



UNIVERSITY OF GOTHENBURG

Access to Maternal Healthcare

*A qualitative case study examining women's access to and the barriers they face
in accessing maternal healthcare in Bản Luộc Commune*



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Bachelor's Thesis in Global Studies
Spring Semester 2025
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Word count: 13 900

Acknowledgement

I would like to express my deepest gratitude to Bent Jørgensen for his time, continuous encouragement, and support throughout the research process.

A heartfelt thank you to all the women and community members who welcomed us into the community and generously shared their experiences. Your kindness, openness, and support made this study possible.

I am also especially grateful to my Vietnamese student partner, Nguyễn Vũ Hòa, whose teamwork and dedicated efforts during the data collection and transcription were of great importance and deeply appreciated.

Finally, I wish to thank the host family in Bản Luốc who welcomed us into their home with exceptional hospitality and provided support throughout the field study.

Abstract

This study explores women's access to maternal healthcare in Bản Luộc Commune, a rural and mountainous region of northern Vietnam. Using Levesque et al.'s Conceptual Framework of Healthcare Access and applying an intersectional lens, the study examines how women perceive and experience access to maternal care during pregnancy, childbirth, and the postpartum period. Through semi-structured interviews, the study identifies persistent barriers across five dimensions of access, approachability, acceptability, availability and accommodation, affordability, and appropriateness. Findings show that although government policies and subsidies have improved access, inequalities remain. Structural and intersectional factors such as women's ethnic identity, socioeconomic status, and remoteness continue to constrain women's ability to fully obtain and benefit from care. The study underscores that equitable access to maternal healthcare must be understood to be limited by multifaceted dimensions of barriers throughout the healthcare system. These limitations are further reinforced by underlying power structures that uphold inequities in women's access to maternal healthcare.

Key words: *Maternal Health; Healthcare Access; Intersectionality; Rural Vietnam; Health Equity.*

Table of Contents

1. Introduction	6
1.1 Background	6
1.2 Issue	7
1.3 Aim & Research Questions	8
1.4 Delimitations	8
1.5 Subject relevance	9
2. Literature Review & Previous Research	9
2.1 Maternal Healthcare in Vietnam.....	9
2.1.2 Health Programs & Insurance	10
2.2 Previous Research.....	11
2.2.1 Multisectoral approach	11
2.2.2 Participatory approach.....	12
3. Theoretical Framework.....	13
3.1 Levesque et al’s conceptual framework of Healthcare Access	13
3.2 Intersectional Approach.....	15
4. Method & data collection.....	16
4.1 Research design.....	17
4.2 Empirical Material	18
4.3 Sampling of respondents	18
4.4 Qualitative semi-structured interviews	19
4.4.1 Interview design	19
4.4.2 Conducting the interviews	20
4.4.3 Recording and transcription	20
4.5 Analytical method	21
4.6 Ethical considerations	22
4.7 Limitations	23
5. Results & Analysis	24
5.1 Approachability	24

5.1.1 Increased awareness and trust	24
5.1.2 Limited health promotion	25
5.2 Acceptability	27
5.2.1 Cultural factors	27
5.2.2 Discomfort and shyness	28
5.3 Availability and Accommodation	29
5.3.1 Lacking infrastructure and geographical distance	30
5.3.2 Poor emergency infrastructure.....	30
5.4 Affordability	32
5.4.1 Direct costs	32
5.4.2 Opportunity and indirect costs.....	33
5.5 Appropriateness	33
5.5.1 Differential of technical quality between health facilities.....	34
5.5.2 Interpersonal quality of care	35
6. Final discussion	36
7. Conclusion	38
8. Suggestions for future research	39
9. References.....	40
Appendix. Interview guide.....	43

1. Introduction

1.1 Background

Access to maternal healthcare is a critical component of global health and development and plays a crucial role in ensuring the survival and well-being of mothers and newborn babies worldwide. It is emphasized by the International Federation of Gynecology and Obstetrics (FIGO) in 2019 that every woman should have access to comprehensive antenatal care, skilled assistance during labor, and adequate support during the postpartum period (FIGO, 2019). Equitable access to comprehensive and respectful maternal health is therefore closely aligned with the realization of fundamental human rights, including the right to life, equality and health (Amnesty International UK, n.d., p. 8). Access to maternal healthcare is also central to the global efforts to achieve the United Nations Sustainable Development Goals (SDGs) particularly Goal 3 (Good Health and Well-being) and Goal 5 (Gender Equality). In this context, the SDGs aim to reduce the global maternal mortality ratio (MMR). They also reflect a broader vision that high-quality maternal healthcare should contribute to a world where all women have access to the highest attainable health and well-being throughout all stages of pregnancy and beyond (WHO, 2023, p. 51).

Despite global progress in reducing maternal mortality and improvements within healthcare systems, inequalities persist. According to the 2024 report by the World Health Organization, roughly 800 women lost their lives each day in 2020 and between year 2010 to 2020 did an estimated of 3 million women die (WHO, 2025b). This unequal access to maternal healthcare is globally important because it reflects broader structural inequalities in the world. WHO acknowledge how approximately 90% of all maternal deaths in 2023 occurred in low- and lower-middle-income countries. In 2023, the maternal mortality ratio (MMR) was 346 deaths per 100,000 lived births in low-income countries, compared to just 10 deaths per 100,000 lived births in high-income countries. They elaborate that the high rate of maternal deaths in certain parts of the world shows clear inequalities in access to quality healthcare and reveals the gap between richer and poorer countries. WHO also describes that within countries there is evident disadvantages for women that belongs to low socioeconomic groups, is a part of an ethnic minority or live in rural areas (WHO, 2025a). Maternal health affects entire communities, when women die or are injured during pregnancy, it has consequences for the child's life, education, household economies, and long-term development. Investments in maternal healthcare are therefore not only life-saving, they are essential for breaking cycles of poverty and achieving sustainable global development (World Economic Forum, 2024).

Vietnam, as a low-middle-income country, has achieved significant milestones within maternal healthcare over the past 10 years driven by state investments, national policies like the National Targeted Programs for Health, and international collaboration. The country's maternal mortality rate has dropped fivefold, from 233 deaths per 100,000 live births in 1990 to approximately 44 per 100,000 in 2023, which even surpassed the SDG target (Ministry of Health, 2024). Despite progress from applying with SDG and recommendations from international organizations such as WHO. Ethnic minority women in remote and mountainous regions in Vietnam continue to face considerable barriers in accessing adequate maternal healthcare services (UNFPA, 2018, p. 53). Gaps in maternal health and inequalities is alarming prominent between different regions and socio-economic groups. UN Viet Nam acknowledge how ethnic minority women has a four times higher maternal mortality rate compared to the majority Kinh women (United Nations Viet Nam, 2018, p 34). It is therefore a need to improvement maternal health especially for ethnic minority groups due to their vulnerability in society.

1.2 Issue

Research has shown that disparities in maternal health are not only a result of geographical distance or resource limitations but rooted in broader structural inequalities related to gender, ethnicity, poverty, education, and cultural practices (McKinn et al., 2019, p. 2). For instance, the United Nations Population Fund expresses that ethnic minority women in rural Vietnam often experience language barriers, inter alia, lack of culturally sensitive care, and limited trust in the health system. All of which may discourage them from seeking care even when services are available (UNFPA, 2018, p. 52). John McCormick also describes how investing in women to reduce countries poverty should be of priority. Simultaneously he acknowledge that gender discrimination is one of the main causes of poverty and women worldwide has generally least access to healthcare and education (McCormick, 2018, p. 181). Women's insufficient access to healthcare globally must be understood as a gender issue, and the fact that women are being disadvantaged for being just a woman is alarming. This highlights that access to maternal healthcare is dependent on more than just terms of physical proximity or affordability, it includes broader terms of structural gender inequalities and socio-economic development.

Consequently, there is a growing recognition of the need for context-sensitive, locally grounded research that explores barriers affecting maternal healthcare access in Vietnam. Levesque et al.'s Conceptual Framework of Healthcare Access offers a useful approach for a context sensitive and multidimensional examination of both the healthcare systems ability to provide and individuals ability to attain equitable access to maternal health services (Levesque et al., 2013, p. 4). McKinn et al. (2019, p. 2) describe how some women due to low socioeconomic

background, lower education, and residing in remote areas has a decreasing accessibility and utilization of maternal healthcare. To address these disparities in access, Bohren et al.'s (2023, p. 10) intersectional approach provide insight into underlying social structures of inequality that uphold marginalization and oppression of some social groups. Therefore, this study aims as an in-depth qualitative case study to analyze how ethnic minority women in the rural areas of Bản Luốc Commune perceive and experience maternal healthcare to uncover what barriers limit their access. Understanding how these women navigate the healthcare system during pregnancy, childbirth, and the postpartum period is crucial for addressing persistent inequalities in access and developing culturally and contextually relevant healthcare policies.

1.3 Aim & Research Questions

The study aims to explore women's access to maternal healthcare in Bản Luốc Commune, focusing on those who have given birth within the past decade (2015–2025). Particular attention is given to how women access healthcare during pregnancy, childbirth, and the postpartum period. Through semi-structured interviews, the research examines dimensions of women's experience of access to maternal healthcare, as defined by Levesque et al.'s conceptual framework. Access is therefore understood in terms of the five dimensions of approachability, acceptability, availability and accommodation, affordability, and appropriateness. With an intersectional lens will the study further explore how intersectional factors of social identities, structural systems and power relations influence women's access to equitable maternal healthcare.

The research questions the study aim to answer are:

- To what extent do women in Bản Luốc Commune access maternal healthcare during pregnancy, childbirth, and the postpartum period?
- What barriers affect women's access to maternal healthcare in Bản Luốc Commune, as understood through Levesque et al.'s five dimensions of accessibility?

