

Real life is different: A qualitative study of why women delay abortion until the second trimester in Vietnam

Maria F. Gallo^{a,*}, Nguyen C. Nghia^b

^a*Research and Evaluation, Ipas, 300 Market Street, Suite 200, Chapel Hill, NC 27516, USA*

^b*Hanoi Obstetrics and Gynecology Hospital, Hanoi, Vietnam*

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Abstract

Although legal and safe-induced abortion services are available on request in Vietnam, second-trimester abortion still occurs. Given the increased risks and higher costs associated with later-term abortions, we conducted a qualitative study to understand the determinants of delaying abortion until the second trimester. We used purposive sampling to conduct semi-structured face-to-face interviews with 60 women aged 14–47 receiving an abortion at 13–24 weeks of gestation in 5 health facilities in 3 provinces in Vietnam. We also interviewed 6 providers from the study facilities. Three broad categories for factors influencing delays in obtaining abortions emerged: most women failed to recognize their pregnancy during the first trimester; women described structural barriers to accessing services earlier; and some women either needed time to make a decision or only decided to abort after other events had transpired. A richer understanding of the factors that prevent women from obtaining an abortion during the first trimester could be useful for informing interventions that support women in receiving care earlier during their pregnancies.

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Introduction

Legal and safe-induced abortion services are available on request in Vietnam. The nation has 1 of the highest abortion ratios worldwide, with 45.1 abortions per 100 live births reported in 2000 (Committee for Population, Family and Children Vietnam & ORC Macro, 2003; Nghia & Khe, 2001). Unsafe abortion accounts for an estimated 11.5% of the direct causes of maternal mortality in Vietnam (MOH MCH/FP, 2003). The Ministry of

Health restricts second-trimester abortion to central and provincial public health facilities, contending that lower-level public facilities and the private health sector might lack trained health care providers, adequate medical equipment, or necessary emergency support (MOH, 2003). While national, official figures for second-trimester abortion are not available, second-trimester abortion accounted for an estimated 8–11% of the abortion caseload in 2001 at 3 referral hospitals where data were available (VINAGOFPA, 2002). Few studies have explored the barriers to obtaining an abortion in settings with accessible, safe elective abortion services (see Jewkes et al., 2005). Understanding the delays to obtaining abortion, though, is an

*Corresponding author. Tel.: +1 919 308 0144.

E-mail addresses: mfgallo@gmail.com (M.F. Gallo), nghia@email.unc.edu (N.C. Nghia).

important public health concern, given the higher risk of morbidity and mortality, additional time required of providers and clients, and increased health system costs associated with later-term abortions (Bartlett et al., 2004; Lawson et al., 1994).

Recently, the Vietnam MOH approved dilatation and evacuation (D&E) following misoprostol administration as the sole method for abortion at 12–18 weeks of gestation (MOH, 2003). Traditionally, however, the most prevalent second-trimester abortion procedure in Vietnam has involved a modified Kovac's method, in which a condom-covered catheter with saline solution is introduced into the cavity of the uterus in order to create strong pressure on the uterine cavity and induce labor (Nguyen, 2001). This method is associated with serious complications and is restricted in Vietnam to gestation of 16–22 weeks or greater (Baird, Castleman, Gringle, & Blumenthal, 2002; Jarnbert, Klang, Vinh, & Ham, 1999). Reliance on this method could delay services if women present earlier in the second trimester but then are instructed to return at a later gestation. Thus, second-trimester abortion could occur as a result of a shortage of providers trained or equipped to perform D&E.

We also hypothesized that women might obtain a second-trimester abortion if they only decide to abort after other events have transpired. For example, despite the illegality of the practice, Vietnamese cultural ideology related to the continuation of the ancestral line (Bélanger, 2002) might cause women to engage in sex-selective abortion after ultrasound in the second trimester reveals a female fetus. Furthermore, researchers have suggested that some Vietnamese individuals or couples use premarital pregnancy as a conscious strategy to obtain either their partner's acceptance of marriage or parental consent to wedlock (Efroymsen, Vu, & Nguyen, 1997; Gammeltoft, 2003). Thus, if pregnancy does not lead to the desired outcome, women might resort to a later-term abortion. Finally, because biological tests, such as chorionic villi sampling, used to detect common anomalies at an early gestational stage often are unavailable and because amniocentesis cannot be used for diagnostic purposes during the first trimester, fetal abnormalities generally are not diagnosed until at least the second trimester in Vietnam.

