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Women's experiences of and interactions with the health system in post-Doi Moi Vietnam

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ABSTRACT

How people experience their interactions with their health systems are central to the notion of health systems responsiveness. These experiences may be 'personal', but they are also shaped by the broader historical, political, cultural, social, and economic contexts within which they occur. Yet, few studies on people's experiences of care, particularly those focused on health systems responsiveness, explicitly take this into account. In this study, and drawing on in-depth interviews with 28 pregnant and postpartum women in a rural province of Vietnam, we use a novel approach that draws on the work of Archer and Chalari to uncover and analyse women's 'internal conversations', in which they reflect upon and make sense of their maternity care-related experiences. Women's 'internal conversations' reflected their need for short waiting times and high-quality ultrasonography, concerns regarding privacy and confidentiality, expectations of receiving dignified care, and their experiences of decision-making relating to caesarean section. Our findings reveal how women's preferences, demands, and expectations have likely evolved in response to the Doi Moi-related shifts that have changed the organisation and structure of Vietnam's economy, society, and health system. We make the case for health systems researchers and actors to consciously take into account the society and health system-level evolutions and changes when researching or developing interventions for improving responsive health systems.

1. Introduction

How people experience their interactions with health systems is central to the notion of health systems responsiveness (Mirzoev and Kane, 2017). The World Health Organisation (WHO) has proposed seven elements of health systems responsiveness – dignity, autonomy, confidentiality, prompt attention, access to networks, quality of amenities, and choice of provider (World Health Organisation, 2000). More recently, Mirzoev and Kane (2017) have argued that health systems responsiveness relates to the "actual experience of people's interaction with their health system", shaped by people's initial expectations of care and the health systems response to these expectations. As such, their expanded framework locates people's experience of their health system interactions at the centre of responsiveness. Yet, people's experiences of their interaction with health systems, as it relates to responsiveness, has been examined in a limited way - through the WHO health systems responsiveness surveys (Coulter and Jenkinson, 2005, Peltzer, 2009, Liabsuetrakul et al., 2012, Chao et al., 2017, Awoke et al., 2017, Ratcliffe et al., 2020, Kapologwe et al., 2020, Negash et al., 2022). While a number of studies shed light on the antecedents and determinants of peoples' care experiences, such as their needs, concerns, and expectations, few locate and understand peoples' experiences of their health system within broader and evolving historical, political, cultural, social, and economic contexts (Bramesfeld, Klippel et al., 2007, Bramesfeld, Wedegartner et al., 2007, Coulter and Jenkinson, 2005, Mirzoev and Kane, 2017). This is despite work by Gartner et al. (2022) revealing how the patient experience can be influenced by temporal, spatial, geographical, emotional, social, and cognitive dimensions, and by broader and evolving historical, political, cultural, social, and economic contexts.

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In this paper, we aim to present a novel account of pregnant women's past and current experiences of their interactions with the Vietnamese health system and the determinants of these experiences – women's needs, expectations, choices, and decisions. We do so in light of the wide-ranging social, economic, gender, and health systems transitions that have occurred in Vietnam in the last twenty-five years. We reflect on the implications for researchers examining healthcare encounters in similar contexts, and for policymakers and practitioners working to improve health systems responsiveness, globally and in Vietnam.

2. The Doi Moi reforms in Vietnam

In the last two decades, Vietnam has experienced a series of social and economic transitions as part of the Doi Moi reforms that began in the 1980's and 1990's. These reforms have seen Vietnam transform from a centrally planned economy to what some have termed "market socialism". This transformation has led to dramatic falls in the rates of absolute poverty and ultimately to Vietnam progressing to become a middle-income economy within a single generation (Vo & Lofgren 2019, Ekman et al., 2008, The World Bank, 2022). In this way, Doi Moi had, and continues to have, broader social implications – the reforms not only changed the structure and organisation of Vietnam's economy but society too. This prompted Werner (2002) to argue that Doi Moi should not only be viewed as a series of economic policies, but as a "socially embedded process" shaped by many, often gendered, components. For instance, Doi Moi has had a profound impact on women's participation in the labour workforce – today, Vietnam has maintained a particularly high female employment rate of 70 % (Banerji et al., 2018, Long et al., 2000). However, this has meant that relations and workloads between men and women, both within households and in society, are increasingly unequal – within the "public" sphere, women must maintain a "socialist work ethic", while simultaneously conforming to Confucian traditions and practices still prevalent within their "private spheres" These gender dynamics can impinge upon all aspects of social life including, as our recent review has shown, shaping how childbearing women interact and engage with the Vietnamese health system (Lakin et al., 2024). While some studies have revealed that childbearing Vietnamese women (hereafter referred to simply as 'women') have little choice in when and where to seek maternity care, others suggest that, today, they encounter few cultural and social barriers to accessing maternal health services (Graner et al., 2010, McKinn et al., 2019, Duong et al., 2004, Heo et al., 2020).

