Cùng thực hiện, ‘joint implementation,’ but...

An Exploratory Study of Gender Dynamics in Birth Control in Vietnam

Thesis for the Master’s Degree

Submitted by: Dang Vu, Trung
Supervisor: Anita Hardon, MSc., PhD.

Amsterdam Master’s in Medical Anthropology
Faculty of Social and Behavioral Sciences
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Table of contents

Table of contents ................................................................. ii
List of figures and tables ......................................................... iii
Acknowledgement ................................................................ iv
Summary ................................................................................. v
I. Introduction ........................................................................... 1
   1. Country's background .................................................. 5
      Historical background ................................................ 5
      Population policy ...................................................... 6
      Policy implementation .............................................. 7
   2. Objectives ........................................................................ 14
      Specific objectives ..................................................... 14
II. Methodology ......................................................................... 15
   1. Study design: ............................................................. 15
   2. Sampling ........................................................................ 15
   3. Data collection techniques ........................................... 17
      Observations .............................................................. 17
      Ethnographic interviews ........................................... 17
      Focus group discussions: ........................................... 18
      Case studies (reproductive life stories): ....................... 19
   4. Methodological and ethical considerations: .................... 19
III. Findings ............................................................................. 23
   1. Study location .......................................................... 23
      The sample ............................................................... 24
   2. Local implementation of state population policy ............ 25
      Provision of contraceptives ....................................... 26
      Provision of abortion service ................................... 27
   3. Gender norms and practices ....................................... 27
      Division of labour ..................................................... 27
      Sex and communication on sex ................................ 29
      Decision making ...................................................... 32
   4. Desire to control fertility ............................................... 33
      Troi sinh voi troi sinh co – an old fashioned concept .... 33
      Preferred child spacing ............................................. 36
      Son's preference ....................................................... 38
   5. Perceptions and practices of birth controls ....................... 39
      Case studies ............................................................. 39
      Sharing responsibility and making decision ................. 44
      Contraceptive choice and perception ......................... 47
      Abortion experience ................................................ 51
IV. Discussion and conclusion .................................................. 52
Appendix 1: Life of Liên Bào commune in pictures .................. 60
Appendix 2: Glossary of Vietnamese expressions ...................... 65
Appendix 3: References .......................................................... 67
Appendix 4: Some pictures used as interview guide for data collection 74
List of tables and figures

Table 1: Short description of interviewed couples ......................................................... 16
Table 2: Characteristics of population of Tiên Du district and Liên Bão commune, 2000 .......................................................................................................................... 23
Table 3: Distribution of the informants by age .............................................................. 24
Table 4: Distribution of couples by number of living children ..................................... 24
Table 5: Current contraceptive use and abortion experience of the informants ............. 25
Table 6: Average hours spent on different tasks for men and women during last day .. 29
Table 7: Major events in reproductive life, case 2 ....................................................... 41
Table 8: Men's involvement in contraceptive choice and contraceptive use .................. 46
Table 9: Average hours spent on family care for men by condom user ....................... 47

Figure 1: Centre of the Lienbao Commune ................................................................. 60
Figure 2: Step-by-step house construction -- a survival strategy because of the lack of cash for housing .......................................................... 60
Figure 3: Rice fields in Liên Bão .............................................................................. 61
Figure 4: Immunisation day at the Liên Bão Community Health Centre ................ 61
Figure 5: Market primarily is women space, very few men go to the market .......... 62
Figure 6: Women and children harvested paddy rice from flooded fields ............... 63
Figure 7: Ploughing is no longer men task only ....................................................... 63
Figure 8: Image of happy family in family planning posters ................................... 64
Figure 9: Problems caused by overpopulation (Family planning posters) .............. 64
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Dang Vu Trung
Summary

An increasing number of women all over the world want to limit number of their children for the time being. As a result, the majority of them are using some birth control methods, ranging from indigenous methods and abortion to more modern methods like hormonal implantations. Vietnamese women are not an exception.

It is known that the choice of birth regulation methods depends the on social, cultural, political and economic context of birth regulation. The choice also largely depends on gender relation between spouses, and their perception of different birth regulation methods. Studies have shown that Vietnamese men are much involved in the birth regulation. Yet, these studies either focus on women or men perceptions on birth regulation or focus only on the provision’s side of the family planning. None of these studies take into account the gender dynamics in decision-making on birth regulation and fail to show how couple choose different birth regulation methods.

This ethnographic study aims to gain insight in couples’ decision-making in choosing different methods of birth regulation and the way they define and share responsibility in family planning, taking into account the gender dynamics between spouse in the social, cultural, political and economic context of Vietnam as a whole. This study also aims to make some contribution to reducing women’s sufferings associated with birth regulation.

The findings show that decision-making in birth control is a complex process. It situates on social, cultural, political and economic contexts of a couple. State population and gender policy has dual impacts on couples’ decision. Though population policy aims to make couples equally motivated in birth control, policy implementation is women-centred. IUD, pills and female sterilisation are provided free of charge, but only IUD is promoted regularly. Only irreversible method, male sterilisation, is provided free of charge. Condoms are perceived as low quality and unreliable: too tight, thick, and break frequently.

In this context, plus long the history of IUD promotion in Vietnam, the IUD becomes method of first choice for most of the couples. Pills and condoms usually are the methods of second choice. Therefore, though men and women make decision together, their choice of birth control methods often leaves women alone to implement
their decision. Even in the case of condom use, women often are responsible for its purchase.

Cultural perceptions on gender roles in reproduction and perceptions about different birth control methods contribute final retouch to implementation of couples’ decision. It is important to note that there is a similar pattern between gender division of labour and family planning. Concerning division of labour, men are ready to participate in women’s tasks such as childcare, doing household chores... when women are overloaded with family chores. Similarly, men are ready to assume responsibility in family planning by using male contraceptive when women are unable to use female contraceptive due to side effects of IUD or pills... Yet, this not always necessary translates to men’s use of effective contraceptive methods because of the limited choices available for them: perceived poor quality of condoms, uncommon and irreversible male sterilisation. Many men assume their responsibility by using withdrawal and periodic abstinence. As a result, they often fail in contraception. In that case, men again participate in the decision-making for abortion and both men and women are faced with equal economic burden because of the costs of abortion or sanctions for violation of the population policy. Thus, improvement in provision of male methods, specifically promotion of vasectomy, diversified provision and promotion of condoms, and better counselling on male methods may reduce contraceptive failure.
I. Introduction

The vast majority of women all over the world want to limit number of their children the time being. As a result a growing number of women want to control their fertility. Globally, 58% of women are practicing contraception. The use is even higher in developed regions, Latin America, the Caribbean, and East Asia (The Alan Guttmacher Institute [AGI] 1999: 14-15).

An increasing number of Vietnamese women also want to limit their fertility. If there were only 53% of currently married women using any contraceptive in 1987 (Nguyen Van Phai et al. 1996: 7). This increased to 75% in 1998 (General Statistic Office 1999: 114). While many of them were using modern female contraceptives like IUD – 38%, pills – 3.7%, less the 1% were using other methods (female sterilisation, injection, diaphragm). A substantial part of women use the methods that require male participation and skills: 6% were using condom, 32% were practicing either withdrawal and periodic abstinence, or a combination of the two methods.

When women attempt to limit their fertility but fail due to ineffective use of contraception, they bear the direct consequences of contraceptive failure alone. There are fifty million women over the world who resort to abortion every year, 70,000 of them died from unsafe abortions annually (WHO 1998). Only in Vietnam, there are 1.5 million women, who resort to abortion annually or 83 abortions per thousand of reproductive age women per year. This is among the world's highest abortion rate (Goodkin 1994, Henshaw 1999).

Technically most of the female methods (hormonal implants and injectables, IUD, and pills) are highly effective with the failure rate of 0.1% - 5% (for perfect and typical use relatively), while methods that require men participation (condom, withdrawal, and periodic abstinence) are less effective except male condoms. Failure rate of male methods, which vary from 5% (for perfect condom use) to 40% (for typical use of withdrawal and periodic abstinence), depends much on male cooperation and skills rather than the method itself (Kubba et al. 2000, citing from Trussell 1998).
The choice of birth control methods, varying from indigenous methods and abortion to modern contraceptives (Newman 1985), is different from countries to countries and depends on the women’s contexts: perception of contraceptive methods, socio-economic status, cultural, political, religious affiliations, and particularly gender relation with their partners. Men’s reproductive responsibilities received global attention at the International Conference on Population and Development (Cairo 1994) and at the Fourth World Conference on Women (Beijing 1995). The conferences reaffirmed the connection between population and development and the understanding that gender equality, together with men’s participation in reproduction and paternity are essential component for sustainable development:

Special efforts should be made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high risk pregnancy; shared control and contribution to family income, children’s education, health and nutrition; and recognition of the equal value of children of both sex (UNFPA 1995: 5, citing from ICPD 4: 27).

Though male responsibility and participation are important, the concepts of ‘male responsibility’ and ‘male involvement’ are not consistently operationalized in different studies. UNFPA in its report Male involvement in Reproductive Health, Family Planning, and Sexual Health, has defined men’s involvement, men’s responsibility and men’s participation as:

‘Men’s involvement’ is used as an umbrella term to encompass the various way in which men relate to reproductive health problems and program, reproductive health rights and reproductive health behaviour. Men’s involvement in reproductive health has two major facets:

- The way men accept and indicate support to their partner needs, choice and right in reproductive health; and
- Men’s own reproductive and sexual behaviours.

The term men’s responsibility implies the need for men to assume responsibility for the consequences of their sexual and reproductive behaviour such as caring for their offspring, using contraception to take the burden off their partners and practicing safer sexual behaviours to protect themselves, their partners and their families from STDs, including HIV.

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1 By birth control method I mean all kinds of contraceptive methods (to prevent pregnancy) and abortion to distinguish with fertility regulation methods, which besides that also include fertility enhancing methods and infanticide practices.
The term ‘men’s participation’ refers to men’s supportive role in their families, communities and work place to promote gender equity, girls’ education, women’s empowerment and the sharing of household chore and childrearing. “Participation” also suggests a more active role for men in both decision-making and behaviours, such as sharing reproductive decision making with their partners, supporting their partner’s choice and using contraception and or periodic abstinence (UNFPA 1995: 8-9).

The report also notes that “men de facto involve in fertility, and they have important role in contraceptive decision. The support of men for women throughout their reproductive lives, e.g. before, during and after delivery...” Yet, it has not operationalized the fine line of what can be understood under male responsibility, involvement, and participation. Corrêa (2000) has criticized UNFPA concepts of male involvement and male responsibility. Corrêa argues that ‘male responsibility’ denotes negative impact of male domination, while male involvement implies that men have been excluded from reproductive health, while they de facto somehow are involved. Karra et al. (1997) define male involvement as “the participation of men in the family planning decision process, and men’s knowledge and use of male methods of contraception.” Mundigo (2000: 332) used the ratio between tubal ligation and vasectomy as indicator of male involvement. The author argues that the decrease of the rate of female to male sterilisation indicates the increase of male involvement in Latin America. As Corrêa (2000: 339-40) criticised, Mundigo’s arguments were based on his interchangeable concept of male patriarchy and gender, which “does not captures all forms of male-female relation in a rapidly changing world.” Similar to Mundigo, Karra et al. viewed gender relations in Indian families as an absolutely patriarchal, where husband’ involvement lies in line with his strong traditional beliefs about the husband as a primary income earner and decision-maker.

Johansson et al. (1998) have shown that when unplanned pregnancy happened, Vietnamese men involved much in abortion-seeking behaviour. The authors portray men as a ‘pillar decision-maker,’ who have a final say in decision-making for abortion. Gammeltoft (1999) also portrayed submissive Vietnamese women, whose decision on Intra-uterine device (IUD) use was stemmed from the cultural context of norms and values on gender and sexuality. Yet, both these two studies portray gender as unidirectional process with male domination and do not take into account decision-making in birth control as a dynamic process, in which both husband and wife communicate, and negotiate about sex and contraceptive use. They fall into a category
of either 'demography of women' or 'demography of men.' Gammeltoft in her study did not take into account men's perception, while Johansson et al. did not take women's into the studies.

Greenhalgh has criticized 'anthropology of women,' and advocated for 'anthropology of gender,' in which gender ‘entails study of both men as well as women; it is a cultural construction rather than culture-free; it denotes power differentials and sex-related ideologies as well as material inequalities; and it is a structuring principle of social life rather than simply an attribute of individuals’ (Greenhalgh 1995: 23-24). According to Greenhalgh, “gender shapes reproduction in different times and places.” The author emphasized three points in order to understand gender. [1] Gender is a “pervasive force that structures all aspects of life.” [2] Gender connotes “agency.” Greenhalgh criticized some demographers, who seek to emphasize women subordination and have portrayed a passive picture of women in patriarchal societies, while women in patriarchal Indian society found ways to go behind their husbands and in-laws to arrange for contraception and abortion. [3] “Theories of gender are less optimistic and more agnostic about the direction of change in gender relation and thus women life.” The author cited Bradley’s critics from her chapter on fertility in Kenya, where Bradley challenged the view that improvement of women status in social economic terms did not lead to fertility decline.

Thus, it is imperative to look at men and women decision-making in birth control as a dynamic process, stemmed from the social, cultural, political and economic contexts within and outside the family. This study I proposed to gain insight on men and women decision-making in birth control in a dynamic process, to show how men and women make choices on specific birth control methods and explore the context, in which couples make choices in contraceptive use.
1. Country's background

During the last century, Vietnam has experienced dramatic changes, influencing all aspects of family life. To understand gender dynamics in present family life, it is necessary to know about the historical, political, and economic changes in contemporary Vietnam.

Historical background

The present gender relation is situated in dramatic changes in Vietnamese contemporary history. Starting with the August Revolution and declaration of independence from the French and Japanese colonialists in 1945, Vietnam got factual independence only after three war times: for independence against French colonialists until 1954, and re-union against the United States until 1975. During and after the war, women were encouraged to involve in all aspects of society, including state management and production.

Soon after the American war, the whole country continued to be involved in the Cold War, which ended with the collapse of the East European Block in 1989 and the Soviet Union in 1991. Before that, all aspects of the country’s political and economical life were oriented to the Eastern European Block and the Soviet Union. The collapse of Eastern European block and Soviet Union has deepened the economic difficulties facing the country during the Cold War. The traditional export-import market collapse while new markets were not yet established.

The Đổi mới, political-economic reform, started in 1986, but its first effects became visible only after 1990. On the one hand the reform, Đổi mới brought economic development, making Vietnam one of the biggest world rice-exporters. On the other hand, with the Đổi mới most of the socialist state welfare systems broke down. User fees, introduced in all state services including education and health care, create great needs the cash for all families. This certainly influences people’s perception and choice recently. As Barry (1996) and Truong (1996) point out, Vietnam’s development

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1 According to the Geneva’s Agreement, signed after the loss of the French at the Điện Biên Phủ battle, Vietnam was divided into two parts at the 17th parallel. Hồ Chí Minh’s communist government controlled the North and the French controlled the South and were supposed to withdraw within three years and then the Vietnamese would organise general selection. Yet, the Geneva’s agreement has never been fully implemented. As soon as the French withdrew, the Americans came in to ‘stop the spread of communism.’ Vietnam therefore was divided into the North and the South. The war against the America for unification ended only in 1975.
process has double influence in gender. On the one hand, it encourages women involvement in production and society management and breaks down traditional women confinement to the private sphere, on the other hand, it may further deepen gender inequality by creating new job opportunities and advancing the men first.

