. Experience refers to being older and working, being more educated, having had more than one boyfriend and more than one abortion.

Table 5. Characteristics of single Vietnamese women according to contraceptive behaviour

(Percentage)

Characteristics	Has never used a method	Has ever used a method	χ^2 test
Age			
15-19	88.6	11.3	χ^2
20-24	69.4	30.6	33.59[a]
25-29	33.3	66.7	
30 and older	0.0	100.0	
Current activity			
Work	61.34	38.66	χ^2
Study	82.18	17.82	15.60[a]
At home	87.10	12.90	
Education			
Secondary	83.22	16.78	χ^2
College	66.00	34.00	18.08[a]
University	55.93	44.07	
Number of boyfriends			
One	76.67	23.33	χ^2
Two	69.51	30.49	5.74[b]

	Three or more	50.00	50.00	
Number of abortions				χ^2
	One	80.31	19.69	16.86[a]
	Two	54.39	45.61	
	Three	55.56	44.44	
Spontaneous mention of knowledge of method				χ^2
	No method	94.92	5.08	17.68[a]
	At least one method	67.50	32.50	
Communication about sexuality/contraceptive methods				χ^2
	Never	92.70	7.20	45.30[a]
	Yes, with boyfriend, friend or family member	55.97	44.03	

[a]Significant at 0.001

[b] Significant at 0.05

Opportunities for exchanges and communication about sexuality partly indicate whether or not women get the needed information. Close to half of the women revealed that they had never talked about sexuality with anyone, and did not have anyone to turn to when they needed information. As shown in table 6, one-third of the women discussed sex with female peers, but only 20 per cent did so with a boyfriend and 17 per cent did so with a family member. Clearly, women in our sample did not have many opportunities for exchanges with other people on sexual matters. This situation could have hampered them from obtaining appropriate information and acquiring proper contraceptive skills. In our sample, 75 per cent of the women mentioned having learned the most about sexuality from printed material. However, between reading and actually acting to prevent an unwanted pregnancy, there are many obstacles to action that remain in Vietnamese society today.

Table 6. Communication about sexuality and/or contraceptive methods among single Vietnamese women

(Percentage)

Communication with:	Yes	No
Female friend(s)	34.36	65.64
Boyfriend(s)	20.46	79.54
Family members	17.37	82.63
Other people (in school, with health worker)	5.02	94.98

A self-perceived need for information could indicate whether young couples engaged in a risk-taking behaviour as a result of a lack of information and skills, or because they consciously relied on abortion in cases of unwanted pregnancy. More than 93 per cent of the women believed they could have avoided their pregnancy had they been better informed about sexuality and contraceptive methods. Most women (90 per cent) agreed that single women need more information, and that single youth should be provided with information about, and easy access to, contraceptives. Most women (95 per cent) appeared particularly interested in having access to good-quality printed information and over 80 per cent of them thought that an information centre or a clinic specifically addressing the needs of youth is necessary and would have been useful to them. Such high proportions of women expressing the need for better information and accessibility suggest that they feel ill informed and ill prepared to have safe and protected sexual relations.

While low contraceptive use was characteristic of all the women in our sample, it would be interesting to observe women who had more than one abortion to determine whether or not their behaviour differed from that of others. One-fourth of the women we surveyed by questionnaire were having their second or third abortion at the time of the survey. Since the questionnaire did not trace a detailed history of contraceptive use patterns between each abortion, the data do not allow for a thorough study of this question. In fact, in preparing the questionnaire, we did not expect to find such a high proportion of repeat abortions among our sample of single women. However, results show that repeat users tend to use contraception more, although more than 60 per cent of them still never used it at all. The modest difference in contraceptive use between first-time abortion users and second- or third-time abortion users implies that, after having had one abortion, a significant proportion of the women we surveyed would rely on abortion if they had a second unwanted pregnancy. In fact, we found that second- or third-time users had a pregnancy termination earlier in their pregnancy than first-time users; they also had a greater proportion of menstrual regulations than the first-time users, who had a higher proportion of abortions. Also, second- and third-time abortion users exchanged information about sexuality more often with their boyfriend, girlfriends or family than others. Further, the duration from the first to the second abortion was twice as short on average as the one between the onset of intercourse and the first abortion. These statistics (results not shown) indicate that, after having had one abortion, women are motivated to limit their fertility, although for the majority this desire might not be translated into the adoption of contraceptive use. Issues of limited access and negative social attitudes towards single women using contraception most likely are continuing to play a role in limiting contraceptive use after a first abortion.

