Peoples' Expectations of Responsive Health Systems: Insights from Maternity Care in Vietnam

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Abstract

Health systems responsiveness is the "health system's ability to meet the population's legitimate expectations". Despite growing recognition of the importance of responsiveness in recent years, several theoretical and empirical gaps remain. Theoretically, there is limited explicit engagement with and understanding of what corresponds to a legitimate expectation of care. Moreover, current analytical frameworks of responsiveness and resultant empirical work do not yet sufficiently consider the broader contextual conditions which define what people expect from their health systems. Such a consideration is particularly important given the political, economic, and health system transitions and changes experienced by low- and middle-income countries (LMICs) in recent decades.

Vietnam has experienced rapid economic growth in the last two decades, spurred on by the Doi Moi reforms. Within the health system, the Doi Moi reforms saw the official recognition of the private sector, as well as the covert privatisation of the public health system. These social, economic, and health system transformations are insufficiently reflected in the current scholarly literature on women's encounters with maternity care. In light of the social, economic, and health system evolutions occurring in post-Doi Moi Vietnam, this qualitative study aimed to unpack women's expectations and experiences of their health system interactions during pregnancy and childbirth.

Drawing on in-depth interviews with 28 pregnant and postpartum women in rural Bắc Giang province, this study reveals how expectations are powerful determinants of women's care-seeking choices and decisions, motivating their actions and interactions with the Vietnamese health system during pregnancy and childbirth. Drawing on key theoretical literature on the concepts of expectations and legitimacy, it critically and comprehensively examines women's legitimate expectations of the Vietnamese health system. By adopting a translocational lens to analysis, the study uncovers how these expectations are shaped at the intersection of women's social, temporal, and spatial 'locations' within their unique social environment of post-Doi Moi Vietnam. The findings shed light on how the legitimation of women's expectations is also defined by the normative, market-driven relations and processes evident within the Vietnamese health

system. More specially, the findings highlight how complex gender dynamics shape Vietnamese women's autonomy and agency during care seeking.

Using maternity-related care seeking in Vietnam as an illustrative case, this study identifies key implications for improving health systems responsiveness, globally, but particularly in LMICs. In particular, the findings presented in this thesis highlight the need for health system actors to explicitly consider the role of market dynamics in responsive care provision. The findings also emphasise the importance for future health systems research in Vietnam to take into account the complex gender dynamics and relations present in post-Doi Moi Vietnam.

Declaration

This is to certify that:

i. the thesis comprises only my original work towards the PhD, except where indicated in the preface,
ii. due acknowledgement has been made in the text to all other material used, and
iii. the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed:

Kimberly Joyce Lakin

4th April 2024

Preface

This “thesis with publications” reports on original research undertaken during my PhD candidature. Peer-reviewed publications, as well as those “in-progress”, are included within Chapters 2, 3, 5, and 6 of this thesis. Some of these publications use referencing styles which differs from that used within this thesis.

The publication status of the journal articles included in this thesis are detailed below. My contribution for each journal article was 80%.

1) Lakin, K., & Kane, S. (2022). Peoples' expectations of healthcare: A conceptual review and proposed analytical framework. Social Science & Medicine, 292, 114636. https://doi.org/10.1016/j.socscimed.2021.114636

2) Lakin, K., & Kane, S. (2023). What can one legitimately expect from a health system? A conceptual analysis and a proposal for research and action. BMJ Global Health, 8(7), e012453. https://doi.org/10.1136/bmjgh-2023-012453

3) Lakin, K., Ha, D. T., Mirzoev, T., Ha, B. T. T., Agyepong, I. A., & Kane, S. (2023). "We can't expect much": Childbearing women's 'horizon of expectations' of the health system in rural Vietnam. Health & Place, 85, 103166. https://doi.org/10.1016/j.healthplace.2023.103166

4) Lakin, K., Ha, DT, Ha, BTT., Mirzoev, T., Agyepong, IA., & Kane, S. (2023). Women’s experiences of and interactions with the health system in post-Doi Moi Vietnam. SSM-Health System. *Currently under review.*

5) Lakin, K., Nguyen, TH., Kane, S. (2023). Childbearing women’s experiences of and interactions with the health system in Vietnam: A critical interpretive synthesis. Community Health Equity Research & Policy. *Currently under peer review.*

6) Lakin, K., & Kane, S. (2024). The role of the market in health systems responsiveness: A conceptualisation for an age of economic transitions. Critical Public Health. *Currently under review*

I presented the findings of this PhD research project at two conferences:

1) 7th Global Symposium on Health Systems Research (HSR 2022): *"Peoples' Expectations of Healthcare: A Conceptual Review and Proposed Analytical Framework"*, presented on 3rd November 2022 (virtually).
2) Qualitative Health Research Network Conference (QHRN 2024*): "Childbearing women's experiences of and interactions with the health system in post-Doi Moi Vietnam"*, presented virtually on 29th February 2024.

For this PhD research project, I developed the study proposal with guidance from my supervisory panel, as well as project partners at Hanoi University of Public Health. I supported the recruitment and data collection processes and undertook the qualitative analysis of all data included in this thesis and in the journal articles. I independently prepared the primary drafts of all manuscripts before sharing with co-authors for review. I submitted all the articles to the journals for peer review, responded to peer-review and co-author comments, and made the necessary revisions.

My PhD candidature was supported by the Research Training Program Scholarship 2020 – 2024 (fee-offset). The PhD research was aligned with and linked to the RESPONSE study which is funded by the Joint MRC/ESRC/DFID/Wellcome Health Systems Research Initiative (grant ref: MR/T023481/1). RESPONSE is a collaborative study which seeks to co-produce, implement, and evaluate context-sensitive interventions to improve health systems responsiveness to the needs and expectations of pregnant women, particularly those with neglected mental health problems.

Other journal articles published during my PhD candidature, including as part of the RESPONSE project, are listed below.

1) Do, TTH., Bui, QTT., Ha, BTT., Le, TM., Le, VT., Nguyen, QCT., Lakin, KJ., Dang, TT., Bui, LV., Le, TC., Tran, ATH., Pham, HTT., & Nguyen TV. (2023). Using the WHO Self-reporting questionnaire-20 (SRQ-20) to detect symptoms of common mental disorders among pregnant women in Vietnam: a validation study. International Journal of Women's Health, 15. https://doi.org/10.2147/IJWH.S404993

2) Lakin, K., & Kane, S. (2023). A critical interpretive synthesis of migrants' experiences of the Australian health system. International Journal for Equity in Health, 22, 7. https://doi.org/10.1186/s12939-022-01821-2

3) Trang, DTH., Ha, BTT., Vui, LT., Chi, NTQ., Thi, LM., Duong, DTT., Hung, DT, Cronin de Chavez, A., Manzano, A., Lakin, K., Kane, S & Mirzoev, T. (2024). Understanding the barriers to integrating maternal and mental health at primary health care in Vietnam. *Health Policy and Planning,* https://doi.org/10.1093/heapol/czae027

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I would firstly like to thank the women who participated in this study for freely giving me their time and sharing their experiences. I hope that this study does justice to your stories.

