# CHAPTER V

# Conclusion and Recommendations

## 5.1 Conclusion

Obviously, abortion still remains one of the most hotly debated issues and it has been practiced worldwide. As far as economic, social and ideological aspects are concerned, there exist various debates between the pro-life and pro-choice of abortion, leading to serious conflicts. The major arguments turn around the issue of the sanctity of life (whether the embryo has a right to life or whether the woman's bodily rights justify abortion even if the embryo has a right to life) and the issue of controlling sexuality in society and the issue of a mother's choice (should women be the one who make a decision about abortion? should abortion be performed within appropriate time limits set by medical and scientific criteria?). Nowadays, there are a number of scholars, politicians, socialists, feminists, trade unionists and organizations raising their voices in an effort to find out the more suitable policies and laws. These social movements somehow create a springboard for social change in the future with the slogan: "It's the most basic right a woman has" and that women should be the ones who make their own decisions when or whether to have children based on their economic, physical and psychological background. Banning abortions is thus contrary to women's rights. In Thailand, there are calls for legalization of abortion because it will be a sounder and more humane social policy than prohibition. In addition, it is irrefutable that banning abortions does not eliminate them; it merely forces women to go the dangerous route of illegal or self-induced abortions that affect negatively women's health physically and mentally.

The differences in the laws on abortion between Thailand and Vietnam result from different factors such as religious beliefs, historical reasons, views on family planning issues, and conservative ideas about virginity as well as premarital sex.

In terms of religion, the Vietnamese leaders, as communists and atheists, consider Marxist-Leninist theories a firm background on which they build their laws and they have no belief in karmic consequences as Buddhists do. It can be inferred from this that the Vietnamese laws and policies on abortion are by no means affected by Buddhist principles as Thai's laws and policies are. In case of Thailand, a Buddhist country, although the Thai state claims that abortion is illegal, there is undeniable evidence showing that a number of Buddhists in Thailand that have tolerant views on abortion issues and few people consider religion the prior concern when making decision about abortion. Thus, the excuse for making abortion illegal on Buddhist ground does not seem to be logical. Furthermore, it somehow reveals the fact that the abortion debate in Thailand is not simply about the killing, but it has something to do with issues related to women and sexual morality and it is the issue of sexual morality that affects women's decision. Thus, making abortion illegal has little to do with Buddhism and more to do with attempts to control women's behavior.

Regarding ideological reasons, even though Thai and Vietnamese women share the same traditional role as wife and mother, Thai women were free from the burden of wars and the pressure of giving birth to as many children as possible, while Vietnamese women had to suffer a lot from the colonial yoke to the Confucian dogmas.

As far as views on family planning are concerned, Thailand's government does not include abortion as a means to control population growth rate; meanwhile in Vietnam, abortion is legal and regarded as one of the important alternatives to terminate unwanted pregnancies. Furthermore, abortion as a tool of family planning in Vietnam is compulsory, whereas that is not the case in Thailand. To some extent, by legalizing abortion, Vietnam's government has been more successful than Thailand's in controlling complication cases. Thus, Thai government should consider this aspect and apply the similar solution that suits Thai condition in order to limit the complication cases that are increasing in current Thai society.

With reference to the issues of conservative ideas of virginity and premarital sex, it is obvious that although female virginity is highly valued in both Thai and Vietnamese societies, it is well documented that the practice of premarital sex has

existed in both countries. By making abortion illegal, Thai's government does not stop Thai women from making the decision to look for an abortion but simply make it unsafe for women, especially for poor women who cannot afford to seek a competent hand for their problem. After all, abortion manifests a women's desire to limit her fertility. Basically, the abortion issue is not simply about abortion but it somehow represents the value of women in society. Thus, women should have a right to make their own decisions regarding family issues and be responsible for their own lives.