We conducted a qualitative study to understand the determinants of delaying obtaining abortion until the second trimester. A richer understanding

of the factors that prevent women from obtaining an abortion during the first trimester could be useful for informing interventions that support women in receiving more timely care.

Methods

We conducted semi-structured interviews with clients presenting for an abortion at 13–24 weeks of gestation in 5 health facilities in 3 provinces in Vietnam during May–August 2005. The study protocol stipulated that we would recruit consecutive eligible clients at each facility until 20 interviews were completed or 3 complete weeks of data collection elapsed (whichever occurred first). Thus, 1 of the authors (NCN), a male physician–researcher, interviewed 20 women at each of the 2 specialized obstetrics and gynecology hospitals in the north and south of the country; 17 women at the obstetrics and gynecology departments of a provincial-level ($N = 15$) and a national-level hospital ($N = 2$); and 3 women at a private clinic. Three additional recruited clients declined participation. The 5 facilities were selected to represent geographic diversity (delta, mountainous and midland) as well as the different clinical procedures used for second-trimester abortion.

The client interview guide consisted of open-ended questions with probes for the following topics: demographic factors; medical and obstetric history; process of recognizing pregnancy; abortion decision-making factors; barriers to abortion services; and reasons for delays in obtaining services. Only women who gave written informed consent (or informed assent accompanied by parental or guardian consent if <18 years of age) participated in the research. The informed consent and interview process lasted 45–90 min on average. Most interviews were conducted after the women were admitted to the facility and before the abortion; 2 were conducted between the abortion procedure and discharge.

We also interviewed 6 providers: 1 physician and the head midwife at each of the 2 specialized obstetrics and gynecology hospitals and 1 physician from each of the obstetrics and gynecology departments. The private clinic provider declined to be interviewed. The provider interview included questions about the facility's second-trimester abortion procedures, service fees, and client documentation and other requirements. We only interviewed providers who gave informed consent. We gave

both clients and providers a small monetary compensation for their participation time. The Vietnam MOH's ethics committee approved the research.

All client and provider interviews were conducted in Vietnamese and were audiotaped. After transcribing the interview proceedings, we analyzed the data with NU*DIST (QSR International, Cambridge, MA) software using an iterative coding process. We developed deductive codes before the interviews based on the key concepts of our hypothetical conceptual framework, following our hypothesized themes and literature review (e.g., Anonymous, 2006). We continued to develop the codebook during both the fieldwork and data analysis to identify new phenomena using inductive codes. We used both content and exploratory analysis approaches to understand the text. During the first review of the transcripts, we concentrated on patterns that fit the deductive codes and any newly developed codes. Non-relevant deductive codes (e.g., “maternal chronic disease” and “fear of abortion procedure, pain or complication”) were deleted and some deductive codes were modified to reflect participant responses more accurately. Subsequent transcript reviews focused on identifying new patterns. The final codebook included 45 deductive codes and 16 inductive codes. NCN was the sole coder. Only the final findings were translated into English (also by NCN).

Results

The providers described diverse methods employed by the facilities for second-trimester abortion (Table 1). Two facilities used the modified Kovac's procedure for late second-trimester abortion; 3 facilities provided D&E for second-trimester procedures before 15–16 gestational weeks; and 3 offered medication abortion with misoprostol.

The sociodemographic characteristics of the 60 client respondents are shown in Table 2. Their mean age was 27.3 years (SD, 7.1; range, 14–47), and just over half (53%) were unmarried. Most clients either had high school (22%) or college-level education (35%). Only 4 respondents were ethnic minorities (i.e., Tay and Sanchi).

Three broad categories for the reasons for experiencing delays in obtaining abortions emerged. First, many women failed to recognize their pregnancy during the first trimester. Women also reported structural barriers to obtaining timely

services. Finally, some women either hesitated to make a decision or decided to abort only after other events had transpired. Almost all women described multiple—and overlapping—factors that influenced the timing of the receipt of services.

