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Abortion in Thailand: a Feminist Perspective

By Malee Lerdmaleewong, R.N., M.N.  
*Associate Director School of Nursing and Nursing Service  
Department Ramathibodi Hospital  
Associate Professor, Faculty of Medicine Mahidol University  
Bangkok, Thailand*  
Email: ramlm@mahidol.ac.th

and

Caroline Francis, B.A., M.A.  
*Visiting Lecturer  
Center of Human Resources Development  
Faculty of Graduate Studies  
Mahidol University Bangkok, Thailand*

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Caroline Francis

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## ABSTRACT

With the passing of the Fourth World Conference on Women in Beijing, China, women's issues in Asia have moved increasingly to the forefront. One such issue, abortion, continues to generate controversy as many women argue for protection and/or recognition of their reproductive rights. The objectives of this paper are threefold: (1) To examine the abortion debate in Thailand, identifying issues raised by Thai feminist scholars about the status of women; (2) To overview some of the more prominent feminist arguments regarding abortion (particularly those written by Canadian and American scholars) as a tool for defining women's reproductive rights; (3) To focus on a study of attitudes toward abortion among health care personnel and post-induced abortion patients in Bangkok, Thailand in order to discern the degree of support (if any) for feminist abortion arguments.

## INTRODUCTION

With the passing of the Fourth World Conference on Women in Beijing, China, women's issues in Asia have moved increasingly to the forefront. One such issue, abortion<sup>1</sup>, continues to generate controversy as many women argue for protection and/or recognition of their reproductive rights. Encapsulated within the realm of reproductive rights are issues of access, patriarchy, and familial roles. Women tell of their subjection to illegal and often unsafe abortion procedures, which result in feelings of shame, humiliation, and often fears of death or sterility. They identify patriarchal influences that accord them secondary status and inhibit them from making informed and independent reproductive decisions. They further comment on their traditional role of "woman as nurturer" which strongly goes against decisions to terminate pregnancy. A question emerges from the debate: with regards to a highly charged issue like abortion, what do we see in Thai feminist studies of abortion relative to the more international feminist debates on the subject?

The objectives of this paper are threefold: (1) To examine the abortion debate in Thailand, identifying issues raised by Thai feminist scholars about the status of women; (2) To overview some of the more prominent feminist arguments regarding abortion (particularly those written by Canadian and American scholars) as a tool for defining women's reproductive rights; (3) To focus on a study of attitudes toward abortion among health care personnel and post-induced abortion patients in Bangkok, Thailand in order to discern the degree of support (if any) for feminist abortion arguments.

It is hoped that such information may contribute to the growing body of literature on women's issues in this fast-developing nation. In addition, this paper calls for further feminist studies of this and other controversial issues that affect women in Asia.

## ABORTION IN THAILAND

### Abortion Legislation

Thailand's current abortion law became effective in 1956.<sup>2</sup> Under this legislation, a woman may obtain an abortion if there is substantial risk that continuation of the pregnancy would endanger the woman's health, or if the pregnancy resulted from rape or incest (Siriboon 1987). The term 'health' in these instances has been variously interpreted by physicians and health care personnel; generally speaking, it is defined in a strictly physical sense as endangerment to the woman's life (Rauyajin 1979; Population Council 1981).

Typical of countries where legal abortion services are seriously restricted, an underground system operates in Thailand whereby women seek illegal termination of their pregnancies (Simmons 1996). Exact numbers of women undergoing such procedures remain elusive; however, the number of illegal abortions appears to be on the increase (Worakamin 1995). By way of illustration, a 1978 national survey (International Fertility Research Program 1981) recorded over 26,000 induced abortions in rural Thailand. In 1993, the Ministry of Public Health estimated that as many as 80,000 illegal abortions were performed that year alone (Ratanakul 1998). Among the factors contributing to the rise in the number of illegal abortions are the country's national development plans to reduce population growth<sup>3</sup> and rapid modernization. Knodel et al. (1987) and Yoddumnern-Attig et al. (1992) have identified several socio-cultural factors influencing fertility decline in the country. One factor is the positive role played by Thailand's National Family Planning Program (NFPP) in increasing the accessibility and acceptance of contraceptives. This role has been crucial in raising awareness of the need for fertility regulation in Thailand's rapidly modernizing society (Yoddumnern-Attig 1995).