1.4 Delimitations

This study focuses on women's access to maternal healthcare during three phases of healthcare during pregnancy such as the prenatal care, labor and delivery care and postpartum care. Related topics such as preconception care, interconception care or infertility care are not included in this research. Women's access to maternal healthcare is limited to a social scientific approach, emphasizing a qualitative analyze of women's experiences and perceptions, rather than a biomedical approach. The research is limited to women that have given birth between 2015 and

2025 in the commune of Bản Luộc. The time frame is limited to the last ten years to ensure participants' that hold recent and relevant experience of women's access to maternal healthcare. The geographical limitation is to ensure the study's aim to analyze the current situation for women in Bản Luộc Commune.

1.5 Subject relevance

The study is relevant to the Bachelor's Programme in Global Studies because of its focus on sustainable development and justice, which have been a unifying theme throughout the programme. The programme also focusses on questions about how global trends affect the world, cultures, economies, ecology and politics. Women's access to maternal healthcare is a global issue directly aligned with structural power dynamics and countries socio-economic development. These global structures influence and limit global and local policies in their promotion of adequate healthcare strategies to realize women's access to maternal healthcare. Understanding the barriers of ethnic minority women's access to adequate maternal healthcare in northern Vietnam are therefore of relevance to the Bachelor's Programme in Global Studies.

2. Literature Review & Previous Research

In this section, will background information of the essential parts of Vietnam's healthcare system be outlined, to provide an understanding of maternal healthcare in Bản Luộc Commune. Following this, previous research on maternal healthcare access will be explored for a contextual foundation to the study.

2.1 Maternal Healthcare in Vietnam

2.1.1 Health Facilities

Since the year 1989 Vietnam's health system has been organized through a mixed public-private system. The public healthcare system is divided into four parts of central, provincial, district and communal levels. The Commune Health Stations are at the lowest local level and provides basic and primary healthcare within local communities. Every district has a District Health Department (DHD) and a district health center that provide preventive care services and hospital functions. Provincial-level facilities include hospitals and specialized centers overseen by the Department of Health (DOH) where more advanced care is offered. At the top, central level hospitals and institutions are directly managed by the Ministry of Health (MOH) and provide the highest level of specialized and tertiary care (Tran Khanh Toan, 2023, p. 313). Apart from the public system has the Doi Moi reform with its market-oriented approach increased the development of private health clinics throughout Vietnam (Målqvist et al., 2013, p. 2).

Despite increasing development within Vietnam's health sector, challenges remain. As of 2020, Vietnam had over 11,000 commune health stations, and most communes within remote and mountainous areas, access at least one. However, the World Bank express how only 68% of these communal health stations met the Ministry of Health's national standards on infrastructure, due to perceptions of low service quality and insufficient medical resources (World Bank, 2020). UNFPA acknowledge that high quality commune health stations often are in urban areas, which leads to a geographical inequity between rural and urban areas (UNFPA, 2018, p. 2). Målqvist et al. elaborate how healthcare staff and communities describe lack of quality within health facilities and trends in perceptions that district hospitals often are preferred over commune health stations due to lack in quality and recourses (Målqvist et al., 2013, p. 9). UNFPA also acknowledge that a lot of women choose private facilities over Commune Health Stations because of perceptions that the services and facilities are of lower quality (UNFPA, 2018).

2.1.2 Health Programs & Insurance

To improve ethnic minority women in rural areas access to healthcare services the Vietnamese government has implemented several policies, health insurances, and subsidy programs (WHO, 2015, p. 2). The 'Reproductive Health Strategy' (2001-2010) has had a significant impact for prioritizing essential maternal health interventions including family planning services, vaccination of pregnant women and children, skilled birth attendance and emergency obstetric services (WHO, 2015, p. 16). The government issued the 'National Plan for Safe Motherhood' (2003-2010) to ensure that safe motherhood services are accessible for all woman (UNFPA, 2018, p. 2). Most recently has the 'National Target Program for Socio-economic Development' in ethnic minority and mountainous areas (2021-2030) been implemented, that includes national efforts to improve access to maternal healthcare for ethnic minority women. Project 8 is one of the projects under the program and aims to dismantle gender stereotypes, reducing domestic violence, improve access to education, and support socio-economic development in ethnic minority and mountainous areas. The women's union explain how project 8 provide support measures to improve maternal and child health among ethnic minority women. The project consists of four tailored support packages aimed to among other things promote safe childbirth, encouraging prenatal check-ups, covering travel expenses for mothers and caregivers, and supporting postnatal nutrition (Viet Nam Women's Union, 2023).

WHO points out that Vietnam has advanced towards Universal Health Coverage (UHC) through investment policies and efforts towards social health insurances for all citizens. The Vietnamese

government has implemented target subsidies for poor households and ethnic minority women that has reduced or fully subsidized health services (WHO, 2020). Notably, national initiatives such as Decree No. 39/2015/NĐ-CP have provided direct financial support of 2 million VND to women from poor ethnic minority households in remote areas who comply with population policies such as attending prenatal check-ups (Government of Viet Nam, 2015). The Decree 146/2018/ND-CP emphasizes that ethnic minorities who have recently escaped poverty receive 95% medical cost coverage, while those still classified as poor or living in extremely disadvantaged areas receive full coverage (Government of Viet Nam, 2018). Many delivery-related expenses are also financially subsidized by the government. For example, with each birth at public health facilities local women will receive financial support including one million VND for baby items such as diapers and clothes, and additional one million VND for family members accompanying the mother. Furthermore, in cases of C-sections, an extra 200,000 VND will be provided for recovery. This support is implemented under Decision No. 53/QĐ-UBND of the People's Committee of Bản Luộc Commune, which provides financial aid to eligible ethnic minority women as part of policy packages for safe childbirth and child healthcare under the National Target Program for Socio-economic Development in Ethnic Minority and Mountainous Areas. WHO describes that even though remarkable progress in health outcomes for all groups and social health insurances for the poorest, co-payments and high out-of-pocket expenditure remains. They argue that there is a need for the government to further address the equity gap and evaluate the quality and coverage of healthcare interventions in its promotion of healthcare for all especially vulnerable groups (WHO, 2018, p. 5).

2.2 Previous Research

2.2.1 Multisectoral approach

Souza et al., argue that maternal ill-health and mortality is a consequence of wider structural deterrents such as eco-social forces, lifestyles and exposures, as well as individual factors. They divide this multifactorial process into two main groups of superdeterminants and social determinants. Superdeterminants refer to overarching contexts and forces that broadly influence women's health and well-being before, during and after pregnancy. These include features of the biosphere such as negative effects of climate change, human biological characteristics, and the economic, political, and cultural foundations of society e.g. health policies, legislation on reproductive rights and gender norms. Social determinants are derived from the economic, political and cultural superdeterminants and are defined as the non-biomedical factors influencing health risks and outcomes throughout life. In the context of maternal health, these include the conditions of women's lifestyle and livelihood before pregnancy as well as during

pregnancy, childbirth, and the postpartum. Structural biases related to gender, ethnicity, and socioeconomic class are also highlighted as critical social determinants. They argue that gender disparities, income, education, ethnicity, and race are powerful predictors of increased health risks women may face during and after pregnancy (Souza et al., 2024, p. e307-e308).

The authors argue that this biomedical approach has contributed to that many countries remain at the same stage or decrease in their prevention of maternal mortality and women's ill-health related to pregnancy. Therefore, they advocate a broad multisectoral approach that includes social, economic, environmental determinants of health. In which they acknowledge that the health system plays an essential part in interrupting the chain of events that can lead to maternal ill-health or maternal mortality. Souza et al. argue for an expansion of the health sector's ecosystem to address maternal health determinants and adapt health systems to reduce the harmful effects of eco-social factors, by improving access to quality-assured services and essential resources (Souza et al., 2024, p. e314).

WHO exemplifies the arguments of the multisectoral approach. They argue that Vietnam's existing policy system for ensuring SDG 3 (healthy lives and well-being for all) lack effective implementation due to a deficiency in cross-sectoral coordination. They elaborate that the policies do not consider wider contexts of healthcare needs such as increased impacts of climate change and the inability of the health sector to respond to them. Furthermore, they argue that regional inequalities and vulnerabilities of different socio-economic and ethnic minority groups are not considered (UN Viet Nam, 2018, p. 33). UNFPA exemplifies that women from ethnic minorities and poor households have a three folded risk of not fully attend antenatal care (UNFPA, 2017, p. 3). McKinn et al. describe that previous research shows that these women due to low income, lower education, and living in rural areas determines accessibility and utilization of maternal healthcare decreases (McKinn et al., 2019, p. 2). This previous research show that ethnicity is an important social determinant for understanding the access and utilization of maternal healthcare in Vietnam.

2.2.2 Participatory approach

McKinn et al. elaborate how social determinants are essential in the understanding of women's access to maternal healthcare in Vietnam and emphasize a need to understand how individuals perceive healthcare services. They acknowledge that lack of accessibility to maternal healthcare is not solely a lack of technical and physical accessibility and availability of health facilities but a question of underutilization (McKinn et al., 2019, p. 2). The authors argue that this underutilization of services, is a result of how women perceive quality of health services and how these services align with ethnic minority women's social and cultural contexts. Services

that are not seen as beneficial to attend because it lacks to outweigh potential harms and costs will continue to be underutilized (McKinn et al., 2019 p. 10). They explain that ethnic minority women in Vietnam tend to attend antenatal care less often than the Kinh majority (McKinn et al., 2019, p. 2). Through their study did they find that the main cause of this is the perception that the facilities lack quality. Women from the Thai ethnic minority explain that primary care facilities lack quality in terms of hygiene level, space and overcrowding, waiting time and staff shortage. They explain that these factors of lack in quality made them sometimes choose to not seek care. To increase maternal healthcare access McKinn et al. argues that a participatory approach is needed to include communities' perceptions into health programs and policy processes. Through these programs and policies, that are adjusted after patient's needs, will patients' willingness to utilize health services increase (McKinn et al., 2019, p. 7).