Lack of early pregnancy detection

Eighty percent of women failed to identify their pregnancy before 12 weeks of gestation (Table 3). One-third of study participants ($n = 20$) reported having irregular menses, a condition that could interfere with early pregnancy detection. Fourteen women reported experiencing irregular menses since puberty while 4 women attributed their menstrual changes to advanced age. One woman said she was advised by her physician of possible menstrual changes from using anti-osteoporosis medicine, and a second thought that her irregular menses was the result of anesthesia use from a recent operation.

... my case is different. Before Tet [Lunar New Year], in February, I had an operation on my leg. I thought the anesthesia drugs made me lose my period. I was *chu quan* [“state of not paying much attention”] and didn't think that I was pregnant. (Office worker, aged 25 years, unmarried)

Five single, non-lactating women had amenorrhea without realizing that this was a symptom of pregnancy. For example, a farmer, aged 24 years, reported that she did not feel “strange” and simply thought that amenorrhea “happens sometimes.” Likewise, a student, aged 20 years, said that she had never learned about pregnancy symptoms. The others thought that their cessation of menses was a consequence of advanced age or engaging in hard physical labor or stressful employment.

I thought I wouldn't have my period anymore. I didn't feel anything abnormal. In previous times [pregnancies], I did sometimes feel like eating this or that. This time, I was still working very hard in the field, and I was healthy. So I didn't have an examination until my pregnancy was big. (Farmer, aged 35 years, with 4 children and abortion at 23 gestational weeks)

The 8 women who were lactating believed that conception was unlikely even though, in some cases, their infant was older than 6 months or they had experienced irregular, postpartum menses. (Lactation is an effective method of preventing pregnancy among women who are within 6 months of delivery,

Table 1
Abortion method and client requirements by study facility reported by facility provider(s), Vietnam, 2005

Facility	Abortion method by gestational weeks completed	Fees	Client requirements
Obstetrics/gynecology hospital in Northern Vietnam	<ul style="list-style-type: none"> ● <i>12–15 weeks</i>: 400 mcg misoprostol buccally followed 4 h later by D&E; second dose of misoprostol possible ● <i>16+ weeks</i>: 400 mcg misoprostol buccally every 3 h until completion or total of 10 doses administered 	<ul style="list-style-type: none"> ● <i>D&E</i>: \$45 USD ● <i>Medication abortion</i>: \$65 USD 	<ul style="list-style-type: none"> ● <i>Married</i>: Identification card, family book, and letter of commitment signed by client and her husband ● <i>Unmarried</i>: Identity card or written document authorizing procedure by administrator from her area of residence ● <i>Exception</i>: Minors (<18 years of age) need a parent or guardian with identification card
Obstetrics/gynecology hospital in Southern Vietnam	<ul style="list-style-type: none"> ● <i>12–16 weeks</i>: 400 mcg misoprostol buccally followed 4 h later by D&E; second dose of misoprostol possible ● <i>17–18 weeks</i>: No services provided ● <i>18+ weeks</i>: Modified Kovac's procedure 	<ul style="list-style-type: none"> ● <i>D&E</i>: \$65 USD ● <i>Kovac's method</i>: ~\$65 USD^{a,b} 	<ul style="list-style-type: none"> ● <i>Married or unmarried</i>: Name and address ● <i>Exception</i>: Unmarried minors need the presence of parent
Obstetrics/gynecology department in provincial-level hospital	<ul style="list-style-type: none"> ● <i>12–15 weeks</i>: 400 mcg misoprostol buccally followed 4 h later by D&E; second dose of misoprostol possible ● <i>16+ weeks</i>: Modified Kovac's procedure 	^a	<ul style="list-style-type: none"> ● <i>D&E</i>: Name and address ● <i>Kovac's procedure</i>: Letter of commitment signed by client and her husband; presence of guardian if client is unmarried. ● <i>Exception</i>: Minors need the presence of parent or guardian
Obstetrics/gynecology department in national-level hospital	<ul style="list-style-type: none"> ● <i>13–24 weeks</i>: 200 mcg misoprostol vaginally followed by second dose after 4 h if needed. May give oxytocin intravenously 	^a	<ul style="list-style-type: none"> ● <i>Married</i>: Identification card, family book, and letter of commitment signed by client and her husband ● <i>Unmarried</i>: Identity card or written document authorizing procedure by administrator from her area of residence ● <i>Exception</i>: Minors (<18 years of age) need a parent or guardian with identification card
Private clinic	<ul style="list-style-type: none"> ● <i>13–24 weeks</i>: 200 mcg misoprostol orally and 200 mcg misoprostol vaginally; second dose possible after 6 h 	Data not available	Data not available