Second, profound economic changes have occurred in conjunction

with other fundamental changes in Thai social and familial structures. Many couples, for example, now feel that a large family size is an unnecessary burden that interferes with the parents' more immediate problem of raising and educating their children (Yoddumnern-Attig 1995). A study conducted by the East-West Center Population Institute (1990) discovered that small families—consisting of one or two children—tend to be wealthier, own more consumer goods, save more money, and have better-educated children than large families (four or more children). Yoddumnern-Attig (1992, 1995) further maintains that children have progressively come to be seen as consumers of parental energy rather than valuable contributors to the household, as in the past. In the words of one Northern Thai woman: “In the past, the parents' responsibility was to feed their children. Today the parents' responsibility and concern is to educate their children.” (Yoddumnern-Attig 1992, p. 20)

It is precisely these realities of modern life, i.e., the small family as ideal plus the demographic pressures affecting Thai society, which fuel the abortion debate in the country. While abortion runs contrary to the principles of Buddhism (a religion adhered to by almost 95% of the Thai population), evidence suggests that many Thais view abortion as a supplementary means of fertility control (see Knodel et al. 1987; Siriboon 1987). Among the most commonly cited reasons for illegally induced abortions are economic hardship, unreadiness or unwillingness to bear a child, and contraceptive failure (Rauyajin 1979; Ratanakul 1998).

The World Health Organization estimates that approximately 500,000 women around the world die each year from pregnancy-related causes (Cook 1993). Unsafe abortions “cause some 25 to 50% of [maternal] deaths, simply because women do not have access to family planning services they want and need, or have no access to safe procedures or to humane treatment for the complications of abortion” (in Cook 1993, p.73). Koetsawang and Koetsawang's 1984 study of the health hazards of illegally-induced abortion in Thailand suggests that while access to illegal but medically-skilled abortion services was available in private organizations and clinics across the country, such services were largely inaccessi-

ble to poor people and young adolescents because of high service fees. As a consequence, women regularly turned to unqualified people to perform illegal abortions.<sup>4</sup> Complications from such procedures included fever resulting from pelvic infection and excessive bleeding, which, in extreme cases can lead to death. Recent evidence (Worakamin 1995; Sopchokchai 1995) suggests that illegally-induced abortion continues to be a significant cause of maternal mortality in Thailand. The shame a woman feels before and after the procedure may lead her to neglect pre- and post-termination care, even with the best medical treatment and up-to-date technology (Simmons 1996).

#### The Status of Women in Thai Society

The fight for the protection and/or recognition of women's reproductive rights has been slow to develop in Thailand, compared with Western countries like the United States and Canada. The traditional view of men as protectors, leaders and breadwinners, and women as followers, homemakers and mothers remains pervasive, despite the fact that many women now work outside the home. From an early age, girls are taught to help with the family's domestic chores and to take care of younger siblings. In contrast, boys—especially in rural areas—are encouraged to assist their fathers in the fields and to run errands outside the home (Thomson and Bhongsvej 1995b).

According to Thomson and Bhongsvej (1995b, p. 6), the deep-rooted perceptions of the different roles of men and women shape the differential behavior patterns of boys and girls. Boys are taught to be strong, assertive, and in control of their emotions. Girls are taught to be submissive and to behave like ladies: soft-spoken, polite and non-assertive. For girls, emphasis is placed on being good daughters, good wives and good mothers. Women who do act assertively are sometimes criticized by Thai society at large as being “too radical” or “acting like a *farang* [imitating Westerners]” (Tantiwiranond and Pandey 1991, p. 162)<sup>5</sup>.

Yoddumnern-Attig (1995) states that the status of women in a soci-

ety is of great import in determining their reproductive health, since status permeates and affects all aspects of health. Assessing the position of women in Thai society, however, is fraught with difficulties. On one level, Thai women may be viewed as having a relatively high degree of status and autonomy. Compared with women in many parts of the developing world, women in Thailand rank high in literacy, participation in the labor force, and constitutionally-guaranteed equal rights (Thomson and Bhongsvej 1995b; Yoddumnern-Attig 1995). In addition, Thai women have the right to choose their own spouse, to maintain relationships with their relatives upon marriage, and to choose their place of marital residence. Within the family, Thai wives generally control the family budget and are key participants in important family decisions (e.g., family problems and family planning, such as family size, birth spacing and child care). Dyson and Moore (1983, as cited in Yoddumnern-Attig 1995, p. 49) characterize societies with a high degree of female autonomy as “possessing freedom of movement and association for adolescent and adult females; post-marital residence patterns that permit continued social contact between the bride and her natal kin; the ability of females to inherit and dispose of property; and some independent control in choice of marriage partners.” In this sense, Thai women act more independently in many areas than women in the majority of developing countries (Knodel et al. 1987; Yoddumnern-Attig 1995).