Previous research provides a foundation for understanding the broader structural and social determinants that shape women's access to maternal healthcare, where both an multisectoral approach and participatory approach indicate factors contributing to low quality access to maternal healthcare. While previous research illustrates factors affecting equitable access to maternal healthcare and social determinants that makes women disproportionately affected. It lacks a comprehensive and systematic breakdown of how access occurs throughout the entire process of healthcare, from identifying the need for care to ultimately benefiting from it.

3. Theoretical Framework

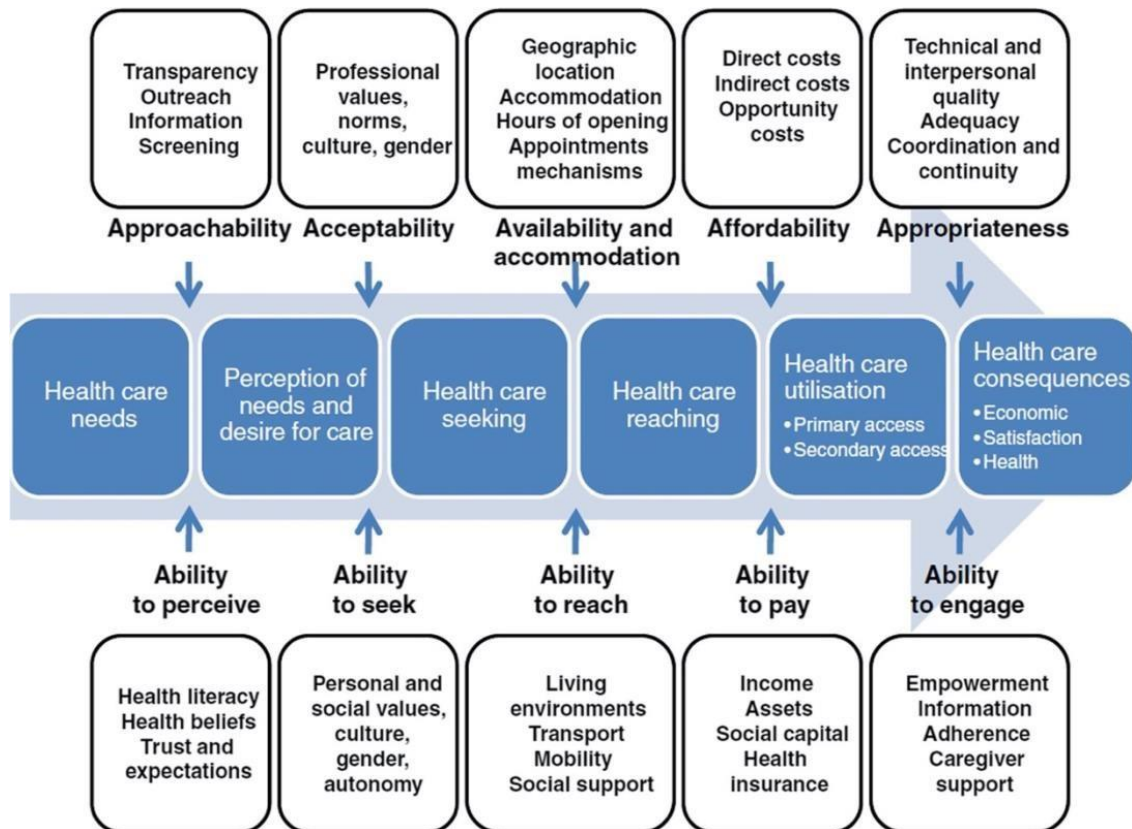
In this section will the theoretical foundations of this study be presented to get an understanding of the multifaceted dimensions throughout the whole health seeking process and underlying social identities and underlying power structures influencing access to maternal healthcare.

3.1 Levesque et al's conceptual framework of Healthcare Access

Healthcare access is a multifaceted concept, and understanding its broad dimensions and complexities is necessary to identify the barriers women face in accessing maternal healthcare within Bản Luốc Commune. Levesque et al. (2013) provide a patient-centered approach in which they describe healthcare access as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services and to actually have the need for services fulfilled" (Levesque et al., 2013, p. 4, 8). By acknowledging both systematic (supply-side) and individual (demand-side) factors, the authors offer an approach that allows an understanding of not just services existence but also if and how women obtain and benefit from healthcare services (Levesque et al., 2013, p. 2-3). To conceptualize this, Levesque et al. divides accessibility into five interrelated dimensions:

- 1) Approachability; Refers to the extent to which individuals are aware of the existence of healthcare services, understand that they can be accessed, and perceive them as potentially beneficial to their health. This dimension encompasses the transparency of services, the availability of information, and the presence of outreach initiatives. This dimension is crucial to gain an understanding of whether women in Bản Luốc Commune know where to seek maternal care, and if information about pregnancy-related services is reaching them. It helps to explore how social beliefs, lack of outreach, or limited health promotion affect their engagement with the healthcare system (Levesque et al., 2013, p. 5).
- 2) Acceptability; Encompasses the cultural and social determinants that influence whether individuals are willing to engage with healthcare services. This includes perceptions of the provider's characteristics, the type of medical system offered, and the perceived appropriateness of seeking care. In a setting like Bản Luốc, where Dao women may have traditional beliefs about childbirth and postpartum practices, this dimension helps us examine how cultural norms, gender dynamics, and perceptions of health staff influence their decisions to seek or avoid institutional care (Levesque et al., 2013, p. 5).
- 3) Availability and accommodation; Addresses the presence of sufficient healthcare resources that can be physically accessed in a timely manner. Key factors include the geographic distribution of services, operating hours, and the mechanisms for scheduling appointments (Levesque et al., 2013, p. 6). This is relevant in the case of Bản Luốc, a rural and mountainous commune where road conditions and travel distances may affect women's access to healthcare.
- 4) Affordability; Captures individual's financial and time-related capacity to access and utilize healthcare services. It includes direct costs, indirect expenses, and opportunity costs associated with seeking care (Levesque et al., 2013, p. 6). In the case of Bản Luốc this dimension allows for an investigation of the economic challenges women face throughout maternal care.
- 5) Appropriateness; Describes the degree of alignment between the services provided and the needs of the client. It considers the timeliness and quality of care, both technical and interpersonal, as well as the coordination and continuity across services (Levesque et al., 2013, p. 6). For the study this dimension are essential in assessing the quality and continuity of maternal healthcare as experienced by Dao women, including whether staff are respectful, care is fulfilling the patients' needs and follow-up support is available during postpartum.

Corresponding to these five dimension the authors define five abilities of the populations which include their ability to perceive, seek, reach, pay and engage with healthcare services which is furthered illustrate in Figure 1:



Levesque et al.'s conceptual framework will be used to systematically structure and explore the extent of the current access to maternal healthcare and remaining barriers for women in Bآن Luآc Commune. The framework is particularly relevant because it provides a broad and contextualized understanding of ethnic minority women's access to healthcare from the process of seeking to obtain care. With the qualitative and experience-based aims of this study Levesque et al.'s patient-centered approach allows for an in-depth analysis of the participants' experiences. Experiences that the authors recognize as important for understanding the barriers limiting patients' ability to access healthcare services (Levesque et al., 2013, p. 4). This framework will therefore also be able to acknowledge remaining barriers of women's access to healthcare throughout the whole healthcare process.

3.2 Intersectional Approach

Bohren et al. (2023) provide an even more comprehensive approach for analyzing underlying power structures that uphold barriers of women's access to maternal healthcare. In their article they underscore how an intersectional approach is needed to understand how social structures and power relations uphold inequities in women's access to maternal healthcare (Bohren et al.,

2023, p. 3). The authors argue that these inequalities are a result of intersectional gender power relations, where social identities, such as gender, class, ethnicity and geographical location, interact with structural systems of oppression and power. They elaborate that women from poorer households are both oppressed by gender and class. A poorer woman does not have the resources to protect themselves from the effects of poverty, and poverty limit their ability to for example shield themselves from gender oppression such as a violent relationship. The article acknowledges that these power relations of oppression and privilege shape norms and structures that effect women's lived experiences, limit their agency and influence their ability to access respectful, person-centered care. They also acknowledge how the structures of society such as legal frameworks and policies but also the governance, education, and health systems is rooted in ideologies of historical, political, economic and cultural contexts (Bohren et al., 2023, p. 2). These structures can be understood to through legal frameworks and policies uphold inequities and social exclusion. To address inequity of health the authors highlight that research and health policies must apply an intersectional approach that acknowledge how social identities and structures contribute to maintenance of social power relations and inequities in maternal health (Bohren et al., 2023, p. 6).

This intersectional approach is of relevance to the study because of its provision of a nuanced and holistic analysis of how and what access women have to maternal healthcare with a focus on social injustice and gender inequality. The participants in this study consist of women with social identities influenced by their gender, socioeconomic status, belonging to an ethnic minority and living in a rural area. Social identities that Bohren et al. argues effect their access due to social structures and power relations (Bohren et al., 2023, p. 8). Even though there has been a remarkable development within maternal healthcare in Bản Luốc Commune, women in this region still face disadvantages which could be results of their social identities and structures of power. This approach will be used as a lens to further analyze how intersectional factors, and social structures may uphold inequities and barriers to women's access to maternal healthcare within Bản Luốc Commune.

4. Method & data collection

This section outlines the research design and epistemological stance of the study. It will furthermore present the empirical method, including the sampling of participant, use of qualitative semi-structured interviews and the process of conducting interviews. Lastly will the analytical method, ethical considerations and limitations of the study be discussed. The method choices will be motivated, and the role and influence of the researcher will be discussed throughout this section.