This PhD journey was filled with many challenges. But it provided me with some incredible opportunities too, including the chance to work with and learn from scholars around the world. My sincere thanks and appreciation goes to my primary supervisor Professor Sumit Kane. Your unwavering support, guidance, generosity, and mentorship helped me to navigate some of the most difficult obstacles I have ever encountered as a student and a young researcher. Over the four (nearly five) years, you have helped me to grow into a thoughtful, critical, and independent researcher and the knowledge I have gained from working with you is truly invaluable. I am also greatly appreciative for the intellectual and practical guidance and support of my secondary supervisor, Professor Rosemary McKenzie and my Advisory Committee Chair, Associate Professor Meghan Bohren, throughout the four years of my PhD. This PhD was made possible by the Australian Government Research Training Program Scholarship for which I am extremely grateful.

I would like to thank the Vietnam RESPONSE country team, especially Professor Bui Thi Thu Ha, Dr Do Thi Hanh Trang, and Dr Le Minh Thi for welcoming me so warmly to HUPH and supporting me with the fieldwork. I owe special gratitude to Dinh Thu Ha for her tireless support and generosity during the fieldwork and my visit to Hanoi. You made my trip to Hanoi so memorable. I am thankful for the support from the Head of the Department of Human Resource Management at Bắc Giang Provincial Department of Health, the Vice Head of Hiệp Hòa District Health Centre, as well as the managers of the two CHCs who supported data collection. I am grateful to Dr Vu Manh Loi for the opportunity of meeting at the Vietnam Academy of Social Sciences and to Dr Liem Nguyen for his kindness and support during my time in Hanoi. My sincere thanks to Professor Huong Thu Nguyen from Vietnam National University of Social Science and Humanities for her insights on Vietnam's ethnic minority groups. This PhD was greatly informed by my involvement in the RESPONSE project. I especially would like to thank Professor Tolib Mirzoev and Professor Irene Akua Agyepong for their intellectual

support with various outputs from my PhD. Also, my sincere thanks and appreciation to Dr Anna Cronin de Chavez and Dr Ana Manzano for their mentorship (and encouragement!).

I would like to thank my Grandfather Ronald, Grandmother Joan, and Uncle Michael. Though you are so far away, you have been with me through every step of this journey.

I am indebted to my sister, Tracy. There have been moments when this all seemed so impossible. But you always reminded me of how far we have come and never doubted my capabilities for a second. You gave me the courage to see this through.

I dedicate this thesis to my parents, Christopher and Sharon, without whom this would not be possible. You sacrificed so much when we migrated to Australia from India. Despite all the difficulties we faced, you worked tirelessly to give us the opportunities you never had. I hope that this thesis goes some way to show you that it has not gone in vain.

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List of abbreviations

CHC	Commune health centre
CHE	Catastrophic health expenditure
CHI	Compulsory health insurance
CIS	Critical interpretive synthesis
CPV	Communist Party of Vietnam
DHC	District health centre
GDP	Gross domestic product
HCFP	Health care fund for the poor
HUPH	Hanoi University of Public Health
IHE	Impoverishment due to health expenditure
LMIC	Low- and middle-income
LSHTM	London School of Hygiene and Tropical Medicine
MoH	Ministry of Health
OPP	Out-of-pocket
SHI	Social health insurance
UDHR	Universal Declaration of Human Rights
UoM	University of Melbourne
VHI	Voluntary health insurance
WHO	World Health Organisation

Outline of the thesis

This is a "thesis with publications" and incorporates in-progress and published, peer-reviewed material throughout.

Chapter 1 introduces health systems responsiveness, one of the three intrinsic goals of national health systems. In this Chapter, I seek to tackle some of the complexity around the concept of responsiveness by reviewing key conceptualisations and reflecting on adjacent concepts, including quality of care and patient satisfaction.

In **Chapter 2**, I provide a broad overview of global political, economic, and health systems transitions that have occurred in the last two decades. I then specifically reflect on Vietnam's country and health system context. I reflect on three pivotal moments or shifts in the country's history – Confucianism, the communist revolution, and the Doi Moi reforms of 1986 – which have brought about significant social, gender, economic, political, and health system evolutions. I close this Chapter with a critical interpretive synthesis (CIS) on childbearing women's experiences and interactions with the Vietnamese health system.

In **Chapter 3**, I conduct a conceptual mapping exercise in which I analyse the concepts of 'expectations' and 'legitimacy' – concepts that are central to our understanding of health systems responsiveness but have been overlooked in inquiries thus far.

Chapter 4 outlines the study's approach and methodology. I begin by presenting the rationale for this inquiry, its place within the broader RESPONSE project, and the research questions and objectives I seek to tackle in this study. Drawing on key theoretical insights from the conceptual mapping exercise in **Chapter 3**, I discuss the theoretical approaches that framed this inquiry. I then describe the study site of Bắc Giang and delineate the processes of participant recruitment, data collection, analysis, and ethics.

In **Chapter 5**, I present the study's findings along three broad lines. The first sheds light on childbearing women's experiences of and interactions with the health system in post-Doi Moi Vietnam. The second uncovers women's 'horizon of expectations' of the health system in rural Vietnam. Finally, I examine what the empirical data revealed about women's autonomy and agency in contemporary Vietnam.

In **Chapter 6**, I unpack the study's findings and extrapolates the implications for research, policy, and practice, globally, and specifically in Vietnam. I then reflect on this thesis as

a scholarly enterprise – I examine my engagement with self-reflexive practices throughout this inquiry, and the potential study limitations, in light of the eight "big-tent" criteria for high-quality qualitative research. I conclude this thesis with some final reflections on the implications of this inquiry.

Chapter 1: Health systems responsiveness

1.1 What is health systems responsiveness?

In the World Health Report 2000, the World Health Organisation (WHO, 2000) introduced three intrinsic goals of health systems: good health, fairness in financial contribution, and responsiveness. While the primary or defining goal of any health system is to improve peoples' health, fairness in financial contribution and responsiveness are also intrinsically valuable, contributing towards making health systems more affordable, accessible, and equitable to the populations they serve. In the discussion paper which foregrounded the WHO's initial conceptualisation of health systems responsiveness, de Silva (2000) defines the concept as:

"…the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the ***universally legitimate expectations*** *of individuals."*

Broadly, a responsive health system is said to contribute towards public participation, social cohesion, and state-legitimacy and, ultimately, improve population health (Khan et al., 2021). A responsive health system also safeguards the rights of patients to receive healthcare which meets their needs and expectations. Hence, it is argued that health systems responsiveness is fundamentally important as it links directly to human rights (Gostin, Hodge, & Valentine, 2003, de Silva, 2000). In this way, peoples' interactions with a responsive health system are likely to improve their well-being, irrespective of improvements to their health (Gostin, Hodge, & Valentine, 2003). Given this, improving health systems responsiveness is said to be a legitimate endeavour of any health system (and government) (WHO, 2000, Khan et al., 2021).