Despite these characteristics, traditional values and customs have ascribed a subordinate position to Thai women, leading to gender discrimination in areas of religion,<sup>6</sup> health, employment, representation before the law, and participation in political decision-making at all levels (Sopchokchai 1995; Thomson and Bhongsvej 1995b). In the employment sphere, women tend to earn less than men for equivalent work; they tend to be less educated than their male counterparts; and they tend to suffer from a lack of occupation safety and training opportunities on the job (Thomson and Bhongsvej 1995a). While they may be active politically as campaign organizers, supporters and voters, recent statistics show that Thai women hold less than 5% of decision-making positions at the

national level and only 1% at the local level (Thomson and Bhongsvej 1995b). Such negligible political opportunity places women in a compromised position to influence the shaping of public policies and the charting of the country's development directions that affect their lives and welfare. Women's issues and concerns were not well-articulated in the country's Sixth (1987–1991) and Seventh (1992–1996) National Development Plans (Sopchokchai 1995; Economic and Social Commission 1996). To fill this gap, the government appointed a team of experts to formulate a detailed twenty-year Women's Development Plan (1982–2001). The Plan sets forth objectives relating to women's basic needs, freedom of choice and participation in socioeconomic and political activities, and it includes fixed quantitative targets for women's development in the areas of health, education, employment, public administration, politics and law. To date, however, few aspects of the twenty-year plan have been integrated into existing five-year development plans.<sup>7</sup>

As Thai society experiences rapid economic and social change, increased public participation by women often conflicts with their traditional roles as wife/mother, grandmother, daughter and sister. The family—considered to be one of Thailand's most important institutions—has experienced significant changes in recent years, particularly with regards to size, composition, and the role of women. Parents' responsibilities to their children have been modified as the role of education becomes increasingly important. In the past, parents encouraged their daughters (and sons) to marry as soon as possible in order to establish social and economic security. Now, many parents want their children to obtain a stable financial future before marrying and having children. Census data indicate that there have been small but steady increases in the proportion of never-married individuals at each age bracket (see Economic and Social Commission 1996, p. 31). Yoddumnern-Attig (1995) further suggests that these changes have been accompanied by a steady increase in premarital sexuality, a practice which strongly conflicts with family-held proscriptions against sex before marriage and the widely held assumption that single women are unknowledgeable about sex. The incompatibility



of sexual innocence and sexual activity among younger women may contribute to a reluctance to discuss sexual experiences and, accordingly, may cause them to neglect family planning behaviors (Yoddumnern-Attig 1995).

In addition to single women, women who have families must juggle a number of different demands, including caring for husbands and children and working outside the home. With a greater proportion of women's lives spent outside the family or home, the multiple roles played by women may lead to role conflicts and family pressures. Working women may have to devote more time to their jobs and less time to caring for and socializing their children. They may also be unable to assume a number of domestic responsibilities, calling on other family members (particularly husbands and daughters) for assistance. The implication is that, in the future, family may be less central to the lives of many women (Yoddumnern-Attig 1995). Stresses associated with these role conflicts include health and social problems ranging from psychological distress and reproductive system problems to increases in the numbers of self-induced abortions and divorces (Chaiphibalsarisdi 1995; Yoddumnern-Attig 1995).

In Thai society, the term 'feminism' sometimes connotes strong anti-male and anti-family sentiments and is frowned upon by segments of the Thai population because of its association with confrontation (male hatred) and individual pursuits (bra-burning, free sex) (Tantiwiranond and Pandey 1991). Accordingly, the word 'feminist' is seldom applied to Thai female academics and women's organizations focusing on women's issues. Other terms, such as social welfare, autonomy, choice, and justice figure prominently in their calls for improved women's rights and status (Tantiwiranond and Pandey 1991).