The qualitative survey

In light of the quantitative results, we analysed our textual data with the objective of exploring in greater depth the process leading up to the unwanted pregnancy for the women we sampled. Since we interviewed these women after they had the abortion, we also studied the period following the abortion. We wished to gain a better understanding of the obstacles to contraceptive use. We did a content analysis of the textual data using the Ethnograph software package, which supports Vietnamese language scripts. Overall, the quantitative and the qualitative data proved to be very consistent concerning sexual and contraceptive behaviour.

Misconceptions about contraceptive methods prevented some women from using any method. For example, some women understood from family planning campaigns that contraceptive methods were for married women only; others associated the condom only with the prevention of HIV/AIDS. Incredibly, a woman working for the National AIDS Committee had three boyfriends, three abortions and yet never used a condom. She said that she did not because she trusted her boyfriends and knew they were not visiting prostitutes and that the condom was too uncomfortable anyway to use every time. For her, the condom was mainly to avoid the transmission of STDs and not to prevent unwanted pregnancies. Some other women thought that using the pill could lead to infertility. These examples illustrate to what degree some women lack adequate information on contraceptive methods. Other research on adolescents'

concepts about and knowledge of sexuality has documented the serious misconceptions that exist in Viet Nam that can lead to unsafe behaviour (Efroymson, 1996; Efroymson and others, 1997).

Following their first abortion, the women were concerned about avoiding another unwanted pregnancy, but few used a contraceptive method. Women who had repeat abortions thus provided an interesting case for the study of why and how some women apparently rely on abortion to avoid unwanted pregnancies. In the case of these women, some did use a contraceptive method, but relied on withdrawal, or on irregular use of condoms. A few ended their relationship and a few relied on abstinence. Some clearly considered menstrual regulation and abortion to be contraceptive methods, as shown by the following discussion between the interviewer (I) and respondent (R):

Woman from Hanoi: Aged 22, she had already had two abortions at the time of the survey. She was not using any contraceptive method and was having sexual relations for two years.

I. :*When you started having sexual relations, did you know about contraceptive methods?*
R. :*I did, a little bit.*
I. :*What did you know about?*
R. :*I knew about menstrual regulation and abortion. There is medication also, a few kinds.*
I. :*Did you know about the condom?*
R. :*I did; I hear a lot about it on television.*
I. :*So you had a fairly good knowledge of how to prevent a pregnancy?*
R. :*Yes, but how could I have used a method?*
I. :*Why not?*
R. :*I was not prepared at all. I could not know.*
I. :*Since you had an abortion, how is your relationship? Do you continue to have sexual relations?*
R. :*No, I refuse. I do not agree.*
I. :*Would your boyfriend like to continue?*
R. :*Of course.*
I. :*How do you manage?*
R. :*I think that if a man wants it (to have sex), it is important to listen. But I think that if the woman refuses, it (her objection) has to be respected.*
I. :*Have you discussed contraception with him at all?*
R. :*Not yet.*

Among those who had repeat abortions, a clear distinction emerges from the data in the self-perception of women concerning a menstrual regulation procedure versus an abortion. As mentioned previously, all women interviewed had been tested for pregnancy and, therefore, knew they were pregnant and were not simply experiencing a delay in their menstruation. However, the women described a menstrual regulation procedure as being of minor importance, whereas the procedure performed after six weeks of pregnancy was described as being more serious and as raising more concerns. Menstrual regulation appeared to be used as a post-gestation method, or as a form of emergency contraception. This conceptual distinction between an early and later abortion could affect the contraceptive behaviour of these women. If a menstrual regulation is perceived as a convenient way to avoid an unwanted pregnancy, then the low use of contraceptive methods after a first abortion could be linked to this perception. The following examples illustrate this point:

Another woman from Hanoi: The following extract was taken from an interview with a 22-year-old woman. Her current boyfriend was her second one. She had her third pregnancy at the time of the interview and had decided to keep the child and to marry her boyfriend. She previously had two pregnancies with her first boyfriend. She had one menstrual regulation and one abortion. She and her second boyfriend used condoms, but as their relationship became more committed, they stopped using this method.