Specifically, within the health sector, the Doi Moi reforms legalised private medical practice, triggered the creation of a compulsory health insurance scheme, and introduced user fees in public health facilities via hospital autonomisation policies (Vo & Lofgren 2019, Dao, 2023, Witter, 1996, Ekman et al., 2008). As Dao (2023) recently argued, these Doi Moi-related policies have created several new "medical routes" and have broadly underpinned the increasing shift of healthcare costs from the State to citizens, alongside a transition towards a mix of state subsidy and fees-for-services (Vo & Lofgren 2019). For instance, hospital autonomisation has prompted public providers to charge fees for the use of 'high-tech' diagnostic equipment and other "on-demand services" which, in turn, can serve to maximise their revenues (Vo & Lofgren 2019). Moreover, as work by Ngo and Hill (2011) revealed, private providers are found to better respond to patients' demands and expectations with more convenient opening hours and advanced medical equipment. As such, in 2010, private health facilities accounted for 40 % of total outpatient visits (World Health Organisation, 2018). Our recent analysis of the literature (Lakin et al., 2024) has shown that, during pregnancy and childbirth, Vietnamese women pursue "private" or "on-demand" medical routes to meet their expectations of flexible working hours and high-quality ultrasonography. This was found to even be the case for women residing in rural areas who felt that the additional costs of visiting private providers were acceptable (and affordable) (Heo et al., 2020; Lakin et al., 2024). Therefore, as a result of these social, economic, and health system shifts, the preferences, demands, and expectations of Vietnamese women have potentially evolved and, with that, their experiences of their interactions with the Vietnamese health system.

Yet, as our recent review has highlighted, the current literature examining pregnant women's care encounters insufficiently reflects these important societal developments, particularly Vietnam's shift towards market-oriented care provision (Lakin et al., 2024). At another level, much of the literature also adopts a deficit perspective towards women's decision-making and agency during pregnancy and childbirth, potentially overlooking the presence of multiple and complex gender roles and norms in post-Doi Moi Vietnam. As yet, no study has unpacked Vietnamese women's experiences of their interactions with the health system during the maternity period in light of the social, economic, gender, and health systems transitions occurring in post-Doi Moi Vietnam. Particularly, how these transitions and changes have shaped the antecedents and determinants of their interactions – their needs, concerns, expectations, choices, and decisions. Vietnam's societal and health system evolutions reflect ongoing social, economic, and political transitions occurring in many LMICs, particularly the shift towards for-profit care provision (McPake et al., 2020). Yet, and as described above, the global empirical literature which examines health systems responsiveness fails to sufficiently capture how these evolving social, cultural, political, and economic contexts shape peoples' interactions with their health systems (Mirzoev and Kane, 2017). Addressing these gaps is important now more than ever as scholars and policymakers increasingly work towards improving health systems responsiveness, globally, and in LMIC-contexts (Mirzoev and Kane, 2017, Khan et al., 2021, Lakin and Kane, 2022, Lakin and Kane, 2022).

In this study, we tackle these gaps by engaging with the question: what are childbearing women's experiences, actions, and interactions with the health system in post-Doi Moi Vietnam? Using childbearing women's care experiences in Vietnam as an illustrative case, we highlight the need for health system actors to explicitly situate peoples' care encounters within ongoing societal and health system developments currently impacting many LMICs.

2.1. Theoretical framing

Mirzoev and Kane (2017) contend that peoples' experiences of their interactions with health systems lie at the centre of responsiveness and are shaped by both the 'people' (the initial expectations of individuals, their families, and communities) and the 'health system's response' (processes, structures, resources). They propose that this interaction occurs within a given historical, political, cultural, social, and economic context – a consideration that is overlooked by the WHO framework, as well as other health service-encounter frameworks (Mirzoev and Kane, 2017, World Health Organisation, 2000, de Silva, 2000). Lakin and Kane (2022) have also highlighted the importance of considering peoples' past and current care experiences, which are framed by intersecting social structures and relations and can shape future expectations of care. Chalari (2009), drawing on the work of Archer (2003), proposes an analytical approach for understanding peoples' actions, interactions, and their subsequent experiences of these interactions. The premise of Chalari's (2009) approach is that people's deliberations on their experiences and actions occurs via the 'internal conversation' – the inner dialogue that individuals have with themselves (Chalari, 2009). It is through these 'internal conversations' that people deliberate about and articulate what is most important to them – their ultimate 'concern' – and decide on an appropriate 'course of action' (Fuller, 2013, Archer, 2003). One can glimpse individuals' 'internal conversation' through their "self-talk" or "thinking aloud" – the external conversation individuals produce when they vocalise their thoughts, but address this dialogue to themselves (Chalari, 2009). However, Chalari (2009) contends that, through the process of "mediation", one selectively chooses which part of the 'internal conversation' they will share with others,

when they will do it, in what way, and for what reasons. By engaging in this process, individuals selectively choose which social expectations, structures, and norms they will follow, reproduce, reform, and express. Alderson (2021) extends upon Chalari's (2009) work to suggest that society is a necessary precondition for, and an integral part of, individuals' 'internal conversations', with structural and cultural powers impinging upon individuals and operating as constraints or enablements of their actions (Alderson, 2021).

In this study, we draw on these theoretical insights to uncover and analyse women's 'internal conversations', in which they make sense of their past and current experiences of their interactions with the Vietnamese health system – a notion that is central to health systems responsiveness. We demonstrate how this approach can also shed light on the determinants of their actions and experiences – their needs, expectations, concerns, choices, and decisions.