^aDepends on length of hospital stay and medications used.

^bFee could be reduced or waived in cases of low income, fetal anomalies or contraceptive failures.

who have not had menses return yet after delivery, and who have not yet introduced solids or supplements to their infant. See Kennedy & Trussell, 2004). Some were waiting for the return of menstruation before beginning contraception.

One month after the delivery of our second child, we had *quan he vo chong* [“wife–husband activity” implying sexual intercourse between a married couple] without any contraceptive methods. My period hadn't come back. I had heard

Table 2
Sociodemographic characteristics of 60 second-trimester abortion clients, Vietnam, 2005

Characteristic	N	%
Marital status		
Married	28	47
Unmarried	32	53
Age (in years)		
≤20	7	12
21–39	50	83
≥40	3	5
Number of living children		
None	33	55
1	7	12
≥2	20	33
Education		
<High school	26	43
High school	13	22
>High school	21	35
Occupation		
Student	8	13
Laborer worker	12	20
Farmer	21	35
Office worker	12	20
Private business	5	8
Unemployed, non-student	2	3
Residence distance to facility		
< 30 km	30	50
30–50 km	10	17
> 50 km	20	33
Partner age		
≤20	2	3
21–39	46	77
≥40	12	20
Partner education, completed		
<High school	15	25
High school	14	23
>High school	18	30
Do not know	13	22

that I could get pregnant, even though I didn't have my period, but the likelihood is very low, so I was *chu quan* ["state of not paying much attention"]. (Private business owner, aged 28 years, with a 10-month-old infant)

I had my first child soon after my marriage. One year after giving birth, I used the IUD, and it was good. Last year, I had my IUD removed and got pregnant. This time, I planned to get an IUD, but I didn't have my first period yet. (Farmer, aged 29 years, with a 14-month-old infant)

Table 3
Gestational age at discovery of pregnancy and at abortion by marital status among 60 second-trimester abortion clients, Vietnam, 2005

Gestational age (in weeks)	Married		Unmarried	
	N	%	N	%
At discovery of pregnancy				
<12	6	21	6	19
12–16	18	64	17	53
≥17	4	14	9	28
At abortion				
12–16	12	43	16	50
17–24	16	57	16	50

Six women had pregnancy symptoms but mistakenly attributed them to other health conditions—especially gastric ulcers—or medicine use. For example, an unmarried accountant, aged 23, related that she had gotten “cold” in the winter, which she believed to have made her fall into an unhealthy state. Thus, even though she had nausea in the third gestational month, she attributed this to getting “cold” rather than a possible pregnancy.

Twenty-two of the 32 unmarried women reported contraceptive non-use. A common belief, expressed by 17 of the single women who were not using contraception, was that their low frequency of sexual intercourse made pregnancy unlikely. Among the 26 women (16 married and 10 unmarried) who reported contraception use, several described reliance on the withdrawal method or inconsistent contraceptive use. Two women thought that the protective effect of oral contraception against pregnancy would remain for an extended period (“some months”). Some used condoms only on the days when they thought they were fertile.

Only 3 women reported contraceptive failure. One woman had used an IUD for the past 6 years for pregnancy prevention; a second woman used emergency contraception without realizing that pregnancy was still possible; and a third respondent used a condom but only during the middle days of her cycle. One woman reported having regular intercourse without a contraceptive method because she believed her partner to be infertile. His parents had advised him that he had “very weak” sperm from a childhood disease. Another respondent had been told by her partner that she had a “high” *cua minh* (“body door” meaning vagina), which would

impair her fertility by preventing the passage of sperm. Thus, contraceptive failure (as a result of method failure or incorrect or inconsistent use); beliefs about fecundity related to infrequent intercourse; and inaccurate assessments of infertility could have prevented women from identifying their pregnancy earlier.