Yet, despite growing recognition of the importance of health systems responsiveness in recent years, it remains the least studied health system goal. Recent work which mapped the evidence on responsiveness highlighted that, while there has been increasing interest in responsiveness in the last two decades, there is limited empirical and, particularly, theoretical work which advances our understanding of the concept (Khan et al., 2021). As such, conceptually, health systems responsiveness is layered with complexity. Below, I seek to tackle this complexity by providing an overview of existing conceptualisations

of health systems responsiveness, while also reflecting on the adjacent concepts it is often conflated with.

1.1.1 Conceptualisations of health systems responsiveness

Health systems responsiveness has been conceptualised in a variety of ways and several scholars have attempted to map the numerous theoretical and conceptual frameworks (Mirzoev & Kane, 2017, Khan et al., 2021). Perhaps the most widely known and used is the WHO-proposed framework and associated survey tool, which has been adapted and used to measure health systems responsiveness in various country-contexts. Scholars have proposed other conceptualisations that have drawn on or have adapted the initial WHO conceptualisation, while others have incorporated responsiveness as a determinant or element of social accountability (Gostin et al., 2003, Joarder et al., 2017). Recently, Mirzoev and Kane (2017) proposed a conceptual framework which places peoples' experiences of their health system interaction at the centre of responsiveness. Below, I provide a brief overview of the key conceptualisations and theorisations of health systems responsiveness.

1.1.1.1 WHO and WHO-based conceptualisation

In World Health Report 2000, the WHO proposed responsiveness as an intrinsic goal of health systems, alongside good health, and fairness in financial contribution. Providing the blueprint for this conceptualisation was Murray and Frenk's (2000) framework for assessing health system performance, as well as de Silva's (2000) framework on measuring responsiveness. Within the WHO framing, responsiveness is understood as the health system's ability to respond to peoples' legitimate expectations of care (WHO, 2000). Murray and Frenk (2000) suggest that the demarcation of 'legitimate expectations', within health systems responsiveness, is necessary as people may have "frivolous" expectations of their health system. De Silva (2000) echoes this consideration, further arguing that the specification of legitimate expectations overcomes the issue of "divergence of expectations" across health system contexts – I delve further into and examine the notion of legitimate expectations in Chapter 3. More broadly, within this framing, responsiveness is defined as to consist of the non-health enhancing and non-financial aspects of the health system. As Table 1 outlines, this focus is reflected within the WHO-proposed domains of health systems responsiveness which are classified within two overarching categories of "respect for persons" and "client orientation". These

domains, and the methodology of their measurement, were informed by literature reviews on patient satisfaction and quality of care, as well as relevant survey instruments (Valentine & de Silva, 2003, de Silva, 2000). As such, there are notable overlaps between these concepts and health systems responsiveness, which I briefly reflect on in section 1.1.2. De Silva (2000) stresses that not all the seven elements might be of equal importance with socio-cultural factors, in particular, shaping the importance attributed to each element in different countries. Other conceptualisations of responsiveness have therefore also included additional elements, such as clarity of communication, trust, and continuity of care (Valentine & de Silva, 2003, Mirzoev & Kane, 2017, Bramesfeld et al., 2007).

Element	Description
"Respect for persons"	
Dignity	• Safeguarding of human rights • Respectful treatment by healthcare staff • The right to ask questions and provide information during consultations and treatment • Privacy during examination and treatment
Confidentiality	• Privacy of consultation environment • Confidentiality of medical records and information
Autonomy	• Providing individuals information about their health status, risks, and alternative treatment options • Involving individuals in the decision-making process • Obtaining informed consent for testing and procedures • The right for patients of sound mind to refuse treatment
"Client orientation"	
Prompt attention	• Entitled to rapid care in emergencies • Entitled to care within reasonable time periods • Reasonable waiting times for consultations and treatment
Quality of basic amenities	• Clean surroundings • Regular cleaning and maintenance procedures • Sufficient ventilation • Adequate furniture • Clean water • Clean toilets • Clean linen • Healthy and edible food
Access to social support networks	• Regular visits by family members and friends • Provision of food and other consumables by family members and friends • Ability to follow or participate in religious practices
Choice of provider	• Choice of institution and individual providing care

Table 1: Elements of health systems responsiveness (de Silva, 2000, Valentine & de Silva, 2003)

A notable application of this conceptualisation is the WHO health systems responsiveness questionnaire. The survey tool has been validated and adapted to suit different country

contexts and many studies have used the instrument to examine the state of responsiveness of various country health systems (Coulter & Jenkinson, 2005, Peltzer, 2009, Liabsuetrakul et al., 2012, Chao et al., 2017, Awoke et al., 2017, Ratcliffe et al., 2019, Kapologwe et al., 2020, Negash et al., 2022). In this way, responsiveness is measured by producing "quantifiable indicators" which specify overall health systems performance (Khan et al., 2021). Scholars have however pointed out that a single tool may not adequately measure a complex, multi-dimensional concept like responsiveness – the tool may not allow for fair comparison of the responsiveness of different country health systems and between public and private sectors. Moreover, as Mirzoev and Kane (2017) argue, the WHO health systems responsiveness framework (and other responsiveness frameworks which follow) consistently overlook the broader social, cultural, economic, and historical contexts that shape peoples' expectations and perceptions of responsive health systems.

Several scholars have adapted the WHO framing, offering alternative approaches or lenses to understand and examine health systems responsiveness. Gostin et al., (2003) demonstrate how the domains of responsiveness can relate to one or more principles of human rights. For instance, while respect for dignity is a core element of health systems responsiveness, Gostin et al., (2003) explain how it is also a consistent theme in human rights, as outlined within the Universal Declaration of Human Rights (UDHR). As such, they argue that human rights principles can be used to enhance, or even justify, the relevance of the domains of responsiveness. On the other hand, Joarder et al., (2017) present a framework specifically on the responsiveness of providers, drawing on findings from a qualitative study in Bangladesh. Within their conceptualisation, they define responsiveness as it applies to human resources for health, as "the social actions by health providers to meet the legitimate expectations of patients". Hence, they outline five key domains of *provider* responsiveness – friendliness, optimising benefit, respecting, gaining trust, informing, and guiding – as well as an associated tool to measure physicians' responsiveness.