Health sector reforms started much later with the introduction of user fees in 1989 and structural reform of the community health centres in 1995. The period of the late 80s and early 90s was characterised by the deterioration of the health care system. The health care system was described as a stagnated and decayed system (Johansson 1998: 25, citing Guldner et al. 1993). Health recourse limitations led to skewed provision of contraceptives and made IUD and abortions the only available birth control methods at that time.

Population policy

Population policy and its implementation contribute to the final retouch in the present picture of gender relation. Its propaganda and disincentives (see Policy implementation) make both husband and wife interested in birth control, but the women-centred service provision limits couples’ choices to women methods. This very much influences men and women’s choices.

The first effort to control population growth was the introduction of the three-child norm in the North during the 60s. Due to lack of resources and wartime, this policy has not been fully implemented. In the South there was not any population policy, except some attempts to make contraceptives available in urban areas (Allman et al. 1991, Goodkin 1995).

The present population policy, aiming primarily to control population growth, started in 1988 with the official introduction of the one-or-two-child policy, and was reinforced in a new decree in 1993 (Johansson 1998). Specifically, the policy states that each couple should have a maximum of two children with an interval of at least three to five years; and the minimum childbearing ages for state servants are 24 for men and 22 for women; and for the others: 21 for men and 19 for women. The policy also states

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1 In the past, health care, including family planning services, was free of charge and financed from the state budget or local public funds. Community health centres, first referral points in the health care system, were financed by agricultural cooperatives, which became almost non-functioning with the economic reform, and therefore deteriorated the most because of lack of funding. Other facilities of higher levels also suffered from lack of funds.
some exemptions for people of ethnic minorities and people with special conditions. The policy states that the Ministry of Health and other agencies should provide contraceptives free of charge for those who want to limit their fertility (JPRS 1989). Those who violated population policy will be “penalized in accordance by their immediate management agency” (Goodkin 1995).

Very recently, a new national population strategy for the period of 2001-2010 has been introduced (National Committee for Population and Family Planning [NCPFP] 2001). The new policy does not emphasize control, and targets etc. Rather, it emphasizes quality of family planning and reproductive health services, and the reduction of number of abortions... But in practice, it may take time for the new policy to take effect.

Policy implementation

Population policy was implemented by a combination of creating normative changes and service provision. Information, education and communication (IEC) campaigns and mass media propaganda create the new image of a happy family. Reproductive health agencies provide contraceptive and abortion services. Implementation of the population policy was successful in its aim to reduce population growth rate. Total fertility rate has reduced from 6.0 during the 60s to 2.4 in 1999 (Goodkin 1995: 91-2, Barbiery et al. 1996: 217, Nguyen Minh Thang et al. 1999: 10-11, UN 2001). Yet, policy implementation is challenged with new problems as high abortion and inadequate quality of reproductive health service.

Creating a new image of a happy family

Since 1946, the Vietnam Constitution outlawed polygamy and forced marriage. State policy promotes women ‘liberation’ by encouraging women’s involvement in all aspects of life. The 1987 Law on Marriage and the Family states:

**Article 1:** The State guarantees the implementation of a matrimonial regime based on free consent progress, monogamy, equality between the spouses, and designed to promote a democratic, harmonious, happy and solid family.

**Article 2:** The spouses have the duty practise family planning. The parents have the duty to bring up their children into citizen useful for society.

1 In the context of period before 1989, all health care services were free of charge. First introduction of partial user fees was made in 1989. Nowadays, most of the costs health care services at public facilities are still subsidized by the state.
The children have the duty to respect and care for the living of their parents.

Mass media propagandas and population programs' IECs provide image of happy family with two children spaced three to five years apart. The image portrays husband and wife equally responsible for family planning and child rearing. Educational messages concerning family planning encourage men to take responsibility in family planning (Bac Ninh Population & Family Planning Committee 1999). Traditional gender relations, where men dominate in society, often is criticized as 'feudal.' Mass media propagandas and family planning posters emphasize a 'family of new life style' gia đình nghiệp sống mới, which encourages an equal gender relationship.

(Dis)Incentives

Incentives and disincentives affect men and women decision-making very much. The incentives include both incentives for the providers and for the couples. The disincentives include economic sanctions for both men and women, who violate the population policy, and costs of abortions. This makes both men and women motivated in family planning. Couples violating population policy have to pay a fine of VND 200,000 - 400,000. State employments violating population policy will have their salary's promotion delayed for one year. The fine will be collected at the Commune People Committee at the moment of getting birth certificate, which is compulsory for each child, otherwise the child cannot go to school and have other civil rights. However, as the informants stated, this sum would not prevent them from having another child if they want more children.

However, provider incentives make the provision women-centred. The provider's (dis)incentives make health workers prefer IUD to other methods. Health providers and population collaborators have to meet annual targets, which are set top-down based on previous plans. The targets specified a number of new contraceptive insertions, number of couples exceeding the two-child limit. At the end of each year, providers are paid incentive only for meeting the targets for the number of IUD insertions and the reduction in the number of couples violating the two-child limit during that year. The reason for health manager to prefer number of IUD users to number of users of other method, as the health staff argued, is that only the number of IUD insertion is the most accurate and easily can be monitored by higher managerial level. The number of other contraceptive users may not be accurate and difficult to
monitor. In case of not meeting targets, the providers will repetitively be criticized at meeting at difference level.

Besides the annual incentive payment, health providers are reimbursed a sum of VND 5,000 for each IUD insertion procedure\(^1\) from the district committee on population and family planning fund. Population collaborators are paid incentive for meeting targets on new IUD acceptors but not for new acceptors of other contraceptive methods.

Thus, incentives and disincentives reinforce the primacy of women's responsibility for contraception.

**Vietnam health care structure and provision of reproductive health services**

Public reproductive health services are provided through two parallel vertical channels: Ministry of Health (MoH) and National Committee for Population and Family Planning (NCPFP) at four levels: central, provincial, district and commune levels. The MoH clinical-based channel is responsible for the provision of gynaecological and obstetrical, abortion, and family planning services (mainly IUD insertion). Each district has its Maternal Child Health Care and Family Planning (MCH/FP) team, who provide MCH services, abortion, IUD insertion, family planning counselling, and supervision for the Communal health centres (CHCs). CHCs provide consultations, contraceptives, and serve as the first referral point in the health care system. Some CHCs with specially trained personnel may provide menstrual regulations (abortion of less than 6 weeks of gestation). Once a week, district mobile MCH/FP teams go to the communes to provide consultation, IUD insertion, and other services.

Second vertical channel - the NCPFP channel have their own budgets and personnel with provincial, district, and communal branches. NCPFP branches are responsible for the coordination, planning, management, and distribution of family planning resources to achieve population targets. At district and communal levels, they mainly responsible in provision of IEC (information, education and communication) campaigns and also in distribution of contraceptives through their own 'population collaborators' network. Population collaborators are usually members of the local women unions. They encourage women to use contraceptives, provide some basic

\(^1\) US$ 1.0 is approximately. VND 15,000
counselling, and distribute contraceptives free of charge. Population collaborators are the grass root points in the NCPFP channel.

Private channel, legitimised since 1993, also provides private family planning services such as contraceptives, menstrual regulation, and abortion. Subsidized condoms and pills are supposed to be available at low prices in a growing number of private clinics, pharmacies, and simple drugstores. This is supposed to fill partly the gaps in public provision of free-of-charge contraceptives.

Unfortunately, accurate information as to what extent private sector involves itself in the provision of reproductive health services is not available. Some estimates suggest that private providers may perform 500,000 induced abortions or one third of all abortions each year (Henshaw 1999). Another study (World Bank 1999: 107) suggests that private health contacts, including contacts at private clinics, private doctors, pharmacies, and drug vendors, which are mushrooming over the country, may contribute up to two third of all health contacts in Vietnam. Though this study does not have direct data on reproductive health service, this finding suggests that private channel may substantially contribute to the provision of contraceptives and other reproductive health services.

Quality of Care


Choice of birth control methods is limited by imbalanced provision. Women choices are often limited with IUD, tubal ligation, and abortion. Men choices are even more limited. Except for irreversible vasectomy, condom provision is irregular and with dissatisfaction in quality. With clear focus of policy on population growth control, IUD as a method, allowing maximum state control over fertility, was preferred (Goodkin 1995). Targets and incentive are set for health providers in accordance with the number of IUD acceptors (Johansson 1998: 64-65). Several studies show that IUD was the most available and preferred by providers (Knodel et al. 1995, Trinh Huu Vach 1998, Phan Thi Thu Ha & Schuler 1999, Pham Bich San et al. 1999, Nguyen Minh
Economic difficulties and the lack of foreign exchange contributed to the imbalanced provision of contraceptives. IUD, the effective and cheap contraceptive, imported from Eastern Europe was preferred by the state. It was the most available contraceptive for the decades. Abortion was used as a back up for contraceptive failure; other contraceptives were almost non-existent (Gammeltoft 1999: 15, citing from World Bank 1992).

Counselling was absent or insufficient. In a study of client perspectives on quality of care, Nguyen Minh Thang et al. (1998) reported insufficient counselling regarding available methods, possible side effects, and post-abortion counselling. Studying a sample of women seeking pregnancy termination, Do Trong Hieu et al. (1993) and Trinh Huu Vach et al. (1998) documented that more than a half of the women in their sample had repeated abortion. This could indicate that these women, besides other factors, did not receive or received insufficient post-abortion counselling. Providers did not provide counselling abortion clients at the moment of abortion, arguing that it was not a suitable moment for counselling and it would be better to provide counselling later. But in fact, only 10% of clients, those who had complications, went back for counselling. That meant the remaining 90% did not get post-abortion counselling (MoH et al. 1997).

MoH et al. (1997) have noted that in many service delivery points, health care providers had insufficient knowledge and technical skills. Johansson et al. (1996) reported that 11% of women having abortion were using IUD, and suggested that the quality of IUD insertion was rather low in Thaibinh province. Moreover, Trinh Huu Vach et al. (1998) report that of the women seeking menstrual regulation, 17% had negative pregnancy tests and concluded that although this number may be an overestimate of unnecessary menstrual regulation, improving algorithm in diagnosis of pregnancy may substantially reduce the number of menstrual regulation.

Although official policy strategies consider normative changes in people’s desire and practice for a small family as a core of family planning activities, many people feel obliged to have no more than two or three children for economic reasons (Gammeltoft 1999: 14). Official policy promoted IEC campaigns and diversified provision of contraceptive methods available for those who wish to practice contraception (Council of Ministers 1988, Gammeltoft 1999). During the 80s and 90s, incentives and disincentives were implemented differently from place to place,
depending on the level of local population pressure and local authority’s motivation. The fine for violation of population policy varied from one minimum monthly salary to 800 kg of paddy rice (Goodkin 1995, Johansson et al. 1998), the latter almost equal to half a year’s harvest for an nuclear family with two children.

In addition to the direct fine, other norms such as the norm of land distribution for the peasants, based on the norm of a two-child family, also discouraged people from having more than two children. These substantially increased marginal costs of having additional children. Goodkin (1994) argues that though the country’s population policy did not compel abortion, it raised the marginal cost of child bearing to such extent that it made abortion financially more acceptable.

Abortion services

As a backup for the IUD, abortion has been legalized and used as back up method to regulate fertility in Vietnam since the early 60s (Goodkin 1994, 1995). Efforts have been made to make abortion more accessible and acceptable. Before the 80s, abortion was experienced as stigmatising. Many documents need to be submitted as a requirement. Nowadays abortion can be obtained anonymously on a woman’s request. First-trimester abortions are available on women’s demand at all secondary or higher levels at MoH’s channel: MCH/FP units of District Health Centres, which is available in most cases in a radius of 20 km, or at specialised obstetric and gynaecological clinics or hospitals at provincial and higher levels. Abortion service can also be obtained at private clinics and some Commune Health Centres (CHCs) with specially trained medical personnel. The availability and accessibility of abortion services reduces the stigma attached to abortion (Khuat Thu Hong 1998).

Whatever techniques were used, both medical staff and clients use the term hút điều hòa kinh nguyệt (menstrual regulation)\(^\text{1}\) to denote under-six-week abortions. All later-term abortions are called nào thai, abortion or phá thai, which literally means to destroy the foetus. According to the MoH et al. (1997), 60% of the first-trimester abortions were menstrual regulations, which were performed by two techniques: [1] vacuum aspiration, which is performed either manually (MVA) to terminate pregnancy of less than 6 weeks of gestation, and [2] electrically (EVA) to terminate pregnancy of

\(^1\) During the field work health staff reported that the term ‘suck foetus’ hút thai is used instead of the term điều hòa kinh nguyệt, ‘menstrual regulation,’ in the study site during the last five years.
less than 12 weeks of gestation. The other 40% of first-trimester abortions were performed by dilatation and curettage (D&C), which is used to terminate pregnancy of 8-12 weeks of gestation. These services can be obtained at a relatively low cost. According to Khuat Thu Hong (1998), abortion can be obtained for VND 32,000 (for menstrual regulation) or for VND 52,000 (for abortion), which is not high for Vietnamese standards. Second trimester abortions contributed to about 1% of the total number of abortions (Järnbert 1999) and can be obtained only at specialized hospitals of tertiary levels.

As we have seen, Vietnamese population policy and its implementation reinforce women’s responsibility for contraception. On the one hand, the population program’s propaganda advocates for both men and women participation in family planning; its implementation on the other hand, centres on women responsibility. Yet until now there is no available study, which takes into account the whole context of population policy, existing reproductive health services, and social and cultural norms on sexuality and gender, according to which couples make decisions and share responsibility for contraceptive use. This study proposes to fill this gap and explore how men and women make choices on specific contraceptive methods in a broad context, in which couples make choice in contraceptive use. Given the vague definition of men’s responsibility and participation in current literature, I will take men’s and women’s views on responsibility and participation as a starting point in this study.

---

1 US$ 1 = VND 10,500 (1996 price, Khuat Thu Hong 1998)
2. Objectives

To learn how husbands and wives make decisions in birth control in a broad socio-cultural and political economic context of rural Vietnam.

Specific objectives

1) What are the social, cultural, and political and economic contexts that shaped men’s and women’s decisions in birth control?

   - What are the social, cultural and political norms on fertility?
   - What family planning services are available? How are services provided?
   - What are gender norms and practices on division of labour between husband and wife?

2) What are men and women’s perceptions of responsibility in family planning, and how is responsibility in family planning shared?

3) How do Vietnamese couples make decisions on choosing different birth control methods?

   - What methods do they use and why?
   - What are their experiences with and perception of different methods?
II. Methodology

1. Study design:
This study uses an exploratory design (Hardon et al 1995) to gain more in-deep focus on such sensitive problem as sexual practice and abortion. For a short period of six weeks, I focused mainly on men’s and their partners’ perception and practice.