Four unmarried, young (aged 14–22 years) women were unaware of their pregnancy until relatives informed them. These cases demonstrated lack of knowledge about the reproductive process.

My mom knew that I didn't have my period recently, and she knew that I still had sexual relations with my partner. Some neighbors told her that I got pregnant, because when I was walking, the old people recognized that my appearance looked like a pregnant woman. (Unmarried farmer, aged 22 years)

Structural barriers

The respondents described factors that delayed their accessing or receiving adequate abortion services. Four women described difficulties in obtaining leave from an employer or taking time off from agricultural labor that had prevented them from obtaining health care earlier.

I work for a private company everyday from 7 AM to 10 PM. I have only a free evening on Saturday... I have a lot of work, I can't ask for my absence. I got an ultrasound a week ago. This time [visit to obtain the abortion], I told my boss that I wanted to visit my parent. (Unmarried laborer, aged 21 years)

You see, my family doesn't have many adolescents, my children are little, my husband is working far away, my husband's parents are too old to do anything. I had to finish the harvesting, planting, etc. before going for an examination. (Farmer, aged 35 years, with four children)

Other women experienced delays in ending their pregnancy as a result of deficiencies in their health care. Four women visited a health care provider at 2.5–8 weeks after their expected menses for a pregnancy test and examination but the pregnancy was not detected. Two other women recognized their pregnancy early (at approximately 5–6 weeks of gestation) and received manual vacuum aspiration (MVA) at a hospital; however, their pregnancies continued. Two respondents sought an abortion

between 12 and 16 weeks of gestation at the study sites that did not perform D&E. They were told to return to the facility for an abortion after the gestation was advanced enough for the providers to perform the modified Kovac's procedure.

Most clients had sought abortion at another health facility prior to receiving services at the present site; 9 women had attended 2 or more prior facilities. Referrals might be appropriate if women present at a primary care facility at an advanced gestational age. However, the 9 women who attended multiple facilities before reaching the place where they received the procedure suggest that either providers did not make appropriate referrals or providers at authorized facilities did not provide the needed care. Rather than performing second-trimester abortion, providers at central and provincial facilities might opt to refer pregnant women to another health facility, a process that could lengthen the time to obtaining an abortion.

Two women stated that the compulsory documentation for obtaining a second-trimester abortion was a barrier. Facilities differed in their requirements (see Table 1), and providers held different opinions about the requirements. For example, a provider justified requiring a signed letter of commitment from husband for married clients based on the perceived need to involve the husband in the abortion decision-making as well as to confirm his acceptance of the risks of the procedure. In contrast, a provider at a facility with less stringent prerequisites warned that creating barriers to services could cause women to resort to illegal abortions from the *co moi* ("decoy-ducks") in front of the facility. (*Co moi* station themselves in front of hospitals or other service offices, where in exchange for payment, they "help" people who are unfamiliar with the procedures for receiving care. The term has a negative connotation; they are viewed as taking advantage of naïve individuals.)

...if we do make any barriers, the clients may be willing to get abortions somewhere else, or at illegal facilities, which may lead to many of dangers, even death. The Board of Directors always emphasizes that we have to do anything to make abortion services available and easily accessible; we can't get rid of our clients. If they get an abortion illegally, that is our fault.

Finally, services fees could have contributed to an increase in gestational age at the time of abortion. The surveyed providers differed in their views of

fees charged. One provider suggested that fees should be reduced for women who cannot afford them. A second provider, though, argued that charging low fees for second-trimester abortion could lead to more women obtaining these services: “Easy and cheap abortion may not be really good.” Despite sliding scale fees, about one-third of respondents recounted difficulties paying for the abortion. For example, a farmer, aged 33 years, with 2 children related that the second-trimester abortion fee was equivalent to their annual savings. Some women described borrowing money to pay for the procedure or needing time to acquire enough money for the procedure.