4.1 Research design

The study adopts a qualitative case study design given the aim to gain a deeper understanding of ethnic minority women's experiences and perceptions regarding access to, and barriers of maternal healthcare in Bản Luộc Commune. Alan Bryman (2012, p. 383) describes how qualitative research is often criticized for its subjectivity and perceived lack of validity, due to the researcher's perspective and position, which critics argue influences the selection and interpretation of data. At the same time Bryman acknowledges, how qualitative research allows for an in-depth exploration of individuals perspectives, cultural influences, and structural conditions. He explains that a qualitative approach is particularly valuable when researchers seek to engage directly with a social setting to better understand the dynamics of a specific culture or social group (Bryman, 2012, p. 383). This approach aligns with an interpretivist epistemology, which posits that knowledge of the social world is constructed through the subjective experiences and interpretations of individuals (Bryman, 2012, p. 28). Grounded in a qualitative and interpretivist approach the study aim to explore women's personal experiences and perceptions of their access to maternal healthcare, placing emphasis on participants' own wording and explanations.

The study's case study design further supports the research aim by providing insights into women's experiences within the specific cultural and geographical context of Bản Luộc Commune. Although Bryman (2012, pp. 69-71) acknowledge that case studies are limited in terms of generalizability, they offer a detailed, comprehensive understanding of a particular context. Focusing on the case of Bản Luộc Commune therefore enables an exploration of how the local context and healthcare structures intersect with ethnic minority women's access to maternal healthcare.

An abductive approach has been used to examine women's accessibility of maternal healthcare. Bryman (2012, p. 401) describes abduction as an approach where the researcher takes an interpretive stance, aiming to understand the social world through the participants' own perspectives. While also translating those insights into a broader theoretical explanation grounded in the participants' worldview. Given the study's aim to explore women's lived experiences, this approach is appropriate. The study is initially grounded in a theoretical understanding of healthcare access based on Levesque et al's conceptual framework, but it is not bounded by it. The context, worldview, language and meanings attributed by the participants' are essential considerations throughout the research process. This flexibility to move between empirical findings and theoretical interpretation is particularly relevant to the

exploratory nature of the study, as it allows for the emergence of unexpected findings and support the development of context-sensitive data.

4.2 Empirical Material

The empirical material in this study is gathered through qualitative interviews conducted over a period of 16 days in Bản Luốc Commune, located in Hoang Su Phi district in the northern province of Ha Giang, northern Vietnam, during the spring semester of 2025. Throughout the study in Bản Luốc did we stayed with a host family in Suoi Thau village 2. When addressing the communal health station in this study is it referring to the communal health station of Bản Luốc Commune. Similarly, when addressing the district hospital is the district hospital of Vinh Quang referred to, which is the nearest district hospital women in Bản Luốc Commune often seek maternal care and childbirth at. The field study was carried out as part of a field course within the Bachelor's Programme of Global Studies and resulted in a field report, which serves as a background for this study. To complement the primary material, has an interview with the doctor of the communal health station of Bản Luốc Commune been included. This interview was conducted by Vilma Overgaard and Nguyễn Hoàng Sơn during their field study conducted within the same field course of the spring semester 2025. Their study aimed to similarly explore women's barriers to accessing maternal care and potential improvements in access. The empirical data of their study was also obtained through semi-structured interviews and conducted within the same period and location as the primary material.

4.3 Sampling of respondents

The sampling of participants' was carried out through a combination of purposive sampling and snowball sampling. The purposive method was used to strategically seek woman who had given birth between 2015 and 2025, ensuring participants with recent and relevant experiences of maternal healthcare (Bryman, 2012, p. 418). The sampling was also shaped by practical factors such as accessibility during the fieldwork. As a result, participants were primarily women residing in or visiting the area due to community fieldwork or family matters within Suoi Thau village 2, or women from nearby villages such as Suoi Thau village 1, Nam Ly, and Thai Binh. The limitation with purposive sampling is that it does not allow for generalization and carries a risk of selection bias (Bryman, 2012, p. 419). At the same time, it ensures rich, context-specific data by providing the researchers with the ability to target participants' who aligns with the research aim.

The first point of entry into the community was through the host family and nearby neighbors, who recommended participants. To complement this, snowball sampling was employed to reach

a larger number of interviewees, where the initial contact was provided by participants. After the interviews did some participants recommend other women within their social network that had given birth within the past ten years and who they saw fit the study. This approach was also practical, as local women could suggest others who were more willing to share their experiences or who had encountered situations particularly relevant to the study. At the same time Bryman acknowledge the risk of biases due to that the sampling relies on existing social networks (Bryman, 2012, p. 424). Participants recruited through this network may therefore share similar backgrounds, experiences or perspectives which can limit the diversity of the sample and findings and influence the results.

4.4 Qualitative semi-structured interviews

4.4.1 Interview design

To empirically analyze access to maternal healthcare including barriers in Bản Luốc Commune, 11 qualitative semi-structured interviews were conducted to collect data. The interviews consisted of eight formal interviews with women who had given birth within the years of 2015 to 2025, as well as three informant interviews, one with the midwife of the commune health station of Bản Luốc and two representatives of the Women's Union. In line with the study's abductive approach was the purpose of the interviews to gather participants' individual experiences and perspectives of women's access and barriers to maternal healthcare in Bản Luốc Commune. The formal interviews aimed to explore women's perceptions and experiences of their access and barriers of maternal healthcare. Whereas the informant interviews offered a more professional and system-level perspectives of maternal healthcare access in Bản Luốc. By interviewing informants such as healthcare staff and representatives from the Women's Union the study was able to gain a broader institutional and policy-level perspectives of access to maternal healthcare. The use of both formal and informant interviews therefore provided a deeper and more varied understanding of the systemic and individual barriers of maternal healthcare access.

All interviews were conducted using a pre-formulated interview guide that responded to the three different groups of participants'. Interview guide 1; 'local women', Interview guide 2; 'local health worker - midwife' and Interview guide 3; 'women's union representatives' (see appendix:). The interviews began with general questions about the participants' background and moved on to the main questions addressing the key dimensions of maternal healthcare during pregnancy, childbirth and the postpartum period. The questions were also inspired by essential factors mentioned within Levesque et al.'s (2013) framework of healthcare access.

4.4.2 Conducting the interviews

The interview guides were used to structure the interview. However, the guides were applied flexible which means that no strict order was followed, and follow-up questions were asked to explore the participants' perspective. As Bryman (2012, pp. 470-471) explain, this flexibility is effective in obtaining more detailed and context-sensitive responses from participants' because it opens for a more freely conversation where the researcher can focus on topics that the participant finds most interesting and can share more about. The ability to show interests and curiosity in the participants' answers also makes the interview more natural and dynamic which contributes to more in-depth and reflective answers from the participants.

At the same time Bryman acknowledge that the disadvantages of semi-structured interviews are that they can sometimes lead to that the interviews drift into topics unrelated to the study's aim (Bryman, 2012, p. 472). When interviewing women about their experience with the healthcare system, or for example their recovery process after giving birth they could often spin away with other stories from other communes or elderly generations. This has resulted in long interviews spinning between 30 minutes till 1 hour, and large amount of data that are of less value for the study. However, the personal stories were sometimes necessary and to our advantage. In some interviews was it challenging to obtain nuanced answers from women regarding their experiences of being pregnant and their access to maternal healthcare. To focus on connecting on a more personal level and to listen to the stories that women found meaningful to share, gave an opportunity to steer the interview towards subjects relevant to the study.

4.4.3 Recording and transcription

With the participants' consent was the interviews recorded and later transcribed. Bryman (2012, p. 482-483), emphasizes the importance of being attentive and observant during qualitative interviews. Which enables the researcher to follow up on relevant points, encourage elaboration, and clarify unclear responses from the participant. Recordings of the interviews was therefore used to be able to be attentive on the interaction with the participants', but also because it helped to recall everything that had been said. However, it is important to consider the potential impact of recording on participants. Some participants became more reserved and a bit self-conscious knowing they were being recorded, which may have affected their response and willingness to share openly. There is also an important ethical stance when recording individuals, which made informed consent of recording the participant highly prioritized and will further be discussed un the section – '8.7 Ethical considerations'. Participants was informed of their free participation and that they could stop the interview at any time or chose to not answer a question they did not want to (Bryman, 2012, p. 140).

The recordings were later transcribed as thoroughly as possible to not take women's experiences out of their context, and to try to portrait the participants' as correctly as possible. Within the transcriptions has repeating's or irrelevant parts of the interview been marked with a parenthesis along with an explanation for their exclusion in the transcript. As the interviews were originally conducted in Vietnamese, the transcripts were translated into English. This translation process may pose a limitation as culturally embedded meanings or misinterpretations could have been lost in translation, potentially affecting the interpretation of participants' experiences.

4.5 Analytical method

The empirical material collected through the semi-structured interviews was analyzed using thematic analysis, to identify, analyze and interpret patterns of meaning within the data. As Bryman (2018, p. 702) explain is thematic analysis based on the researcher's interpretation of meanings and widely used in qualitative research but criticized for its lack of clear and strict codification of data. He acknowledges Bazeley's interpretation that the researcher of a thematic analysis needs to indicate why the emerging themes are significant and meaningful, what their implications are and how they connect to previous literature. She also acknowledges the need to thoroughly explain the process of coding and identification of themes (Bryman, 2018, p. 706). To strengthen the validity of the findings will this study transparently outline the coding process and justify the analytical relevance of the identified themes in the analysis, which will be discussed in the section of – '9. Results and Analysis'.

In line with the study's abductive approach will Levesque et al.'s conceptual framework on healthcare access be used to guide and structure the thematic analysis. The framework's five key dimensions of access; approachability, acceptability, availability and accommodation, affordability and appropriateness, were applied deductively to guide the initial coding and inductively to allow subthemes to emerge from the participants' narratives. These five dimensions were therefore used to organize the data and enable an analyze of the interpretation of maternal healthcare throughout the whole health seeking process from the perception of health need to individuals' ability to obtain adequate healthcare. Through thorough and repeated reading of the interview transcripts, the most prominent recurring subthemes were identified and developed.