Given the fact that the Thai public opinions have been changing in the concepts of religion, health and sexuality, and in the context of social economic transformation that leads to a more open-minded viewpoint toward the abortion issue, sexuality is no longer a strong taboo as it used to be. Instead, reinforcement of family planning and sex education are considered decisive factors to prevent abortion and its complications from galloping in Thailand. Thus, it can be included that the public acceptance of premarital sexual relationships are on the increase, and the youths today are less likely to value female virginity and more likely to accept premarital sex as well as the right to abortion. In Vietnam, the legality of abortion resulted from the government's effort to control population growth and to attend to women's productive health in order to enhance the quality of family planning service. Thanks to annual nationwide survey of the practice of abortion, methods of population control, and public opinion about premarital sex, the current government's focus is equipping people in the age of fertility with better knowledge related to reproductive health to prevent increasing premarital pregnancy. Importantly, Vietnamese government is making an enormous effort to include sex education in high-school curriculum for adolescents step by step because it comes to realize that it will be much worse to blind the youth to sexual issues: they may have access to unofficial and false information and the consequences are unpredictable. This new tendency is manifested through increasing sex education provided by a number of doctors and health providers who are invited to give lectures and discuss issues relating to productive health with students at schools and colleges. In brief, calls for sex education are true and urgent in the current society and it is undeniable that sex education should be systematically built and transferred. The reality cannot be covered or avoided, but it must be faced with calmness and wisdom. With good intentions and without bias, we together will find the way out.

## 5.2 Recommendations

In Asia and the Pacific, the Fifth Asian and Pacific Population Conference, held in Bangkok in December 2002, reported that some countries, including Thailand, had integrated family planning with other components of reproductive health services and was providing integrated services, whereas in Vietnam, the situation was different in that several government organizations were responsible for different service components. Both Thailand and Viet Nam had tried to encourage the involvement of communities and the private sector as well as introduced social-marketing mechanisms to provide non-clinical methods of contraception (UNESCAP, 2002). Even though the clear desire to provide integrated reproductive health services had been found, there were major obstacles that hindered progress, such as management arrangements, financial constraints, training of service providers and logistic systems. Thus, the fact was that these programs were not ready for integration and that the move towards a reproductive health approach might "dilute" family planning efforts. (Population Policies, 2003)

### 5.2.1 Efforts into improvement of family planning policy and family national program in Thailand and Vietnam

#### 5.2.1.1 In Thailand

Since the 1960s, the Government of Thailand has tried to sponsor an integrated national family planning program. The service network of the Thai Family Planning Program has tried to provide complete, accessible family planning services free of charge. The modern contraceptive prevalence rate is high, estimated in 1993 at 72 per cent and in 1997 at 75.2 per cent, according to the report of Family Planning and Population Division. Consequently, fertility has fallen dramatically in Thailand, in both urban and rural areas from 6.4 children per woman in 1965 to 2.6 by 1990 and 1.7 by 2000. The population growth rate is currently 0.9 per cent (2000). Despite the ready availability of contraceptives, however, several studies have shown that a significant proportion of abortion patients were not practicing any method of contraception prior to the most recent abortion.

It was stated that contraceptive methods, except for condoms, were used in the previous days. According to the research of The Population Division (1984: 11), almost all couples chose different kinds of methods that suit their current circumstances, e.g. pill and inject-tables seemed to be preferred by young couples; meanwhile, IUD or sterilization were chosen by most older couples. The most popular contraceptive method used by married couples is the contraceptive pill (28.4%), while female sterilization ranked second (23.9%) in popularity. Use of other kinds of methods is very low. (Family Planning and Population Division, 1998: 3)

In fact, the attitude towards family planning and the knowledge of abortion prove to be both significant, greatly affecting the attitude towards abortion. It was found that ***"those who have more knowledge of abortion and have a more positive attitude towards family planning tend to be more in favour of abortion than those who have not."*** (Siriboon, 1987). Moreover, the majority of people just viewed abortion as the only method of family planning that can bring down unwanted birth rates rapidly (National Family Planning Program, Ministry of Public health and The Population Council, 1972: 24). Due to the fact that even when precautions are taken, accidents can and do happen. For some families, this is not a problem. But for others, such an event can be catastrophic. An unintended pregnancy can increase tension, disrupt stability, and push people below the line of economic survival. Family planning, thus, should be taken into consideration as the answer. All options must be open in which such programs like family planning counseling, sex education, and contraception for those who wish it will be able to diminish the number of unwanted pregnancies before they occur.