I had to wait until I got enough money. I had to wait for money sent from my family. This money is normally for my meals and studying fee in school. My boyfriend did so too. The total money for this time is more than one million [~63 USD]. I think the abortion fee is high. (Unmarried student, aged 22 years)

Early recognition with late abortion decision

A minority of women recognized the pregnancy early but only later decided to terminate it. One-fifth of respondents reported needing more than 1 month to reach a decision. Women might have hesitated to make a decision because of difficulties in reconciling conflicting social norms or socioeconomic conditions with their desires regarding the pregnancy. For example, strong pressure to preserve *the dien* (“face” roughly translated as “reputation,” “honor” or “prestige”) of their family was a prominent theme described by 17—especially rural—women as driving their decision to terminate pregnancy. *An com truoc keng* (“eating rice before the bell rings” or “premarital intercourse”) and pregnancy are perceived to hurt *the dien* of a family, even of an entire clan.

I didn’t want to get an abortion, but my parents are still in my homeland. If I had a pregnancy without a husband, people would start a lot of gossip, my parents would be ashamed. They wouldn’t be able to go out and see others. (Farmer, aged 22 years)

I’ve made a decision, even though I know about the possible dangers. First, I would like to keep my family *the dien*. It’s very important for my parents. We have a good relationship with each

other, and I really respect family value, over my own value. (Accountant, aged 23 years)

Nobody in my homeland accepts a woman having a baby without a husband [crying as she speaks]. They would talk a lot about that. They would say my parent don’t know how to teach me. My parent would lose *the dien*. (Worker, aged 22 years)

Some women said that they had wanted to keep the pregnancy but feared the social consequences. One adolescent respondent related that she would not be able to return to her family in their homeland if her pregnancy was known. Others described the social difficulties their parents would face in their homeland. A young farmer related that her parents would fear the reaction from their strict, conservative clan members: “If they [referring to clan members] knew, they would kill [literal meaning] me.” These conflicting forces—cultural norms against premarital intercourse or having a child out of wedlock combined with “moral skepticism” regarding the practice of abortion (Gammeltoft, 2002) or a desire to continue the pregnancy—could have caused women to hesitate in reaching a decision to abort.

Similarly, women might have hesitated in making a decision because of a conflict between wanting to continue the pregnancy and their economic or educational situations. About half of the women identified inadequate resources as the primary factor for ending their pregnancy.

My child is still so little, only 16 months, and he’s stunted. I sympathize so much with him. If I have another one, it will be very bad for him. If my family could earn more money, I would give birth one more time. (Farmer, aged 26 years, with two children)

Fifteen women specifically described negative consequences to their educational or employment opportunities from having a child at the present time. An unmarried student aged 20 years explained that she could not have a child and study at the same time. Other respondents described constraints on employment opportunities from childbearing.

I wanted to keep [the pregnancy] and get married at the moment [time that she detected her pregnancy, which was almost one month before the interview]. However, only some days later, I knew that I could be eligible for work abroad.

Abortion is compulsory. (Unmarried student, aged 21 years)

Thus, women might have been initially ambivalent about the pregnancy as a result of discordant demands from cultural mores, economic realities, or educational aspirations, and this ambivalence could have delayed their decision to seek an abortion.

While some women required a lengthy process for deciding on a course of action because of the complexity of the abortion decision, in other cases the late timing of abortion was due to a change in their decision about the pregnancy after other events had transpired. For example, women (or couples) might become pregnant on purpose in hopes of either enticing their partner to marry them or to convincing their parents to consent to their marriage. They might resort to a later-term abortion only after it is apparent that the strategy will not succeed. Several women stated that their plans to marry and keep the pregnancy were thwarted by their or their partner's parents. Parental opposition to marriage was based on a negative assessment of their partner's character (*an chôi co bac* meaning a "playboy" or "gambler"); "mental impairment" in the partner's family; partner's lack of land; or unknown reasons. One respondent's family did not accept her partner but, instead, arranged for an engagement with a different man, whom she did not know. The marriage conditions were predicated on her having an abortion: "My new partner's family is willing to forgive my fault, but they only accept to raise their own grandchild, not another's grandchild. He [fiancé] said he was the only child in his family, but he was willing to forgive me." As the sole offspring in his family, her new fiancé likely held a central familial role with much expected of him. His consent to marry a woman with a prior pregnancy would be considered unusual.

