

The Growth of Biomedical Infertility Services in Vietnam: Access and Opportunities

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Abstract

This article focuses on the rise of biomedical infertility services in Vietnam since the late 1990s. While the number of ART service sites has grown over the past fifteen years, the patient demand outpaces the supply, and the economic and supply barriers are insurmountable for many potential patients. The article focuses on legal, economic and supply factors that affect the experience of seeking medical care for infertility, as well as explores the sociocultural context that shapes values related to the pursuit of treatment.

Key words: ART, assisted reproductive technologies, barriers, infertility, IVF, surrogacy, Vietnam.

Introduction and Background

From an anthropological perspective the challenge of infertility and the use of assisted reproductive technologies (ARTs) for its treatment must be viewed as complex – intertwining sociocultural values, and structural and institutional variables that shape the experience of infertility, its prevention, and treatment. The globalization of ARTs has enabled new reproductive possibilities, more recently in low-resource countries, although not equity in access (Ombelet, 2011). In most settings the use of ARTs has preceded its regulation. Regulations have arisen in contexts of local cultural values and institutional processes. It is in these settings in which everyday practices are enacted, reflecting “local moral worlds” of cultural values and politics that shape and situate the experience of infertility (Kleinman, 1995). How do the regulations of the state influence the practices of infertile patients and practitioners? Moreover, how do such regulations work in concert with regulations in regional countries to shape the local moral worlds of those seeking treatment for infertility?

Vietnam is a relative newcomer to biomedical infertility treatments, such as in vitro fertilization (IVF), and has benefitted from the global circulation of ARTs. After extensive planning beginning in 1990, overseas training of doctors, and collaboration with French infertility specialists, one state-run

hospital Từ Dũ Hospital in Ho Chi Minh City, Vietnam created a highly successful IVF and microsurgery centre. Vietnam’s first IVF births occurred in 1998. Từ Dũ Hospital made rapid strides in providing infertility services. The infertility clinic in this one hospital has more than 20,000 visits and more than 10,000 infertile couples per year, including 3000 IUI cycles, and 2000 IVF and related procedures (Wiersema et al., 2006). Anecdotally, doctors who planned the microsurgery centre reported a high level of tubal-factor infertility, although reliable national statistics are difficult to come by. Since 1998, more than ten assisted reproduction centres have been put into place in Vietnam, primarily in major urban areas (Ho Chi Minh City and Hanoi), and primarily in the state sector. Initially, unlike numerous other countries in which ARTs have flourished in the private medical sector, the proliferation of IVF was largely limited to public sector, including Từ Dũ Hospital, which quickly became the leader in biomedical assisted reproduction in Vietnam. Privatization of medicine has been gradual in Vietnam, initiated only in the late 1980s. The provision of ARTs in Vietnam reflects this trajectory and IVF has been slow to proliferate widely in the private sector in Vietnam, in part due to a guarded process of privatization of the medical services industry.

The IVF technology was received initially with some scepticism by women I spoke with, not all of

whom were infertile, and who questioned the quality of children that might be produced through the procedure. Ultimately, the technology was embraced by those seeking fertility treatments. The application of IVF itself, and the techniques associated with it developed quickly. Legal regulations of the use of the technologies followed after a delay of several years. After numerous IVF births and the first cases of surrogacy, in 2003 the law on Childbirth by Scientific Methods was promulgated which stipulated the use and limitations of ARTs in Vietnam, including the banning of surrogacy and restricting ARTs in unmarried women (Official Gazette, 2003).

Infertility has long been a cultural concern in Vietnam, where it is generally held that all women should become mothers (in addition to filling other roles in society), and infertility is seen as a serious social problem for women. Yet, only recently has infertility become a recognized problem on a policy level. For decades, infertility in Vietnam was eclipsed by emphasis on family planning, aiming to increase the use of contraceptives and to reduce the total fertility rate. Funding supported family planning efforts, but did not exist to grow the quality and availability of infertility treatments. After a focus on a one- or two- child family planning policy beginning in 1988, which reduced the fertility rate to replacement level, Vietnam shifted its policy emphasis to focus on population quality and setting reproductive health goals (Socialist Republic of Vietnam, 2006a). The national reproductive health strategy included objectives to reduce the incidence of infertility, and to promulgate laws on in vitro fertilization and surrogacy, an important recognition of the problem of infertility (Socialist Republic of Vietnam, 2006b). In its current Population and Reproductive Health Strategy (2011-2020) one of the objectives is to improve accessibility to infertility services and lower by half secondary infertility rates (Socialist Republic of Vietnam, 2011). The gradual inclusion of infertility in these strategies reflects the recognition of the need for effective infertility treatment, the stabilization of the total fertility rate, and socioeconomic change that has occurred as Vietnam has moved from a low- to middle-income country. These strategy decisions have coincided with the increase in infertility services and pre-existing desire for such services among the affected population. However, a number of intersecting factors currently exist that shape the experience of infertility and complicate the search for its treatment in Vietnam, and which constitute the focus of the current article.