To support the analytical process, Excel was used as a tool to systematically code the empirical materials. The software was used to first structure the interview transcripts according to the five dimensions of access. Within each of these, interview quotes were grouped into smaller

subthemes. This method provided clarity, transparency, and traceability throughout the analysis and helped to find patterns of meanings between participants' experiences.

4.6 Ethical considerations

The research has been conducted with respect for cultural norms and values of the local ethnic communities and participants' within Bán Luộc Commune. Bryman (2012, p. 136) acknowledge the need for awareness of potential power dynamics between the interviewer and participants'. These interpersonal dynamics and the researchers position as an outsider in the local context have therefore been considered. Due to the cultural context of the study has it been important to remain aware of potential preconceptions that may influence the study, a critical stance to the researcher's subjectivity has therefore been considered throughout the study to respect the culture and individual experiences of each participant. Throughout the research process, has a remained awareness of the researcher's own preconceptions regarding the cultural context and has strived to maintain as objective a stance as possible, while showing respect for the culture and experiences of each individual participant.

Some of the local women may have perceived topics related to pregnancy as sensitive and private, particularly if their experiences differ from community norms or healthcare recommendations. It was therefore of utmost importance that the woman interviewed felt respected and that we gained their trust. We therefore followed Bryman's outline of ethical principles such as ensuring sensitivity and attentiveness (Bryman, 2012, pp. 135-136). Extra attention was therefore given on how the participant behaved. If they were uncomfortable, hesitant or irritated regarding a question or subject did we choose not to include that question. However, as Bryman notes, ethical and unethical research practices are not always clearly delineated, especially in qualitative research where interviews are open-ended and flexible, participants may therefore unintentionally disclose more than intended (Bryman, 2012, p. 148). As researchers, it was therefore crucial to remain responsive to participants' comfort levels and ensure they felt in control of what they chose to share. Ethical considerations were continuously integrated throughout the research process, transparency and cultural sensitivity was therefore prioritized.

Ethical considerations were also considered during the recording and coding phases of the study. Informed consent of recordings of the interviews was essential in the study. Participants' were therefore informed of their free participation and how they could stop the interview at any time or choose not to answer a question they did not want to (Bryman, 2012, p. 140). Transparency in data usage was also prioritized in accordance with the principle of avoiding deception,

participants were therefore informed of the study's aims and how their responses would be used in the research. Bryman also acknowledges the ethical importance of integrity, confidentiality and anonymity of the interviewees. To comply with this, it has been important that the participants are portrayed correctly, the transcriptions of the participants' answers has therefore been done as detailed and direct to assure that it reflects their perception (Bryman, 2012, pp. 143-144). To further ensure integrity and anonymity was all participants anonymized and local women are in the coding's and analyze identified as 'respondent X' or 'RX', while other informants has been labeled after their work title. These labels are also used to distinguish between empirical accounts and analytical interpretation throughout the analysis.

In this study, the term 'women' is used to describe individuals with the reproductive capacity for pregnancy and childbirth, including cisgender women, and others who are transgender, nonbinary, gender fluid, intersex, and gender non-confirming. The use of the term 'women' is made with awareness of the limitations and lack of gender-inclusive language in the study. But the choice is based on the cultural context of the study setting. A context where LGBTQI+ rights are not widely recognized, and where the use of more inclusive terminology could risk stigmatization or misunderstanding.

4.7 Limitations

There are limitations of the study that should be acknowledge. The empirical data was collected during a short field study of 16 days, which restricted the scope and depth of data collection. Eight interviews were conducted with women from four villages, while Bản Luốc Commune consist of ten villages in total. As a result, the limited sample size may not fully capture the diversity of experiences and access to maternal healthcare across the entire commune. A larger and more geographically inclusive sample could provide a more representative understanding of the challenges and barriers faced by ethnic minority women within other parts of Bản Luốc Commune.

The timing of the fieldwork presented additional constraints related to both time and accessibility. Most interviews were conducted during the daytime, when a lot of potential participants' were occupied with agricultural and forestry work. As a result, several women were unavailable or difficult to reach, which led to rescheduling of interviews, and in some cases cancellations. These limitations may have resulted in missed perspectives that could have further enriched the study.

5. Results & Analysis

In this section will the empirical findings be presented and discussed. As mentioned in the methodology, the five main themes are structured according to Levesque et al.'s (2013) five dimensions of healthcare access, approachability, acceptability, availability and accommodation, affordability and appropriateness. This enables an analysis of women's access to maternal healthcare throughout the entire health-seeking process, from the perception of health needs to the ability to obtain adequate care. Furthermore, will the most recurring subthemes emerge based on the participants' experiences, in line with the abductive approach of this study. The analytical relevance of each theme will therefore be supported by frequent and consistent subthemes based on the interviews and participants' expressed experiences. Quotes from participants are therefore included to support identified patterns and to illustrate how the results are based on the empirical material. Throughout this section will the results be discussed using both Levesque et al.'s Conceptual Framework of Healthcare Access and Bohren et al.'s intersectional approach, to provide an understanding of to which extent and what remaining barriers women face in accessing maternal healthcare in Bản Luộc Commune.

5.1 Approachability

The first theme, 'approachability' examines women's capacity to perceive that healthcare services exist, can be reached and are beneficial to their health.

5.1.1 Increased awareness and trust

The interviews indicate a shift towards more frequent hospital births in recent years within Bản Luộc Commune. Among the eight women interviewed, all gave birth at the hospital, while two of these women delivered their first child at home due to not being able to reach the facility in time. According to the doctor at the commune health station, this trend reflects increased community awareness, largely driven by educational efforts:

Recently, fewer cases occurred due to increased community awareness. Home births in Bản Luộc Commune have decreased significantly, averaging once or twice per year. Most people now prefer hospital births due to effective educational efforts about the dangers of home births. (Doctor)

Furthermore, the vice president of the Women's Union acknowledges government-led encouragement and outreach of information about hospital births:

Before, many gave birth at home, but now the government encourages hospital births. We often go to households to share information about the benefits of giving birth in a medical facility. (Vice president of Women's Union)

She elaborates that health outreach is in some cases, adjusted based on how isolated and remote the family are:

We consider the family's circumstances; assessing whether this household is relatively isolated from society, in which case, their knowledge will certainly be more limited compared to others. Then we go to advice and counsel them [...].

(Vice president of Women's Union)

This outreach of information promoting the benefits of hospital births aligns with the perception of five women who describe hospital births as safer than home births, respondent 4 express:

Because at the hospital, if there is any problem, they can provide emergency care. Essentially, if any risk arises, there are doctors available at the hospital, so you don't have to worry. It's safer for both mother and baby. But if you deliver at home, there are many risks that could affect both the mother and the child. (R4)

The results indicate an increasing trend of promoting hospital births which point to a shift in women's ability to perceive healthcare services as delivery care as trustworthy and beneficial to their health. In line with Levesque et al.'s (2013, p. 5) definition of approachability, have the increased awareness from successful health promotion and targeted outreach, led to women being able to perceive the availability and benefits of maternal health services as delivery care. The findings also indicate that the outreach by communal health workers sometimes consider intersectional differences such as remoteness's and educational level when providing health promotion. Through Bohren et al.'s (2023, p. 3) intersectional approach it can be understood that this consideration contributes to a more inclusive and equal approachability of maternal healthcare for all women. Because it adjusts outreach to underlying social structures and identities that impact women's ability to obtain health literacy which is needed to understand their health needs and available services.

5.1.2 Limited health promotion

The interviews highlight inconsistencies and differences in how health promotion is communicated and accessed. Two women shares that they have taken part in maternal health campaigns in the commune. Respondent 5 shares:

Yes, at the commune they often conduct maternal health campaigns, perhaps once every 1–2 months. (R5)

When asking other women, three expressed that they did not attend any health campaigns. They explained that they either had not heard of it, known enough about them or could not attend due to personal limitations, respondent 2 and 7 express:

They don't do any campaigns, I figured everything out myself. (R2)

At the time, I didn't dare to go anywhere from up here [in the village], and I didn't have transportation either. My husband was away working. (R7)

The chairwoman of the Women's Union even acknowledges how they do not have enough resources to reach out to every woman and how they lack knowledgeable staff:

In general, it is also difficult, because there are times when we have so many tasks that we cannot conduct the awareness-raising regularly according to a fixed schedule. We cannot always disseminate the knowledge to the mothers.
(Chairwoman of Women's Union)

There are personnel, but the community health workers have not been trained deeply in maternal healthcare knowledge, which partly affects the effectiveness of my awareness-raising efforts. (Chairwoman of Women's Union)

Respondent 8 expressed fear of getting uterine prolapse, when asked about if she were informed of the risks by health providers, she shared how she relied on older women and the internet:

No, I looked it up myself. During pregnancy, I researched what to do post-birth. Older women advised me to be careful, or I might get sick later. (R8)

Despite improvements, health promotion remains inconsistent. While a few women participated in commune campaigns, other remained unaware or unable to attend due to personal constraints. The structural barriers that the chairman of the Women's Union acknowledge such as staff shortage and lack of professional knowledge reduce the system's capacity to provide inclusive and consistent outreach. According to Levesque et al. (2013, p. 5), a lack of information from the health system reflects insufficient transparency and undermines efforts to promote health literacy, including awareness of available services and knowledge of symptoms that require medical attention. When women rely on elders or online sources for maternal health information, their access to accurate, evidence-based care is overlooked. This may contribute to delayed health-seeking or harmful practices, due to women's lack of perceiving their healthcare needs. These findings indicate that approachability, as conceptualized by Levesque et al. (2013) remains unevenly distributed, largely due to limited health promotion efforts and persistent gaps in information.