Within the realm of reproductive health, these women's rights proponents have made several recommendations for changes in socioeconomic and legal structures which they believe will improve the overall situation of women in the country (see National Committee 1985; Meesook et al. 1995; Economic and Social Commission 1996). Of prime impor-

tance is the continued or increased availability of reproductive health services to all women, including family planning information and services. Participants at the World Health Assembly in May 1992 (Chaiphibalsarisdi 1995) concluded that:

Women must have access to family planning information and services to ensure their reproductive rights. The ability to decide freely and in an informed manner the number and spacing of one's children is the first step in enabling women to exercise other choices. When a woman realizes that she can make decisions regarding her reproductive function, this experience of autonomy spreads to other aspects of her life (p. 38).

In particular, female adolescents and young never-married women must have access to sex education from an early age onwards. Such educational opportunities may reduce the numbers of women who discontinue contraceptive methods or experience contraceptive failure because of inaccurate knowledge. In addition, it will encourage these groups to consider contraceptive usage from the onset of sexual activity, which in turn may help to curtail complications like HIV/AIDS transmission and self-induced abortions (Yoddumnern-Attig 1995).

Some women's organizations and concerned individuals (see Rauyajin 1979; National Committee 1985; Thomson and Bhongsvej 1995b) have argued for reform of the country's abortion laws, to ensure that when women do have unwanted pregnancies, they have access to safe procedures and quality care. Others have advocated that the law's purview at least be broadened to include situations when the fetus is physically or mentally infirm, and when pregnancy threatens a woman's mental health. Still others have stated that exceptions should be more extensive, to cover cases where there is an economic or social necessity, where the family has enough children, and where the contraceptive method has failed (National Committee 1985).

Because of the complex inter-relationship between the health of women and their social, political, cultural and economic situations, most women's groups also advance the greater participation of women in political spheres (as elected or appointed political representatives), in eco-

conomic spheres (particularly in administrative, managerial and executive positions), in religious circles, and in the legal realm (National Committee 1985; Thomson and Bhongsvej 1995a/b; Meesook et al. 1995). At the family level, equality between men and women must be promoted through the strengthening of husband-wife relations, including the equal sharing of responsibility for child care-giving and domestic duties (Yoddumnern-Attig 1995). The transformation of ingrained societal attitudes toward women and their status can only be possible, some believe (see Thomson and Bhongsvej 1995b), if women themselves are the starting point. As the first educators of future generations, women in their role as mothers are responsible for bringing up their children and for the socialization process whereby basic social values are inculcated. The empowerment of women through education, therefore, is crucial to facilitate advances toward the elimination of gender discrimination and inequality in future generations (Thomson and Bhongsvej 1995a/b).

For women today, the movement towards gender equality in Thai society, and more particularly the eradication of gender biases in the realm of reproductive health, requires general support from peers and the populace at large. The level of support for reforms in controversial areas like family planning education and abortion legislation must be determined before change can be effected. Evidence to date, however, suggests women's issues and concerns have not been well-articulated in public policy and have been slow to influence public opinion. Advocates of women's rights sporadically relate their positions through the media but have shown reluctance to organize mass protests for abortion reform. The fact that abortion legislation remains unchanged since the 1950s further underscores a tendency of the Thai populace to avoid controversial issues (Tantiwiranond and Pandey 1991; Simmons 1996).

In contrast, women in Western countries have been more successful in linking women's experiences and issues to the abortion debate. The next section describes the debate in the West and examines arguments raised by feminist scholars, particularly those in Canada and the United States.

## FEMINIST APPROACHES TO ABORTION: EVIDENCE FROM CANADA AND THE UNITED STATES

Abortion in the West stands at the center of an intense public controversy over religious and moral beliefs about the status of the fetus and a woman's right to make choices about pregnancy and motherhood (Jacobson, 1990). In the majority of discussions, the important issue is to determine whether, or at what stage of development, human fetuses have a right to life that outweighs the woman's interest in determining an unwanted pregnancy (Baylis et al. 1995). The relative attention given to the interests and experiences of women constitutes the most obvious differences between feminist and non-feminist approaches to abortion. Sherwin (1995) notes that feminists consider it self-evident that the pregnant woman is the subject of principal concern, while non-feminist accounts render the woman invisible and focus on the moral status of the developing fetus. The central premise of such arguments concerns the idea of personhood: abortion can be tolerated only if it can be proven that the fetus is lacking in some criterion of full personhood.