1.1.1.2 Responsiveness as accountability

Other scholars have equated health systems responsiveness with the concept of accountability. Accountability has its roots within the political sciences (as I discuss in Chapter 3) and is defined as the representational procedures that link governments with

citizens (Weatherford, 1992). Within the healthcare literature, it is the notion that service providers, as well as political and governmental actors, are held to account by the public for their decisions and actions (Lodenstein et al., Khan et al., 2021, Mirzoev & Kane, 2017). In this conceptualisation, therefore, improvements in provider responsiveness to citizens' needs and demands is a direct outcome of social accountability initiatives. For instance, in their realist review, Lodenstein et al., (2016) suggests that provider responsiveness to citizens' demands are the result of a mix of the broader governance and health system context, as well as "features of the social accountability initiatives". In their framework of accountability mechanisms in health care, Cleary et al., (2013) distinguish between two forms of accountability initiatives – external accountability between service providers and citizens, and internal accountability between politicians and policymakers, and service providers. Berlan and Shiffman's (2012) framework specifically centres on the social accountability of providers to citizens (or internal accountability). Within the framework, they specify that a key determinant of the social accountability of providers is the broader health system context. This includes sources of revenue and oversight mechanisms which, they argue, may result in providers being accountable to entities other than service users (Berlan & Shiffman, 2012). However, they also acknowledge the "social" or "people-related" factors shaping provider accountability. Therefore, as Lodenstein et al., (2016) concur, one must consider how both broader and local contextual factors influence social accountability and provider responsiveness – politics, of participation, histories of citizen-state engagement, and the presence of citizen 'voice'. Such considerations prompt Cleary et al., (2013) to argue that promoting spaces of decision-making at lower levels of the health system, though "local-level innovation" can enhance the responsiveness of the health system to the expectations of citizens.

1.1.1.3 Responsiveness as peoples' experiences of their health system interactions

Recently, Mirzoev and Kane (2017) reviewed the current frameworks on health systems responsiveness, identifying key conceptual shortcomings in the existing literature. They argue that health systems responsiveness relates to, "an actual experience of people's interaction with their health system" and that this experience either validates or disconfirms their a priori expectations of the system. In this way, Mirzoev and Kane (2017) propose that the experience of the health system interaction is shaped both by people's initial expectations of care and the health systems response to these expectations. Yet, while current frameworks have acknowledged both the 'people' and 'health systems'

side of this interaction, they suggest that the interaction itself has received limited scholarly attention. Crucially, they point out that the WHO framework, as well as other health service-encounter frameworks, fail to consider the contextual determinants that impinge upon peoples' interactions with the health system. These determinants, such as political history and cultural norms and traditions, shape and define people's expectations of care, as well as determine the health system's ability to respond to these expectations. Tackling these gaps, Mirzoev and Kane (2017) propose a comprehensive conceptual framework on health systems responsiveness. Within the framework, they locate people's experience of their health system interaction at the centre of responsiveness. These experiences relate to the elements of responsiveness, as proposed by the WHO, however, they build upon these widely accepted elements by adding trust. The framework further illustrates that the health system interaction is shaped by both the *people* (the initial expectations of individuals, their families, and communities) and the *health system's response* (processes, structures, resources, and relationships between service providers, managers, and policymakers). They propose that this all occurs within a given historical, political, cultural, social, and economic context (Mirzoev & Kane, 2017). Key insights from this conceptualisation foregrounds and informs this inquiry, as well as the broader RESPONSE project (discussed further in section 4.3).

1.1.2 A note on adjacent concepts to health systems responsiveness

Health systems responsiveness is commonly conflated or associated with a number of adjacent concepts within the healthcare literature. One such concept is quality of care. As de Silva (2000) suggests, quality of care covers a wide spectrum, with several scholars articulating the various aspects or elements of the concept. Perhaps the most well-known model was put forth by Donabedian (1988) outlining the various levels at which quality of care can be assessed. This includes, firstly assessing the care provided by practitioners – their technical knowledge and judgments, as well as the interpersonal relationship they have with the patient. Also examined, is the care implemented by the patient (including the contributions of provider, patient, and their family in this implementation) and, ultimately, the care received by the broader community (access to care, and the performance of provider, patient, and their family). From these assessments, Donabedian (1988) suggests that inferences can then be drawn about the quality of care relating to "structures", "processes", and "outcomes". The latter corresponds to the effect of care on the health status of the population, including improvements in patients' knowledge and

behaviour. “Structures” are the attributes of the setting in which care is provided or received (human resources and organisational structures), while “processes” denote the act of giving and receiving care (the patients’ journey to seek care and the providers’ activities in providing care).

A key feature of Donabedian’s (1988) framework are the interpersonal interactions between patients and providers, corresponding to “clinical quality of care”. However, as Hanefeld et al., (2017) suggests, patients’ perceptions of the quality of care – “perceived quality of care” – can be a crucial driver in healthcare utilisation or, as Donabedian (1988) outlines, “process outcomes”. Such perceptions, they contend, may relate to the non-clinical aspects of the care encounter, the primary focus of health systems responsiveness. For instance, whether patients perceive that confidentiality is maintained in a healthcare setting or, in the case of marginalised populations, the care environment is non-discriminatory and supportive (Hanefeld et al., 2017). Valentine et al., (2003) and de Silva (2000) argue that while some of the interpersonal elements of quality of care have shaped conceptualisations of responsiveness, no quality of care framework acknowledges all the dimensions of health systems responsiveness. While I note the overlap between health systems responsiveness and the concept of quality of care, I do not delve further into this in this thesis.

Responsiveness has also been linked to the concept of patient satisfaction, which, like responsiveness, is also imbued with complexity (de Silva, 2000). According to Donabedian’s model on quality of care (1988), patient satisfaction can be viewed as one of the desired outcomes of care, or even an element of health status itself. In this way, a person’s expression of satisfaction or dissatisfaction may also be their judgement on the quality of care received. Within this model then, patient satisfaction can be defined as a “patient-reported outcome”, while healthcare structures and processes of care might be considered as “patient-reported experiences” (Bjertnaes et al., 2011) Nevertheless, Donabedian (1988) stresses that patient satisfaction can be indispensable to assessing the design and management of health systems. This could indeed explain why much of existing literature focuses on examining patient satisfaction, with many surveys too being biased towards evaluating peoples’ satisfaction or dissatisfaction with their care (de Silva, 2000). However, as Jenkinson et al., (2002) argued, surveys which asks patients to merely rate their satisfaction/dissatisfaction with their care, do not sufficiently shed light on the

specific problems that impact the quality of care. They instead propose an instrument which asks patients about their experiences of care.