Being well aware of this issue, Thailand's Sixth National Economic and Social Development Plan that covered the years 1987-1991 emphasized permanent contraceptive methods and attended specially to youth issues in order to decrease their fertility levels and rate of abortion (e.g. provided materials for adolescents on the topics of family planning). In fact, the Sixth Plan was achieved some other good results such as systematic study for family, expanded support for the provision of sterilization services at private hospital and clinics as well as social marketing system

throughout drugstores to improve the quality of services and contraceptive products (Family Planning and Population Division, 1998: 14-15).

Following this trend, Thailand's Eighth National Economics and Social Development Plan (1997-2001) focused on "human development" that considered people at the center of all development and activities so as to make the more sustainable development. Including in this goal are four major activities in the first sub-strategy concerning population and reproductive health:

- Firstly to sustain and maintain family planning activities in the areas that have replacement level fertility and promote family planning activities in the remaining high birth rate areas and Maternal and Child Health indices.

- Secondly to improve the quality of care in reproductive health

- Thirdly to develop a communication campaign and provide continuous education to the population in reproductive health its contexts and available services

- The final sub-strategy is to promote the social business programmes and increase community funds for reproductive health and quality of life within the community.

(Family Planning and Population Division, 1998: 18)

As confirmed in National policy on reproductive health declared in 1997 (cited in Family Planning and Population Division, 1998: 19-20), ***"All Thai citizens, at all ages, must have good reproductive life"*** in which ten reproductive health components were stated as follows:

- Family Planning: Counseling, services and Information Education Communication (IEC)

- Maternal and Child Health: Education and services for pre-natal care, safe delivery and post-natal care, especially breast feeding and infant and women's health care

HIV/ AIDS: Prevention and reduction

- Reproductive Tract Infection: Information, education and treatment

- Malignancy of Reproductive tract: Diagnosis, treatment and education
- Sex education, sexuality, Reproductive Health and responsible parenthood
- Adolescents Reproductive Health: information, education, counseling and services
- Abortion: Prevention of unsafe abortion and management of its consequences
- Infertility: Prevention and appropriate treatment
- Post-reproductive age and old age care: Information, education and care.

#### 5.2.1.2 In Vietnam

Emphasis on family planning varied greatly between Northern and Southern Provinces of Vietnam before unification. Beginning in 1962, in Northern provinces, the government planning policy was directed to reducing the rate of population growth. The use of certain relatively permanent contraceptive methods was promoted. Abortion on request (with the husband's consent) was available during the first trimester of pregnancy and was usually performed by vacuum curettage. In contrast, the family planning program in Southern provinces began in the late 1960s, largely in response to concern over maternal and infant mortality and the increasing numbers of illegal abortions. However, up until the early 1970s, family planning clinics offered services only to women with at least five living children. Even when family planning services were later expanded to include women with one living child, a marriage or cohabitation certificate was required to obtain services. In the mid 1970s, the Government of the Republic of Vietnam stated that family planning had been adopted as an official policy, but inadequate medical facilities made it impossible to implement an effective family planning program.

Since the unification of Vietnam, family planning has been considered a major national priority. In 1982, the National Committee for Population and Family Planning was founded and various family planning measures were adopted by the Government, including the use of abortion. After 1983, limiting families to two children became obligatory. Incentives for contraceptive and abortion acceptors, as well as penalties for family planning violations, were further increased in 1985 in an

effort to promote implementation of family planning. Vietnam has successfully lowered its total fertility rate over the period 1970-2000 from 5.9 children per women to 2.6.