Anti-abortion advocates have structured the debate so that the fetus is accorded the same value as other human beings (and hence entitled not to be killed), while many defenders of abortion, in contrast, have argued that the fetus is without intrinsic value whatsoever (see Warren 1973, in Sherwin, 1995). Other scholars (see Roy et al. 1994) have taken a middle-ground approach, maintaining that the development of personhood reflects the gradual development of the fetus, whereby personhood is lacking in the early stages of pregnancy but present in the later stages. As Sherwin (1995, p. 442) concludes, the abortion debate rages between opponents who describe the fetus as an "innocent, vulnerable, morally important, separate being whose life is threatened and who must be protected at all costs, and abortion supporters who try to establish some sort of deficiency inherent to fetuses which removes them from the scope of the moral community . . . ."

Unlike non-feminist accounts which inevitably pit woman against fetus, feminist proponents maintain that fetal development must be examined in the context in which it occurs, within women's bodies rather than in imagined isolation. A number of feminist scholars (see Dworkin 1993) have criticized arguments which treat the woman and her fetus as morally and genetically separate entities and which overlook the special meaning of pregnancy for a woman. Catharine MacKinnon writes:

In my opinion and in the experience of many pregnant women, the fetus is a human form of life. It is alive . . . More than a body part but less than a person, where it is, is largely what it is. From the standpoint of the pregnant woman, it is both me and not me. It "is" the pregnant woman in the sense that it is in her and of her and is hers' more than anyone's. It is "not" her in the sense that she is not all that is there. (in Dworkin 1993, pp. 54–55)

For Mackinnon and other feminist writers (e.g., Sherwin 1995), fetuses are morally significant, but their status is relational rather than absolute. Fetuses do not have any independent existence without the support of a specific other; their very state of being is tied to that of the mother. To assume that her fetus is merely "in her," as an inanimate object might be, or something alive but alien that has been transplanted into her body, relegates a pregnant woman's experiences to the same level as the relationship between an employer and employee or tenant and landlord (Dworkin 1993). It treats pregnancy "as if it were just another case in which two separate entities have become connected in some way and one party plainly has a sovereign right to sever the connection if it wishes" (in Dworkin 1993, p. 54). Such arguments overlook the intense emotional and physical investment that a mother already has—she has provided an intimate viability to the fetus—and ignores everything special, complex, ironic and tragic about pregnancy and abortion.

In their studies of abortion, feminists therefore consider it crucial to

examine the issue within the context of power and sexual subordination. MacKinnon makes an arresting point regarding the status of the fetus in changed political and economic circumstances. If women were free and equal to men, she writes (in Dworkin 1993, p. 56), if they had a more genuinely equal role in forming the moral, cultural and economic environment in which children are conceived and raised, then the status of the fetus would be different, since it would be the woman's intended and wanted creation rather than something imposed upon her. Abortion would increasingly be seen as a kind of self-destruction, a woman destroying something which she has partly made. Women cannot take that view of abortion now, some feminists argue, because a significant proportion of sexual intercourse remains forced (e.g., rape or incest), because pregnancy is too often the result of women's subordination, and because the material and emotional costs of pregnancy are so unfairly distributed, falling heavily and disproportionately on women's shoulders.

Since coerced pregnancy has implications for women's oppressed status generally, it is important to ensure that abortion and other reproductive health services are accessible to women who seek them. Women must have control over their reproduction, not merely to ensure their right to privacy (as mandated by *Roe v. Wade*), but to give them the responsibility to make complex decisions that they are most able to make. According to Robin West, a prominent feminist lawyer:

Women need the freedom to make reproductive decisions not merely to vindicate a right to be left alone, but often to strengthen their ties to others, to plan responsibly and have a family for which they can provide, to pursue professional or work commitments made to the outside world, or to continue supporting their families or communities. At other times the decision to abort is necessitated, not by a murderous urge to end life, but by the harsh reality of a financially irresponsible partner, a society indifferent to the care of children, and a workplace incapable of accommodating or supporting the

needs of working parents . . . . Whatever the reason, the decision to abort is almost invariably made within a web of interlocking, competing, and often irreconcilable responsibilities and commitments. (in Dworkin 1993, pp.57–58)

West's comments reflect the feminist demand that moral discussions of abortion be more broadly defined than they have been in most philosophical discussions. Only by reflecting on the meaning of ethical pronouncements on women's lives and the connections between judgments on abortion and the conditions of domination and subordination can we come to an understanding of the moral status of abortion in today's societies. Rosalind Petchesky (1980) perhaps sums it up best: feminist discussions of abortion "must be moved beyond the framework of a 'woman's right to choose' and connected to a much broader revolutionary movement that addresses all of the conditions of women's liberation" (p. 113).