2. Sampling
I intended to draw a purposeful sample of married couples with reproductive age women to include three groups: [1] five couples, who have experienced abortion recently, [2] five couples using female contraceptives, and [3] five couples using male modern contraceptive (condom and/or male sterilization). I intended to find five couples who had recently had an abortion. I intended to find them through from hospital records and in combination with snowball techniques, taking into consideration ethical problems abortion (see section ethical consideration). The recall period depended on the possible number of informants to be found in one commune to meet the sampling quota. Ten couples, practicing (male vs. female) contraceptives, can be traced from commune “population collaborators” as gatekeeper as well as through snowball sampling.

However, arriving to the field I made small changes in sampling after consulting with local health workers. I started by interviewing women without an abortion experience. At the same time, I asked MCH/FP staff and CHC’s health workers to find women, who have had abortion within the last three months and who would agree for an interview. After a two-week unsuccessful attempt to find such informants, I had to choose women with abortion experience at any time in the past. The reason for not finding intended informants was that I wanted to interview both husband and wife. Some women agreed to give interview, but many of their husbands were absent and/or some did not agree to participate. Of ten women, who had aborted during the last three months, only one agreed to participated in the study. As the gatekeepers reported, many women were ready to participate in the study, but when they knew that I needed to interview together with their husbands, they could not participate because of the fact that their husbands had migrated. Some reported that their husbands refused to participate. All of the informants were recruited through
gatekeepers, who are the staff of the local CHC, in combination with snowball technique. Short descriptions of couples are presented in the Table 1.

### Table 1: Short description of interviewed couples

<table>
<thead>
<tr>
<th>Couple ID</th>
<th>Age</th>
<th>No. of children &amp; Sex mix</th>
<th>Current Contraceptive Use</th>
<th>Previous Contraceptive use</th>
<th>Number of Husband Abortion</th>
<th>Migration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Male</td>
<td>45</td>
<td>3</td>
<td>IUD</td>
<td>IUD</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>40</td>
<td>Only male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Male</td>
<td>31</td>
<td>1</td>
<td>IUD</td>
<td>IUD</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>Only female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Male</td>
<td>27</td>
<td>1</td>
<td>IUD</td>
<td>IUD</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>Only male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Male</td>
<td>35</td>
<td>2</td>
<td>Condom</td>
<td>Pill†</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Male</td>
<td>40</td>
<td>2</td>
<td>Condom</td>
<td>IUD</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>40</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Male</td>
<td>36</td>
<td>2</td>
<td>Withdrawal/ Pill</td>
<td>IUD, Pill</td>
<td>3 (?)</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Male</td>
<td>41</td>
<td>2</td>
<td>Pills</td>
<td>IUD</td>
<td>3</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>Only male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Male</td>
<td>39</td>
<td>2</td>
<td>Withdrawal/ Rhythm</td>
<td>IUD</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>Only male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Male</td>
<td>34</td>
<td>2</td>
<td>Condom</td>
<td>IUD, Condom</td>
<td>3</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>34</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Male</td>
<td>30</td>
<td>1</td>
<td>Condom</td>
<td>IUD</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>Only female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Male</td>
<td>30</td>
<td>2</td>
<td>Condom</td>
<td>Condom</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>30</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Male</td>
<td>39</td>
<td>2</td>
<td>IUD</td>
<td>IUD, Pill, Withdrawal,</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>36</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Male</td>
<td>29</td>
<td>1</td>
<td>Condom</td>
<td>N/a††</td>
<td>1*</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>27</td>
<td>Only female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Male</td>
<td>26</td>
<td>1</td>
<td>Condom</td>
<td>N/a††</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>23</td>
<td>Only female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Male</td>
<td>25</td>
<td>2</td>
<td>Condom</td>
<td>N/a‡‡</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>23</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Abortion due to stillbirth

† She took only ten pills and stopped using it because of headache.

‡‡ N/a: not applicable, these couples have a breast-feeding child and just started to use contraceptive a few months ago.
3. Data collection techniques

Observations

I intended to make observations at service delivery points (both private and public) on the availability of resources for family planning: available contraceptive methods, counselling, availability of IEC materials, client-provider interaction, etc... But I could only observe the facility and interview the staff because women clients wanted privacy, and when I was observing at the CHC, there were no clients; therefore I could not observe client-provider interactions and counselling.

Ethnographic interviews

I intended to make fifteen ethnographic interviews separately for male and female partners. Yet, it turned out to be a group interview for both partners at the same time for three practical reasons. First at all, interviews were performed at the home of the informants. The wives were always present and often joined the interviews when I interviewed the husbands. Thus, I felt uneasy and impolite to ask for separate interviews. More important, each ethnographic interview lasted one to one and a half hours. All interviews were done in houses of informants from 8:00 PM to 10:00 PM, when all of the informants would have rest after a heavy working day in the harvest season. This was the only time when the informants would not feel hurry during the day. The time frame did not allow me to do interviews the wife and the husbands at separate occasions. Last, the character of participatory interview is better to carry with a group of informants.

It is a common practice in Vietnam not to start immediately with an interview. Therefore, I always started by asking people about their health, their harvest and other general topics. After establishing rapport with informants, I asked permission to use a tape recorder and started interviewing.

I applied interview technique, used by Schenk-Sandbergen and Chuolamany-Khamphuo (1995) to study gender norms and practices in Laos, which proved to be useful. Beforehand I prepared several pictures for the informants to play a game entitled “whose hand is it.” In this game, men and women are asked to identify who is doing what in the pictures. There are pictures on two topics: division of labour in the
household (production, social life, family chore),¹ and family planning. During the game, informants are asked who of them usually does the same things as in the pictures, and what they think about that topic. In the second part of interviews, informants were given small pieces of paper, in which were written different statements about men and women roles in decision-making and gender role in different activities on sex, family planning, and division of labour. Then, they were asked to sort them into three piles with statements that they agreed, disagreed, and partly agreed or disagreed. After that, they were asked to explain why they sorted in that way. During the interviews, information of pregnancy history, perception and practice with regards to gender roles and gender equality, their practices, perception about sexual norms, reproductive status, perception about contraceptive use and abortion, and their contraceptive practice were collected. At the end of the interview, informants were asked to draw 24-hour clock, describing who did what for how long during last day.

Part of the interview guide was tested during the field exercise at the proposal development stage. All interviews, except one where the informants felt uneasy with tape-recorded, were fully transcribed verbatim within 48 hours after the interview. Interview questions were reviewed after each interview together with field notes, taken during interview.

Focus group discussions:

I intended to organise FGD to confirm findings about norms and values on sexuality and contraceptive use, and to contrast men’s and women’s perception of responsibility for effective contraceptive use. Some men and female informants felt uneasy to talk explicitly about sex in the presence of their partners. Therefore I carried out the FGDs separately for men and women to eliminate the influence of the opposite sex. This strategy proved to be useful although not all invited informants could come in to the FGDs.

The FGDs were performed at the office of the local irrigation brigade, where I stayed during the fieldwork, in the evening from 8:00 PM. The office is a simple house in the middle of the commune, not different from others in the village, and was empty in the evening.

¹For more detail information this method and pictures on these topics see Schenk-Sandbergen and Chuolamany-Khamphuoi (1995)
The first FGD was organised for women. Of twelve invited women, all ‘agreed’ to participate but only five were present. There were three reasons for such a small number of informants. (1) There was heavy rain and the electricity was cut off. Some of the informants thought that the FGD was cancelled. (2) Because the electricity was cut off all the day, some informants could not finish their daily activities in time. (3) Some informants probably were too shy, knowing the topics which would be discussed at the FGD and did not want to talk about sex and family planning issues in publics though they would talk in private. Thus some politely ‘agreed’ to participate but did not want to presence at the FGD. One man accompanied his wife to the FGD but his present did not affect the women’s discussion.

The second FGD was organised for men. Out of the ten invited men, all agreed to participate but three of them had to leave the commune for work at the last moment, three others ‘agreed’ but did not want to come and refused directly or indirectly. Only three were present, and later two others were invited to joint the discussion at the last moment.

Case studies (reproductive life stories):

Three case studies that represent extreme case of couples, who have never experienced abortion until now, and who have repeated abortions were selected for more detail study. They were interviewed in two sessions to inquire of their life detail about their life, and on how gender roles influence their sexual and reproductive behaviours.

4. Methodological and ethical considerations:

The research topic concerns sexuality, contraceptive use, and abortion, all of which are sensitive in different ways and degrees. During the fieldwork I found that both men and female informants hesitated to talk explicitly about sex but they did not have difficulty talking about sex implicitly. I introduced myself as a researcher, interested in family planning and family planning failure. Both men and women discussed openly about their perceptions on sex and sexuality when I myself started to talk implicitly about sex and family planning matters. Some informants were sceptic about the interview when I arrived; some thought I was a reporter or a journalist because people often associated the word phỏng vấn, ‘interview,’ with a reporter.
after establishing a good rapport, the informants participated lively in the game and the discussion.

There may be some reason for the informants to feel free while talking about sex and family planning. First, as some informants expressed, sex and family planning is perceived as a common practice for a married person. The informants feel free to talk with me as a married man. Secondly, due to the informal interview setting the informants felt at ease. I never started an interview by asking direct question about sex and family planning. I always started the interview by a little game “whose hand is it” (see section Ethnographic interviews) and by asking the informants about their daily life, about division of labour in the family, and at the right moment, I jumped into sex and family planning topics. Information was also elicited while asking the informants about their opinion on different statements on topics of division of labour, sexual practices, and family planning, which are randomly given to the informant. The participatory character of the interviews made people interested in the interviews and that gave good results.

Lastly, all the informants were asked for oral agreements to participate in the study before hand by the gatekeepers and/ or their relatives, neighbours or friends. Those, who agreed to participate in the study, were willing to share their experience on family planning. After an interview, each informant was given VND 10,000 as a compensation for the time devoted to the interview. This sum is almost equal to one-day salary for an unclassified worker. The interviewees did not know about the payment beforehand, and some of couples actually refused to participate in the interview. Thus the informants’ motivation was not cash but willingness to help the researcher and to share their experience. The following field notes illustrates:

I came to the house of one’s of the informants. She asked me how I would do the interview. I explained the purpose and the methods I would apply, and said that I would like to interview both she and her husband. Because her husband was not home I said I would come back some time latter, but she asked me to show the pictures that I had, and found them exiting. Later, she introduced me to two of her female friends by the neighbourhood. After I was introduced, I said she can go home but she stayed there and lively participated in the interview with her friends. She was interested in the interview topic and the way I perform interview [...] and her husband agreed to give the interview. Unfortunately though I came back several times, I could not interview him because he migrated to the city and often came home late in the evening without any predetermined schedule.
As a male researcher, I arrived at the field with feeling of ambivalence because my study subject concerned the most private aspect of the life: sexuality, contraceptive use, and abortion. However, the data collection process shown that chosen method was appropriate. The participatory character made informants experience interviews like a game, not an interview. Some female informants asked me “what are your feelings when asking about sex and family planning?” when I asked the same question back to them, the informants said that they did not feel embarrassed while talking with me about family planning because I was a married man, who already had children. The information collected and the lively discussion during the interviews show real interests of the informants in the topics interviewed.

I prepared pictures and statements by topics as a guideline for interview, but most of the interviews jumped randomly from one topic to another, some time the informants also switched to other topics, not related to interviews. Some interviews took more time than planned and I had to stop interview because it was already late in the evening. I was aware that during the harvest season all interviewees need rest for the next day.

My own status as a stranger to the community increased willingness to share sensitive information because they may be more assured about confidentiality. Many informants shared their experiences about abortion though they would not share to their parents or neighbours. As they stated, by sharing information with me they did not fear of gossip but they would avoid sharing with neighbours. With regard to parents, all of the informants said they would never share their abortion experience with their parents because parents might think of abortion as a sin. In addition, researcher’s status of being abroad for long time reduced women feeling of being judged for their sexual activity. Yet, it is important to note that the men and women, who were willing to participate in the study, probably talk more freely about contraception and sexuality than those who refused.

Getting permission: Permissions are needed to obtain from one of the Vietnamese research institution and from local authorities. Both institutions took into consideration technical and ethical aspects of the research. After getting permission from the Hanoi School of Public Health, I went to the field with a letter of recommendation and got permissions from Tiendu district health centre and Lienbao People Committee.
Information on sexual and contraceptive practices is confidential and special care was taken to assure confidentiality. Family planning is not only a private issue but also associate with state intervention in private life. Informants got careful explanation of purpose of the study and possibility to refuse to participate in the study if they wanted to do so. Interviews were performed after getting participants’ consents.
III. Findings

1. Study location

The study was carried out at Liên Bão commune of the Tiền Du district of Bắc Ninh province. The commune is located 30 km, in the north of Hà Nội along the 1B highway. Liên Bão commune is comprised of five communes with 8,300 inhabitants, most of the population are working in rice production. Liên Bão commune is located 5 km from the district centre. Characteristics of studied population are presented in Table 2.

Table 2: Characteristics of population of Tiền Du district and Liên Bão commune, 2000

<table>
<thead>
<tr>
<th></th>
<th>Tiền Du dist.</th>
<th>Liên Bão commune</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Total population</td>
<td>126,847</td>
<td>8,334</td>
</tr>
<tr>
<td>Female 15-49</td>
<td>32,948</td>
<td>25.97%</td>
</tr>
<tr>
<td>Of which, married</td>
<td>23,679</td>
<td>18.7%</td>
</tr>
<tr>
<td>Number of life birth</td>
<td>1,936</td>
<td>137</td>
</tr>
<tr>
<td>Number of abortions</td>
<td>1,008</td>
<td>N/a</td>
</tr>
<tr>
<td>Of which MVA</td>
<td>292</td>
<td>N/a</td>
</tr>
<tr>
<td>DC</td>
<td>716</td>
<td>N/a</td>
</tr>
<tr>
<td>Reported Abortion rate (per 1000 married women age of 15-49)</td>
<td>42.5</td>
<td>N/a</td>
</tr>
<tr>
<td>Reported Abortion Ratio (per 100 life birth)</td>
<td>52</td>
<td>N/a</td>
</tr>
<tr>
<td>Total Contraceptive use</td>
<td>17,972</td>
<td>75.9%</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>13,394</td>
<td>56.6%</td>
</tr>
<tr>
<td>Pills</td>
<td>1,910</td>
<td>8.0%</td>
</tr>
<tr>
<td>Condom (male)</td>
<td>1,734</td>
<td>7.3%</td>
</tr>
<tr>
<td>Sterilisation</td>
<td>934</td>
<td>4.0%</td>
</tr>
<tr>
<td>(Of which male sterilisation)</td>
<td>N/a</td>
<td>(3)</td>
</tr>
</tbody>
</table>

Source: Tiền Du District Committee on Population and Family Planning 2000, and District MCH/FP brigade.
The sample

Most of couples in the sample are 30-39 year old and have completed their two-child limit. Seven couples have never experienced abortion, while four couples have at least one, and the other four couples have repeated abortions. It is necessary to note that the pattern of contraceptive use in the Table 5 is not representative for the Liên Bão population. According to the CHC, there are only 6% of currently married women in the Liên Bão commune reported using condoms in the year 2000 (see Table 2) Summary characteristics of the study sample are presented in the Table 3, Table 4, and Table 5.