5.2 Acceptability

The second theme of ‘acceptability’ acknowledges social and cultural factors that affect women’s willingness to seek care.

5.2.1 Cultural factors

The interviews indicate an increasing medical awareness within the younger generation in Bàn Luốc Commune. Many of the women expressed a critical stance towards limitations of certain traditional beliefs, and a growing preference for scientific informed guidance on maternal health. Respondent 1 shared how her grandparents want her to follow a traditional diet which involves avoiding cold foods after birth, but she says:

[...] The eating habits aren’t scientific, and the doctor never said I had to avoid certain things. I remember when I got home, I was so craving that I even secretly ate a banana without telling my grandparents. (R1)

Despite this shift towards modern healthcare, cultural traditions remain significant. Each of the women interviewed described routinely seeking formal care, especially for pregnancy checkups and serious symptoms. At the same time do they acknowledge their participation in traditional practices such as offerings and worship for milder symptoms. Respondent 7 notes that she went to the hospital for check-ups, but also performed offerings:

I had offerings twice. If someone is too weak, can’t eat, or suffers bad morning sickness and loses weight, they need offerings. I was healthy, so just 1-2 times. Others do it more if they’re not well. (R7)

Respondent 3 mentions how she seeks healthcare only when feeling symptoms of pain:

After worshipping, I felt that the weakness was gone. If I felt pain, wherever it hurt I would go to the hospital for an examination. If I didn’t feel pain and felt weak, I would worship to get rid of all the weakness. (R3)

Furthermore, respondent 1 similarly explained:

[...] if you feel typical morning sickness, you don’t go to the hospital. Only if, on a certain day, you become too weak, or if you experience, in a rather sensitive way, things like bleeding (as I did), or other serious issues, do you go. Otherwise, for normal levels, no one goes. (R1)

Respondent 1 elaborates how these traditions sometimes come with a stigmatizing culture:

If a woman loses milk, they often blame the daughter-in-law for not following these restrictions; meaning if you lose milk due to some issue, they’ll say it’s because you overcooked this or that, and then they’ll blame you for the baby not having milk to drink. (R1)

Similarly, Respondent 8 demonstrate this fear of losing breast milk:

First time giving birth, I avoided cold, hot foods, overly spicy, salty, sour foods, to avoid losing milk. You have to be careful. (R8)

The interviews indicate a critical awareness among women of the limitations of traditional and cultural practices. This awareness increases their agency to navigate their health needs, rather than relying solely on cultural norms and traditions. Many participants were aware of traditional limitations and when formal healthcare services were necessary, particularly in cases of more serious illnesses or symptoms of pain. At the same time, community traditions continue to influence perceptions of when to seek healthcare, such as choosing not to seek care when experiencing milder symptoms. As indicated by respondent 1 above, these cultural norms can be socially enforced through stigma and blame. Such pressures may produce feelings of guilt or fear of judgement, consequently affecting women's willingness to seek care. This tension reflects the dimension of acceptability in Levesque et al.'s (2013, p. 5) framework, which highlights how cultural values and social norms affect access. Despite increased agency, cultural traditions and norms still influence women's health seeking.

5.2.2 Discomfort and shyness

The interviews indicate barriers of healthcare providers unrespectful behavior and social factors limiting women's access to maternal healthcare. Three women expressed that they directly experienced discomfort due to bad behavior from the healthcare staff primarily at the communal health stations and district hospital. Respondent 8 and 1 expressed how they had been scolded by healthcare providers:

I was curious, but the midwives were too gruff, so I didn't ask. Sometimes if I did ask, they would even shout at me. (R8)

The doctors here are a bit strict. [...] If you don't know how to push, they will scold you. (R1)

Some women also expressed shyness when being examined by male staff. Respondent 7 explained that she mostly had male doctors that examined her during pregnancy. When asked if she felt safer or more comfortable with female doctors she answered:

Yes, I think so. I feel safer and more at ease with women. Like that time when I had an ultrasound at the hospital, it was a male doctor who did both the regular and internal ultrasound. [...] Still, if I had to do it again, I might not go, because of the discomfort. (R7)

Within some ethnic minority communities in Vietnam, including the Dao, early marriage and adolescent pregnancies are still common. This stands in contrast to national policies such as the

‘National Strategy on Population and Reproductive Health for the period 2011-2020’, which aims to prevent early and unintended pregnancies, as well as the legal framework that sets the minimum age for marriage at 18 for women and 20 for men (United Nations Viet Nam, 2020, p. 26; UNICEF Viet Nam, 2018, p. 3). Despite these national efforts, the interviews reflect that early childbearing remains prevalent. Three of the women interviewed gave birth to their first child between the ages 16 and 17. According to the midwife, adolescent pregnancies, especially outside of marriage, can result in feelings of shame, which discourage women from seeking healthcare early in the pregnancy:

Some cases involve very young girls, 15, 16, or 17, who are pregnant without being married, so they feel ashamed. During the first three months, they usually won’t tell us. Only when the belly becomes noticeable at 4–5 months, and the family or village notices, do they inform us. (Midwife)

Respondent 7 described the discomfort and fear of mistreatment at the hospital due to her young age which do not follow policy health recommendations:

I gave birth for the first time when I was around 16 or 17 years old. I was shy at home, and even more embarrassed when I got to the hospital, afraid the doctors would scold me. (R7)

These findings highlight how women’s willingness to seek care can be affected by their perceptions of healthcare providers behavior and attitudes. Discomfort, fear of being scolded, and the inability to choose the gender of healthcare provider, can all serve as barriers to accessing maternal care. For young or unmarried women, social stigma surrounding early pregnancy can further reinforce feelings of shame, which can contribute to women delaying seeking healthcare services. In line with Levesque et al.’s (2013, p. 6) framework, these findings illustrate how acceptability are shaped both by cultural and social norms, but also by the interpersonal dynamics between patients and providers. Moreover, the findings illustrate Bohren et al. (2023, p. 10) intersectional approach where women’s access to care is constrained by overlapping social factors such as young age and marital status. Where young and unmarried women by these intersecting barriers are particularly limited in their ability to seek respectful and timely maternal healthcare due to social stigma and policy pressure.

5.3 Availability and Accommodation

The third theme of ‘availability and accommodation’ analyzes if health services are physically reachable and provided in a timely and organized manner.

5.3.1 Lacking infrastructure and geographical distance

Bản Luốc Commune is located in a rural mountainous area characterized by narrow, steep, and often muddy paths. While a main paved road has been developed in recent years, many villagers still reside high in the mountains far away from this infrastructure and rely on moped as means of transport. Respondent 4 shares how the geographical distance have affected her continuous check-up at health facilities during pregnancy:

For the first child I generally only went for the routine check-ups. I went less often because the roads were far, and it was inconvenient while I was pregnant. (R4)

Furthermore, the chairwoman of the Women's Union expresses the vulnerability of the infrastructure during severe weather conditions:

Sometimes when it rains, there are floods, and for one or two days the roads become blocked. When it rains and landslides occur, it is impossible to reach the health stations to access services. This is also an issue that affects the time for mothers to access services. (Chairwoman of Women's Union)

When given a question about if there had been any cases affected by the long travel distance she answered:

Yes, in 2019, there was a woman who left here, traveled along the road, and then went into labor; the journey was so slow that she couldn't make it in time. She intended to reach the health station to deliver, but she ended up delivering on the roadside and after delivery, the baby died immediately, unable to breathe. [...].

(Chairwoman of Women's Union)

The combination of long travel distance, lacking road conditions and unpredictable weather presents as serious barriers to timely maternal healthcare, and in some cases even life-threatening as illustrated in the tragic case of 2019. The lacking road conditions and geographical distance to health facilities can based on Levesque et al.'s (2013, p. 6) dimension of availability and accommodation be perceived as barriers that hinder women's ability to reach healthcare services timely and efficient.

5.3.2 Poor emergency infrastructure

The region's geographical barriers and remoteness can also play a role in restricting access to emergency services, such as ambulances. Due to the mountainous terrain, the few ambulances and taxis that exist are often unable to directly reach remote household and especially in a timely manner. As respondent 8 notes:

There's an ambulance, but it only goes part of the way. We still have to go out and meet it. It can't reach our house. (R8)

In addition to this the midwife of the commune health station highlight bureaucratic limitations in emergency services:

[...] If a vehicle is available, great, but if it's already on another emergency or transferring a patient out of province, there's no car available. Waiting for approval takes 15–20 minutes, and the car takes another 15–20 minutes to arrive, so the whole process can take about an hour. If the family has the means, we advise them to rent a private vehicle, it costs around 250,000–300,000 VND to get to the district hospital. (Midwife)

The geographical distance and lack of emergency infrastructure can be understood to contribute to women giving birth at home. Respondent 5 shares her experience of giving birth at home due to geographical distance:

Yes, my home was far away, and at that moment, I was in so much pain that I thought I wouldn't make it. If I had set off, I might have delivered before even halfway there. (R5)

At the same time the chairwoman of the women's union mention how they have tried to promote women to proactively travel to the hospital to avoid emergency births:

Now the propaganda is that, when you feel that you are at the expected due date, and when the doctor examines you and tells you that it is that day, then you should go to the hospital and wait. (Chairwoman of Women's Union)

The inability of ambulances to reach remote households, combined with bureaucratic delays and limited vehicle availability, hinder rapid response in urgent cases. The geographical distance and lacking emergency services can therefore be understood to limit women's ability to reach health services. This contributes to some choosing or force them to give birth at home due to their inability to reach services in a safe and timely manner. From the intersectional lens provided by Bohren et al. (2023) can socioeconomic status and remoteness be understood to intersect with women's ability to proactively travel to the hospital or afford vehicle in cases of emergency. This ability varies depending on their financial resources or flexibility of time which lead to inequities in women's access to maternal healthcare.