Herein lies the distinguishing feature of patient satisfaction – it is evaluated through assessing peoples' experiences of care, along with their perceived needs and "individually determined" expectations (de Silva, 2000). Patient satisfaction is therefore said to be broader in scope and narrow in range – it is based on clinical interactions within specific healthcare settings, but in relation to both the medical and non-medical aspects of care. In their instrument, Jenkinson et al., (2002), for instance, focused on the dimensions of coordination of care, respect for patients, respect of patient preferences, information and communication, involvement of family and friends, and continuity and transition of care. Responsiveness, on the other hand, is concerned with the health system in its entirety, but solely assess peoples' "legitimate, universal expectations" of the non-health enhancing aspects of care (de Silva, 2000). Drawing on the work of Thompson and Suñol (1995), de Silva (2000) further clarifies that expectations within responsiveness are normative – they are peoples' expectations about what should or ought to happen during their care encounters. This is in contrast to patient satisfaction which broadly encompasses "individually determined", ideal, predicted, and unformed expectations. Thus, as de Silva (2000) proposes, responsiveness is measured through peoples' evaluation of their health system against "objectively set standards", rather than through their relative judgements based on aspirations or predictions. In Chapter 3, I discuss the differences between patient satisfaction and responsiveness further, but specifically in relation to the concept of expectations.

Chapter 2: Context

2.1 Chapter overview

I begin this chapter by reflecting on the global political, economic, and health system shifts that have characterised recent decades. I then provide an overview of these shifts and changes specifically within the context of post-Doi Moi Vietnam. In particular, I delve into three pivotal moments, or "shifts" in the country's history which have influenced, and continue to influence, women's position in both their "public" and "private" spheres. I show how Confucianism, the communist revolution and, later, the Doi Moi reforms of 1986, have given rise to a complex and contradictory set of Vietnamese gender roles and norms. Yet, overwhelmingly so, the current scholarly literature adopts a deficit perspective and emphasises Vietnamese childbearing women's limited autonomy and agency. As I also discuss below in Section 2.3.1, the Doi Moi reforms transformed Vietnam's health system to one that is increasingly shaped by privatisation and commercialisation. However, again, this shift towards market-oriented provision of healthcare is insufficiently reflected in much of the literature examining childbearing women's experiences and interactions with the Vietnamese health system. I articulate these notable gaps in the form of a synthesising argument, which I present within a critical interpretive synthesis (CIS) at the end of this chapter.

2.2 Global political, economic, and health system shifts in recent decades

In the early 1980's, the world was in the grips of a major economic recession. One of the effects of this was a global political shift towards neoliberalism, first in major industrialised economies, such as the US and UK, and then in emerging, formally socialist-oriented economies, including Vietnam (Sanders, 2023). These new policies were coined "neoliberal" as they sought to 'liberalise' or free major markets (including the health care market) from government regulation. Hence, some of the main elements of neoliberalism included a shift towards privatisation, the reduction in government control over private industry, and government cuts for public services (Sanders, 2023). Overall, these neoliberal policies and strategies aimed to grow national economies and the following decades were characterised by major economic shifts and transitions. According to the World Bank (2022), at the turn of the decade in 2000, sixty-six countries were classified as having "low-income status", among these were the major Asian "tiger economies", including Vietnam, India, and Indonesia. Only a decade later, these countries surpassed the low- or lower-income thresholds, representing an economic transition towards "middle income status" (World Bank, 2019). Globally, these patterns of economic growth have resulted in the gradual disappearance of low-income countries in almost all regions around the world (McPake et al., 2020).

The neoliberal turn in the political economies of many countries around the world has seen the diffusion of neoliberal market strategies within the health sector, resulting in widespread health system reforms (Sander, 2023). These included the expansion of the private health sector, the introduction of user fees to recover public health service costs, as well as encouraging competition between providers. These reforms occurred alongside the emergence and proliferation of the "middle class", with an increasing demand for better quality care and with the necessary purchasing power to make private health care profitable (Sanders, 2023, McPake et al., 2020). This saw a paradigmatic shift in the nature of healthcare provision. While previously, a strong public health system was understood as the only "viable option" in underdeveloped countries to provide care to poorer populations, the shift towards neoliberalism now meant that the market could, and indeed should, provide care to all citizens, particularly underserved populations. Ultimately, as Sanders (2023) and Bagchi (2022) suggests, this has given rise to the commercialisation of health care in many LMICs – the provision of health care to those who can afford it, albeit with a view to make a profit.

That said, and as I have highlight in Chapter 1, analytical frameworks of health systems responsiveness currently fail to explicitly consider the broader social, economic, and political shifts which have not only impacted health system functioning, but also peoples' expectations of their health systems (Mirzoev & Kane, 2017, McPake et al., 2020). Therefore, in this inquiry, I seek to uncover how these shifts and transitions shape women's expectations of and interactions with their health systems, within the context of post-Doi Moi Vietnam – a country that has experienced significant economic, social, and health system changes as a result of the shift towards a "market-oriented economy" under the Doi Moi reforms. Changes which, as I discuss above, are reflective of those occurring within other emerging economies around the world. Below, I provide an overview of the context of post-Doi Moi Vietnam.

2.3 Vietnam – a country in transition

Vietnam is situated in the centre of Southeast Asia, bordering China in the north, and Laos and Cambodia in the west (Ashwill & Diep, 2005). It is politically organised into 58 provinces and five municipalities (Hanoi, Haiphong, Da Nang, Ho Chi Minh City and Can Tho), and is further subdivided into districts and communes. As of 2021, the population of Vietnam was 98.17 million, with the majority of the population concentrated in the two main cultivated areas of the Red River Delta and the Mekong Delta (Ashwill & Diep, 2005, UNData, 2021). Vietnam has undergone substantial social and economic shifts throughout its history, from the early influence of Confucianism to Marxism following the revolutionary movement in 1945 and, recently, the social and economic reform program of 1986, Doi Moi (Werner, 2009, Ekman et al., 2008). As a result of the Doi Moi reforms, Vietnam has experienced rapid and sustained economic growth (Ekman et al., 2008). According to the World Bank, GDP per capita increased 3.6 times from 2002 to 2021, and poverty rates (measured as the number of people living on less than 1.90 USD per day) declined from 14% in 2010 to 3.8% in 2020 (World Bank, 2022). As a result, Vietnam has transitioned from a low- to middle-income economy in a single generation (The World Bank, 2022).

The transition to a market-oriented economy under Doi Moi has created new opportunities and challenges for the health system in Vietnam, including, an increasing demand for high-quality healthcare. Vietnam has therefore increasingly extended population coverage of healthcare, especially to poor and vulnerable groups, through both public and private providers (Mao et al., 2020). However, as is the case in other LMICs, rising living standards can also prompt people to demand higher quality care which meets their increasing needs and expectations (McPake et al., 2002, Ekman et al., 2008). Past and ongoing economic, social, and cultural shifts in Vietnam therefore inevitably shape peoples' legitimate expectations of and interactions with the health system, including what women expect from the health system during their pregnancy and childbirth. Therefore, in the following sub-sections, I briefly outline and reflect on the three major social and economic shifts in Vietnam – Confucianism, Socialist Marxism, and the Doi Moi reforms – and the influences such shifts had, and continue to have, on women's position in Vietnamese society. While these shifts potentially occurred at distinct moments in Vietnam's history, I highlight below how their impact is still prevalent today in contemporary Vietnam.