2.2. Study setting

This study was conducted as part of the broader RESPONSE project which aims to improve health systems responsiveness to the neglected health needs of vulnerable populations in Ghana and Vietnam (Mirzoev et al., 2021). Bắc Giang – a rural mountainous province 50 km to the east of Hanoi – was purposively selected as the study site for the RESPONSE project as it has experienced rapid industrialisation in recent years (Mirzoev et al., 2021, General Statistics Office 2020). Bắc Giang province has a provincial hospital, with district health centres and hospitals spread throughout. These high-level facilities manage high-risk pregnancies and caesarean sections, while the primary access point for reproductive health care are commune health centres (CHCs). These facilities register all pregnant women within the commune and provide insurance-covered antenatal check-ups, gynaecology examinations, and family planning services. A number of private clinics and hospitals are found throughout the province, some which also provide certain insurance-covered services. Participant recruitment occurred within the district of Hiệp Hòa.

2.3. Recruitment of study participants and data collection

Recruitment and data collection were conducted from September to November 2022 by DTH and KL. Participants were purposively recruited from two communes – Đông Lỗ and Đoan Bái – in Hiệp Hòa district. Women were deemed eligible for participation in the study if they were pregnant or had given birth within one year. The research team worked with maternal and child health officers in each CHC to purposively recruit participants from a list of registered pregnant and postpartum women in each commune. Contact with potential participants was facilitated by the maternal and child health officer, who provided initial details of our study and arranged a visit at an appropriate time and location. Table 1 outlines the characteristics of the 28 women recruited for participation in the study; 16 women were pregnant and 12 had recently given birth. All women who were approached freely consented to participate in the study.

Semi structured, in-depth interviews were conducted in Vietnamese by DTH, who was supported by KL during the process. Most of these interviews took place in women's homes, however, one interview was conducted at the CHC for convenience. Interviews lasted from 30 to 60 minutes and were conducted privately in a closed room, however in some instances, women's family members were nearby. 'Internal conversations' are reflexive processes - and in the way Archer (2003) elaborated upon the concept, and as reflected in reflexivity theory, they are private and internal to the individual and, as such, are not always accessible to others (Archer, 2003). As described above, Chalari (2009) suggests that an individual can critically choose which part of the 'internal conversation' they share with others, when they will do it, in what way, and for what reasons – known as "mediation". Methodologically, however, one can glean some aspects of these reflections from what a person says or, indeed, does not say in an interview setting (Chalari, 2009). To elicit women's 'internal conversations' during the interviews, we asked open-ended questions and allowed women to reflect uninhibited on their needs, preferences, decisions, experiences, and interactions with maternity care services – with antenatal care, in the case they were pregnant, or delivery care if they recently had a baby. We also prompted women to think about and reflect on the contradictions in their needs and expectations, the trade-offs they appeared to make, as well as the reasons for their subsequent choices and decisions. These probes encouraged women to "think aloud", shedding light on aspects of their 'internal conversation'. A de-briefing session was held at the end of each day of fieldwork, as well as on a weekly basis between KL, DTH, and SK. This enabled us to reflect upon the interview process and to discuss preliminary interpretations and emerging findings. We collected data until analytical saturation was reached and no new insights emerged; we actively discussed this during our regular de-briefing sessions. Ethics approval for the — study was provided by the Ethical Review Board for Biomedical Research at Hanoi University of Public Health (Ethics approval decision number 33/2022/YTCC-HD3) and London School of Hygiene and Tropical Medicine (ref 22981).

Table 1
Participant characteristics.

Participant characteristics	n
Age, years	
< 20	2
20–24	4
25–29	9
30–34	8
35–40	3
> 40	2
Pregnancy status	
Pregnant	16
Postnatal	12
Marital status	
Married	27
Divorced	1
Ethnicity	
Tay	1
Thai	1
H'mong	1
Kinh	25
Years of school	
1–6	2
7–12	17
Post high school	9
Occupation	
Factory worker	12
Teacher (kindergarten)	3
Business owner/worker	7
Unemployed (housewife)	2
Office worker	2
Farmer	1
Cleaner	1
Number of children	
0	4
1	3
2	9
3	8
4	3
5	1
Total	**28**

2.4. Data analysis

Digital recordings of the interviews were transcribed verbatim to Vietnamese and the transcripts were then translated to English. The transcripts were constantly checked for accuracy and consistency by DTH, who is a Vietnamese bilingual researcher. We employed an abductive approach to data analysis. The approach, proposed by Tavory and Timmermans (2014), centres on identifying surprising evidence