Levesque et al. (2013, p. 6), acknowledges that the five dimensions of access are interconnected. Women's livelihoods and occupational constraints can also act as barriers to accessing services, due to women's inability to afford the indirect costs of waiting near the hospital, costs that the healthcare system, as previously discussed sometimes implicitly demand of them. The intersection between the ability to physically reach care and the ability to pay for it will be further discussed in section – '9.4.2 Opportunity and Indirect Costs'.

5.4 Affordability

The fourth theme of ‘affordability’ analyzes economic conditions such as direct, indirect and opportunity cost of care that influence access to maternal healthcare.

5.4.1 Direct costs

As outlined in section 6.1.2 – ‘Health programs and insurance’ government subsidies and increased health insurance coverage have reduced a lot of direct costs especially for ethnic minority women classified as poor households. This has had a significant impact on women’s ability to seek care in Bản Luộc Commune by enabling them to afford healthcare services.

Respondent 4 highlight the financial support women receive:

Generally, nowadays if you’re pregnant, you receive financial support for prenatal check-ups and ultrasounds. [...] Additionally, now after giving birth you also receive financial support. (R4)

At the same time, the midwife of the commune health station notes that not all supplements, such as zinc and calcium are provided free. She acknowledges that some mothers are either unable to afford the supplements or lack sufficient knowledge about their benefits:

Zinc and calcium are not provided for free; we only recommend them. Most mothers here don’t have the means to buy zinc and calcium on their own. Only a few who understand the benefits of supplementing with calcium and zinc will purchase them, but most just use the free iron supplements. (Midwife)

In addition to this, respondent 1 mentions out-of-pocket costs for pain-relief medication:

[...] Only if something happens, like if you need extra medication, or you want pain-relief medication, then they charge for the drugs, which is not covered by insurance.

(R1)

Furthermore, respondent 8 expresses uncertainties regarding insurance:

I have insurance. The commune told me it would be free, but the hospital said I had to pay. Back in 2022–2023, people with insurance didn’t pay much. But starting in 2023–2025, delivery is no longer fully covered. (R8)

While government subsidies and health insurance have significantly reduced direct costs, particularly for ethnic minority women, additional expenses such as zinc and calcium supplements, or pain-relief, remain out-of-pocket expenses. These out-of-pocket expenses could be understood as barrier for women to access necessary medical services due to not being able to pay for care, which aligns with Levesque et al.’s (2013, p. 6) dimension of affordability.

Women's access to equitable maternal healthcare is therefore shaped by their socioeconomic status.

5.4.2 Opportunity and indirect costs

Economical barriers such as opportunity and indirect costs can be seen as limitations of women's access to maternal healthcare. Many of the women interviewed work in the field with farmwork, due to this type of livelihood do some of them express that they do not have time to reach health facilities because they do not afford to lose time of work. The experience shared by the women indicate that the opportunity cost of losing worktime influenced their health seeking during the postpartum period:

We work in the fields during the day, so sometimes I missed the scheduled checkups at the health station. I would go only if there was someone to replace me. (R7)

Similarly, the head doctor at the commune health station express why women may delay or hesitate to go to the hospital, and wait till they feel strong signs of labor:

[...] If they stay at the hospital for too long, the costs will be very high. They might think that they do not have enough money to cover the time spent waiting at the hospital. So partly that is the reason. And partly they also think that if they go there before labor starts, it wastes work time. (Doctor)

These results highlight how opportunity costs such as lost labor, time, and productivity, as well as the indirect costs of travel and accommodation near the hospital, pose barriers to maternal healthcare access. Levesque et al. (2013, p. 6) explain, within their dimension of affordability, that ability to pay goes beyond formal fees where real-life costs such as loss of labor may contribute to women delaying or avoiding care. Access to equitable maternal healthcare, where all women can access the same care and medical resources can therefore be understood in line with Bohren et al. (2023, p. 10) to be shaped by intersectional challenges related to socioeconomic status, geographic remoteness and availability of family support. Woman who lacks the financial resources to cover hidden and structural costs, or who do not have family support to manage their workload. Could be understood to have a reduced ability to access maternal healthcare and may be understood as being especially disadvantaged by the system.

5.5 Appropriateness

The fifth theme of 'appropriateness' evaluate quality of care from the timeliness and technical quality to the interpersonal aspects that effect the coordination and continuity of services across different stages of care.

5.5.1 Differential of technical quality between health facilities

Several participants' highlighted variations in the quality of care across different levels of the health system, with the commune health station consistently perceived as offering the lowest standard of care. Respondent 4 mention lack of equipment at the communal health station:

I usually went down to the district; I didn't have check-ups at the commune. At the commune level, in the beginning people would come in for check-ups when called, but later I would go for an ultrasound on my own because there was no ultrasound available there and if something was wrong with the baby, how would anyone know? (R4)

In addition, the midwife of the communal health station expressed their limitation of professional knowledge and diagnostic capacity, especially when faced with complicated cases but also during prenatal check-ups:

Our professional capacity is limited. [...] In complicated cases, we have to advise patients to go elsewhere, to doctors who have more tools, ultrasounds, and equipment. That's why our work here mostly focuses on initial support only. (Midwife)

Yes, we can still conduct check-ups, but we can't guarantee 100% accuracy. Mostly, we do physical examinations and provide counseling. Our knowledge is still limited. I hope to attend more professional training courses. (Midwife)

Furthermore, some women express the quality difference between public facilities and private clinic. Respondent 2 mention more comprehensive check-up at the private clinic:

At a private clinic, since there are fewer patients, the doctor explains everything clearly and thoroughly, so I understand the service and can decide if I want to do something like tests for gestational diabetes or congenital anomalies. They will advise you. When I went for a check-up, they took samples and sent them to Hanoi, and then they sent back the results to me. (R2)

A lot of women expressed the lack of pain management during childbirth. Respondent 8 mentions how women only receive pain-relief while being sutured for perineal tearing and how she experienced it as insufficient:

Here they only give pain-relief for C-sections. For natural births, they only inject anesthetic when they stitch you up, but I still felt a lot of pain. (R8)

Additionally, she expresses the differences in resources from urban cities:

For natural births, there's no pain-relief here. Only in the city do they have that. This place isn't developed enough to have pain-relief. (R8)

The findings reveal significant disparities in the technical quality of care across different health facilities. At the communal health station, essential equipment such as ultrasound machines are absent, and healthcare providers acknowledge their limited diagnostic capacity. The remoteness and rural characteristics of Bả Luộc Commune can also be understood to lead to lack of essential resources as pain management. These technical insufficiencies can through Levesque et al.'s (2013, p. 6) dimension of appropriateness be understood to limit women's ability to engage and access appropriate care. In contrast can the perceived higher quality of care at private clinics be understood to promote women with the ability to engage with care by providing them with diagnostic procedures and clearer, more responsive communications. At the same time are these private clinics not accessible for everyone due to high expenses. Appropriateness can therefore be understood as unevenly distributed within Bả Luộc Commune due to women's diverse socioeconomic backgrounds.

5.5.2 Interpersonal quality of care

Several women expressed concerns about interactions with healthcare providers, noticing instances of disrespectful treatment. Respondent 2 perceived that she was not fully informed about procedures and illnesses due to her cultural background:

But it's okay even if they don't understand the culture, but at least they should advise me clearly about, for example, what kind of illness this is, what foods to avoid, what drinks to avoid, and how to rest properly. Many people won't even tell you. (R2)

Furthermore, some women mention informational gaps in the healthcare they received. Interviewee 6 shared that she did a c-section during delivery. When asked if she knew about the complications and risks of c-sections she said:

I didn't think much about it then. I wasn't scared, maybe because I didn't know enough to be scared. I just didn't think about it. Looking back now, I feel scared. But not at that time. (R6)

When asked about the recovery process after c-sections, she expressed lack of information:

They didn't say exactly what would happen, just that walking after 24 hours was good for health. (R6)

This result indicates disrespectful treatment and insufficient information during maternal care. Instances where providers withhold information based on a woman's ethnicity not only compromise the quality of care but also violate women's right to be fully informed and engaged in decision-making. When women are not fully informed about their health conditions, procedures and associated risks compromise their ability to engage meaningfully in care.

According to Levesque et al. (2013, p. 6) such barriers undermine the appropriateness of care and negatively impact women's ability to access and benefit from care. In accordance with Bohren et al.'s (2023, p 10) intersectional approach it can be understood how ethnicity and power relations between patient and providers limit women's equitable access to maternal healthcare. Women from ethnic minority groups, particularly with lower educational attainment or unfamiliarity with the medical system are disadvantage. When factors such as ethnicity or social status influence the access to information or quality care, healthcare becomes even more inequitable due to these intersectional factors.

6. Final discussion

To answer the first research question, it can be understood that women's access to maternal healthcare in Bản Luốc Commune consist of multifaceted processes of progress and persistent barriers. The findings show that government initiative through policies and subsidies have made maternal healthcare services such as prenatal check-ups and basic delivery care more accessible and utilized. The results also indicate an increased medical awareness within the community which contributes to women's ability to perceive their health needs and therefore seek care. At the same time the results reveal that women's access to maternal healthcare remains limited and unevenly distributed. Access to maternal healthcare varies depending on individuals' socioeconomic status, geographical location, and health literacy. Although some women express satisfaction with the health system and confidence in their ability to navigate it, many do not fully access adequate care during pregnancy, childbirth, and the postpartum period. Significant barriers continue to affect women's extent of access to maternal healthcare, from the process of obtaining to benefiting from care.