2.3.1 Confucianism

Historically, as Do and Brennan (2015) have revealed, Vietnam had been a matriarchal society with the existence of a 'double kinship system' that combined both matrilineal and patrilineal patterns of family structure. However, the matriarchal culture of Vietnam was challenged when the State officially adopted Confucianism as the official philosophical ideology in the 11th century. Confucianism was "more than a religion" and was perceived as a "mandate for an entire way of life" (Do & Brennan, 2015). Confucianism emphasises patriarchal (male family members are the primary decision-makers), patrilineal (sons carry the family lineage and inheritance), and patrilocal (married couples live with or close by the husband's family) kinship (ISDS, 2015, Barry, 1996). These practices have shaped traditional gender roles and structures for men and women in Vietnam. Specifically, within the "Confucian family system", roles are hierarchical with the husband considered the "pillar" of the family and key decision-maker (Mestechkina et al., 2014, Werner, 2008). After the father, elderly relatives (mainly the husband's family) and older male siblings generally assume the most authority. Women are thus relegated to domestic (unpaid) work and childrearing and are perceived as the primary caregivers in Vietnamese families. The practice of patrilineal kinship has emphasised the expectation that women should give birth to a son to ensure the continuation of the family line (Mestechkina et al., 2014). Ultimately, the Confucian ideal is to achieve "harmony" within the family, particularly through the observance of filial piety (Werner, 2008). That said, scholars have suggested that the influence of Confucianism varies across regions in Vietnam; southern Vietnam is said to be less influenced by Confucian culture compared to Northern provinces (Barry, 1996). Nevertheless, work by Gammeltoft (1998) and Quach (2008) on Vietnamese women's family planning practices and sexual agency have shown that Confucian ideologies are still prevalent in contemporary Vietnam and are influential enough for women to be torn between their ideals and existing Confucian practices (ISDS, 2015). Thus, one must be mindful of how Confucianism, socialism (discussed below), and Doi Moi intersect to, "resource an ambivalent and contradictory set of Vietnamese femininities" (Do & Brennan, 2015).

2.3.2 The communist revolution

More than any other social force, contemporary Vietnam has been moulded by the evolution of the Communist Party of Vietnam (CPV) – the country's party-state. The organisation's history can be traced back to the 1920's when it was formed during a time of anti-colonial struggle and "communist internationalism" (London, 2023). In 1925, the CPV was established as the Vietnam Revolutionary Youth League and later, in 1930, became known as the Indochina Community Party with the aim of liberating Indochina from colonial rule (French colonial rule in Vietnam) and bringing about a socialist revolution (London, 2023). In 1945, the CPV (acting as the Viet Minh) defeated the French at Dien Bien Phu, yet by 1955, US forces began replacing French forces culminating in the "Vietnam War". As I discuss further below, the fiscal crisis of the 1980s saw the CPV adopt a "market-Leninist social order" (London, 2023). A key feature of the Leninist party-state, in contemporary Vietnam and in other contexts, is the administration of complete and permanent political monopoly of the party. This includes the party's domination across political, social, economic, and cultural domains of life. As such, and as I discuss further in Section 3.3, the dominance of single-party political systems like the CPV can mean that basic citizen rights, such as citizen participation, can be undermined (Shi, 2010).

Within the "private sphere" the revolutionary movement in 1945 reformed the "the Confucian family system" and brought women out of their homes and into the public arena. For the revolution to succeed, women were encouraged to work, not only for themselves and their families, but also for the movement (Barry, 1996). Scholars have associated the mobilisation of women during the revolution with improvements in the status of women in Vietnam, particularly, in the north where Confucian ideals were prevalent. Therefore, when the Communist Party came to power in 1945, Werner (2008) argues that the Confucian family system, which held women subordinated, was undermined. In this way, Marxist-oriented feminist perspectives have shaped 'state feminism', the idea that the state, "can and should improve women's social, economic, and political status" (Scott & Chuyen, 2007). On the surface, the Communist revolution had been successful in advancing gender equality in Vietnam (Werner, 2008). For women, it prompted greater access to education, the right to work outside the home and own property, as well as the right to vote and stand for election as early as 1946. Women's political mobilisation was, and still is, mediated by the Women's Union, a national

woman's bureaucracy established in 1930 to represent women at all policy levels (Werner, 2008, Barry, 1996).

Today, Vietnam's high female workforce participation and literacy rates can be traced right back to the mobilisation of women during the revolutionary movement. In 2019, it was estimated that 95% of females aged 15 years and over were literate (The World Bank, 2019). Moreover, according to the International Monetary Fund (IMF), Vietnam has maintained a female labour force participation rate of 70%, out-performing Western economies such as Australia and Sweden (Banerji et al., 2018). However, despite advances in political and workforce participation instigated by the revolutionary movement, Vietnamese women's status within the family can remain unequal; within the "public sphere" Vietnamese women are expected to follow a "socialist work ethic", while in the private family sphere, Confucian traditions and practices still prevail (ISDS, 2015). Gender hierarchies within the family may continue to emphasise that Vietnamese women should be good at both "national tasks", as well as "household tasks". This is echoed in work by Werner (2008) in post-revolutionary Vietnam, where women's and men's discourses still expressed that a woman's place was in the home and that the care of children took precedents over "national tasks", such as public activities and employment.

2.3.3 Doi Moi reforms of 1986

At the historical 6th Congress in 1986, the Communist Party of Vietnam (CPV) demonstrated its commitment towards a market-oriented economy. This was followed by a policy of renovation, known as Doi Moi (Witter, 1996 & Long et al., 2000, Võ & Löfgren, 2019). Prior to the Doi Moi period, Vietnam had encountered numerous and widespread economic crises which led to deteriorating living conditions that undermined the public's confidence in the CPV (Võ & Löfgren, 2019). Various social and economic reforms ensued as a result of Doi Moi, including the liberalisation of foreign trade and the legalisation of the private sector, representing a shift towards neoliberalism (Klingler-Vidra, 2014). These reforms also had a substantial impact on the health system (discussed further below). The mid-1990s saw private and foreign investment leading to rapid growth of major cities, such as Ho Chi Minh, and encouraged rural-urban migration. In 1994, it was estimated that women workers comprised 53% of the total labour workforce, 71% participating in economic activities and 76% in agriculture (Long et al., 2000).