Table 3: Distribution of the informants by age

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
<td>27%</td>
</tr>
<tr>
<td>30-39</td>
<td>8</td>
<td>53%</td>
</tr>
<tr>
<td>40-49</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4: Distribution of couples by number of living children

<table>
<thead>
<tr>
<th>Number of living children</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td>2.0</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 5: Current contraceptive use and abortion experience of the informants

<table>
<thead>
<tr>
<th>Contraceptive use</th>
<th>Non-abort (%)</th>
<th>Have had abortion (%)</th>
<th>Have repeat abortion (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD</td>
<td>3 (43%)</td>
<td></td>
<td>1 (25%)</td>
<td>4 (27%)</td>
</tr>
<tr>
<td>Pills</td>
<td></td>
<td></td>
<td>1 (25%)</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Condom</td>
<td>4 (57%)</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Withdrawal/Rhythm</td>
<td>1 (25%)</td>
<td></td>
<td>1 (25%)</td>
<td>2 (13%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7 (100%)</strong></td>
<td><strong>4 (100%)</strong></td>
<td><strong>4 (100%)</strong></td>
<td><strong>15 (100%)</strong></td>
</tr>
</tbody>
</table>

* The respondent had abortions while not using IUD in the past.
* One of the couples had abortion due to stillbirth.

2. Local implementation of state population policy

The state two-child policy (see section population policy) is enforced by combination of the use of incentives and disincentives for violating or following the two-child policy, and provision of contraceptive and abortion services. The population policy imposes equal economic burdens for men and women who fail to regulate fertility. Although these sanctions equally motivate men and women to assume responsibility for family planning, women often take responsibility for implementation alone. All members of MCH/FP staff are women. Of five CHC staff, only the head of CHC is a man. Men rarely attend or accompany their spouse to family planning clinics and even if they went there, they feel embarrassed asking questions to female health workers. Thus, MCH/FP and CHCs, where family planning services are provided, become female spaces (see Appendix 1).

Contraceptive provision is women oriented. Although the policy promotes the use of both male and female methods, its implementation promotes female more than male methods: only IUD, pills, and sterilisation (tubal ligation and vasectomy) are provided free of charge. Annually, only chiến dịch đặt vòng, ‘IUD insertion campaigns’ promoting IUD use are organised regularly. Information campaigns promoting condom use organised not regularly. Free of charge provisions of condoms - the only effective (and more acceptable compare to male sterilisation) male contraceptive - stopped a few years ago due to lack of resources and gaining popularity ideas of ‘socialization of health services’ xã hội hóa y tế, which in most of the cases means introduction of user
fees into health care. Condoms are provided at subsidized prices. Yet, quality of these condoms is perceived as not to be high.

Thus, if IUD, tubal ligation, and very limited range of the pills limit women choice, men’s contraceptive choice is even more limited. Only irreversible vasectomy is available free of charge. Condoms are in limited range and quality, and not regularly promoted. While IUD is promoted regularly, promotion of condom use is available only through mass media. Information on condom use is available only in printed condom packages.

Provision of contraceptives

**IUD** can be inserted routinely free-of-charge at CHC as well and during IUD insertion campaigns, which are organised twice a year free-of-charge at every village. During the campaigns, women giving birth recently are encouraged by population collaborators to have IUD inserted. However, women can easily get the IUD removed in case they changed their minds at local CHC.

**Pills** can be obtained free-of-charge at the village population or at costs of VND 1,000 at private pharmacies. Women who wish to get the pills can register and get the pills free-of-charge at the network of village population collaborators at the beginning of the month. Three types of contraceptive pills usually are available for distribution: Ideal®, Exluton®, Rigevidon®. Yet, only Ideal® and Exluton® are available at CHC and population collaborators; and Ideal® is available at private pharmacies at moment of observation. According to local health personnel, supply of the pills is not always reliable: some time the pills arrive late or in inadequate quantity.

Domestically produced **condoms** also are available at subsidised cost of VND 200-300 per condom at population collaborators and private pharmacies. There are three branches available: OK, Trust, and Hello. According to condom users, the condoms are inexpensive, but of low quality. They are thick, tight and break often. Other condoms are available only at private pharmacies costing from VND 400 per condom at the district centre, 3 km far from the commune.

**Tubal ligation and vasectomy** are provided by the MCH/FP team free-of-charge at district health centre. To provide incentives for the couple using sterilisation, district committee on population and family planning provides medical insurance
reimbursement to them in case of health complication associated with sterilisation procedure.

Provision of abortion service

The provision of public reproductive health services at the Tiendu district does not differ much from that nationwide except the fact that CHCs are not allowed to perform pregnancy termination. Abortion is available at women’s request to terminate pregnancy up to 10 weeks from LMC at the costs of VND 30,000 for MVA and VND 50,000 for DC at MCH/FP unit of the district health centre. According to MCH/FP staff and those who have experienced abortion recently, only unmarried women or women with pregnancy of more than 10 weeks have to pay informal payment of VND 50,000 - 200,000.

Not allowing CHCs staff to perform MAV, district health managers aims to reach twofold objectives. First, as district health managers argue, the DHC has more advanced equipments and the district personnel have better technical skills. By not allowing abortion at CHCs, district health managers aim to attract more clients to DHC, where abortion services are supposed to have better quality. Second, the DHC managers want to attract more clients for the DCH, which would mean increased revenue for the DHC. However, the number of abortion at DHC is decreasing year after year, while the number of abortion at ‘private’ practitioners is increasing. Private abortions are widely available through unregistered private providers, who are staff of public health services and provide services privately in their homes at comparable prices. Some women prefer private services to public services because of privacy and better provider-client interaction. According to the clients, the same medical personnel behave better, pay more attention, and perhaps provide better quality when they provide service privately. Thus, it is likely that the number of reported abortions decrease at DHC probably because of the increasing number of private abortions rather than the decrease of the demand for abortion.

3. Gender norms and practices

Division of labour

There is both agreement and contradiction between the norm and practice of gender division of labour. Both men and women think that men are supposed to involve mainly in công to việc lớn, ‘big events and/ or difficult tasks.’ The norm reads that men
are supposed to do heavy, difficult tasks such as repairing house, ploughing, harrowing, spraying of pesticide etc. Women are to do all 'easy' tasks such as washing, cleaning, cooking, caring of the children, and routine production activities. Women are also actively involved in social activities such as participation in the Women Union and decision-making process at other meetings at the commune. The following discussion about the Vietnamese joke Làm trai rủ bắt vợ nhà, vợ gọi thì dara, bán bà toí noticias, which reads: "a man that washes the dishes and sweeps the floor, when his wife summons, he says, ‘here I am, Ma’am’,” demonstrates the local norms concerning division of labour:

Q: What do you think of the old saying: Làm trai rủ bắt vợ nhà, vợ gọi thì dara, bán bà toí noticias, “a man that washes the dishes and sweeps the floor, when his wife summons, he says ‘here I am, Ma’am’?”

F. 1: In that case the husband will give you a thick ear. Here is not like in Hanoi, husband can wash clothes for his wife. In our rural areas, husbands cannot wash clothes for wives. Never. It will never happen. Wives and the children must wash clothes.

Q: Why?

F. 1: [Because my] husband has already worked very hard, [when he come back home from the work] wife has to serve him (IUD user, ID: 1)

However, some others name a totally different opinion:

M. 2: Well, about that saying... It’s depends on each family. For example, if the wife is too busy with other business, selling stocks for instance and does not have time to do family tasks... It’s depends on each family. In that case, it’s OK for man to clean dishes and sweep the floor. It’s depends on the family (IUD user, ID 2)

Both men and women talk about equal responsibility in household tasks. A good husband is a tấm lì ‘sensible/ caring’ husband, is hard working, listens to the needs of his wife, and ready to share household tasks such as cooking, cleaning and caring of the children, etc. Most of the couples agree that their husbands more or less take part in the share of family tasks. Some take care of the children, others take part in cleaning, washing or cooking during their free time. Generally speaking, there is a local principle, which reads that when the wife is too busy the husband can take over her tasks and vice versa. However, as a man said “Regularly? No, how can I do [the household chore] regularly. Is it possible that my wife will sit and look at me

1 Literally tấm lì means psychological. But in this context, English word ‘sensible’ has closer meaning.
working?" Therefore, as a rule, women do more household tasks than men (see Table 6).

Table 6: Average hours spent on different tasks for men and women during last day

<table>
<thead>
<tr>
<th>Average hours spent on:</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production</td>
<td>8 3/4</td>
<td>9 1/4</td>
</tr>
<tr>
<td>Family care</td>
<td>1 1/2</td>
<td>3</td>
</tr>
<tr>
<td>Relax and sleeping</td>
<td>12 1/2</td>
<td>10 1/2</td>
</tr>
<tr>
<td>Other activities</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

As we can see in the Table 6, there are differences in number of hours in production, family care, and sleeping and relaxing for men and women. However, this should be interpreted with caution because: (1) the result is not representative for the study population and with small number of informants, and (2) the study was carried out at harvest season, which can change differences within couples and the pattern of time spending between couples. During the harvest time, both men and women were very busy and hard working. Some men returned from urban area to help the family in harvesting rice and other crops, others could not come back during the harvest season, and some women have to do heavy men’s tasks such as ploughing, harrowing,\(^1\) and spraying pesticides (see Appendix 1). During my fieldwork, I could not observe to what extent men take over women’s tasks, but I did observe that many men took part in cooking, preparing fire woods, feeding pigs and poultry... This observation and the quantitative data confirm what informants say in the interviews: men are taking part in household chores. However, this does not mean that household chores are equally shared.

Sex and communication on sex

For the scope of this research I limited myself to the norms and practices of sexuality in terms of who takes the sexual initiative, how husband and wife communicate and negotiate sexual practices and the need for protection from unwanted pregnancy.

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\(^1\) Breaking the ploughed soil in the rice field before seeding or planting rice, using a big agricultural equipment with metal teeth.
There is a sexual norm, which indicates that sex is in the hands of the husbands and only men are supposed to take sexual initiatives, but my informants have different opinions on that. Some men and women say that peasant women should not initiate sex. Women would rather take the passive role in sex. They think, only urban women can be active partners in sex:

Q: What do you do if your husband forgot about sex for a while?

F. 2: I will not remind him.

F. 1: You know, in the city, wives will remind their husbands about sex. [I know that] there are two cases in the city, where the husbands were too busy and forget about sex, then the wives go away.

M. 2: Ooh! It’s the case when you were too busy with the business and forgot about the feelings.

F. 1: But here in the rural area...

F. 2: Well, in that case you just need to ask your conscience. You need to ask your feeling. But for me, I will never demand [sex] (IUD users, ID: 2).

While some women think that they should not initiate sex nor express their sexual needs to husband, some other men and women think that women can, and some stated that they do. Women in rural area rarely initiate sex, but that means sometime they do:

Q: What do you think if the wife initiates sex?

M: It is very rare. As our selves, my wife rarely initiates sex. It is difficult to say some thing about other wives. It is depending on different family. I think some couple do, some not. I think it rarely happen with rural couples. It is more common in the city, is not it?

Q: Why do you think that it more common in city than in rural areas?

M: Firstly, perhaps people in rural area seldom have opportunity to contact outside [their] society. Secondly, it [husband and wife relation] is not so flexible as in the city. In sum, people have less contact outside [their] society.

F: Yes, and here once you came home, you are already exhausted, there for you do not want it [sex] very much. (IUD user, ID: 12)

However, sexual practice depends on communication and negotiation between husband and wife rather than norm. More often than not, the informants say that because husband and wife are in equal relationship, the wife can also express her sexual desire to the husband.
Q: What do you think of the statement 'the wife can not take sexual initiative'?

M: I think, some time the wife can express her desire to the husband. Because... I think, some time I was too tired or I was thinking about something else and felt asleep. My wife might wake me up. It is possible that the wife wake up husband [for sex]. It's OK.

Q: Does that mean that it is not obligatory that women should not express her sexual desire or demand sex?

M: Yes, it is. Husband and wife are equal (Condom user, ID: 14).

In their perception, only urban women, who have more equal gender relation, can be in more equal relation in sexual practice. They clearly perceive that there is difference in gender norms and practices between urban and rural women.

For most couples, sex is seen as a means to maintain family harmony and happiness. It is understood as part of a normal part of a couple's life, and as an expression of love, mutual care, and desire. The most frequently used phrases to imply sexual activities are sinh hoạt với chồng, 'spousal living activities,' and dã lai, 'being on intimate relation'. Normally, sex must be based on mutual desire, without any force from both sides.

M: If you felt that your wife is correct, then you need follow her. If she is not correct, you may not follow. It is not possible to force... As các cụ, 'the elderly,' said: "ép đầu ép mồ ai nê ép đoan, 'you can press to extract oil, but you should not get love under pressure.'" You can use pressure whenever you want, but there is some thing that you should not use pressure. When you press too much, you lost the best feelings. If you sinh hoạt, 'have sex,' under pressures, you do not feel free. It is the best when you do not feel any pressure, you feel relaxing while having sex.

Q: Ohh, I think, well... what husband wants, the wife has to follow.

F: No, never (Withdrawal and Rhythm, ID: 6).

But they do not communicate about sex explicitly. Rather, husband and wife, especially those who practice withdrawal and rhythm method, may have their own 'signals' similar to those of a stop light set. The husband will understand when there is a 'red light' and when there is a 'green light,' which signifies a 'safe' and 'unsafe' period.

In case of 'unsafe' period, couples neither using IUD nor pills usually employ two strategies. If the couples continue to have sex, the husbands would either use condoms or withdrawal. For the others, they may refrain from sex. Yet, as couples
express, it is not easy to practice withdrawal and/ or rhythm methods because sex is an outbreak of feeling and expression of love and mutual desire, and it is uncontrollable. One cannot stop it when it begins. As a man says: "at that moment [when you starting sex], you become unconscious [...] and you can not control yourselves."

Husband migration may change the situation because sex is perceived as mutual desire and care from both husband and the wife. As a woman said:

Q: Your husband agreed that a woman could express her sexual desire to husband, what do you think of that?

F: In general both husband and wife have a say in sex. [That is] Thuần với thuận chồng. Agreement from both husband and wife..

Q: But what if the woman initiates sex or she can give some kind of signal for her husband?

F: You know, if the husband was absent for a while, for one month for instance. When he arrives, the wife should take the initiative. That is the psychology of the wife when the husband comes back after a long period. You know, we all do that (Withdrawal and Rhythm, ID 6).

As consequence, many women say it would be undesirable to deny sex in that case. Many women would go for sex, even knowing that they are not protected. If the husbands do not like condom, they have to practice withdrawal and periodic abstinence, knowing its unreliability, hoping that the pregnancy would not happen at that time.

Decision making

"Thuần với thuận chồng, tất bè Đông Cùng can," the old Vietnamese saying that reads 'when both husband and the wife in agreement, they can even dry up the East Sea [the South Chinese Sea]' is the most frequently used metaphor to describe couple’s decision-making process. All couples stated that they discussed important family matters together. They make decision together on such matters as buying equipment, capital item such as cub board, TV set, motorcycle... As a couple said:

Q: Well, you said you partly agree and disagree with these statements. Can you explain a bit, for instance, about decision making in buying capital items?