Methodology

This article is based on ethnographic research conducted for nearly sixteen months in Hanoi, Vietnam and surrounding areas in 1995, 1997 and 2004, as

well as interviews in 2007 with medical professionals in France involved in Vietnam's first IVF births, and reviews of legal documents and media sources. The ethnographic research focused on the sociocultural and treatment experiences associated with infertility among 40 women who presented themselves as infertile and a comparison group of ten women who had at least one child and had not experienced infertility. Women ranged in age from twenty-one to fifty-five. Most interviews were tape-recorded, transcribed and translated. The primary sample of infertile women was drawn from one urban maternity hospital in Hanoi from women presenting as infertile. Follow-up interviews took place in women's homes or locations of their choosing. I also interviewed healthcare providers of infertility services, including medical doctors and traditional medicine practitioners. Follow-up research in 2004 with key informants from the same group examined changes in assisted reproduction treatments in Vietnam, perspectives on IVF, and the development of legislation regulating the use of ARTs. Ethical clearance for the research was provided by UCLA and Bryn Mawr College. I am unaware of any conflicts of interest.

Sociocultural Pressures and Infertility

Infertility is a serious social concern in Vietnam, especially for women who are often seen as the key to perpetuating the husband's patriline through the birth of a son. Culturally, the achievement of motherhood is important for women in Vietnam to attain full adult status. The birth of a child is believed to create a special form of sentiment (*tình cảm*) between a wife and husband. *Tình cảm* also grows between a pregnant woman and her foetus in utero and lays the groundwork for a close relationship with her child after birth. In addition to the growth of sentiment in utero, some people believe that the mother and foetus share nutrients and blood during gestation and these shared substances link them through the intimacy of the womb (Pashigian, 2009a). Infertility in a couple is often blamed on the woman and infertile women in Vietnam can be subjected to ostracism in their husband's extended family and community. Infertility in men is an understudied subject in Vietnam. Some men deny that they might be the cause of infertility in their marriage and avoid evaluation. Infertility threatens their masculinity and virility. Some women will assume the blame for infertility in their marriage even when the source is their husband. Women with primary infertility have a higher rate of divorce than their fertile counterparts. In a DHS study of women self-identifying as infertile, sixteen per cent of women with primary infertility were divorced or separated (Rutstein and Shah 2004).

In addition to the threat of divorce, numerous infertile married women fear their husband will take a second wife, with or without their knowledge (Pashigian, 2009a). Some of these women were asked by their husband to seek out a second wife for him. For centuries, polygamy served as a way to expand lineages and to address infertility, but has been illegal in Vietnam since 1959 (Pashigian, 2009a). The pressure to take a second wife can also come from the husband's parents and other relatives. Many of the social pressures to bear children have to do with beliefs about maintaining connections between the living and the deceased. Parents believe that when they are deceased, a son, typically the eldest son, must attend to them and previous generations of the patriline in both death and commemorative ceremonies to provide for the needs of the deceased in the spirit world. Thus, the greatest pressure to bear a child, particularly a boy who will continue to propitiate the ancestors, falls on the eldest son and his wife. Adoption is undesirable as the child is not from one's own "blood line" and people believe that the possibility of a negative family history on the part of the adopted child could bring bad luck to the receiving family. Moreover, there is concern that the adopted child will abandon the adoptive parents to search for its birth mother. For a married couple, the social pressures associated with infertility can lead to divorce, polygamy, or physical violence, although there also are childless couples who withstand social pressures with less acrimony. For some, this social context makes for a secretive approach to treatment seeking, with couples keeping secret from their families their search for treatment; and some wives pursue treatment without the knowledge of their husbands for fear of marital instability.