However, since the economic reforms, scholars have argued that relations between men and women, both within the "public" and "private" spheres, are increasingly unequal. This is as Doi Moi shifted "reproductive and productive tasks to the household" (Long et al., 2000). While wives and mothers generally manage household finances, they are still required to consult their husbands before spending money. Hence, in some cases, women may have little say in money spent on healthcare or education. As highlighted above, the reform process has not only prompted increased mobility of goods but also people. The feminisation of agricultural labour following the Doi Moi reforms is a direct consequence of the migration of men; men migrate to urban areas while women remain to care for children (Long et al., 2000). While this may give women more control and flexibility within their homes and occupations, their daily conditions may be more demanding. Werner (2002) goes further to argue that the economic restructuring of Doi Moi is not merely a series of economic policy reforms, but a socially embedded process that is shaped by many gendered components. One of these is the development of the "household economy" – national and local state levels have been charged with the responsibility of encouraging and assisting households to develop their family economy by finding new sources of income. This includes the establishment of small household businesses selling a range of retail items, textiles, and food (Werner, 2002). This has been coined as "shopfront capitalism" and women predominate in managing these household businesses. That being said, and as Long et al., (2000) highlight above, the promotion of women's participation in labour under Doi Moi has meant that women's workloads, both within the public and private spheres, have intensified (Werner, 2002).

2.4 Health system context

2.4.1 Health system reforms under Doi Moi

Vietnam's health system, as we know it today, is the result of significant reforms and changes instigated by Doi Moi. Alongside the country's transition towards a "socialist-oriented market economy", the Doi Moi reforms also led to the diffusion of neoliberal market strategies within the health system (Klingler-Vidra, 2014). Prior to Doi Moi, the health system was considered the responsibility of the State – health services and medications were heavily subsidised and supplied to the public entirely free of charge (Witter, 1996, Võ & Löfgren, 2019). As expected, this placed significant pressure on the State, exacerbated by a series of economic problems occurring throughout the 1980s,

leading to issues with health staff morale, poor maintenance of health facilities, and an overall lack of funding (Witter, 1996). To tackle these issues, health sector reforms under Doi Moi opened up the health sector to for-profit private providers and led to the introduction of user fees at public health facilities (Ekman et al., 2008, Ladinsky et al., 2000, WHO, 2018). These reforms had, and continue to have, a number of effects, specifically, the exponential growth of the private healthcare sector in Vietnam. In 1993, there were no private health services in the country. However, by 2008, the sector included 83 private hospitals and 30,000 private clinics (Thoa et al., 2013). As a result, private health services accounted for 40% of total outpatient visits in 2010, playing a crucial role in healthcare delivery in Vietnam (WHO, 2018). In 1989, Decision 45 also prompted the privatisation of the public health sector through the introduction of user fees. Decision 45 outlined fees associated with specific health services including for health examination, bed occupation, drugs, blood tests, and X-rays. Võ and Löfgren (2019) have argued that these reforms and policies marked the "transfer of responsibility" of public health services from the State to citizens, in parallel with the shift from socialism to a socialist-oriented market economy. On the back of these policies, hospital autonomy reforms, outlined in Decree 10 in 2002, granted public health services varying degrees of autonomy with respect to finance, personnel, as well as the overall management and organisation of health service delivery. In this way, direct government control over the public health system in Vietnam was reduced, exposing the system to the market and market-like forces (Võ & Löfgren, 2019). In their institutional analysis, Võ and Löfgren (2019) have shown how hospital autonomisation has underpinned the increasing shift of healthcare costs from the State to citizens. The authors uncover how public hospitals in Vietnam use hospital autonomy as a "strategic instrument" through the excessive use of high-technology equipment and the provision of various "patient-requested" services. Driven by a desire to maximise revenues, providers may also induce service users to use unnecessary services or increase their length of stay (Võ & Löfgren, 2019). The growth of for-profit care provision has led to calls for the development and enforcement of regulations that promote safety, quality, and equity of healthcare in Vietnam (Nguyen et al., 2023). However, as Tuan et al. (2005) found in a rural region of Vietnam, less than 20% of private providers had their practice registered with the government. Though legal frameworks (the Vietnam Constitution of 1992 and the Law of Medical examination and treatment of 2009) exist, efforts to regulate the private sector are limited, with no system or instruments in place to regulate private health activities and service quality. This

includes the regulation of healthcare costs – without such controls, private providers may seek to increase their profits by charging higher fees (Nguyen & Wilson, 2017).

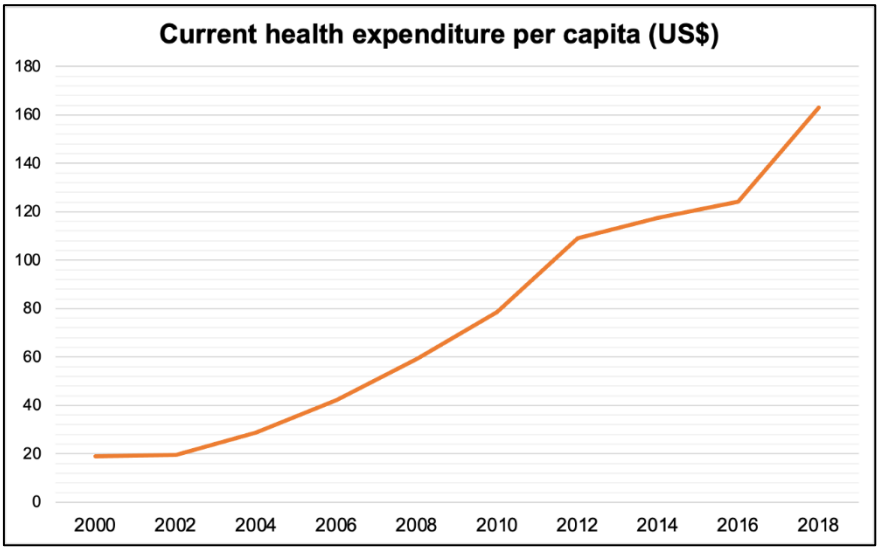

Figure 1: Current health expenditure per capita (US$). Source: The World Bank (2022).

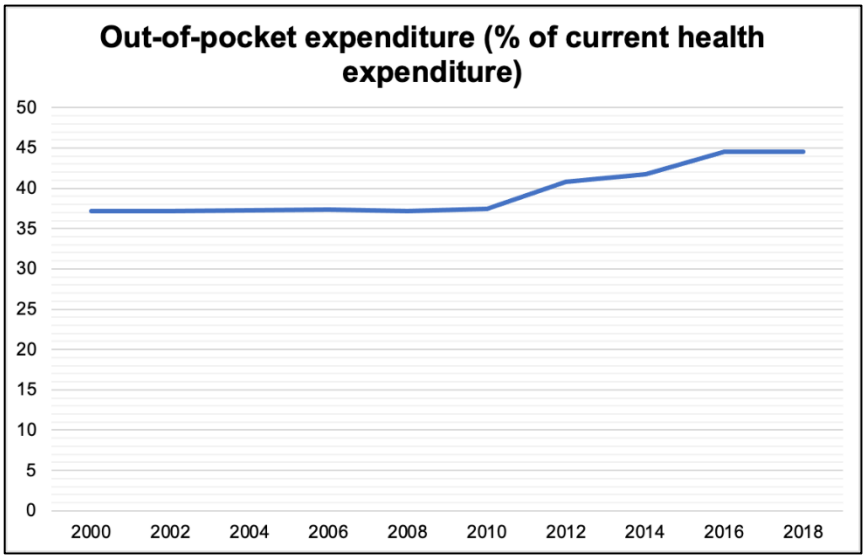

Figure 2: Out-of-pocket expenditure (% of current health expenditure). Source: The World Bank (2022).