Six unmarried women aborted during the second trimester only after their partners ended their relationship. Among these women, 1 described physical violence from her partner before he left her for another woman, and a second related emotional abuse and threats of physical abuse from her partner before he ended the relationship. One woman was involved with a married man, who advised her to have an abortion on the grounds that they could only have a baby when they had a house together. The interviewer did not probe, though, to determine whether conceiving among these women was a conscious strategy that did not lead to the

desired outcome of marriage or whether the pregnancy contributed to the couple's breakup.

Two women based their decision on medically confirmed fetal anomalies. However, 9 women aborted because of unconfirmed fears of anomalies. Three of these respondents had undiagnosed influenza during early pregnancy and were worried about its effect on the fetus. Others expressed concerns about the effects of oral contraceptive or antibiotic use or else subscribed to unscientific beliefs.

I had heard that I could have my fetus examined by ultrasound at 13–14 weeks of gestation, then I can know the fetal development. I had it examined already. The physician told me that the fetus is normal, but that if I feel uncomfortable about it in my mind, I should abort. I had an exam in [hospital name] and here. I asked the doctors, but they said the decision depends on us. I also asked a well-known doctor, and he said nothing could be certain, and that it depends on me. (Worker, aged 29 years, with one child)

I didn't know I was pregnant during the first months, so I ate some peaches. You know, people told me that if I ate *dao diec* ["undeveloped"] peaches, my baby would be dumb [unable to speak]. I'm so anxious. I'm fearful of the future for my baby. (Unmarried architect, aged 25 years)

I didn't know I was pregnant when I was using the contraceptive pill. Now I am afraid that it may affect my baby. I've consulted with many people and visited some doctors. My husband's sister used the pill irregularly, later her son lost the ability to talk at the age of 5–6 years. The doctors here told me that it wouldn't affect [the fetus or the child in the future], but my mother thought that the doctor said so because she didn't want to terminate my pregnancy. If something wrong happened, who would take care of my baby? I believe what other people told me because they have experience... The doctor can say one thing, but real life is different. (Married high-school teacher, aged 24 years, without children)

Only 1 woman recounted aborting for sex selection. The respondent was a 28-year-old woman with a private business and 2 daughters, who had attempted to conceive a male offspring by controlling the day of conception and adhering to a special diet.

Discussion

Most women described multiple barriers to obtaining an abortion before the second trimester. We reported on all reasons expressed without attempting to determine their relative influence as this would have been difficult to discern. In some cases, women themselves might not be cognizant of the primary factors that prevented their obtaining earlier services. For example, some women lacked knowledge of pregnancy symptoms and, consequently, might not realize that their pregnancy could have been detected earlier. Furthermore, women might be reluctant to recount socially or legally proscribed behaviors. For example, although only 1 woman in the current study admitted to aborting after an ultrasound revealed that the fetus was female, women might have under-reported sex-selective abortion because of the illegality of the practice. The unbalanced male-to-female sex ratio measured in Vietnam (109/100 in 2002; [Committee for Population Family and Children Vietnam & ORC Macro, 2003](#)) suggests that abortion for sex selection might occur although the magnitude of the practice has been questioned ([Bélanger, Khuat, & Liu, 2003](#)). Sex-selective abortion has been documented in other settings with restrictive population policies, cultural emphasis on patrilineage, or strong preference for sons (see [Booth, Verma, & Beri, 1994](#); [Jha et al., 2006](#); [Lofstedt, Shusheng, & Johansson, 2004](#); [Miller, 2001](#)).