which does not fit within exiting theoretical understandings. This requires a process of "theoretical sensitisation", whereby researchers deeply engage with theoretical literature pertinent to the inquiry. We began analysis by initially reading the interview transcripts to develop a preliminary understanding of the data. QSR NVivo was then used to code the transcripts, with emerging codes informed both by the data, as well as relevant theoretical literature. This included existing conceptualisations of responsiveness, such as those proposed by de Silva (2000), the World Health Organisation (2000), and by Mirzoev and Kane (2017). Themes and sub-themes were identified and notable patterns which emerged were used as "triggers" for exploring other relevant theoretical literature, including work by Chalari (2009), as well as Archer (2003), Fleetwood (2008), and Fuller (2013). We methodologically elicited women's 'internal conversation' by examining the instances when women "thought aloud" or engaged in "self-talk" during which they made sense of their care experiences, sought to justify the various choices and decisions they made, and "weighed up" 'legitimate' needs, concerns, and expectations. Therefore, by eliciting women's 'internal conversations' we also sought to not only examine women's *actual* experiences of their interactions with the health system, but also the unseen but *real*, determinants of their actions and interactions – their concerns, needs, expectations, choices, and decisions. To shed light on broader social and institutional contexts, we drew on the work of Võ and Löfgren (2019), Witter (1996), and Ekman et al. (2008), as well as Werner (2002). Throughout the results section below, these broader social, economic, and cultural forces are briefly presented to help unpack and explain the findings.

3. Results

'Internal conversations' seemed to serve many purposes for the women in our study. It was a means to test and moderate their own expectations and concerns, to unpack and make sense of past and current care experiences and interactions, and to ultimately decide on the 'course of action' required to fulfil one's expectations. Moreover, it allowed them to locate their experiences within broader individual, relational, social, and institutional contexts which, in turn, shaped their subsequent expectations, decisions, and choices. Below, we unpack childbearing women's 'internal conversations' in which they reflect upon their need for short waiting times and high-quality ultrasonography, concerns regarding privacy and confidentiality, expectations of receiving dignified care, and their experiences of decision-making relating to caesarean section. Throughout, we use these reflexive deliberations as a "theoretical canvas" to uncover how women's agency – their decisions, choices, actions, and interactions – were structured in various ways by the cultural, economic, and social forces they encountered.

3.1. Short waiting time, distance to facility, and high-quality ultrasounds

In the current context of post-Doi Moi Vietnam, the women interviewed felt the need for, or wanted to, maintain full-time employment, while also attending to household and childrearing duties. Indeed, all but two women in our study were employed full-time. As Werner (2002) argues, Doi Moi has meant that women's workloads, both within the "public" and "private" spheres, have intensified – women must maintain both a "socialist work ethic", while conforming to Confucian traditions and practices still prevalent within their "private spheres". These social, economic, and gendered structures and roles, which competed with Confucian cultural traditions, meant that most women had limited time for attending antenatal check-ups. The 'internal conversations' we gleaned from some women therefore revealed how such situational constraints influenced their expectations and guided their decisions and choices:

> *"For us, since we are still working, so we would want them to be quick. Really, everyone wants it to be quick. Long waiting time would make me anxious, so I would prefer it to be close […] So when I went there [private clinic], it would be quicker, while the hospital would take more time. Since the hospital is more crowded…" [30–34 years old, currently pregnant].*

To overcome these temporal, geographical, and spatial constraints and meet their expectations, most women concluded that the best 'course of action' was to seek care at private health facilities, which were often located close to their homes and/or workplaces and had shorter waiting times – considerations consonant with the element of 'prompt attention' within the health systems responsiveness framework (World Health Organisation, 2000). As Table 1 highlights, most women were working full time and felt the cost of visiting a private provider was affordable.

Within Vietnam's market-based health system, 'high-tech' diagnostic equipment can be an established source of revenue for both public and private providers. Thus, provider-induced demand for these medical technologies is also important contextual feature in Vietnam (Vo & Lofgren, 2019). Situated within this institutional context, many women frequently reflected that having access to high-quality ultrasounds was their ultimate 'concern' - the average cost of colour ultrasonography in Bắc Giang was 200,000 VND (equivalent to 8.4 US dollars) which women felt was affordable. In Hiệp Hòa, 4D or 5D colour ultrasounds were only offered by private providers and, many women embarked on several 'courses of action' which involved visiting multiple private facilities (recommended by female family members and friends) to fulfil this perceived need. However, as their 'internal conversations' reveal, women also embarked on such 'journeys' cognitively, "weighing up" how their past experiences of their encounters at each facility met their expectations on ultrasound quality, as well as other competing needs:

> *"Actually, because I mainly have my check-ups at those 2 places [a private clinic and hospital]. Ah, there's also another place, but I find that [private clinic] tend to be more thorough, as well as the [private hospital]. They tend to be more thorough with their ultrasound. I had extra ultrasound at another place way down there, but their ultrasound was rather brief, so I didn't like them. Not to mention that place was far" [25–29, currently pregnant].*

Another woman also reflected on how the private clinic she visited provided her with adequate information about her baby – enabling 'choice' and 'autonomy' (World Health Organisation, 2000): *"At first, I did go to other clinics, but I found their quality, I mean, the diagnosis of the doctors there weren't accurate. That was why I chose this clinic, and I kept going there until I gave birth […] They also provided careful ultrasound, and they would point out to me the parts of the babies during the process. They would explain everything during the process of ultrasound. For other clinics, they would only do the ultrasound then tell us the amnio fluid was normal and that's it."* [25–29 years old, postnatal].