On the other hand, abortion soon rose six-fold between 1982 and 1994 in Vietnam. The country had an estimated abortion rate of 83.3 abortions per 1,000 women in 1996, the highest in the world for that year according to the Alan Guttmacher Institute. The National Committee for Population and Family Planning reported the peak of 1.5 million abortions in 1998. These figures do not include a growing number of private-sector abortions, estimated at 500, 000 or more additional abortions per year. At the same time, the maternal mortality ratio of 160 maternal deaths per 100,000 live births is low, roughly a third of the regional rate of 440. Surveys indicate that contraceptive awareness is very high in the country, particularly in regard to IUDs, the predominant method. The use of modern contraceptive has grown steadily in the 1990s, from 38 per cent in 1988, to 44 per cent in 1994 and to 56 per cent in 1997, according to the most recent Demographic Health Survey. While the IUD remained the most widely used method, supply-based methods and the condom in particular were increasingly used. Yet, there still appears to be a substantial unmet demand for family planning, given the reliance upon pregnancy termination and menstrual regulation and the significant number of women not using contraceptives that do not desire another birth. Limited contraceptive choice, erratic supply and delivery problems in a largely agrarian and mountainous State are some of the continuing obstacles to family planning in Vietnam.

### 5.2.2 Recommendations for family planning policy and family national program in Thailand and Vietnam

#### 5.2.2.1 In Thailand

Abortion is obviously one of the major public health problems in Thailand. However, there have been no systematic basic data on this issue so far. There would appear to be a need for regular data collection on abortion including numbers of cases, age of client, marital status, urban-rural residence, clinical versus traditional methods, and the use of private versus public sector facilities, complications and related date.

Time series data would show the trend in abortions and analysis of data could give a picture of the extent to which abortion is an adolescent problem and a problem related to prostitution (Porapakkham, Vorapongsathorn & Pramanpol, 1986: 93-94). In addition, profiles of abortion cases could be compiled from the records of existing clinics without compromising the confidentiality of clients in order to focus on the extent to which adolescents are currently getting abortions. It is believed that a wider public should be well aware of the social reality of increasing level of non-commercial and pre-marital sexual interaction among the youth. Besides, there should be a kind of more tolerant attitude towards young women's sexuality so that the problem of gender bias that looks down on women for engaging in premarital sex can be decreased. At the same time, it is important to improve strategies to help young women to protect their pre-marital virginity if they wish so.

In fact, it is not that "Thailand's much vaunted 'reproductive revolution'" (Knodel, cited Ford & Kittisuksathit, 1996: 153) has been carried out effectively in solving the problem of youth sexuality and reproductive health. It must be taken into account the important effort in provision of family life and sexual education in schools and some other services that make family planning consultancy accessible to Thai youths (Ismartono &Koetsawang, cited in Ford & Kittisuksathit, 1996). Based on the study of Muangman, former Dean of Faculty of Public Health in Mahidol University (1979:12-18), among 1,598 adolescents interviewed, more "urban school" groups seem to develop sexually faster than the "urban and rural" factory groups. Moreover, the rural factory groups also give more incorrect answers regarding methods to test pregnancy. In terms of contraception, the factory groups use more condoms, pills and other methods, meanwhile among school group, the rural schools seem to have heard and seen more contraceptives than those in the urban. He also states out the problem of lacking information related to that issue, thus Thai youths still call for help, especially in field of ***consultation services***. Unfortunately, based on cultural barrier, it is not easy to make such an education practical in the real context. In addition, sex education is available only at the stage of general understanding, meanwhile a real high-practical one is needed.

As a result, there are some recommendations and strategies for consultation and safe abortion services, together with effective family planning campaigns as follows:

- Besides the more active provision of family planning programmes and services, it is necessary to give proper and timely counseling relevant to reproductive health, especially to the youths, and pay attention to some special, sensitive and confidential cases in case of need to address the socio-personal problems.