Legal Matters

In 2003, five years after the first IVF births in Vietnam, the government of Vietnam put in place a comprehensive law to govern the provision and use of biomedical infertility therapies including IVF, artificial insemination and related practices (Official Gazette, 2003). The law did two things: It clarified who qualified for assisted reproduction services and who could provide services (primarily state entities). It stipulated age limits, marital status and citizenship requirements for those seeking IVF. While it created opportunities, such as a relatively high cut off age for services (45 years for gamete recipients) compared to many countries, it also created limitations that include a ban on surrogacy; limited services for single women; restricted the use of donor ova to married couples; restricted the use of Vietnamese donor gametes to ethnic Vietnamese only; and sperm banks were largely restricted to the state sector. While the law provided needed clarification about

ART services, and protection of some groups, it also contributed to stratifying those who desired services by reproductive need, marital status, and ethnicity.

The law's ban on surrogacy has caused concern among medical practitioners whose patients might benefit from use of a surrogate, and among patients who seek surrogacy services. There has been a call for its revision (Tung, 2009). Currently, gestational surrogates are sought outside of Vietnam, or a woman willing to be impregnated by a man and give up the resulting child to him and his wife can be contracted illegally in the country. The law reflects cultural beliefs about gestation, that the woman gestating a pregnancy is culturally the mother even if she is not genetically related to the resulting child as in gestational surrogacy. However, like many other countries in the region that ban surrogacy, the restriction forces those desiring a child, and having no other assisted reproductive means to accomplish this than by means of surrogacy, to circumvent the law or seek services outside of the country.

Economic and Supply Barriers

Biomedical infertility treatment is expensive compared to the average household income. Treatment cost ranges from 1130-2265 euros per cycle, and services are only partly subsidized, so many costs are borne by the patient and family members (Tung, 2009). Monthly income on average for the country is 50 euros; 74 euros in urban areas; and 36 euros in rural areas (General Statistics Office of Vietnam, 2010b). For those who do not live in a metropolitan area with services, additional costs of treatment include travel to the hospital site, accommodation and food during the stay, which can be lengthy, and possibly transportation to and from the city and within the city during treatment. These costs alone can be prohibitive for those desiring services. The effects on access to treatment of the 2008 Vietnam Health Insurance Law, which mandates universal coverage by 2014, remain to be seen (Castel et al., 2011).

When demand for ARTs outpaces supply, there are multiple ways to stratify access and determine who should receive services. These can include: by need, chance of success, cost of treatment, and income of desiring parents (Dyer and Pennings, 2010). Since the first IVF births in Vietnam in 1998, there has been an unmet demand for services. Although there has been an increase in the number of clinical outlets for assisted reproductive technologies, there are still not enough accessible sites. Moreover, ART services are not available in rural areas where nearly 75 per cent of the population lives (General Statistics Office of Vietnam, 2010a). In the several years following the first IVF births and when only a few IVF centres existed in the country, the shortage of services led to instances of rationing with women

seeking services being turned away and asked to return at a later date (Pashigian, 2012a). For instance, one well-situated middle class teacher described her experiences seeking IVF treatment for the birth of her second child after an ectopic pregnancy. She was instructed by the hospital centre where she sought care to come back in several years if she had not yet had a child as there were women older than she who would be given priority (Pashigian, 2009b). She considered going to Ho Chi Minh City for treatment, concerned about her diminishing chances of having another birth as she aged. For this woman the most constraining factor in access to IVF treatment was a matter of availability based on stratification by perceived need, rather than cost. This sort of rationing reflected an orientation to a socialist, planned economy, long in place in Vietnam until the late 1980s in which the goal was to help as many people as possible by broadly distributing public resources, even if that meant – in this case - reducing the odds of birth success by privileging older bodies over younger ones. Thus, while wealth certainly makes it easier to pay for IVF treatments, access depends on a host of factors that include the qualifying criteria of the prospective patient including age and type of infertility condition.