#### A STUDY OF ATTITUDES AMONG THAI MEDICAL PERSONNEL AND INDUCED-ABORTION PATIENTS

To date, virtually all studies of abortion in Thailand focus on the attitudes of the Thai populace, rather than on women's experiences of abortion and the conditions which compelled them to terminate their pregnancy.<sup>8</sup> Numerous studies conducted from the 1960s onward document changes in the attitudes of Thai people towards induced abortion. The Potharam Study of 1964 revealed that more than 90% of respondents surveyed were opposed to abortion, particularly as a means of curtailing family size. Two years later, the Bang Khen Study found that only 3.8% of participants objected to abortion in all circumstances cited, while 95.6% approved of abortion in at least one case (see Cook and Leoprapi 1974; Rauyajin 1979). More recent studies have documented increasingly supportive attitudes among professionals and students, and acceptance in cases of economic poverty, unemployment, and sterilization failure (Institute of Population Studies 1982; Phuapradit et al. 1986).

As the incidence of self-induced abortion appears to be increasing, more people have become intimately aware of its impacts and risks. Medical personnel and women themselves are two such groups. Between February and May 1995, Lerdmaleewong conducted research at three general hospitals, four nursing colleges and one medical/paramedical college in Bangkok to discern the attitudes of medical professionals and post-induced abortion patients towards induced abortion. Data was collected through personal interviews and self-administered questionnaires.<sup>9</sup> The total sample of 626 persons consisted of three groups: (1) eleven women admitted to hospitals because of complications from illegally-induced abortions; (2) twenty-two obstetricians; and (3) 593 nursing staff and students. Socio-demographic variables such as gender, religion, occupation, social status, and place of residence were taken into consideration in the analysis. Results of the study are as follows.

#### Attitudes of Post-Induced Abortion Patients

Eleven post-induced abortion patients, aged fifteen to forty-four years, were interviewed at two general hospitals in Bangkok. Of those interviewed, five were married with children and the remainder were single. Eight of the women were workers or laborers while the remaining three were students. For the majority (64%), the pregnancy had been the result of the incorrect use of contraceptive methods like birth control pills and condoms. Other participants did not use any contraception, falsely believing that they would not become pregnant. When pregnancy did ensue, respondents felt compelled to have an abortion because (a) they were unmarried; (b) it was an unplanned pregnancy; and (c) they had economic reasons to avoid giving birth. These women, all of whom were Buddhist, knew that abortion was illegal and that it went against Buddhist teachings. When making the decision to terminate their pregnancy, the women subsequently experienced mixed emotions: 64% were worried, 55% were fearful of exposure, and 36% were afraid of the ensuing bad kamma. For a small proportion of respondents (18%), these feelings made them sleep-



less and they experienced loss of appetite. Immediately before the procedure, many women suffered from anxiety relating to the fear of pain and death; others worried about increased vulnerability to illness; while a small minority (9%) believed they might become infertile.

Like other women who have undergone abortion procedures (see Population Council 1981; MacRae 1983), more than half of the respondents in Lerdmaleewong's study felt uneasy and sinful, or were sad and sorry for the aborted fetus. Only 9% either did not relate any feelings at all, or registered relief that "it was over." The majority of women interviewed (73%) stated that they did not intend to undergo this experience again and urged other women to learn by their mistakes. All participants stressed that abortion, because it entailed the destruction of fetal life, should not be used as a primary means of fertility control.

#### Attitudes of Health Care Personnel and Students

Of the sample of 615 medical professionals and students, the vast majority was female (91%), single (84.4%), and Buddhist (97%). Medical and nursing students made up the overwhelming majority of participants (74.8%), while obstetricians and nursing staff members accounted for 3.6% and 21.6% respectively. Most respondents resided in vicinities outside of Bangkok and commuted to work. During the course of the research, all were asked to respond to ten self-administered questions to gauge their attitudes toward induced abortion and current abortion legislation (see Appendix).