The study revealed several serious flaws in the health care system. The gap in services for women at 12–18 weeks of gestation at the facilities using the modified Kovac's procedure, the apparent lack of appropriate referrals evidenced by women attending multiple facilities before obtaining care, the false negative pregnancy tests, and the continued pregnancies among the women who received an early MVA abortion demonstrate important health system deficiencies. In addition, despite policies for reducing or waiving the fee for low-income women described by providers, about one-third of the clients experienced difficulties in paying. Providers in the current as well as past research in Vietnam ([WHO, 1999](#)) have argued that abortion fees should be set high enough to discourage reliance on abortion. However, this study demonstrated that the high fees charged at the facilities for second-trimester abortion (see [Table 1](#)) instead could further delay late-term abortions as a result of

women needing additional time to accumulate funds. Similarly, requiring minors to be accompanied by their parents or guardians in order to receive services could increase the gestational age at the time of abortion among adolescents hesitant to discuss the pregnancy with others. Furthermore, as 1 provider warned, the implementation of barriers, such as requiring parental presence or requiring documents (listed in [Table 1](#)), could lead women to access alternative—and potentially unsafe—abortion services.

Onerous requirements in other settings with legal access to safe abortion have been shown to lead to greater reliance on later-term abortion or unsafe abortion ([Jewkes et al., 2005](#)). For example, because women in Zambia must obtain signatures from 3 physicians (including 1 specialist) before receiving legal abortion services, many resort to illegal abortion ([Likwa & Whittaker, 1996](#)). Similarly, most abortions are performed outside of approved facilities in India, in part, because of numerous restrictions, such as limiting the legal practice of abortion to physicians and requiring a second medical opinion for a second-trimester abortion ([Hirve, 2004](#)).

The present study findings highlight the crucial need to improve women's knowledge of reproduction, fertility and contraception. For example, women underestimated the risk of pregnancy from infrequent intercourse; misinterpreted early pregnancy symptoms; and reported misconceptions about lactational amenorrhea. Currently, providers may be missing key opportunities to counsel women. For example, in their qualitative study conducted in the central hospital in Ho Chi Minh City, [Xinh, Binh, Phuong, and Goto \(2004\)](#) found that half of abortion clients did not receive contraception counseling. Efforts to improve education and health care counseling on reproduction-related topics are needed urgently.

Being diagnosed with fetal anomalies is a recognized cause of some second-trimester abortion (see [Anonymous, 2006](#)). For example, a study conducted in 1 US state showed that one-third of women with major fetal structural abnormalities identified during the second-trimester chose to abort ([Rauch et al., 2005](#)). Recent research in Vietnam, though, has documented a lack of provider training in fetal medicine and limited availability of genetic testing, which lead to uncertainty and anxiety on the part of both providers and women regarding understanding the risk and degree of fetal

abnormalities (Gammeltoft & Nguyen, 2006). The present study discovered that a high proportion of women attributed their decision to abort to non-medically supported concerns about gestational anomalies. Their reports suggest that physicians lack the ability to diagnose fetal anomalies and do not provide appropriate counseling for addressing the concerns of women. Consequently, women appear to elect to abort as a precaution. Alternatively, self-presentation bias could have led women to report this rationale for their late-term abortion rather than admit to a less socially acceptable reason, such as aborting for sex selection.

Finally, improved contraceptive services and education are needed. Gammeltoft (2002) suggests that unmarried Vietnamese youth might not use contraception in order to conform to social mores against premarital intercourse. Focusing on the spontaneity of the act—which necessitates contraceptive non-use—allows them to preserve their socio-moral identity. Our findings support this hypothesis in that most unmarried women admitted that they did not use contraception and many of these women cited infrequent sexual intercourse as the rationale for non-use. Furthermore, contraception services in Vietnam typically are targeted to married women and their husbands, leaving a gap in care for single people and adolescents (Bélanger & Khuat, 1999; WHO, 1999). Women in the current study also expressed concern about health risks from IUD and hormonal contraception use, which is consistent with other research conducted in this population (Johansson, Hoa, Tuyet, Bich, & Hojer, 1996; Xinh et al., 2004). Health concerns led some women to use contraception inconsistently or to rely on less effective methods, such as periodic abstinence and withdrawal, with abortion as a backup. A range of interventions—concentrating on behavioral changes, clinical counseling, provider education, school-based sexuality education, and social marketing—should be implemented to ensure that women adopt appropriate contraceptive practices.

In conclusion, the study findings reveal barriers and other issues that should be addressed to reduce the incidence of second-trimester abortion. However, given that some women only decide to abort in the second trimester after the detection of congenital anomalies or a change in relationship or employment status, the need for safe, accessible second-trimester abortion services will remain.

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