As these quotes also highlight, most women interviewed appeared to be decisive and confident in trading off the costs and benefits associated with each facility they interacted with (Fuller, 2013). This decisiveness stemmed from their engagement with both their own 'internal conversations', as well as selectively internalised 'external discourses' of the 'trusted other' that they encountered. This reflexive, interactive process, we contend, allowed women to evaluate their personal concerns and expectations, shaped by structural forces and institutional contexts, to ultimately "make up their minds" on which facility they would continue to visit throughout their pregnancy (Archer, 2003, Chalari, 2009).

3.2. Privacy and dignified treatment

Within health systems responsiveness, privacy during medical examinations is an essential feature of 'dignity' and 'dignified care' (World Health Organisation, 2000). Yet, privacy, or the lack thereof, was not an expectation or concern women raised during the interviews. When

prompted, however, women described a lack of privacy as a common feature at private health facilities – women attending ultrasound appointments or check-ups were separated from other women by a curtain. Yet, and we develop this further below, as one woman recounts, their privacy and dignity could be maintained at the district hospital where there was a closed consultation room: *"If I go to the hospital for check-up, we will have privacy in a closed room with just me and the doctor. But for [private] clinic […] the last time that I went there, there were a lot of people … and it wasn't really comfortable with me, but since it's a private clinic, so it has to be that way."* [30–34 years old, currently pregnant].

Some private clinics did provide ultrasounds for other conditions and, in such cases, men were also present. One woman feared that such an "awkward" situation could lead to undignified exposure of her body: "*if there were men, it would be a bit awkward, since during ultrasound, I also have to pull my shirt up… sometimes, there were also other patients. They don't provide ultrasound separately, but perform ultrasounds for all of the diseases* [30–34 years old, postnatal].". Yet, despite describing "uncomfortable" or "awkward" situations and care experiences, women still decided to seek antenatal care at a private provider, trading off or compromising on an absence of privacy in favour of other needs and expectations being met - such as those relating to the temporal, geographical, and spatial aspects of the care experience described above. Women therefore appeared to give greater priority to these expectations and, via the process of mediation, seem to "selectively" choose not to externalise their experiences or concerns relating to a lack of privacy during their care encounters (Chalari, 2009).

Following delivery, one woman vividly described the crowded conditions and the lack of privacy she experienced at the provincial hospital: *"In that room, there were 8 beds, 8 patients, not including their family members who went to take care of them. It was so crowded. I felt suffocated with their brag. [Laugh]… Sometimes, there are so many patients that one bed has a mother, a baby, a family member. Three people lying on one bed."* [25–29 years old, postnatal].

Women had the option of choosing an on-demand "service room" at both the district and provincial hospitals – a private room containing a variety of amenities (such as a TV and fridge). As Vo and Lofgren (2018) suggest, like advanced medical technologies, these amenities are also positioned as "patient-requested" services, which can simultaneously serve to maximise the revenue of providers. Due to experiencing the overcrowded, noisy conditions of public hospitals during past care encounters or indirectly through the accounts of other women, many women felt that they had no option but to pay for a "service room". However, through their 'internal conversations', it emerged that some women's decision to use such a service was, not unexpectedly, constrained by their poor socioeconomic situation: *"When I had the C-section, I already had to pay 4 million for the doctor. I also received a pain-reliever shot which costed another 3 million. And when I found that both mother and baby are safe, I wanted to save some money for the family so I would just stay in a normal room with other mothers, and not staying in a room on-demand"* [30–34 years old, postnatal]. As this account reveals, women's choices and decisions to use these "patient-requested" services at public hospitals were both enabled by their past experiences of institutional conditions on the one hand, while being constrained by and contingent upon economic structures and forces on the other.

Another woman echoed this consideration, intentionally emphasising how the economic constraints she encountered was tied to her spatial 'location' as a resident of a rural area: *"I probably need to consult others on this matter. I mean, when I get there, the services would be good already, so it's not really necessary to use more services, making things more expensive. We are from the rural area … we don't have that much money."* [older than 40, currently pregnant] (Lakin and Kane, 2022). As this women's 'internal conversation' reveals, women sought to achieve an 'inner balance' between their inner and external worlds – between their personal concerns (poor socioeconomic situation) and broader, socially- and institutionally-defined expectations (having an "on-demand" service room). Women could achieve this 'inner balance' by selectively drawing on their 'external conversations' with knowledgeable others – family members, colleagues, other women. As Chalari (2009) proposes, the internalisation process of these 'external conversations' (articulated in the interviews with us) can allow one to understand and evaluate both their *external* social world, as well as themselves, to make appropriate choices and decisions (Fuller, 2013).

3.3. Attitudes and expertise of health professionals

On closer examination, women's views and expectations on what corresponded to dignified treatment stretched beyond merely having privacy during consultations, to being treated respectfully by healthcare staff. The health systems responsiveness framework sees 'respectful treatment' as an important aspect of the element of 'dignity' (World Health Organisation, 2000). Women explained how 'respect' was conveyed through the way providers spoke to them and the time they took to consult and advise them during antenatal check-ups. More generally, respect was evident in the tone, body language, and facial expressions of providers and other health staff, as a woman elaborated: *"Their attitude was shown through their facial expressions. When I came in, they smiled, they spoke softly … which felt nice."* [35–40 years old, postnatal].