Approval of abortion was almost universal for certain indications; these included the following: (1) women who are pregnant as a result of rape; (2) women who have tested HIV positive or have become afflicted with AIDS; and (3) women who contract German measles within the first three months of pregnancy. Under these conditions, the majority of participants expressed willingness to assist in the termination of a woman's pregnancy, as such indications fall under the purview of the current abortion law. For other indications, such as economic necessity, large family

size, student status, and low/high maternal age, respondents were less supportive. Seventy percent of nursing and medical students stated that they would not advise women in these situations to have abortions.

Obstetricians likewise admitted reluctance to perform such abortions because of feelings arising from the immorality of the action (59%) and fear of legal violation (4.5%). Nevertheless, 31.8% of respondents stated that they would advise women to have an abortion if the circumstances warranted it. Curiously, women, single persons, and students tended to be more conservative in their responses than obstetricians, who were predominantly male and married. Some researchers (e.g., Phuapradi et al. 1986) suggest that the obstetricians' personal experience of performing abortions contributes to the differences of opinion. Other reasons may include the following: (1) the doctor's educational status, since higher levels of education have been correlated with more permissive attitudes (Raayajin 1979; Siriboon 1987); (2) a courtesy bias phenomenon operating among the student body, whereby participants express only those views they believe the researcher wants to hear (see Fleming 1989); and (3) a general tendency among Thai women to be less opinionated than their male counterparts, particularly on topics which threaten a woman's traditional role as mother and nurturer (Tantiwiranond and Pandey 1991).

Over 80% of the nursing staff and medical students maintained that the existence and/or availability of abortion weakened the moral structure of Thai society. Further, most of these respondents stressed that the abortion law should not be modified to allow women free access to abortion procedures, nor should technological advances be used to assist women in terminating their pregnancies. Half of those surveyed also stated that the current law did not contribute to a lack of available health care services for women seeking abortions or family planning services. Nonetheless, 55% of students and nursing staff believed that current abortion legislation should be revised in keeping with the changing conditions in Thai society.

Obstetricians, too, felt that abortion threatened Thai morals and values, and that abortion services should not be universally accessible to

those who want them. Unlike the nursing staff and students surveyed, 73% of obstetricians agreed to use high-tech equipment to facilitate safer abortion procedures. Most of these participants also felt that the current abortion laws were unsuitable with respect to current conditions in the country.

Because abortion generally was felt to be immoral by the majority of respondents, preventative measures to curb the practice were stressed. In particular, obstetricians stated that sex education must be provided to all girls and women. The provision of such education should be the responsibility of the family, although schools and medical personnel could play a role as well. Sixty-eight percent of obstetricians further maintained that, besides educating their children on family planning topics, families should provide love, understanding and warmth to their members. In this sense, one could surmise that the lack of emotive feelings among family members contributes to the abortion problem, although it is unclear how this factor influences a woman's decision to abort her pregnancy. Post-induced abortion patients in Lerdmaleewong's study instead relate that the fear of their family's disapproval and misunderstanding following their decision to terminate a pregnancy contributes to feelings of shame and abandonment.

## CONCLUSIONS

Lerdmaleewong's study of attitudes toward abortion among medical personnel and induced abortion patients suggests that feminist questions and arguments are not at the forefront of most Thai discussions to date. As other studies conducted on the abortion issue, Lerdmaleewong's research represents the first necessary step: identifying attitudes of the Thai populace. Participants in this study echo general sentiments about illegally induced abortion articulated elsewhere. Most describe abortion as an action which threatens the moral fabric of Thai society; thus, measures which support universal accessibility of the procedure and/or the use of high-tech equipment to facilitate safer abortions were opposed by the majority

of those surveyed. Induced abortion patients, too, expressed feelings of sin, “bad kamma,” and uneasiness because of their decision to terminate their pregnancy. With the exception of a small number of obstetricians, virtually all participants stated that they would discourage friends, family members, or female clients from undergoing this procedure. It is therefore not surprising that induced abortion patients spoke of their fears of exposure and recounted experiences of anxiety and isolation.

Yet, despite the participants’ strong convictions against abortion, medical personnel and students stated that the current abortion law must be revised in keeping with the changing conditions in the country. Technological advances, demographic pressures, economic progress, and changes in Thai social and familial structures present difficulties for rigorous adherence to legal statutes introduced forty years ago. Obstetricians also raised the need for preventive measures, particularly the provision of sex education services, to be available for all women in order to quell some of the causes of abortion (e.g., contraceptive failure and discontinuance).