M: With regard decision-making these item, husband and wife have equal say. Here, it [the statement] said that only husband makes decision. It is not true. Every thing we do, both my wife and I decide together. The wife should also have a say.

Q: So does he give you a say while making decision?
F: Well, you know. When I buy simple things, I make decision by myself. But when we buy big things, we decide together.

M: Decision was made partly by husband, partly by wife (Condom users, ID 14).

The most common practice is that the wife is the nội tướng, the internal general. Wives manage household finances. Both husband and wife contribute all of their earning to a share fund, which is kept by the wife. The wife makes decision herself for everyday purchases. When the couple need to buy capital item, they make decision together. After a decision is made, if it concerns big items, usually the husband will involve in purchasing or choosing. Regarding small items, the wife makes the decision and buys by herself. This pattern of decision making also applies to decision for contraceptive use (see section: Sharing responsibility and making decision). The following conversation during interview demonstrates how the couple make decision:

M: You know. We always discuss together every matter. Decision is made only if both of us agree.

F: Generally speaking, every matter, regardless it is small or big, or buying something. Everything... Because I think, it's like following. One should not make the husband regret about any thing [...]. The same does my husband. Usually it applies to every thing: whenever you do some thing or you buy some thing.

M: I never infringe my wife just because I am her husband.

F: Once something is needed, If I said 'well, my dear, you can do it as you like,' it's one thing. But when I said 'No,' then my husband would not do it at all... You know, though we are peasants, we are not so educated, but we live in harmony, as the elderly said: "Thưa với thói chồng, tất bè Đông cùng can," 'if both husband and wife in harmony, they can dry the East Sea.' (Withdrawal and Rhythm, ID: 8)

4. Desire to control fertility

Troi sinh voi troi sinh co – an old fashioned concept

An old Vietnamese saying reads: “Trôi sinh voi, trôi sinh cỏ”, literally means the God creates elephants; the God provides grass for the elephants. The saying implies that a couple can have as many children as they can give birth to, and there will be enough food for the children. Yet, all couples interviewed express, it is an ‘outdated’ concept, and is not applicable today. Most of the couples state that they cannot afford more than two children. As a women said:

Q: What do you think of the saying trôi sinh voi, trôi sinh cỏ, 'the God creates elephants, the God provide grass for them'?
F: It is not possible to agree with that. If I agreed, I would have a few children more now.

Q: What do you mean?

F: No. Only the elderly said that. If it is true that the God create the grass for the elephant, can he create everything? For example, will new rice fields be created or will new land be added for people? You know, that is what I think. You know, if it could be that trời sinh voi, trời sinh cỏ, ‘the God creates elephants, the God provide grass for them,’ I would have given birth some more children. Because it is not possible, having two children is the best (Withdrawal, ID: 8-189).

There are two practical reasons for desiring only two children. The most commonly held explanation is pressing economic difficulty to meet the couples’ expectation on minimum living standards. Most of the informants were born during the American war in the sixties. They grew up at the very difficult time of the American and the Cold War. Most of them have to stop education because of poverty. As many informants recall, they had to wear trousers and T-shirts with holes. They want their children to have a better childhood than theirs. In addition, situation changed since the Đổi mới, ‘the reform,’ in 1986. Before the Đổi mới health care, child education, and many other services were state welfares, and were provided free of charge. Nowadays, though these services are subsidised by the state, people have to pay part of the costs. Most of people feel the pressure for the cash, while agrarian production provides only subsistence for the household. Perceived incapacity in providing minimum living standards urge people to have small family. As a couple said:

M: If I give birth to the third child...

Q: What then?

F: I cannot nurture them.

M: I already got tired of having two children. Very tired.[....]

F: You know, it is simple that after giving birth to a [addition] child, you cannot nurture him properly and cannot afford your child to continue education. Your child cannot be equal to other children. Nowadays, children grow up, they emulate with each other in good clothes, textbooks, and in studying etc. You feel ashamed not providing proper conditions for you children. If he wished to continue education, but you cannot afford it... your child cannot be equal to other child.... (IUD user, ID: 12)

Secondly, there is a social control on couple’s fertility. Those who already have two children usually do not want to have more children because of the fear of being a
subject of their neighbours' gossips and critics. The critics is stronger for those who already have a son and a daughter:

Q: That means, you wanted to have three children but she wanted only two. What about your parents?

F: Our parents also wanted us to have three children. But you know, each era has its trends and you have to follow. Nowadays if you give birth for the third time, people will said: "Oh, you know, there is the M & F family, who has three children" then all commune will laugh at you. People would gossip: "Oh, they already have a girl and a daughter, why they give birth to the third child" or some thing like that. Then, you hesitate to have the third child. In addition, there is competition in the Commune Women Union. If there were some one who failed in family planning, the Union would loss in competition therefore the Union's member would criticise you each time at the Union’s meetings. That is bothersome. Have you had third child, the Union would have lost competition, the Union’s members would had criticised you, it would be troublesome (Withdrawal, ID: 6).

The social critics for the third or more children may be less for those who have no son; they can try again to quà tam ba bèn, 'to gamble the third chance' (see section Son's preference for other information). ¹

People would not criticise you too much of having third child If you have two daughters. But if you already have a son and a daughter, people will laugh at you of having third child... You know, it is only our time. In the past, people would have three or event four children. But nowadays, there are a lot of family planning methods available... (Withdrawal & Rhythm, ID: 6).

Yet, some feel that two children are not enough. They argue about the benefits of having more children, but for practical reasons, the predicted economic difficulties in nurturing of children keep them to have only two children.

Q: Well, for peasants, are there any benefits of having more children?

M: Generally speaking, for the peasants as well as for people in urban areas, having too many children always troublesome.

F: It's hard, but it also happier. You have to work harder to provide food, care, and education for the children but you can be happier. For example, when you need to do some thing, or you have some event in the family... brothers and sisters will unite together, every body will contribute opinion and forces. They and do it together, then you felt better. In short, it's hard but happy (Withdrawal & Rhythm, ID: 6).

¹ In gambling, people often say "quá tam ba bèn" which means one could try his chance not more than try times.
Preferred child spacing

Preference for child spacing varies from couple to couple. Some prefer to have three or four years of spacing, while others prefer to space for five years or more. The choice of child spacing depends on the financial capacity of the couple, their ability to rely on kin and more often, parents’ assistance, and perception about influence of family planning on fertility.

Those who prefer five or more years of spacing want to stabilise family economy first, then have the additional child.

Q: What is the difference between child spacing of two to three and five years?
M: Hmm... Two and three years of spacing and five years... Of course, five years spacing is better. Our family economy at that time becomes more stable.

Q: What do you think of ồ cả môt thế, nươi môt thế, ‘giving birth at length and having small children at once’?
M: It would be very difficult if you ô cả môt thế, ‘give birth at length’.

F: You know, my husband wanted space at least five years.
Q: At least five years?
F: Yes. We plan have second child only after the first is grown up a bit. You know, tay xãh nhach mang, ‘loaded with packages and bundles’ is too difficult.

Q: You are afraid of being fined, aren’t you?
F: No. I do not afraid of fines, but our life economically would be very difficult. Having many children is very difficult (Condom user, ID: 10-243).

However, some others clearly prefer three or four years spacing to five years. Some fear that five years is too long. Some things may happen to them and they may become infertile or have difficulty in giving birth:

Q: What space you would prefer to have: three or five years?
F: Well, two or three years. Five year is too long. We might have difficulty in giving birth to another child.

M: Two or three years.

Q: That means you would prefer three years of spacing?
F: Yes. After three year of spacing, we would like to have another child when the first child could grow up a bit.

Q: But what are the differences between three years and five years spacing?
F: You know, if we space for five years, you can have difficulty in giving birth to another child. Birth spacing too much the birth would not be secure (IUD users, ID: 12-314).

Another argument for the three-year birth spacing is that couples can have small children at length, and then focus on household economy:

Q: What do you think of birth spacing?

M: [It is better to] space for three years... Once you give birth, it is better to space birth for three years. You know, give birth of the second child three years after giving birth to the first child, you can have easy life later. Five years is a bit too long space... In case of five-year spacing, you just started to stabilize economy then you have another child. It's a bit troublesome. If you have spaced three years, three year after giving birth to second child your first child would be five- or six-year old, your life could be easier and you could focus on household economy.

Q: Yes.

M: Five years is a bit too long space (Condom user, ID: 11-282).

The others, who can rely on living parents, prefer to have small children at length. They argue that it is better to have small children when their parents are still healthy and can help in looking after the children. The following conversation illustrates it:

Q: What do you think of the statement: “child spacing of three years is better than five years?”

M: No. Five years spacing is better than three years.

Q: What is the difference?

F: Generally speaking, if you have possibility, if your parents can take care of your children, so as các cụ, the elderly, said để một thế, nuôi một thế, 'give birth and care for small children at length.' But, you know, we have small house, our parents do not live around with us, we have to space in five years.

[...] Your life is a bit easier when you space in four or five years. But there also are some difficulties. When your [first] child is grown up a bit, you [may] hesitate to have small child again. But... in case you have some one assisting in caring of your [small] children, it is also good to space in two or three years. As the elderly said để một thế, nuôi một thế, 'give birth and care for small children at length'. You know, people of our age, only our children are the youngest. Other couples who give birth the first child at the same time with us they spaced less, therefore their [second] children already grown up, but our [second] child is still small (Condom user, ID: 9-231).
Son's preference

There is a preference for a son in Vietnam. However, the strength of the preference depends much on the couple’s social context and does not always translate into behaviours. Whether the preference will translate into action depends much on the social contexts of the couples. Traditionally most of the Vietnamese societies, except some minority groups, are patrilineal and patrilocal (Pham Van Bich 1999). The son therefore is a *người nối đời dòng dõi*, ‘continuer of family descent,’ or *diệu cúng com*, ‘performer of family ancestral worship.’ But the most preferable option for the couples would be a son and a daughter or *có nếp có té*, ‘having both sticky and ordinary rice.’

Q: What do you think of having two daughters or two sons? What would you want to have?

M: Nowadays, hardly there is any difference between son and daughter. But you know, for most of the Vietnamese, it is the best when you have a son and a daughter. Of course, it's OK to have two daughters. Who ever they are [regardless they are son or daughter], they are our children. In short, men and women are equal today (Condom users, ID. 11).

But later, he continued:

M: However, in those families where none of the sons have any son, people would want to have a son. For example, among three sons in family, if the two elder brothers do not have a son, people would try to have a son to have a *diệu cúng com*, ‘performer of ancestral worship,’ for the family (Condom users, ID. 11-288).

People without a son are faced with great dilemmas. On the one hand they have to contend with everyday pressure from the kin and their neighbours’ gossip to have a son to continue the family descent. At any moment, especially at general meetings or social events, they are joked and ridiculed at being *ông ngoại*, a term denoting ‘maternal grandfather.’ This stigmatises people. The following field notes demonstrate this:

I was sitting with seven men from district irrigation brigade around the table in their office. One of the men, sitting in the opposite side of the table ironically said: “Trung, look at this side. There are three *ông ngoại*, ‘maternal grandfathers’ sitting in this side. The three of us have eight daughters. We are the three *ông ngoại*, ‘maternal grandfathers’ in the brigade.” Later, one of the brigade members told me that one of those men want to have a son because he is the oldest son in his family but has four daughters. I have tried to talk with him, but every time I started to talk
about children he changed to another topic. Other members of the brigade said that the man always avoids talking about children, and he really felt embarrassing not having a son.

Another practical reason for having a son is parents' security for the old age. Some people see the son as their security for the older age, based on the principle of reciprocity: the parents care and nurture the children until they grow up, and they invest in their children, in return the children will care and provide the necessary supports for the parents during their old age. This is especially true in the context of rural Vietnam, where there is no social security for the elderly, especially those employed in the agrarian and informal sectors. The patrilineal and patrilocal marriage practice makes people felt insecure not having a son. The following conversation with a male, who have already had two daughters and who is the oldest son of the family, during the FGD with men illustrates this:

M. 1: My uncle, he is of our age, but already has four daughters. It's a trouble. You know, I differ from him that I am a state servant. At least at the old age I will have some thing [pension] to live on. As you know in rural areas, as all the daughters grow up, they get married and move to their husbands' houses. At home only the two elderly left. You cannot hope that one of your daughter cannot get married and stay with you, can you?

Q: But one of the daughters can get married and stay at natal place?

M. 1: No, it hardly possible. None of the men wanted to live in their in-law house. None of men have such an idea.

M. 2: There are only [men with] big ideas. Every man wants freedom.

M. 1: All of men like that. None of them wants [to stay at their wife's house].[...]

M. 3: Both you and your wife are state employments. At the old age you will have a pension, why do you still need to worry about that? (Male FGD)

5. Perceptions and practices of birth controls

Case studies

Case 1: Women contraceptive choice and failure (ID: 12)

Husband is a 39-year-old chief bricklayer and frequently migrates for cash earning. The wife is a peasant. At none harvest time she also has a job at local road construction. They got married in 1985 and then have two children: a fourteen-year-old daughter, who can do almost all of the household chores now, and an eleven-year-old son. They decided that they could not afford more children.
They did not use any contraceptive until 1990. Since 1990 she got IUD inserted, but she got it removed in 1992 because of increased bleeding during menstruation. Soon after the IUD was removed, she had the first abortion in 1992. Then, they practiced withdrawal and periodic abstinence but they failed again. She had the second abortion in 1993. After that, they used condom, but the husband did not like it because it was thick, and too tight, and so he stopped. Soon after he stopped using condom, she got pregnant again and had the third abortion in 1994. After the third abortion, she decided to use the pills for four year until 1998. Using the pills had advantage of giving regular and less bleeding, but then she had stomach ache. Her peers said that the pill probably caused her stomach aches and so she stopped using the pills to switch back to IUD. As soon as she stopped the pills but still did not get the IUD inserted, she got pregnant again and had her fourth abortion. She is using IUD now but it gives her irregular and increased bleeding. She wants to switch again to the pills but is afraid that she is already 35 year old, therefore she feel, cannot use the pills. Although there are no direct contraindications for women older than thirty five in family planning literature, it advises only smoking women over 35 year old not to take the pills, she feel that she can not use the pills.

In sum, she has been pregnant six times, four of which ended in abortion. All unplanned pregnancies happened during the gap when she switched from one contraceptive to another.

Case 2: Men responsibility and contraceptive failure (couple ID: 6)

The husband is a thirty five-year-old bricklayer. His wife is a thirty four-year-old peasant. At the peak of harvest time besides collecting her own paddy from the rice field, she also exchanges her labour at the rice field for wage. He migrates for job in Hanoi and stay there for approximately two hundred days each year. He even did not come back at the peak of the harvest season until last year, after they bought a mechanic ploughing machine together with the husband’s brother. Since then the husband usually comes back to plough to earn cash in the rice fields. The family has 6.8 sào of rice field,¹ which consists of several lots and spreads out in different locations—a common practice in the Red River Delta. They have two children: a fourteen-year-old

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¹ Sao is a common measurement in agriculture in Vietnam, 1 sào = 360 sq. m. According to the land distribution norm in the commune, each person has been distributed 1.7 sào of cultivating land for 20 year since 1990.
daughter and an eight-year-old son. The daughter helps them in cooking, feeding the pigs, and cleaning the house. The wife manages all the household finance matters by her self; when buying and purchasing capital items, both husband and wife discuss together.