I. :*You had sexual relations and became pregnant by your first boyfriend, you told me. If I understand (you) well, you had an abortion at that time.*
R. :*No, I had only a menstrual regulation; it was not an abortion yet! So I had this one; after that, I became pregnant again (and waited a long time). Then, I was afraid (of having an abortion) and I told my boyfriend I wanted to keep the child.*
I. :*So you were pregnant twice from your first boyfriend? The first time you had a menstrual regulation and the second time, an abortion.*
R. :*Yes.*
I. :*So he did not agree with you to keep the child the second time?*
R. :*He did not. He did not tell me clearly, but I understood how he felt about it and I had an abortion. After the abortion, I did not love him anymore and we ended our relationship.*

Third woman from Hanoi: In this example, the woman was 28 years old. She had four boyfriends and three unwanted pregnancies. The first two times that she became pregnant she had an abortion and the third time, she had a menstrual regulation. Each pregnancy was with a different boyfriend. She and her boyfriend were currently using condoms. The initiative to use the condom method came from her boyfriend.

I. :*With your third boyfriend, did you become pregnant or not?*
R. :*I also had a pregnancy with him.*
I. :*You also had an abortion?*
R. :*That time I had only a menstrual regulation. That time I had been pregnant for only a month and I knew it, so I went right away.*

As in the case of this last example, women who had more than one abortion rarely became pregnant by the same boyfriend more than once. In other words, these women became pregnant as a result of subsequent relationships rather than within the context of the same relationship. We identified a pattern of re-negotiation at the beginning of each relationship between the woman and her boyfriend. Some women who used a contraceptive method with a previous boyfriend did not use any method when they started having sexual intercourse with a new boyfriend. The women expressed a fear of becoming pregnant but were reluctant to raise the issue with their boyfriend, waiting for him to take the initiative instead. This result points to the importance of reaching young men in promoting the use of contraceptive methods, both to avoid unwanted pregnancies and to prevent the transmission of STDs.

But why is there such a reluctance among women to express to their boyfriend their desire to avoid an unwanted pregnancy? None of the women who already had a pregnancy termination with a previous boyfriend revealed this information to their current boyfriend. Women were apprehensive of anything that might lower their boyfriends' opinion of them; thus, insisting on the need to use a contraceptive method might lead the man to suspect that the woman had had previous sexual experiences. The women felt that, if they revealed their previous experiences to their current boyfriend, they might lose his respect and thus damage the relationship.

Woman from Hadong: This 20-year-old woman was in a relationship with the same young man since she was 16 years old. However, she was of the opinion that she would not be able to marry him since her parents did not approve of her relationship at all.

I. :*Do you intend to marry your boyfriend?*
R. :*I would like to, but I think my family will refuse.*
I. :*So if your family does not agree, you will not marry him?*
R. :*That is the way it is.*
I. :*And personally you would like to marry him?*
R. :*Of course!*

I. :*But if you cannot, you will have to have a second boyfriend?*
R. :*I want to have one boyfriend only in my life; otherwise, I will not be respected by the second one (because I will not be a virgin anymore).*

Another woman from Hadong: She was 22 years old.

I. :*What do you think about virginity?*
R. :*I think it is very important. If I had sexual relations with someone else before, only if my husband is very tolerant might he be able to forgive me. But if he does not understand, he will not forgive me.*

Society's ideal of virginity prevents some women from applying their knowledge and skills to their current situation. All the women but one said that their boyfriend took the initiative to engage in sexual relations; many women also were of the opinion that contraceptive use should come from the man as well. Of course, if the method is strictly a "female-method", it may be adopted in secret; one woman pretended she was pregnant, but actually went to a clinic to request an IUD. Normally, women rarely take the lead to initiate sexual relations and so are rarely the first ones to bring up the topic of contraception.

(Click here for photo)

Young Vietnamese women seem to be under the impression that menstrual regulation and abortion are different means of birth control.

The low use of contraceptive methods also appears to be linked to the perception of one's relationship. Not using any method is perceived as a sign of faithfulness in the partner and confidence that the relationship will lead to marriage. The belief that a pregnancy would be a sign of destiny, meaning that fate had led them to their husband, was expressed by some women. In some cases, as the relationship became more stable, the couple gave up using any contraceptive method. Choosing abortion, however, does not mean that marriage is out of question; it can simply be a strategy to postpone it.

In fact, feelings about having an abortion varied according to the degree of commitment in the women's relationship. Women less committed to their boyfriend decided with little hesitation to undergo the abortion, and some of them never shared with their boyfriend the fact that they had been pregnant at all. Among the reasons for such behaviour was their desire to keep their freedom by avoiding any situation that would pressure them into marriage. For these women, their boyfriend was perhaps not the man they wished to marry. Women more committed to their boyfriend, but not foreseeing marriage with assurance, thought abortion was the best option. These women usually shared information about their pregnancy and the decision to abort with their boyfriend, but in most cases made the decision themselves and imposed it on their boyfriend if he suggested that they might marry. Finally, women who were sure that they would marry the man by whom they were pregnant perceived abortion as a way to postpone the marriage. There were several reasons for such a postponement. In some cases, the season of the year was not the traditional one for getting married. But for most of them, the women expressed the desire to finish their studies and the necessity for the couple to be stable financially before marrying. In these cases, they considered abortion as an obvious solution, enabling them to have a better start for their marriage and one that could be timed properly.