These current care experiences were often related to past care experiences – as the following excerpt from a woman who recalled her experiences at the provincial hospital when delivering her third child illustrates: *"…their attitude wasn't exactly nice…He just asked: "Pre-eclampsia? Come here and I will assign you a room. Come over here, this is your room. If there is something, call the number on the wall." That's it. That was his tone."* [35–40 years old, postnatal]. While recalling and comparing these experiences, she tried to make sense of this experience, wondering … debating aloud whether the difference in providers' attitudes was perhaps due to the fact that she was using 'public insurance-covered' services. That is, she was not paying out-of-pocket for her care and, as a result, would naturally expect and receive such poor treatment: *"I expect that whether people were using insurance-covered or on-demand services, the health professional's attitude would be more open. No one wants to go to the hospital, but we go there expecting to feel more assured, more comfortable."* [35–40 years old, postnatal].

Her 'internal conversation' echoes the general consensus among women, in our study, that one would be treated better if one paid for care. Thus, to fulfil their demands and expectations of respectful treatment, the only option seemed to be to seek care at private providers, as one woman reflected: *"The first time I had antenatal check-up was the 5th week, so I went to check the fetus's heart rate in [the district hospital]. But when I went to [the district hospital], right after I stepped in, that doctor already asked me: "What are you here for?" I didn't like their attitude already. So, from the next time, I just went to [a private clinic]."* [35–40 years old, postnatal]. Though it may appear that women were independently making their own decisions and choices on where to seek care, we can see here how past experiences of poor institutional conditions, particularly within the public health system, may indirectly push women down "private" medical routes which, as Vo and Lofgren (2019) have argued, may become the only options. However, in this case, and as opposed to the various "patient requested" services we have outlined above, respectful care was the 'commodity' which women were required to, and choosing to, pay for.

Within the 'internal conversations' we elicited, women were quick to clarify that they were not "professionals" or "doctors" and therefore relied on competent providers to examine them carefully during their check-ups, give them advice about the pregnancy, and respond to their questions or concerns. One woman described her experiences of her interaction with doctors throughout her pregnancy check-ups and how these encounters shaped her expectation of how she, as a patient, should be treated: *"They didn't ask or examine a lot, or advise me about my diet. The doctors were mediocre, didn't pay much attention […] I thought that was as far as a doctor could treat the patient…the doctors wouldn't say anything*

by themselves." [20–24 years old, postnatal].

Some women expressed a concern for the health of their baby and, to meet this emotional need, they discussed their preferences for seeking care from what they considered to be trustworthy, competent providers: *"In general, I am not very knowledgeable, but as long as any facility [laugh] helps me learn more about issues that may affect my baby, or discover the most about her illness, I would go there."* [30–34 years old, postnatal]. This need was often closely associated with having a high-quality ultrasound as, together, they reassured women about the health of their baby. As we have described above, such equipment was only available at private clinics and this, again, prompted many women to pursue the "private" medical route.

Women were quick to emphasise their lack of 'formal power' by way of not having medical knowledge or expertise. However, their reflexive deliberations disclosed how this deficiency prompted women to actively utilise their 'informal power' by drawing on trusted sources of 'formal power' (Do and Brennan, 2015; Lakin et al., 2024). For women, who were faced with the precarity and uncertainty of pregnancy and childbirth, competent doctors were these sources of 'formal' power and knowledge. In such cases of uncertainty and to meet their emotional needs, women appeared to draw on 'external discourses' and interactions with doctors, together with their own 'internal discourses', to decide on an appropriate 'course of action'.

3.4. Decision-making relating to caesarean section

During the interviews, some women who had recently given birth reflected on their experiences of having a caesarean section delivery. Women's accounts revealed how their agency was structured variously, and shaped by intersecting cultural powers and gender structures. The right to be consulted about treatment options and procedures is an essential consideration within the element of 'autonomy' (World Health Organisation, 2000). However, in some cases, women could be seen as 'passive agents' – the decision on having a caesarean section solely rested with the husband and, indeed, only the husband was consulted by health professionals (Fuller, 2013, Archer, 2003). This is illustrated in the following quote:

> *"We didn't plan on having the C-section […] the foetal heart got weaken, so they asked to discuss with my husband urgently to decide whether they should perform C-section, or should we wait to deliver normally. My husband saw that our child's heart rate was faint, so he decided to have the surgery." [20–24 years old, postnatal].*

When asked how she felt about her husband being the sole decision-maker, she reflected: *"I even asked him: "Why wouldn't we wait [to have a normal birth], there might be a contraction later? […] Because I was afraid of C-section. But since the foetal heart got faint, so my husband gave the decision"* [20–24 years old, postnatal]. While she had a preference for a normal delivery, her decision-making power and autonomy was restricted by prevailing and embedded gender structures and cultural norms and conventions of the husband being the primary decision-maker within the Vietnamese family system. While such cultural norms may be prevalent within women's "private spheres", as we have described above, we see here how they also endure within healthcare institutions (Werner, 2008).

On the other hand, a trusted 'other' may intercept and subvert these norms and facilitate women's choices and decisions. One woman described how her relative working at the provincial hospital supported her to have a normal delivery: *"…if it wasn't thanks to her, they would have forced me to have surgery […] Things were quite dangerous that time. It was thanks to my relative there, she supported and followed me closely, that I was able to give birth."* [25–30 years old, currently pregnant].