They decided not to have more children for three reasons. First, they already have a girl and a boy. Second, their last child is already eight year old and the daughter is almost an adult. They are used to their current situation where the children can help them in the household chore, and they already get used to the sense of freedom without being bothered with troubles of having small children again. And lastly, they want to give a better life with good education for their children, which they cannot afford if they have more children.

Three years ago, when their son had otitis, the wife wanted to have a son more. She wanted to be sure that they would have at least one healthy son, but the husband did not want to have another child. Later, the son recovered from otitis. This made her sure about the healthy son and did not want to have more children.

Table 7: Major events in reproductive life, case 2

<table>
<thead>
<tr>
<th>Date</th>
<th>Reproductive life events</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/1987</td>
<td>Marriage</td>
<td></td>
</tr>
<tr>
<td>12/1988</td>
<td>Birth of the daughter</td>
<td></td>
</tr>
<tr>
<td>1989</td>
<td>First abortion</td>
<td>Introduction of the two-child policy (reported only at second interview)</td>
</tr>
<tr>
<td>1990</td>
<td>Birth of the son</td>
<td></td>
</tr>
<tr>
<td>1990-1992</td>
<td>Using IUD</td>
<td>Side effects: weight loss</td>
</tr>
<tr>
<td>1993-1995</td>
<td>Using the pills</td>
<td>Side effect: weight gain, sunburnt cheeks</td>
</tr>
<tr>
<td>1996</td>
<td>Abortion</td>
<td>Mentioned at the second interview</td>
</tr>
<tr>
<td>1997 and forward</td>
<td>Using withdrawal and rhythm</td>
<td></td>
</tr>
<tr>
<td>1997/8</td>
<td>Abortion (?)</td>
<td>Mentioned at the second interview</td>
</tr>
<tr>
<td>1999</td>
<td>Abortion (?)</td>
<td>Mentioned at the first interview</td>
</tr>
<tr>
<td>12/2000</td>
<td>Abortion</td>
<td>Mentioned at first and second interview</td>
</tr>
</tbody>
</table>
They have tried several contraceptive methods including IUD and pills. But both methods gave side effects such as losing/gaining weight, sunburnt cheeks (see Table 7). After discussing together, the husband said, “well, you can choose what ever you want. Just not to get pregnant again, otherwise we have to have abortion. It is harmful for the health and costly.” She chooses withdrawal and periodic abstinence. She calculates her ‘safe’ period as seven days before and after menstruation. However, her menstrual cycle is irregular and they often failed. They continue using withdrawal and safe period until now. They did not wanted to use condom because they think the condom may have a hole on it and many couple, using condom still resorted to abortions. In addition they said that the condom looks dirty and unhygienic (because of the lubricant), and can give allergy, although they have never tried it.

Abortion is perceived as last resort and a back up for the other contraceptive methods. They would try their best to avoid unwanted pregnancy and abortion, but in case of contraceptive failure, abortion is an acceptable solution to keep their desired family size. Abortion is an unpleasant medical intervention, associated with pain, physical and emotional suffering in their life, and which they do not want to recall. During interviews, their statement about the number of abortion they have experienced is contradictory. At the first interview, the wife stated that she had two abortions, but in the second interview, she recalled three abortions. Furthermore the date of abortion was different at the two interviews (see Table 7). During interviews, she often tried to escape direct answers to the questions regarding the number of abortions:

Q: You said that you have failed in family planning several times, how many times it happened?
F: Two times since I last gave birth to my son.
Q: Two times.
F: One time since [the moment that I gave] birth of my daughter to my son. One time.
Q: In which year did it happen?
F: In two consecutive years, but I can’t remember [which one].
Q: Sorry, in which year?
F: That’s all.
M: [grumbled] In which year?
Q: Can you remember in which year it happened?
F: Last year. Yes, last year and perhaps every one... or two years. But it happened last year.

M: Once it happened in 1996.

She had most of her abortions done at local CHC during supervision visits of the district MCH/FP health worker. The district MCH/FP health worker some time provides private abortions at CHC during her weekly supervision. One of the CHC’s health workers states that this woman has at least six abortions performed at the CHC, but there is no available record on privately performed abortions and it is not possible to confirm the information from the health worker.

However, it is clear that some women felt it is stigmatising to have too many abortions. They would either underreport the number of abortion or recall incorrect date of the abortion.

Case 3: Men responsibility and success (ID: 4)

The wife is a thirty-year-old female peasant. Her husband is a worker of a railway company. The wife has full autonomy to manage everyday financial matters but they make decision together on important issues. At free of work time, he sometime helps her in agricultural tasks, washing and cleaning, but not in cooking since he has allergy to smoke a few year ago.

They got married in 1990, and have a ten-year-old son and six-year-old daughter now. After having their first child, they wanted to space for five or more years. At first she tried the pills, but could not bear strong headache and stopped using it after ten days. They do not want to use IUD because they are afraid of back pain, tiredness, and losing weight. After they have discussed together, he agreed to take responsibility for condom use. He himself regularly went to the village Women Union to get condom, which was available free of charge few years ago. Now, he buys the condom on the way to his work at the district centre, which is five kilometres from the Lienbao commune, because the imported Thai condoms are available only there. The Thai condoms, according to him, are more reliable, thinner, durable, and ‘more sensitive’ than domestic condoms like OK, Hello, Trust, which are available at local providers at Lienbao commune. He continuously uses the condom and failed only one time when his wife got pregnant to their daughter six years ago. According to him, they failed while using the Trust, which is easily breakable and perhaps had a hole on it.
Sharing responsibility and making decision

Chúng tôi cùng kế hoạch, ‘we jointly plan’ or Kế hoạch hóa gia đình là trách nhiệm của cả hai, ‘family planning is a joint responsibility’ of both husband and the wife, are the common expressions that I hear every time at the interviews during my study. Both men and women consider family planning as a joint responsibility of both husband and the wife. Joint responsibility, according to both male and female informants, includes joint decision-making on how to kế hoạch, ‘plan’ their life: when and how many children to have. Joint responsibility also means husband’s support of the wife’s decision on contraceptive use and come to help the wife by using male contraceptives such as condom, withdrawal and periodic abstinence.

However, the realization of the joint responsibility is different from couple to couple. Some men realize their responsibility by giving women full autonomy to choose contraceptives. Most of couple using condom leave women responsibility to take care of its supply. Only a few men take care of the condom by themselves. The followings conversations demonstrate different patterns in male participation in decision-making in family planning. Some couples make the decision together:

Q: How did you two make decision on family planning?
M: Well, we discussed together to get agreement. Only when both of us agreed, we can cooperate together [laugh].
Q: Did you?
M: Yes. You know, you need cooperation.
Q: Have you ever asked him to go to buy condoms?
M: [laugh] Ooh, she just needs to ask me, I always cooperate in that. It is impossible not to cooperate.
F: [I’m] afraid of giving more birth so I have to use condom. I am very afraid of becoming pregnant again (Condom user, ID 5-112).

Some give women full autonomy to choose.

Q: I have the feeling that while talking about family planning, men are not very...
M: Men are not conversant about family planning, aren’t they?
Q: Not very talkative. I do not know why.
M: No. It is not correct.
F:1: You know, it is because women decide almost every thing.
F.2: Usually... women arrange this thing [family planning] for themselves. It’s more often... that they decide more than men do.

M: Decision was made according to women’s desire. It is like men give women the right to decide. It’s like this: ‘well, it is up to you. Do it as you alike. If you like the pills, you take the pills. Do it [FP] as you like it to be’ (IUD user, ID: 2-46).

Whatever option is chosen, both men and women say that they cùng thực hiện, ‘jointly realize’ their ‘plan.’ These ideas are shared during the ethnographic interviews, and are confirmed by both men and women at the FGDs. The cùng thực hiện, ‘joint realization,’ often is expressed as husband and wife communication on a chosen method. Whatever method was chosen, husband and wife communicate with each other about family planning. Usually the wife gets information from the peers, population collaborators, health workers, or cadres of the Women Union, and then communicates with the husband. Most of the men think that women know better than men about family planning and said that their wives are important sources of information besides leaflets, the TV, and newspapers... As a man said:

Q: What do you think about the statement: ‘women are the main responsible person for family planning?’

M: Well, you know, women often go to [community] health centre, they know more [about family planning] than we [men] do. We [men] usually do not have much experience on family planning. Women, for example my wife, usually have more experience. Some time, there are health campaigns for women where [health workers] provide information on family planning, and encourage people to use contraceptive. There for my wife know better than me.

Q: If she gets some news from the counselling, does she tell you later?

F: Yes, I do.

M: Yes, she does. For example, sometime the staff of district health centre organised mass examinations for women in the village. At such campaigns, the district health workers perform physical examination and provide some counselling for women. If she has come there, she then would have told me about the examination later.

F: You know, our family has only two [adult] members... [if I do not talk with my husband then to whom I will talk?] (Condom users, ID 11-374).

The design of the study does not allow us to assess how the pattern of decision-making influencing contraceptive choice, but the study does show that there likely is some association between men’s involvement in decision-making and their contraceptive choice (Table 8).
Table 8: Men's involvement in contraceptive choice and contraceptive use

<table>
<thead>
<tr>
<th>Decision making on birth control</th>
<th>Condom user</th>
<th>Non-condom users</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decided together or mainly husband decided</td>
<td>8</td>
<td>4</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Only the women decided</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>7</strong></td>
<td><strong>15</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Though all men and women say that family planning is 'trách nhiệm của cả hai,' 'joint responsibility,' of both husband and wife, husbands are not always involve equally in the decision making. In some couples, the husbands withdraw more from the decision-making process, leaving women more autonomy, in other couples, both husbands and wives discuss together in different extent. Those couples who reported husband involvement in decision-making in choosing contraceptive (husband decides alone or both husband and wife decide) are more likely to use condoms than those couples who said women take lonely or main responsibility in family planning. As the table 7 shows, twelve couples (80%) make decisions together or the husband is involved in decision making for contraceptive choice. Only among three out of fifteen couples (20%) do men leave women alone to choose contraceptive. However, when men give women 'autonomy' to choose, none of them have chosen condom. This suggests that when the men withdraw from decision-making process, they also more likely withdraw from contraceptive use, particularly the condom.

One may suggest, men with more egalitarian perceptions and practices on gender division of labour probably are more likely to use the condom. In that case there probably is different perception in condom users and none-condom users. Yet, in both condom user and non-condom user groups, men and women share similar perceptions on division of labour, and the differences reflect individual differences rather than for different contraceptive user groups. Quantitative data confirm that men, who are involved more in family care, are more likely to use condoms (Table 9).
Table 9: Average hours spent on family care for men by condom user

<table>
<thead>
<tr>
<th>Condom use</th>
<th>Hours of family care</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-condom user</td>
<td>0.6</td>
<td>4</td>
</tr>
<tr>
<td>Condom user</td>
<td>1.8</td>
<td>7</td>
</tr>
<tr>
<td>Missing information</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>1.4</strong></td>
<td><strong>Total: 15</strong></td>
</tr>
</tbody>
</table>

Contraceptive choice and perception

IUD – the contraceptive of first choice

Women’s experience and perception of IUD is a creolization of biomedical knowledge and learned popular experiences. Usually before a woman has the IUD inserted, she gets counselling and gynaecological examination. If there are no contraindications, health worker will insert the IUD. To women experience, if they can get IUD inserted that means the IUD is *haop,* ‘suited,’ to them. During the IUD use, if there are no side effects, women experienced as if they *ura* the IUD, ‘the IUD is compatible’ to them. All of the studied women were well aware of or had already experienced the side effects of IUD such as irregular and increased menstruation disturbances, headache, back and abdominal pains, and weight loss...

However, women perceived these side effects as an indicator of whether the IUD is *ura,* ‘compatible,’ to them or not. Those who are *ura,* ‘compatible,’ with the IUD will be healthy. They even gained weight. For the women, IUD is the most effective, convenient contraceptive method, which once inserted, can be used for three years or more. Some women have used one IUD for ten to thirteen years and have had terrific back pain because of too old IUD. After getting the old IUD removed, she has another IUD inserted and does not have any complaint. Those, who switched from IUD to another contraceptive method because of side effects, explained that they did not *ura,* ‘compatible,’ with the IUD.

Pills – a contraceptive suits for those who do not want more children

Similar to the IUD, biomedical and popular knowledge about the pills intertwined together. All of the women who ever used the pills know that they have to use the pill every day, and if they miss one pill, they have to take two pills on the next day. They are well aware that some women may not use the pills because of
contraindications. Yet, here the biomedical concepts of indication and contraindication
are also interpreted as if the pills were *həp* 'suit,' and *ura* 'compatible' to different
people. For those who *ura,* the pills, the pills are perceived as good, inexpensive and
effective contraceptive given regular use. Compare to the IUD, pills have the advantage
that women have regular and less heavy menstrual bleeding. Women perceive weight
gain differently. For some, gaining weight means that they *ura,* the pills and are
healthy. But for some other, gaining weight was one of the reasons to stopping using it.
Biomedical notion about contraindication on the use of the pills for women with
cardiovascular diseases, or with liver problems etc. is interpreted as the pills can
exaggerate the existing health condition. Thus a woman stopped using the pills when
her peers said that the pills have caused her stomach pains.

Besides other possible side effects such as headache, nausea, and dizziness,
which may decrease after one or three months, pills are also generally perceived as a
chát dộc, 'harmful substance,' which can cause foetus deformity. All men and women
express concerns that the pills can delay the return of fertility after a long period of use.
Therefore, only those couples who do not want to have more children would use the
pills. Couples who wish to postpone their child's birth would not 'dare' to use the pills.
The following field notes taken during informal talk with a man illustrates this:

Thanh is a 33-year old member of local irrigation brigade. He has two children: an eight-year-
old daughter and a four-month-old son. After giving birth to the first child, his wife had used the
pills for a few months. She did not experience any side effect but she stopped using the pills and
switched to the IUD, fearing that the pills might have impact on her ability to have another child
in the future. According to Thanh, 'the pills is a harmful substance,' which can cause infertility
or delay the return of fertility and may give deformed child (Field note - 357).