To answer the second research question was persistent barriers identified across the five dimensions of healthcare access based on Levesque et al.'s conceptual framework:

- Approachability: Structural barriers of inconsistent health promotion, informational gaps, staff shortage and lack of professional knowledge, has contributing to uneven and inconsistent outreach and lacking health promotion for women. This limit women's health literacy, and therefore their ability to perceive their health needs and available healthcare services.
- Acceptability: Social structures as cultural norms, social stigma, and discomfort or shyness because of negative experiences with healthcare providers, sometimes restrain women from accepting and seeking services in Bản Luốc Commune. These structures therefore act as barriers to women's ability to seek maternal healthcare independently and with trust. Furthermore, certain policy interventions may themselves contribute to these barriers and

upholding stigma in health settings. ○ Availability and Accommodation: The mountainous and remote terrain, poor road conditions and inadequate emergency infrastructure pose significant barriers. Long travel distance, severe weather conditions or delayed emergency services prevent women's ability to reach healthcare services timely and safely.

- Affordability: Structural barriers as, out-of-pocket expenses, uncertainties about insurance coverage, and opportunity costs pose barriers to women's access to equitable maternal healthcare services due to individual's inability to pay or loss of work when engaging with maternal healthcare.
- Appropriateness: Structural barriers of insufficient technical quality among and between health facilities, along with disrespectful treatment and inadequate information sharing undermine barriers to women's access to appropriate care. These barriers constrain women's ability to participate in health-related decision making and limit their access to services that are both acceptable and effective.

These barriers cannot be understood as isolated from each other but rather as interrelated. For example, some women were fully aware of available maternal health services, but still unable to reach them due to geographical distance or occupational constraints.

Furthermore, the findings of this study reveal not only systematic barriers to maternal healthcare access in Bản Luốc Commune but also intersectional forms of disadvantages which affect women's access to maternal healthcare. For example, while some women were able to attend private clinics, which are perceived as higher quality, some women could not afford these services limiting their ability to access equitable quality of care. In addition, structural inequities between rural and urban healthcare system also became visible through the lack of essential medical resources, such as pain-relief medication, in local facilities within Bản Luốc Commune. These disparities in resources reflect broader national patterns of health policy prioritization and uneven infrastructure investment, which systematically deprioritize remote and marginalized areas. It could also be seen as a gender issue of inequality, where systemic undervaluing of women's health needs, normalize women's suffering during childbirth, especially in rural and under-resources areas. Furthermore, some women especially those from ethnic minority backgrounds like the Dao, policy implementation itself may unintentionally contribute to marginalization. As seen in the example of how ethnic minority women, particularly when young or unmarried often navigate access to maternal healthcare when facing restrictive social norms, limited policy protections, and fear of getting mistreated at formal health facilities. These intersectional disadvantages that women face in Bản Luốc Commune such as gender, ethnicity, lower socioeconomic status, remoteness interact to reinforce barriers of their equal access to dignified, acceptable and patient-centered maternal healthcare. The current healthcare system within Bản Luốc Commune could therefore be understood to uphold

inequities of access where some are privileged while others continue to be oppressed and excluded. Addressing these structures of power both within and beyond the commune is necessary to understand how overlapping social identities and structural system together limit women's access to maternal healthcare.

The study contributes to the research field of maternal healthcare access in rural and ethnic minority settings by providing a contextualized, experience-based perspective from ethnic minority women in Bản Luốc Commune. The findings support earlier research by McKinn et al. and the report issued by UNFPA in 2018, which emphasize the importance of perceived quality, systemic inequality, and the role of social determinants such as income, education, and ethnicity in shaping healthcare utilization. Furthermore, the use of Levesque et al.'s framework in combination with an intersectional lens by Bohren et al., add a depth to previous research by revealing local experiences of barriers to access but also how multiple, overlapping forms of disadvantage, such as remoteness, socioeconomic background, ethnic identity, and gender interact to create uneven patterns of access within the commune and on a national level. This study also offers a nuanced understanding of how intersectional differences between regions and uphold inequitable access to maternal healthcare.

7. Conclusion

To summarize, the study demonstrates that while maternal healthcare to some extent is formally available and accessible in Bản Luốc Commune, access remains far from equitable and comprehensive. To achieve patient-centered care, in which women can not only formally access healthcare services but also fully obtain and benefit from quality care, these multifaceted barriers need to be addressed. These barriers and underlying structures, which consist of intersectional disadvantages such as women's ethnic belonging, geographical remoteness, and socioeconomic background, must be understood and addressed to prevent inequitable access to maternal healthcare in the region. As this analysis has indicated, access to maternal healthcare is not only defined by availability, but also by the dimensions of acceptability, approachability, affordability, and appropriateness. Furthermore, improvement of women's access to maternal healthcare cannot rely solely on expanding services it must also involve transforming the social, political and cultural systems that continue to shape who receives care, how they receive care, and whether that care is truly adequate, acceptable and just.

Future research and policy interventions aimed at improving maternal healthcare access must therefore acknowledge and address this broader understanding of access and include the lived experiences of local women and healthcare providers. Only by understanding these experiences

within their broader social and structural context and including the voices and needs of ethnic minority women, can maternal health interventions effectively address the power relations and systemic barriers that sustain inequity. This is essential to ensuring truly equitable access to maternal healthcare.

8. Suggestions for future research

In concluding remarks this study opens for a range of possibilities for future research. Given the study's limited generalizability and small sample size, a larger and more inclusive study covering the whole commune could provide an even more comprehensive understanding of the barriers to maternal healthcare in Bản Luốc Commune.

The study primarily focused on challenges and barriers to maternal healthcare access, it would be valuable to explore which healthcare interventions have contributed to positive development within the local healthcare system. Understanding which interventions work and the reasons for this can provide important insights into effective and locally contextual solutions for promoting access to maternal healthcare.

Furthermore, it would be interesting to combine social science with biomedical research to explore maternal health outcomes of women facing barriers of access outlined in this study within Bản Luốc Commune. It would be especially interesting to investigate how social identities such as ethnicity, remoteness, and socioeconomic background interact to shape health outcomes through intersecting structures of inequality.

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Appendix. Interview guide

Interview guide 1 - local women:

General information about the women

- How old are you? / When were you born?
- Where are you living?
- How many children do you have?
- How old are they?

Personal experiences

Prenatal check-ups

- How often did you attend prenatal check-ups during pregnancy?
- Where did you have regular pregnancy health check-ups?
- Why did you choose this place to have prenatal check-ups?
- How do you feel about the check-ups experience? Are you satisfied? If so, then which aspects? If not, is there anything that you want to improve?
- Did you take any medication during pregnancy? Was it enough?
- Is there any improvement that you want to make to enhance check-ups experience?

Experience of delivering

- Where did you choose to give birth?
- Why did you choose this place to give birth?
- Did you give birth naturally or do you have to attend a C-section?
- Did you meet any complications during the labor?
- Is there any improvement that you want to make to enhance your childbirth experience?

Postpartum

- How long after your childbirth did you stay at home/postpartum rest?
- Do you think that is enough for you?
- Did you receive any help from the hospital or health station?

Barriers

Cultural factors

- Are there any customs or beliefs, folk remedies or treatments that you followed during your pregnancy?
- Do you feel that the healthcare staff understand and respect your traditions and needs?

Geographical and Transportation Barriers:

- What kind of transportation do you use to get to the commune health station/hospital for check-ups/ giving birth?
- How long does it take from your home to the commune health station/ district hospital?
- In case of an emergency (such as premature birth), is it possible to find transportation to the hospital in time?

Economic Limitations

- Are there any other costs that you have to pay during pregnancy/childbirth?
- Did you have to work much to earn a living during pregnancy?

Roles of communication:

- Are there any antenatal health campaigns/workshops/classes held in the village?
 - o If yes, did you participate? Were these programs effective/useful? In what ways were they useful?
- In general, how do you feel about the doctors and medical staff that helped you throughout your pregnancy?
- How do you feel about the facilities in commune health stations/ district hospitals?

Interview guide 2 – local health worker, midwife

- What is your current position?
- How long have you been working in this role?

Role of the Health Station

- What types of maternal healthcare services does the health station provide to women during pregnancy, childbirth, and postpartum?
- Are the local people open to seeking your help or an examination?
- Are the medical facilities at the station (e.g., ultrasound machines, etc) sufficient to meet the needs? If not, do you wish to see any improvements in the equipment for maternal healthcare here?

- Have you encountered any difficulties in providing maternal healthcare services to pregnant women here (e.g., lack of staff, equipment, budget)?
- Do the women here use traditional medicine during pregnancy and after childbirth? If yes, then why? Is this practice common?
- In the past 5 to 10 years, has there been any change in the rate of women giving birth at home versus at the commune health station? If giving birth at home, what risks might be involved?
- Over the past 5 to 10 years, has the rate of prenatal check-ups increased or decreased? Are there any policies that encourage women to attend regular prenatal check-ups?

Interview guide 3 - Women's Union representatives

General questions:

- What is your role in the community? / What is your current position?
- How long have you been working in this role?
- Do you participate in maternal and child healthcare within the community?
- Have you received any professional training in maternal healthcare?

B. Assessment of the Current Situation and Service Quality

- In your opinion, how is the maternal healthcare service for Dao women in Bản Luốc currently functioning, and what are its notable strengths and weaknesses?
- What do you think are the biggest barriers that Dao women face in accessing maternal healthcare services (before, during, and after childbirth)? Are these challenges related to economic, cultural, infrastructural factors, or others?
- Has the local government implemented any specific programs or policies to improve access to maternal healthcare for Dao women? How effective have these programs been?
- Have you noticed any improvements in Dao women's access to maternal healthcare services recently? If so, what is the most significant achievement and what challenges still need to be addressed?

Role of the Commune Women's Union

- What activities has the Women's Union organized to raise Dao women's awareness regarding maternal health before, during, and after childbirth (e.g., workshops, outreach)?
- How does the Women's Union coordinate with the commune health station and local authorities to support pregnant mothers?
- Do women have to pay any fees during pregnancy, childbirth, and postpartum period? If so, is this considered a burden?
- Does the Union provide any financial or material support to poor women during pregnancy and after childbirth?