Sperm donation also poses a dilemma. There are few sperm banks. The 2003 law regulating biomedical infertility therapies has restricted sperm banks to approved state sector facilities. Demand for sperm from the banks overwhelms supply. To contend with the shortage, the banks require patients who need donor sperm to bring a third party donor to the hospital to make a sperm deposit so the patient can make a separate withdrawal of an anonymous sperm sample (Tung, 2010). Some people prefer donor sperm that is anonymous. Cultural concerns about perceptions of incest and adultery shape the desire to seek sperm outside of the family. The desire for anonymous donor sperm stems from practical matters and cultural beliefs. Both individuals and medical practitioners have conveyed to me concerns that the mother of the child will pine for its father (the sperm donor), if she knows who it is, which will destroy her marriage to her husband. The 2003 law prohibits the sale of gametes, but penalties are minimal. Fresh sperm from the underground market has been reported in the mainstream media. Individuals sell sperm, as do brokers. Some donors reportedly are willing to have a health check and have sperm analysis if the customer pays for the medical check costs. Some are reportedly willing to impregnate a woman for a fee. Fees for donor sperm in the underground market have been reported to range from VND10million (364 euros) to VND6million (218 euros) depending on perceived quality of the donor in terms of education and other qualities such as height and attractiveness (Tuoi Tre, 2010). This supply issue poses a host of

problems, first and foremost the public health implications of the potential risk of transmission of HIV and STIs, among other health consequences.

Treatment Trajectories

There are two major systems of medicine used for infertility treatment in Vietnam: biomedical assisted reproductive treatments, and those in traditional medicine (*thuốc Đông y*). While many women seek biomedical services of varying levels of sophistication, some women pursue traditional medicine first and delay biomedical evaluation and treatment. Such a treatment trajectory may be due to the availability and proximity of traditional medicine services in contrast to biomedical ARTs, as well as comfort and familiarity with traditional medicine treatments (Pashigian, 2012b). Traditional medicine is believed to balance the body and address idiosyncratic and changing bodily health needs to rectify infertility, in contrast to biomedical treatments in which treatment is selected from a narrow array of techniques and medicine applicable to all female patients with a particular infertility condition. Further investigation is needed into current treatment trajectories. Is this behaviour unduly delaying treatment and lengthening the course of infertility? How might both traditional medicine practitioners and biomedical practitioners be included in addressing infertility? The previous generation typically began their treatment with traditional medicine or alternated between traditional treatments and biomedical treatments. Given increasing numbers of IVF centres, but sustained supply barriers, will future patients follow a similar trajectory?

Regulation and Regional Movement

Vietnam's ART regulatory environment does not exist in a vacuum and patients who can afford to cross national borders in the region in search of medical care look to neighbouring countries such as Thailand to seek services they cannot access at home, such as surrogacy. Most countries in the region ban commercial surrogacy including Vietnam, Taiwan, Singapore, Japan, and Hong Kong. Some of these countries ban all forms of surrogacy. Thailand has been the exception, neither condoning nor condemning commercial surrogacy, although legislation on the matter of commercial surrogacy has been pending. These regulations also have created a market in which Vietnamese women go to Thailand on tourist visas to be ovum donors or surrogates. In 2011, such movement across borders produced an ethically complex international legal case surrounding the discovery by authorities in Thailand of Vietnamese commercial surrogates working in suburban Bangkok, reportedly carrying babies for

Taiwanese couples. The Vietnamese surrogates were taken into custody by Thai authorities and subsequently the surrogates and the developing fetuses and newborns (who were not necessarily genetically related to the surrogates) were together repatriated to Vietnam under the United Nations protocol to prevent and punish trafficking in persons. Cases such as this one speak to the need to address the movement of persons across borders for infertility services as well as improved access to local services in their home countries. But they also encourage discussions of access to assisted reproduction as a right (Inhorn, 2009, 2011) and how best to balance legal environments that serve the majority of people in a country with those in the minority who desire infertility services that may not be available within their national borders (Pennings, 2002).

Summary

Infertility continues to be a significant social and policy concern in Vietnam. Increased availability of biomedical infertility services has improved access to treatment for a select group of patients, however barriers to access persist that include financial and geographic barriers to accessing treatment, access to safe donor gametes, and for some access to services that are legally unavailable in country. Gender beliefs affect treatment-seeking behaviour in some couples such that men may be more reticent to seek services than their wives, and women may not receive efficient or effective care without the evaluation of their husband. Additional research on both sperm and ovum donation in Vietnam would benefit the field of study. The increasing privatization of ART services will expand access to biomedical infertility services. Ongoing changes to the structural and institutional factors cited here, along with the changing regulatory environment will continue to mediate the treatment experience in Vietnam presenting new opportunities for those seeking infertility services.

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