- Hospitals play undeniable important role in spreading the knowledge of contraceptive methods, other ***health centers and drugstores*** appear to be of great assistance as well. Thus, their knowledge should be updated and enhanced to serve better consultation services for the communities.
- It is necessary to set up hotlines to offer timely counseling and services for women in distress, as well as to attend to the need to improve foster care and adoption services at the community level.
- Safe and more available abortion services should be provided. It should be borne in mind that abortion itself is an unpleasant and disturbing issue, easily leading to psychological stress. Only when women have no choice do they choose to abort. Thus, physical check-up and psychological counseling as part of the healing process should be paid more attention to.
- It is useful that women who come for abortion at hospitals or clinics should be better informed about contraceptive methods and services to avoid "repeated abortion". In addition, women who do not come for abortion should also be consulted about the same information and services at the same places.

#### 5.2.2.2 In Vietnam

The International Conference on Population and Development called for government and other relevant organizations to reduce the abortion case by expanding and improving family planning services (WHO, 1999). It is believed that the high level of induced abortion in Vietnam somehow reflect the unmet need for effective contraception. Moreover, the findings once again confirm the need to improve the quality of care in the national family programs.

Vietnam's family planning programs greatly contribute to the improvement of reproductive health of Vietnamese women. Nevertheless, policy-makers and program managers have not had appropriate concerns about how to decrease the gallop of unwanted pregnancies and abortion cases, or how to improve the safety and quality of care of abortion services being provided in the public sector nationwide.

Thus, there are some recommendations as follows:

+ ***For abortion services***

- Material relevant to abortion and contraception should be available wherever abortion services are provided. Information should be in detail about appropriate use of each method, its effectiveness, and potential side-effects.

- It is important to conduct an in-depth assessment of potential users' need and perspectives, knowledge and attitude of health providers towards emergency contraception, as well as the capabilities of both public and private sector sources to provide appropriate method and information during counseling services for different potential clients.

- Post-abortion counseling needs to be enhanced. Clients should be provided with materials relevant to post-abortion recovery period with basic instructions, the warning signs for serious complications, information about return to fertility and family planning. They should be encouraged to pay a follow-up visit to the clinic as an assessment of their post-abortion general health status.

- Abortion services should be better equipped to facilitate counseling to make sure that all clients receive good abortion and family planning counseling. Providers should be well aware of the importance of providing information and emotional support to women before, during and after the abortion procedure.

### 5.2.3 Recommendations for sex education in Thailand and Vietnam

#### 5.2.3.1 The reality and attitude towards sex education in Thailand and Vietnam

According to Nitirat (2007: 27-30), and Tran (2004: 20-25), the attitudes of Thai and Vietnamese people toward sex education for adolescents can be chiefly classified into three groups by level of agreement. Firstly, they are groups of people who are still skeptical about the worth and value of sex education. Most of these people care about their own culture, especially the value of female virginity and not being promiscuous. Secondly, they are those who agree with "abstinence-only sex education" and oppose comprehensive sex education, focusing on safe sex. They view sex as a private issue and feel embarrassed to mention. As a result, they do not want to talk about sex openly, which implies that they might not support sex education. Thirdly, they are supporters of sex education with the belief that it is beneficial for Thai and Vietnamese adolescents. They are well aware of the youth's problems of productive health and regards sex education as a potential solution to their problems.

***"Accurate and straightforward information is essential. Problems will exist as long as our health classes explain only body parts and internal organs in technical terms, but skip information that teenagers are curious about and fail to tell them how they can take care of themselves when they do have sex ...It is impossible to tell them to entirely avoid sex until the time of marriage. Telling the youth to delay sex until they are physically and mentally mature would be preferable. Yet, our youth still need to be guided towards safe sexual behavior, including the correct and consistent use of condoms"*** (The Nation Reporter, 2003)

In an effort to enhance the health of adolescents, Thailand have used school-based sex education in both middle and high schools for more than two decades as a main strategy to prevent students from high-risk sexual behavior; meanwhile in Vietnam, there are basic reproductive health lessons given at schools in order to reduce morbidity and mortality caused by risky behavior and educate adolescents about all aspects of sexual health including reproduction, sexual intercourse and sexual behavior. Regretfully, sex education, to be honest, is still ineffective at appropriate level in many schools in both countries.