**Condom – a sex 'mediator' that takes away the best of your pleasure**

Perceptions on condom diverge between condom users and none-users. For the
users, condom is an inexpensive, effective, and convenient method, which is *həp,*
'suited,' for every body. Condoms can prevent not only pregnancy but also STD.
Though condom reduces sexual pleasure, men accepted it because the benefit of
condom use overweighs the displeasure that the condom may cause. Condom use is
perceived as part of men's participation in family planning. As a man said "Condom
use reduced sexual pleasure, but I have to bear that because if I do not use it, [my wife]
may get pregnant [because she can not use other methods] and it is too troublesome."
Even though a couple decide to use condoms as a family planning method, the wife often remains responsible for implementation of the couple’s joint decision. Though men are using condom, only few of them feel free while buying condom. Most of the informants feel ashamed while buying condoms. They have to hide it from other eyes. Most of the men, who use condom would use it but never buy it, leave buying condom for their wives. Women also feel ashamed buying condom, but they have to do it because they do not wanted to become pregnant and because shopping is part of women tasks. There are two explanations for men to feel uneasy in buying condoms. First, market place is a place for women. In general, very few men go to market. Thus men feel uncomfortable while shopping at the market. Second, all of the condom providers, whether private or public, are women. Therefore, men feel uneasy to buy condom, which unlike other contraceptive method, is directly associated with sexual activities. Of all eight condom-users, only two men regularly buy condom. The two men state that they would go to buy condoms if needed. Four others said it is women’s concerns because they [men] never go to the market at all.

Reasons for not using condoms are reduced sexual pleasure, tightness, fear of allergy, and the unreliability of the condom. Most of men share the perceptions that condom use is bothersome and reduce sexual pleasure. Some men stopped using condoms after a few trials. One of the men said, “I have tried once, but the condom is like a ‘mediator’ in sex. It takes away the best feelings from you. Using a condom is like having sex through a ‘mediator’.” Men also feel condoms too tight and unreliable. Many informants share the fact that some couples using condom become pregnant and have to resort to abortions. This makes some couples share perceptions that some condoms have holes and condom use is not reliable. Therefore they stop using condom and in order for men to take part in family planning, they switched to withdrawal and periodic abstinence, which are perceived as more reliable than condom. Some men and women said that condom is dirty and unhygienic. As a woman said:

I do not like it [condom]. You know, it’s dirty and I afraid that it not hygienic. It is said that condom use is hygienic, but who know what is the truth. Just look at it, it is so dirty, so awful [...] I have never bough it. But my kids used to play with it. They were at their uncle’s home and got it there. Then they washed out the lubricant and made air balloon from it. It was a few years ago, my kids were too young and we did not know it was condom at that time. Now, we know that it was condom (Withdrawal & Rhythm user, ID. 6-409).
Withdrawal and periodic abstinence – method of self control

Withdrawal and periodic abstinence are the two methods that require a high level of men participation. It is a quite common practice in the community. But perception on these methods differs from couple to couple. For some, these methods are effective and are good for those couples, whose husbands can control their sexuality and fertility. For some others, using withdrawal and periodic abstinence is a safe, effective method of tự giác, ‘self-consciousness, self-control,’ and tự nguyễn, ‘voluntary control,’ over fertility. Indeed, some men reported that they have never failed in contraception. But most of the couple stated that withdrawal and periodic abstinence are ineffective methods and difficult to practice.

Withdrawal and periodic abstinence are the methods that both husband and wife have chosen together, and require the cooperation of both. More often than not, women calculate safe days and communicate with husband when to use withdrawal. However, sometimes it is the only method available to the couple, especially when they cannot use the IUD or the pills, and do not like condoms either.

Other methods

Postpartum abstinence for three months is a traditional method and a common practice. Lactation amenorrhoea is perceived as ineffective method because of early introduction of weaning food though mothers often stop breastfeeding after twelve months.

Female sterilisation is more common than male sterilisation, and people perceived male and female sterilisation differently. Female sterilisation is talked about as triệt sẩn, ‘sterilisation,’ but male sterilisation is talked of as tiến, ‘castration.’ In general, sterilisation is perceived as ‘good’ only for those who are not educated and cannot control their sexuality. Only three men in the commune are sterilised but they felt stigmatising and hide this fact from other people in the commune. Therefore, all of the informants said that there was no case of ‘castrated’ men in the commune. Only few men and women have heard about injection, but they only know that the injection can be effective for some months. Where to obtain it and other information about it they do not know. Norplant® is not mentioned by all informants.
Abortion experience

Abortion is a common practice to regulate birth in case of contraceptive failure. Though some of the informants mentioned abortion as a sinful practice because it kills the foetus, most of men and women are concerned more about the future of their children than the foetus, which is still a **cuc máu**, ‘a clot of blood.’ All informants associate abortion with health risks and economic loss, but view it as a method of last resort but acceptable to maintain the desired small family (see section **Desire to control fertility** for more details). The desire to maintain a small family outweighs possible risks associated with abortion. They would want to avoid abortion, but when contraception fails, abortion is the only possible solution for them: “Abortion... It is terrible. I am so afraid of it. But I had to do it because I felt that if I could not afford to have more children, then I have to do abortion though I am so afraid of it” (F. 12-307). The main reason for fearing abortion was that abortion is perceived as an medical intervention in the women’s body, which can bring painful suffering, infection, and blood loss.

Main motivation for doing abortion is that once they can not afford to provide good education, food, clothing etc. for the unplanned child (see **Desire to control fertility**), it is better to stop the foetus when it is still a “clot of blood.” They often compare the hardship they have experienced, with the future that they want to give to their children. All informants wanted to give their children a better live than what they have experienced.

Though men and women accept abortion as a back up solution to regulate their fertility, they feel awkward about their own abortion experience. While talking about abortion, some women would recall the number of abortions they have experienced, but did not state explicitly about the date of abortion. The two others took their recent abortion experience as if it happened long time ago. The reason is that both men and women see abortion as their failure in using contraceptives, which is introduced and become a common practice for a long time ago. They feel ‘backward’ when they fail in contraceptive use. Abortion is, according to them, as indirect indication of their lack of knowledge and their failure to control their sexuality. Thus, they rarely communicate with other people about their abortion experience, fearing to be talked about as being an **dè cu’,** ‘old goat,’ the term denotes sexually overactive person.
IV. Discussion and conclusion

Decision-making to regulate fertility is a complex process. It 'situates' not only on socio-cultural but also and political economic contexts (Greenhalgh 1995: 5). My findings suggest that the decision-making process of the Vietnamese couples on birth control, is shaped by social, political economic context and based on cultural perceptions of their own reproductive status i.e. how many and when to have children, and how to control their fertility using different birth control methods. Moreover, birth control is not just a simple men’s or women decision. In contrast, men and women communicate their needs and desires, plan and implement their lives within a broad context of norms, practices, and learned experiences, which are shaped in social, cultural and political economic context of Vietnam.

Pham Van Bich (1999) has argued that state policy has enormous impact in the life of Vietnamese family. In traditional patriarchal relations, husbands hardly involve in family care, while women are confined to private sphere. By creating image of harmonious happy family with two children, where both husband and wife equally involve and share responsibility in caring children, maintaining happy family, the state policy promoting gender equality creates big changes in Vietnamese family, specifically in gender division of labour.

My findings show that men are taking part in women tasks, while women take over men tasks. Though the policy implementation is not ideal (Truong 1996), the state policy to promote gender equality since 1945 and traditional high status of Vietnamese women compared to their counterparts in other Asian country (Barry 1996) has given its fruits. My findings on gender division of labour are similar to those of another study in Red River Delta (Schenk-Sandbergen and Le Thi Nham Tuyet 1996: 67). In that study, Vietnamese women have reasonable autonomy in controlling their own bodies: 24.3% of women report that they make decision concerning having children by their own in decision making, 62.3%- together with their husbands, and only in 5.6%- the husbands decide. The study also (ibid. 39-42) finds that in the Red River Delta men’s migration has strong impact on gender division of labour: men participate in some women’s activities while many women take over men’s task.

The findings also show that state policy on population strongly affects the way, in which men and women make decisions and share responsibilities in controlling their
fertility. Couples’ decisions to control their births highly agree with political economic context in Vietnam. This explains the fact that many couples perceive family planning as ‘their own’ matter rather than ‘state’ interference.

Recent changes in economic situation affect couples’ fertility decisions. Introduction of user fees in education, health care, and other state welfares, which were free of charge in the past, raises the costs and economic burden of childrearing and imposes certain constrains for the couples to have many children. However, in some context the desire to provide better living standard for children, couples’ social, cultural, and economic status do not affect couple’s desire as much as the desire to have both son and daughter, or có dép có tê, ‘to have both sticky and ordinary rice.’ Most of the informants state that they are ‘forced’ to have small family because of their perceived (in)capacity to overcome economic burdens of raising children and providing them a good life: education, clothing etc. Some couples, knowing that they have to pay for sanction ready to try again and again, hoping to get a child of other sex. Others without a son clearly state that they might try again to get a son when their economic status is improved.

The state propaganda and the calls for men and women implementation of family planning affect the way, in which couples wants to build their life. All informants say that they cùng kê hoach, ‘jointly plan’ or cùng thực hiện, ‘jointly realize’ their kê hoach, ‘plan.’ All informants clearly want to ‘plan’ their life as well as fertility. According to them, kê hoach hoạch gia đình là trách nhiệm của cả hai, ‘family planning is joint responsibility of both.’ This ‘joint responsibility’ often realized by sharing decision-making, sharing and communication information on family planning, and sharing the burden of contraceptive use: though women are the main carriers of contraceptive burdens, men are ready to come for help by using male contraceptives. Their shared responsibility in family planning often goes beyond contraceptive use. They also share decision in case of contraceptive failure.

However, implementation of the population policy, as well as the realisation of couples’ decisions to plan their lives, places more responsibility and physical burdens on women. Historically, lack of resources caused the limited choices of contraceptives and left factual implementation of the population policy to women. Long period of international isolation, the collapse of economic systems in the 80s, and its impacts on health sector until beginning of the 90s (see Country’s background) made the IUD
almost the only available method to women. This made women faced with the ‘dilemma’ of limited contraceptive choice and state population policy (Johansson 1998).

Nowadays, couples’ contraceptive choices still are limited. Although women choices are often limited within the IUD, a few ranges of pills, and tubal ligation, men’s choices are even more limited. Vasectomy is the most effective male method but it is irreversible. This makes it not a common practice. Withdrawal and periodic abstinence are unreliable. Condom, the only effective and reversible male method, is provided in limited range and with unsatisfied quality.

Furthermore, the service provision promotes female rather than male methods. Incentives, numerical target setting, and monitoring make providers prefer IUD to other methods. Except irreversible vasectomy, only female methods are provided free of charge and only IUDs are promoted regularly in IUD insertion campaigns. Condom, the only male reversible and effective method, is not free of charge. Yet, around available condoms, there are a lot of dissatisfactions concerning their quality. They are thick, tight, and often break. Thus, when a couple uses male contraceptives and fails; women are the main carriers of physical and psycho-emotional burdens of abortion, though both men and women face with equal economic burdens. High abortion rate in the studied sample points out that physical burden of contraceptive failure lies mainly on women.

Besides influence of the political economic situation, social cultural perceptions of different birth control methods and fertility practices are important factors that shape couples’ decision-making in contraceptive choices. Craig (2000) has shown that Vietnamese layperson often combine biomedical concepts with popular knowledge about indication, contraindication and effectiveness of medicines. The choice of medicine is often based on what medicine is ‘suit,’ to the layperson. Similarly, lay perception of modern contraceptives introduced by biomedical personnel is some kind of creolization of biomedical knowledge and lay learned experience about the contraceptive. From their own experiences, which are communicated among users and potential users, lay (wo)men learned about contraceptive side effect and potential risks associated with contraceptive use. If a chosen method does not give any side effects, it means they are ‘compatible,’ with that method.
The concepts that different contraceptives are ‘suit’ for different couples make perception and experiences of the informants in my study differ from those experiences and experience described in previous studies in Red River Delta. Gammeltoft (1999: 14) has found that people feel obliged to have two or three children due to economic burden of state sanction though state policy consider normative change in people desire and practice for small family. In the contrary, my findings show that state population policy agrees with couples’ motivations for small family. Johansson et al. (1996, 1998) and Gammeltoft 1999) find out that women have negative experience of the IUD. For many women, IUD has become ‘point of condensation’ of their everyday life hardship and endurance, “IUD is perceived by women as a burden and self-sacrifice, a necessary tribute paid for the stability and economic survival of their family” (Gammeltoft 1999: 242). According to Gammeltoft, women’s complaints about IUD’s side effects were ‘somatic expression’ of their distress.

Explanation for such differences in my finding compared to the others probably is different study contexts. The period of 1994-1996, in which Johansson et al. and Gammeltoft did their studies, which followed after reinforcement of the two-child policy in 1993. Population policy at that period was implemented in a draconian manner (Goodkin 1995). Therefore, many people might not agree with the policy at that time. The manner, in which IUD was inserted in the past, makes women feel ‘forced’ to have IUD. If in the past, health providers resisted IUD removal, now women can get IUD removed on request. This makes women feel not being ‘forced’ to have IUD. The familiarity with the IUD makes people take it for granted as method of first choice. In addition, the period of 1990-95 characterised with the collapse of community health system, which was financed from agrarian cooperatives, which are temporary collapsed due to economic reform. Since 1995, there was a reform in financing of CHCs, which brought improvement in financing and performance of the CHCs. Some improvement in performance and counselling probably occurred since 1995.

Similar to women in the Gammeltoft’s study, many female informants in my study experienced back pains, headache, dizziness, increased fatigue, and prolonged and heavy menstrual bleeding after long period of IUD insertion. Women interpret these physical symptoms as indicator of whether they use, ‘compatible,’ the IUD or not. These physical symptoms do not get enough attention in the counselling practices. Several studies show that IUD use may result in lower level of haemoglobin and
ferritin. These studies suggest that IUD use in developing countries may exaggerate existing anaemia (Milsom et al. 1995, Hassan et al. 1999). To my knowledge, such studies are not available in Vietnam until now. Given high popularity of IUD in Vietnam, studies are needed to investigate the influence of IUD on manifestation of pre-clinical anaemia among Vietnamese women. Such study can contribute to IUD insertion and counselling practice, and can reduce women physical burden associated with the IUD.

In addition, gender division of labour affects the way, in which couples share responsibility for contraceptive decision. Gender division of labour places reproductive burden primarily on women. Normally, men come to help women only when she is overloaded with family chores. Although men and women make decisions on equal basics for big events, management of most of the every day life in the family places primary on women responsibilities. Very often, men use male contraceptives only when women cannot bear the burden of side effects caused by IUD and the pills. Event when a couple choose condom, responsibility on its purchase still relies on the wife.

However, the fact that some men use condom constantly from the start of their contraceptive lives indicates the diversity of decision-making process. It confirms the fact that men are ready to take responsible in contraceptive use. It point out that given the historical reasons of the familiarity of the IUD in Vietnam, couples have their own ideas of what is the best that ‘suit’ to them. It also indicates that even in the context of limited choice, some men are ready to take off the burden of contraceptive use from women; and male contraceptive use, specifically condom, depends on how a couple make the first choice on contraceptive use. The case No. 3 illustrates that in given context of limited choice, if a man wants to effectively take off the burden of family planning from their spouse; he finds his way to increase contraceptive choice.

Karra et al. (1997) note that men perceived them self as benevolent participants, whose participation increases male contraceptive use, and spousal communication does not engender male support for family planning in Indian families. Carter (1995) argues that people use their ‘agency’ to regulate fertility. Agnin and Shorter (1998) argued that contraceptive use depends on how Turkish women and men ‘negotiate’ on birth control rather than women ‘empowerment.’ However, using concept of ‘negotiated conduct,’ the authors view birth control as matter of women-subordinators, who have to ‘negotiate’ with or use their ‘agency’ against a benevolent husband, who have
dominating power in decision making to regulate fertility. This may be applicable in society when only women wanted to limit their fertility. But when both husband and wife interested in birth control, how do they make decision?