Conclusion

In sum, our results suggest that, for our sample, the majority of single women having abortions failed to use contraceptives because of poor knowledge and limited skills. According to our results, this situation appears to stem from the social taboo associated with premarital sex and pregnancy, scarce and weak information sources and networks, and a lack of post-abortion counseling in order to prevent repeat abortions. These observations have implications for future research and policy.

Studies based on representative samples of young single men and women are needed. While large-scale youth surveys have been conducted in other Asian countries, such an initiative has yet to be taken in Viet Nam. Premarital sexuality, contraceptive behaviour and abortion use are among other important issues affecting young people's lives that need to be researched. Also, future demographic and fertility surveys could include a sub-sample of women who never married. While this is common practice in African and Latin American countries, it is very seldom done in Asia. Also, the availability and cost of contraceptives for unmarried couples represents a research area that needs to be investigated. Overall, the bulk of research on reproductive health has been focused until now on married women. However, unmarried youth should definitely be included in future research intitiatives addressing this issue.

The policy and programme implications arising from our study correspond to many recommendations of the 1994 ICPD Programme of Action (United Nations, 1994). First, population, family planning, health and education policies should address issues of sexual and reproductive health of adolescents, such as unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS. As in many other countries, Viet Nam's family planning programme addresses the needs of married couples only. Evidence of increasing premarital sexuality calls for changes in this approach and for a rapid integration of single youth into the national programme. Post-abortion counseling should automatically be offered to all single women using abortion services in order to reduce repeat abortions. In the context of the HIV/AIDS pandemic, the promotion of condoms aimed at single youth as a target audience should stress the utility of this method which can also be used as an effective contraceptive method. The low contraceptive use rate following the onset of sexual relations suggests that there is greater potential for promotion of all forms of birth control. While single women having an abortion should definitely be included in the family planning programme, ideally, all single youth should also be granted access to adequate information and complete services to ensure the greatest protection of their reproductive health.

Second, our study indicates that gender equality needs to be promoted among single youth. Our results show that young men play an important role in the couple's use of contraceptive methods and abortion. Therefore, male responsibility should be encouraged. Information, education and communication (IEC) initiatives should promote their active involvement in using effective contraceptive methods. Also, young women's empowerment could be enhanced by increasing knowledge, skills and self-confidence. Our study points to a need to improve communication between young men and women on sexuality and reproductive health matters. Promotion of their joint and equal responsibility should be emphasized.

Third, education and social policy should promote dialogue between families, schools and youth. Our results show that social and family pressure to hide sexual activity is an important barrier to contraceptive use. The education of parents in order to improve the interaction between them and their children could help parents to deal with their responsibility to educate their children about sexuality and reproductive health. Teachers should be better prepared to provide comprehensive information about sexuality and contraceptive methods. A public education campaign could be designed to create a better social environment in order to encourage single youth to adopt safe sexual reproductive health behaviour.

Acknowledgements

The authors would like to acknowledge with gratitude the fieldwork assistance provided by Pham Bich San, Nguyen Thi My Huong, Nguyen Thi Van and Nguyen Thu Giang. A preliminary version of this article was presented at the 1997 Population Association of America Annual Meeting in Washington, D.C. Funding for this research was provided by Canada's International Development Research Centre (IDRC) under its Award for Young Researchers, and by the United Nations Population Fund (UNFPA). The opinions expressed are solely those of the authors; they do not necessarily represent the views of IDRC, UNFPA or the organizations with which they are affiliated.

Endnotes

1. Since then, the issue of premarital sexuality has been more openly discussed and researched. In December 1997, the Population Council organized a seminar on adolescents' reproductive health; the most important government agencies involved in family planning and health participated.

2. We used the word *ngu'o'i yêu* in our questionnaire. This word for boyfriend literally means "the loved person" and clearly refers to a love relationship as opposed to a friendship.

3. The average progress of pregnancy at the time of the first abortion was 10 weeks.

4. First-time abortion users either used the condom or withdrawal, while safer methods such as the pill or the IUD were used mainly by second- or third-time abortion users.

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