Joint decision-making between a woman and her husband was however also supported in some situations, and for some – the health professional consulted both the woman and her husband about having a caesarean section and they made the final decision together:

> *"I started having contractions, so the doctor requested to consult with me and my husband [about having a c-section], and half an hour later, I was on the surgery table. The doctors were really caring". She further reflected: "I prefer I and my husband [making decisions]. Even at home, it's important to me that I and my husband make the decisions together". [30–34 years old, postnatal].*

As the excerpts above suggests, this woman engaged in both 'internal' (with herself), as well as 'external conversations' with her husband before making a decision, both in relation to the birth but generally too. Again, by engaging in this reflexive process, women could achieve an 'inner balance' between their personal needs and concerns, and broader social and gendered expectations and norms. Indeed, our work highlights (Lakin et al., 2024) that joint decision-making may actually suggest that traditional gender roles and structures, as well as cultural norms, still limit childbearing women's autonomy and agency in Vietnam – while women may have greater control within the family (such as in relation to finances), many a final decision may still, though not always, lie with the husband.

4. Discussion

By eliciting women's 'internal conversations', in this study, we have illuminated and elaborated upon women's experiences of their interactions with the health system in Vietnam, which is central to the notion of health systems responsiveness (Mirzoev and Kane, 2017). We believe that, by utilising this novel approach, one can also methodologically uncover the potentially unseen, determinants of peoples' actions, interactions, and experiences – their needs, expectations, concerns, choices, and decisions. We have shown how broader structural and cultural forces, within post-Doi Moi Vietnam, shape women's expectations, decisions, and choices, as well as their past and current care experiences.

The Vietnamese health system's shift towards market-driven care provision has underpinned the proliferation of private providers in the country and induced the supply of "on-demand" services, including advanced medical technologies and amenities (Vo & Lofgren, 2019, Dao, 2023). It is within this institutional context, that women in our study indicated that having access to high-quality ultrasounds during their pregnancy was their main concern and expectation. Vo and Lofgren (2019) have suggested that conditions, especially within the public health system, may also be strategically "manipulated" so that the only option is to pay for "on-demand" services. Women in our study reflected on their past experiences of the overcrowded, noisy conditions of public hospitals which, they felt, left them with no option but to choose an "on-demand" private service room following the birth. Though it was not just tangible commodities that women felt the need to pay for – women perceived that they were treated respectfully if they paid out-of-pocket for their care. Therefore, as the 'internal conversations' we elicited revealed, many women reflected that, in order to meet such needs and expectations, their only option was to embark down "private" or "on-demand" medical routes. Indeed, empirical inquiries conducted in other LMICs contexts, have similarly reported private providers as being more responsive to service users' expectations, potentially driven by their need to increase demand and maximise profit (Peltzer, 2009, Negash et al. 2022). Therefore, as healthcare markets shift towards for-profit care provision, particularly in emerging economies, service users are now able to choose and pay for care which better responds to their needs and expectations. We argue that such findings emphasise the need for health system actors to recognise the role that market relations and forces can play in responsive care provision, and in shaping what people expect from health services. In the context of post-Doi Moi Vietnam, women's care-seeking choices and decisions were further influenced by social, economic, and gendered expectations, intersecting with Confucian cultural norms. As such, future research examining care experiences, in various contexts and for different population groups,

should explicitly consider how evolving social and economic conditions, both within and external to the health sector, shape peoples' interactions with and experiences of their health systems (Lakin and Kane, 2022, Mirzoev and Kane, 2017, McPake et al., 2020).

Mirzoev and Kane (2017) contend that peoples' experiences of their health system interaction, which is central to health systems responsiveness, is shaped not only by the policies, structures, and process of the health system (as we have shown above), but also by peoples' *a priori* expectations. Apart from women's preferences, needs, and concerns, expectations also emerge as particularly powerful, unseen determinants of women's choices and decisions and motivating their interactions with the health system during pregnancy and childbirth. Indeed, as Koselleck, (2004) and Lakin and Kane (2022) contend, meaning of actions are constituted within a 'horizon of expectation' which shapes both individual and collective experiences. Women appeared to compromise on certain expectations in favour of other needs being met and thus, during the interviews, seemed to choose not to discuss or externalise these elements of their care encounters (Chalari, 2009). In particular, women appeared to "trade-off" their expectations relating to privacy and confidentiality, for receiving prompt and respectful care, and what they saw as high-quality ultrasounds. That said, Lakin and Kane (2022) also reveal the importance of considering peoples' past and current care experiences which can shape what they expect from future care encounters. In this study, we observed the reciprocal relationship of women's care experiences and their needs, expectations, choices, and decisions; their experiences of past and current care encounters, as well as those of other women, shaped their future expectations and the subsequent choices and decisions they made. Their experiences, and the determinants of these experiences, interacted with the evolving socio-cultural-economic realities of Vietnam. Further research, globally and in Vietnam, is therefore needed to examine peoples' expectations of responsive health systems - what are considered important, 'legitimate' expectations to them (including but not limited to elements of responsiveness), and how, as Lakin and Kane (2022) propose, such expectations are shaped by past care encounters and the intersecting social structures and relations within their unique social environments.