What is still missing in many discussions of abortion in Thailand, however, are the voices of women themselves, including experiential accounts of abortions, analysis of the conditions which compel women to terminate their pregnancy, and discussions of the role and status of Thai women relative to men. Only by reflecting on the connections between judgments on abortion and the conditions of domination and subordination can we come to a full understanding of abortion in Thai society. Accordingly, this paper calls for further studies on abortion in Thailand which explore these issues from the perspective of women and feminists.

## Appendix

### *Research Questionnaire*

#### Attitudes Toward Abortion Among Medical Personnel and Students, 1995

1. Is menstrual regulation a type/method of induced abortion?
2. Should induced abortions be used as a method of contraception control?
3. Do induced abortions solve the problem of conception control when other birth control methods have failed?
4. Does the existence and/or the availability of induced abortion weaken the moral structure of Thai society?
5. Does induced abortion entail the destruction of fetal life?
6. Should new technological methods be used to assist women in having induced abortions?
7. Would you advise your close friends or relatives to have an induced abortion?
8. Is the current abortion law a reason for the lack of available health care services for pregnant women?
9. Is the abortion law suitable for contemporary Thai society?
10. Should women have access to free induced abortions performed by obstetricians?

## Notes

<sup>1</sup> Abortion is defined as “the deliberate termination of a pregnancy resulting in the intentional death of the fetus, prior to normal or spontaneous delivery” (Roy et al. 1994, p. 195). In Thailand, abortion is classified as either therapeutic or illegal. Therapeutic abortions may be performed when there is evidence of rape or when the mother’s health is endangered. Abortions are classified as illegal if the patients give a history of having abortion induced illegally and/or when evidence of manipulation, genital trauma or a foreign body is found (Koetsawang and Koetsawang 1984).

<sup>2</sup> Sections 301–305 of the Thai legal code deal with abortion. Section 301 states that induced abortion, whether self-induced or induced by another person, is a crime leading to punishment with imprisonment not exceeding three years or a fine not exceeding 6000 baht or both (National Committee 1985).

<sup>3</sup> Between 1969 and 1979, Thailand experienced what has been termed a “reproductive revolution” (Knodel et al. 1987). Fertility declined by nearly 40% during this time, while contraceptive usage among women of reproductive age rose from under 15% to approximately 50%. By 1984, contraceptive prevalence had increased further to 65%, and evidence points to a continuing incline (Knodel et al. 1987). These changes are reflected in the nation’s population growth: presently, Thailand is growing at a rate of only 1.2% per year compared to over 3.0% three decades earlier (Yoddumnern-Attig 1995).

<sup>4</sup> In Koetsawang and Koetsawang’s study, the majority of those surveyed (79%) paid under US\$40 per procedure. The most common method of inducing abortion consisted of an intrauterine instillation of some kind of fluid through the cervical canal by a rubber catheter. Other procedures included uterine massage, and insertion of a solid object, such as a wooden stick, into the cervical canal.

<sup>5</sup> Historically in Thailand, conflict was mediated by a model of social harmony, merit, and gratitude, while society was characterized by hum-

ble, obedient people (Tantiwiranond and Pandey 1991). People had high regard for their parents and were often considerate and affectionate to those younger or weaker. However, when Thai society was faced with the economic pressures of modernization, imposed by the borrowed Western model of development, its fabric of social harmony and mutual obligation became threatened. Weaker people now suffer (both politically and economically) because those who are stronger are capable of manipulating the new opportunities and economic forces. In order to overcome class and gender oppression, assertiveness, organization, and a questioning attitude among the disadvantaged is required (Tantiwiranond and Pandey 1991).

<sup>6</sup> Theravāda Buddhism prescribes that women are ritually inferior to men. This is especially reflected in beliefs regarding the relative purity and impurity of the sexes; the inability of women to attain nibbāna; and the differential treatment of monks as opposed to nuns (Yoddumnern-Attig 1992).

<sup>7</sup> It is expected that the 20-year Plan will be included in the Eighth National Development Plan (1997–2001) (Economic and Social Commission 1996).

<sup>8</sup> This statement excludes studies on the medical implications of abortion. See Bibliography for sources.

<sup>9</sup> Self-administered questionnaires were sent to 720 medical personnel and students. Six hundred fifteen questionnaires were returned, accounting for an 85% response rate. Analysis of the data was done by the SPSS/PC computer program.

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