Department of Educational Technique (cited in Nitirat, 2007: 4) stated that sex education was just included as part of a comprehensive health education curriculum

taught at the middle and high school. The highlight is that sex education handbooks produced by outside organizations are occasionally distributed to Thai adolescents to improve the quality of the curriculum.

> ***Given the degree to which socially-constructed gender roles influence individual sexuality in every society, it is important to reduce the prevalence of practices which involve risk of infection and unwanted pregnancy through appropriate education programs. The problem is to overcome some societal taboos, which in Thailand restrict the adoption of sex education as a separate subject in national school curricular.*** (Gray & Punpuing, 1999: 43)

Similarly, sex education is not a separate subject in Vietnam as it should be; it is just included in the curriculum as part of Biology subject. The content is quite superficial and teachers have so far given lessons based entirely on the syllabus and hardly extend the lessons or give direct answers to the issues that their students are interested in or curious about.

#### 5.2.3.2 Some recommendations for both countries

**"There is no better time than now to have sex education in school. Do not just teach them about the science of reproduction, but also the pitfalls of unsafe sex"** (Kungsawanich, 2001).

***"It's necessary to provide youth with the knowledge they need to protect themselves from unwanted pregnancies and sexually transmitted diseases including HIV and AIDS,"*** said Dr Thanh from V-M hospital.

It should be noted that 52 sex education programs implemented in developing and developed countries in 2005 have shown that 99% of those did not affect sexual engagement and some were proved to have actually postponed sexual initiation (Kriby, Laris & Rolleri, cited in Nitirat, 2007: 236-237).

The goals and content of sex education vary from place to place although sex education for adolescents is typically understood as structured education to increase knowledge and skills related to sexual conduct that will ultimately enhance

reproductive health. Globally, the most common goals included in the majority of sex education programs can be classified into three groups: (Bruess & Greenberg, 2004)

1. Increase in knowledge and sills related to sexuality
- To provide accurate information about sexuality
- To reduce fear and anxiety about personal sexual and emotional development during puberty
- To integrate the notion of sex as a natural occurrence in a balanced and purposeful life
2. Improvement of behavioral control and problem solving
- To facilitate insight into personal sexual behaviors
- To promote more responsible and successful decision-making
- To develop skills to manage and resolve sexual problems
- To promote appropriate sexual expression
3. Enhancement of interpersonal relationships
- To enhance communication about sexual issues with partners and others
- To increase meaningful interpersonal relationships

Thailand and Vietnam should, therefore, be well aware of this structure of education and put forwards practical sex education lessons to achieve the above-mentioned goals. The content of sex education programs usually includes sexual growth and development, reproductive health, interpersonal relationships and intimacy, attitudes toward sex and body image, and gender roles. The ultimate purpose of providing sex education for adolescents is to enhance reproductive health, unwanted pregnancies, and abortions. Sex education should be viewed as a likely strategy to enhance reproductive health and should be a separate subject taught at schools. Numerous studies in Thailand and Vietnam as well as in other countries suggest that sex education-related programs developed by either health practitioners or by a community play an important role in improving youth's knowledge and positive attitudes about sex, and reducing risky sexual behaviors such as premarital sex and unsafe sex.

Due to the fact that family sex education is not found commonly both in Thailand and Vietnam, teachers and health providers should be considered proper sex

educators. Yet, there are a number of teachers admitting that they might not have adequate knowledge and skills to conduct sex education effectively and they have never got any chance to actually participate in sex education training, which results in the inevitable fact that most teachers use course book as the primary source of information. In addition, they feel embarrassed and lacking in confidence to deliver sex education effectively. Thus, sex education training is necessary in order to improve sex education among teachers in charge. Besides, teaching materials and technical aids, both audio and visual, should be well equipped to make sex education practical, interesting, and effective to students.