While women did appear to be confidently weighing up the costs and benefits associated with each facility they interacted with (were *autonomous reflexives*), our findings have revealed how their actions and interactions were directly or indirectly constrained by both cultural and structural powers (Archer, 2003). For instance, when faced with economic constraints, some women felt the need to "consult others" before spending money on "on-demand" services. Women associated such constraints with their broader 'spatial' locations – as residents of a rural area in Vietnam (Lakin and Kane, 2022). In these cases, women therefore appeared to distrust their own 'internal dialogues' and selectively drew on 'external conversations' with trusted 'others' – family members, other women, colleagues – to decide on an appropriate 'course of action'. Women's healthcare decisions were therefore influenced by a combination of their own assessments of their past and current care experiences and expectations, as well as the views and experiences of knowledgeable, trusted others. Archer (2003) classifies individuals who make decisions as a result of both 'internal' and 'external' conversations with 'similars or familiars' as *communicative reflexives*. Those who adopt this 'mode' of self-talk, Archer (2003) contends, creates and maintains a 'micro-world' and are insulated from exposure to structural or situational constraints. However, rather than being immune from such influences, our findings suggest that it is indeed these situational or contextual constraints that prompted women to consult with 'trusted' others, which shaped their decisions, actions, and interactions.

An explicit focus on women's 'internal conversations' also offered a 'theoretical canvas' to uncover how women thought, how they accounted for their decisions and actions, and how their agency was structured during pregnancy and childbirth. The vast majority of current literature on childbearing Vietnamese women's care encounters emphasises women's unequal decision-making power (Lakin et al. 2024). Foregrounded in Confucianism, the patriarchal Vietnamese family system can specify that the husband (and his family) play a dominant role in decision-making relating to women's sexual and reproductive health, including when and where to seek maternity care (Graner et al. 2010, Thu et al., 2015, Graner et al. 2013, McKinn et al. 2019). In some cases, as our findings above highlight, such gender and cultural norms can be prevalent within healthcare institutions. Yet, our findings also reveal that women were not merely 'passive recipients' of healthcare – when constrained by their social situation and lack of 'formal power', they actively drew on the expertise of those with 'formal power'. The uncertainty surrounding childbirth, for example, saw women seek reassurance from and selectively draw on the 'external discourses' of competent doctors, as well as technologies like ultrasonography - these external discourses were major drivers of women's interactions with private providers in the study context. Several studies echo this finding - Vietnamese women prefer to follow the 'science-based' guidance of health professionals, as opposed to the 'experience-based' advice of other women (Heo et al. 2020, McKinn et al. 2019). More broadly, as their experiences of caesarean section reveal, women expressed a preference for joint decision making, both in relation to the birth and in their lives too. Indeed, Chalari (2009) emphasises that individuals are not merely 'passive' observers or agents to "whom things happen". Through the process of mediation, individuals deliberately draw on specific structures for knowledge, inwardly consider them, and selectively choose to follow, reform, express, and reproduce certain social expectations, structures, and norms within their social environment (Chalari, 2009, Alderson, 2021). In doing so, one is able to achieve an 'inner balance' between personal hierarchies and social expectations (Chalari, 2009). Therefore, Vietnamese women's experiences and care-seeking decisions cannot be simply explained with a traditional Confucian, patriarchal gender lens. As we have shown, social and economic changes are shaping gender identities in Vietnam in complex ways, and this requires future inquiries to examine care encounters explicitly taking this complexity into account. If policymakers and health system actors are seeking to improve the Vietnamese health system's responsiveness to the expectations of childbearing women, then there needs to be a shift away from solely viewing gender identities, norms, and relations with a Confucian, patriarchal lens.

5. Conclusion

The Doi Moi reforms of the 1980's and 1990's continue to have an impact on Vietnam's economy, society, and health system and, how people experience healthcare. However, no study as yet has unpacked women's experiences of their health system interactions during childbirth and pregnancy, in light of these social, economic, gender, and health system changes occurring in post-Doi Moi Vietnam. By eliciting women's 'internal conversations', in this study, we uncover childbearing women's experiences of their interactions with the Vietnamese health system. We shed light on the determinants of their actions and interactions – their needs, concerns, expectations, decisions, and choices – which women reflect and debate on in their 'internal conversations'. We show how when structural and cultural forces constrained women's choices and decisions, they actively drew on their 'external conversations' with 'trusted' others. Engaging in this reflexive, interactive process emphasises that women are not merely passive agents in the act of seeking care as the current literature disproportionately seems to suggest, but are reflexive, calculative, and wield significant agency. We illustrate the value and importance of research that explicitly engages with and better situates people's care encounters, as well as their care-related expectations, within broader social, cultural, economic, political, and historical contexts.

CRediT authorship contribution statement

Tolib Mirzoev: Writing – review & editing. **Irene Akua Agyepong:**

Writing – review & editing. **Sumit Kane:** Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization. **Kimberly Lakin:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Dinh Thu Ha:** Writing – review & editing, Formal analysis, Data curation. **Bui Thi Thu Ha:** Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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