In the contrary, my findings show that the informants make decision on birth control together in equal basics, they cùng thực hiện, ‘jointly realize,’ their decision though in some cases women mainly are responsible for implementation of couple decision. Perhaps, different traditional gender role and state population policy has shape different gender role in contraceptive use. The findings shows that changed gender division of labour probably influence perception and practice of birth control. The process of men and women negotiation on contraceptive use shifts from separate men or women’s spheres to couple joined sphere. Yet, factual use of contraceptive often depends on available choices for a couple, as well as their own perception on how a contraceptive may work for them.

One may expect that different research approaches applied in different studies probably give different results i.e. while interviewing couple together, them are more likely to represent themselves as harmonious union and this may distort picture of gender relations. In this case, we probably can expect women and men to give different pictures at FGDs, organized for men and women separately. Yet, the information collected during FGDs confirms the same pattern of decision making revealed during ethnographic interviews. Furthermore, quantitative data confirm the fact that men do take part in family care. This strengthens my conclusion that men and women make decision together in birth control.

It is important to note that in my study many, men and women consider and use condoms constantly as a family planning method rather than a method to prevent STD. Some couples primary started using condom constantly as contraceptives, but more often, male condom use is in the second choice. Most of men are ready to participate in family planning when their wives cannot ‘bear’ the side effects of female contraceptives as IUD and the pills. This pattern of condom use differs from those of couples in the United State (Woodsoong & Koo 1999) Latin America (AVSC International & IPPF/ Western Hemisphere Region 1998: 13). In these regions, men and women in stable relation would switch from condom use to other methods for contraception; condom is primarily used as a method for prevention of STDs rather than pregnancy.
In sum, although women remain the main carriers of physical burden of family planning both in its implementation and in case of its failure, Vietnamese men in my study are taking responsibility in the family planning. The study provides some insights in the gender relation in family planning. It confirms high level of men responsibility in family planning. Perhaps, state population policy and gender policy have influenced gender division of labour as well as perception regarding gender roles in birth control. Though family planning lies largely in the female space, men are ready to take part when needed. Couples make decision on birth control together but implementation of the decision is often women responsibility, but men are ready to use of condom or withdrawal and periodic abstinence when women cannot use female contraceptives.

However, current provision of family planning is female oriented and challenges the male participation. It limits couples’ choices in different ways. Service provision promotes female methods, and makes them methods of first choice. Though women choices are limited, men’s choices of effective contraceptives are even more limited. To make men participation more effective in taking off the physical burden of family planning from women, the increase of men’s choice may be an effective way of men’s involvement in family planning. Given the limited choice of male contraceptives, some men realise their responsibility by using withdrawal and periodic abstinence, other find his way to increase the choice by trying different kinds of condoms. This indicates that within the limited possibility for men, diverse provision of condoms of good quality probably will increase condom use. Within the context of the lack of resources for the health sector, private provision of high quality condoms need to take into consideration. Yet, better marketing of diverse range of condom need to be done in order to provide more information for men. Effectiveness of experimental projects with interventions that provide condoms in diverse range together with marketing of different condoms need to be assessed. To motivate more men’s participation in effective contraception, such projects need to overcome the gender bias and providers’ preference in provision. Improvement in male condom use could gain double goals in the era of the AIDS epidemics.

Withdrawal and periodic abstinence are the methods that are the least effective, but require the most participation of men. Unfortunately, these methods do not get substantial attention from providers. The absence of information on couples using withdrawal and periodic abstinence in regular reports of the local family planning
programs indicates that these methods do not get enough attention from the providers. To increase men’s effective participation, men need to get adequate information on unreliability of withdrawal and periodic abstinence, and if these methods are men’s choice, men need to get enough information on effective use of withdrawal as well as its unreliability. How to provide information to the men within the current resource constrains and health care structure is a serious challenge, but this need to be taken in the future programs. Probably different male organisations and informal formations can be involved in this process.

Culturally, vasectomy is not widely accepted as a contraceptive of choice. Promotion and counselling on vasectomy to make it more acceptable to men can increase their choices and participation.

The study is exploratory and its result is not representative for the Liên Bão commune, therefore the quantitative data on condom use and abortion rate is not representative for the whole community. However, the findings show the gender dynamics in the birth control practices among Vietnamese couples. The results from ethnographic interviews have been triangulated by participation-observation and focus groups discussions, which provide strength for the above conclusions. The strength of the results makes it applicable to similar social, cultural and political economic settings.
Appendix 1: Life of Liên Bảo commune in pictures

Figure 1: Centre of the Lienbao Commune

Figure 2: Step-by-step house construction – a survival strategy because of the lack of cash for housing
Figure 3: Rice fields in Liên Bào

Figure 4: Immunisation day at the Liên Bào Community Health Centre
Figure 5: Market primarily is women space, very few men go to the market
Figure 6: Women and children harvested paddy rice from flooded fields

Figure 7: Ploughing is no longer men task only
Figure 8: Image of happy family in family planning posters

Figure 9: Problems caused by overpopulation (Family planning posters)
Appendix 2: Glossary of Vietnamese expressions

<table>
<thead>
<tr>
<th>Vietnamese</th>
<th>Literal translation (and or description)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cảc cụ</td>
<td>“The elderly”. Opinions of ‘the elderly’ often carry authority and respected. It also means folk knowledge and experience.</td>
</tr>
<tr>
<td>Chiến dịch đặt vòng</td>
<td>“IUD insertion campaign”</td>
</tr>
<tr>
<td>Có ngôi, có tế</td>
<td>“Have sticky and ordinary rice”</td>
</tr>
<tr>
<td>Cồng to việc lớn</td>
<td>“Big, important events”</td>
</tr>
<tr>
<td>Cùng thực hiện</td>
<td>Joint realization</td>
</tr>
<tr>
<td>Dế cụ</td>
<td>“An old goat” (Denote a person, who sexually is too active)</td>
</tr>
<tr>
<td>Dế một thẻ, con mọn, con mọn một thẻ</td>
<td>“Giving birth at once, having small children at length.” (To describe short birth spacing)</td>
</tr>
<tr>
<td>Đi lai</td>
<td>“Be on intimate relation,” (in this context it usually implies sexual intercourse).</td>
</tr>
<tr>
<td>Đổi mới</td>
<td>Political economic reform since 1986</td>
</tr>
<tr>
<td>Dưa cùng com</td>
<td>Performer of ancestral worship (imply a son)</td>
</tr>
<tr>
<td>ETYPE ép mǔ, aí nô ép duyên</td>
<td>“You can press to get oil, but you should not press to get love.” (Nobody can use pressure to get love).</td>
</tr>
<tr>
<td>Gia đình nghiệp sống</td>
<td>“Family of new life style”</td>
</tr>
<tr>
<td>Họ</td>
<td>“Compatible, compatibility”</td>
</tr>
<tr>
<td>Hút thai</td>
<td>“To suck the foetus” (to denote abortion by MVA/ or EVA)</td>
</tr>
<tr>
<td>Kế hoạch hoà gia dinh</td>
<td>Family planning</td>
</tr>
<tr>
<td>Làm trai rửa bất quyết, nhà, vợ gọi thì đa, bàm bà tối đầy</td>
<td>“A man washing the dishes and sweeping the floor, when his wife summons, he answers: ‘Here am I, Ma’am’.”</td>
</tr>
<tr>
<td>Vietnamese Word</td>
<td>English Translation</td>
</tr>
<tr>
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</tr>
<tr>
<td><em>Nào thai</em></td>
<td>“Scrape the foetus” (abortion of more than 12 weeks of gestation, D&amp;C)</td>
</tr>
<tr>
<td><em>Nơi tướng</em></td>
<td>“Internal general,” “internal manager”</td>
</tr>
<tr>
<td><em>Người nội đời tổ</em></td>
<td>“Family descent”</td>
</tr>
<tr>
<td><em>Phá thai</em></td>
<td>“To destroy foetus” (means induced pregnancy termination by any method)</td>
</tr>
<tr>
<td><em>Ông ngoại</em></td>
<td>“Maternal grandfather” (In some context, this term denote person without a daughter, who can be only maternal grandfather, but cannot be patrilinean grandfather)</td>
</tr>
<tr>
<td><em>Sinh hoạt vợ chồng</em></td>
<td>“Spousal living activities” (or sexual activities)</td>
</tr>
<tr>
<td><em>Sinh hoạt tình dục</em></td>
<td>“Sexual activities”</td>
</tr>
<tr>
<td><em>Sào</em></td>
<td>Vietnamese measurement in agriculture, equal to 360 sq. m.</td>
</tr>
<tr>
<td><em>(Husband) tâm li</em> (adj)</td>
<td>“Psychological” (in this context it means ‘sensible’ husband)</td>
</tr>
<tr>
<td><em>Tay xách nách mang</em></td>
<td>“Loaded with bundles” means having too close birth of small children</td>
</tr>
<tr>
<td><em>Thuận vợ thuận chồng, tất bé động</em></td>
<td>“When husband and wife in harmony, they can dry the East Chinese Sea.” (If both husband and wife agreed, they can complete any task)</td>
</tr>
<tr>
<td><em>Trách nhiệm của cả hai</em></td>
<td>Joint (husband and wife) responsibility</td>
</tr>
<tr>
<td><em>Trời sinh voi, trời sinh cỏ</em></td>
<td>“The God created elephants, the God will give also the grass.” (You can have as much children as God give you, the God will give every thing to the children)</td>
</tr>
<tr>
<td><em>Ua</em></td>
<td>“Fit/ suit/ suitable”</td>
</tr>
<tr>
<td><em>Xã hội hoá y tế</em></td>
<td>“Socialisation of health care”</td>
</tr>
</tbody>
</table>
Appendix 4: Some pictures used as interview guide for data collection

(For other pictures on gender division of labour in agricultural production and family care see Schenk-Sandbergen and Chuolamany-Khamphuo (1995)
ĐOỊ KỆ HOẠCH HÓA GIA ĐÌNH
Appendix 3: References

AGI (Alan Guttmacher Institute)

1999  

Allman, J., Vu Quy Nhan, Nguyen Minh Thang, Pham Bich San, & Vu Duy Man

1991  

Agnín, Z. & F.C. Shorter

1998  
Negotiating Reproduction and Gender During the Fertility Decline in Turkey. *Social Science & Medicine.* 47: 555-64.

AVSC International and IPPF/Western Hemisphere Region

1998  

Bac Ninh Population and Family Planning Commitee

1999  

Barbieri, M.J. Allman, Pham B.S., & Nguyen M.T.

1996  

Corrêa, S.

2000  

Council of Minister

1988  
Craig, D.

Do, Trong Hieu, John Stoeckel & Nguyen Van Tien

Gammeltoft, T.

Goodkin, D.

Goodkin, D.

Greenhalgh, S. (ed)

GSO

Hardon, A.

1997a Reproductive Rights in Practice. In Hardon, A., & E. Hayes (eds.): 
Reproductive Rights in Practice: A Feminist Report on the Quality of 

Hassan, E.O., M. El-Husseini, and N. El-Nahal

1999 The Effect of 1-year Use of the CuT-380A and Oral Contraceptive Pills 

Henshaw, S.K., S. Singh & T. Haas

Perspective. 25 (Supplement): S30-38

Hunte, P.A.

Newman (eds.), Women Medicine: A Cross Cultural Studies of 
Indigenous Fertility Regulation. New Brunswick: Rutgers University 
Press, p. 43-77.

Järnbért, A., B. Khang, N.T. Vinh, & N.N. Ham

1999 Comparative Study of Cervical Laminar Tent Prior to Extra-amniotic 
Injection of Ethacridine Lactate (Rivanol) and Condom-Melathon 
Catheter Methods for Second Trimester Pregnancy Interruption in 

Johansson, A., Le Thi Nham Tuyet, Nguyen The Lap, & K. Sunström

1996 Abortion in Context: Women’s Experience in Two Villages in Thai Binh 
Province, Vietnam. International Family Planning Perspectives. 22: 
103-107.
Johansson, A., Nguyen Thu Nga, Tran Quang Huy, Doan Du Dat, & K. Holmgren
1998  

Johansson A.
1998  
*Dream and Dilemmas – Women and Family Planning in Rural Vietnam*.  
Stockholm: Repro Print AB

JPRS (Joint Publication Research Service’s Series on East and Southeast Asia)
1989  

Karra, M.V., N.N. Stark, & J. Wolf
1997  

Knodel, J., Phan Thuc Anh, Truong Viet Dung, & Dao Xuan Vinh
1995  

Khuat, Thu Hong
1998  
*Studies on Sexuality in Vietnam: the Known and Unknown Issues*.  

Kubba, A., J. Guillebuad, R.A. Anderson, E.A. MacGregor
2000  

Milsom, I., K. Andersson, K. Jonasson, G. Lindstedt, and G. Rybo
1995  
MoH, NCPFP, VWU, Hanoi Obstetric and Gynaecological Hospital, Centre for Mother and Child Protection- Hochiminh city, AVSC International, & The Population Council

1997

Danh Gia Chien Luoc ve Chinh Sach, Chuong Trinh va Nghien Cuu Lien Quan Den Pha Thai o Viet Nam (A Strategic Assessment of Policy, Programs and Researches Related to Abortion in Vietnam). Unpublished draft report. Hanoi: MoH

Mundigo, A.I.

2000


NCPFP (National Council on Population and Family Planning)

2001


Newman, L. F (eds.)

1985


Nguyen, Minh Thang, B. Johnson, E. Landry & R. Columbia

1998

Client Perspectives on Quality of Reproductive Health Services in Viet Nam. *Asia-Pacific Population Journal* 13(4): 3-54

Nguyen, Minh Thang (ed).

1999

Nguyen Van Phai, J. Knodel, Mai Van Cam, Hoang Xuyen


Nguyen, Van Phai


Pham, Bich San, J.A. Ross, Nguyen, Lan Phuong, & Nguyen Duc Vinh


Pham, Van Bich

1999  *The Vietnamese Family in Change*. Richmond Surrey: Curzon

Phan, Thi Thu Ha, & S. R. Schuler


Schenk-Sandbergen, L. & Le Thi Nham Tuyet


Schenk-Sandbergen, L. & O. Choulamany-Khampuoi

1995  *Training Manual on Methodology, Use and Practice of Participatory Gender Studies for Irrigation Development, and Women and Development Approach*. Vientian: SRIDP (Strengthen and Reconstruction of Irrigation Development Project)
Tien Du District Committee on Population and Family Planning


Trinh, Huu Vach *et al.*


Truong, Thanh-Dam


United Nation (UN)

2001 *Population and Development Indicators for Asia and the Pacific, 2001.* Bangkok: ESCAP.

UNFPA

1995 *Male Involvement in Reproductive Health, Including Family Planning and Sexual Health.* Technical Report No. 28. UNFPA.

WHO


World Bank, & MoH


Woodsoong, C., & H.P. Koo