Numerous scholars have argued that these health system reforms and strategies have shifted the financial burden from the State onto service users, and high out-of-pocket (OOP) expenditure on health care highlights this (Thoa et al., 2013, Võ & Löfgren, 2019, 2018, Ekman et al., 2008). As Figure 2 shows, out-of-pocket expenditure on health care in Vietnam has remained high, with an increase from the period between 2010 (37.42%) to 2018 (44.58%). While the State does continue to fund healthcare services, total health

expenditure in 2019 was 5.25% of Gross Domestic Product (GDP), with OOP expenditure accounting for 42.95% of current health spending (World Bank, 2019). Overall health expenditure per capita (as shown in Figure 1) has also increased from 18.92 USD in 2000, to 78.64 USD in 2010, and to 163.15 USD in 2018. Hence, the financial burden associated with health care can bring about income-related inequalities in Vietnam. This is as, prior to Doi Moi, healthcare used to be free, however now access to care is increasingly dependent on income. This is particularly the case when it comes to accessing care which is responsive to peoples' increasing healthcare expectations. Health insurance coverage (discussed below) may go some way in reducing OOP payments. However, as Ekman et al., (2008) and Thoa et al., (2013) argue, it is not the only solution.

2.4.2 Health system structure

Vietnam has a tiered health system comprising of both public and private providers (see Figure 3). At the grassroots level, there is vast network of more than 11,000 commune health centres (CHCs), one in each commune, that are administratively managed by the Commune People's Committee (Hoa et al., 2019, Takashima et al., 2017, Thi Hoai Thu et al., 2018). CHCs serve a population of 5,000 to 10,000 people and have the capacity to provide preventative, acute, and chronic care and treatment for residents of a particular commune. Most CHCs are typically staffed by a general doctor, as well as ancillary staff, and deliver a range of services including immunisation, family planning, first aid, maternal and child health care and treatment of chronic diseases and infections. Village health workers are also responsible for primary care provision, particularly the delivery of healthcare for mothers and children at the village level (Hoa et al., 2019, Thi Hoai Thu et al., 2018). District health centres (DHCs) and hospitals are the next step up in Vietnam's tiered public health care system, serving as the first referral point for CHCs. Administratively managed by the District People's Committee, district hospitals and health centres also provide administrative and technical guidance to CHCs. District hospitals deliver diagnostic and curative services with outpatient departments in various disciplines such as, obstetrics and gynaecology, paediatrics, and surgery (Hoa et al., 2019, Thi Hoai Thu et al., 2018). As a result of district-level health sector reforms in 2005, district hospitals have split from DHCs which now largely have a preventative focus (Thi Hoai Thu et al., 2018). Together, it is estimated that district hospitals and health centres serve around 100,000-200,000 people. Beyond the district level, other hospital levels include provincial hospitals in each province and central hospitals in each region that are

administratively and technically managed by the provincial government and the Ministry of Health (MoH). These hospitals provide more complex inpatient and outpatient services, serving approximately 1-2 million people (Hoa et al., 2019, Thi Hoai Thu et al., 2018). Hence, a significant challenge faced by policymakers in Vietnam is the overcrowding of higher-level public hospitals by patients that bypass commune- and district-level facilities. An annual health review by the MoH in 2015 revealed that 54-65% of patients accessing care at the central-level have health conditions that are treatable at lower health system levels (Hoa et al., 2019). Potentially driving this pattern of care-seeking, is the fact that patients expect better quality of care at these seemingly more advanced hospitals (Hoa et al., 2019, Ngo & Hill, 2011).

In their quest for higher quality care, patients may alternatively pursue private sector services. Private hospitals are now estimated to provide greater than 60% of outpatient services and are thus an important component of Vietnam's health system (Hoa et al., 2019). The private health sector in Vietnam comprises of three different service structures. Private hospitals, located in major cities, have a reputation for access to high-tech diagnostic and therapeutic technology, as well as a capacity to provide technically advanced services (Ngo & Hill, 2011). In rural, urban, and suburban areas, private outpatient clinics are operated by individual or group physicians that are under license by provincial health authorities. Alternatively, "mobile" private practitioners (retired doctors, assistant doctors, or even nurses) are commonly present in rural areas of the country and provide services to the public from their homes or other public locations. As they are not licensed, these "mobile" private practitioners are often not included within the formal health system. Nevertheless, these practitioners do play an essential role in providing basic health services, particularly in rural areas (Ngo & Hill, 2011).

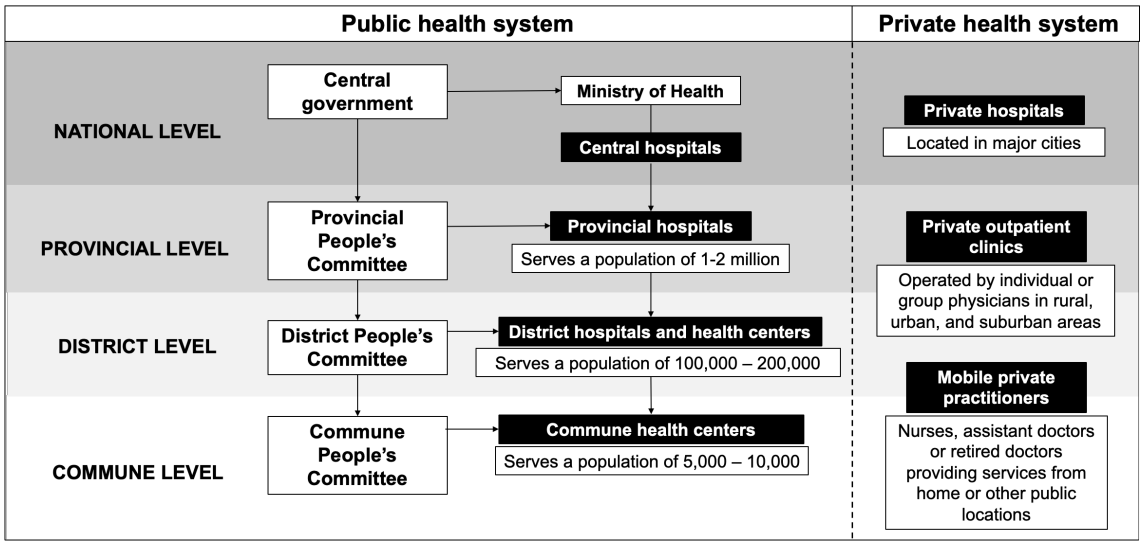

Figure 3: The health system in Vietnam

2.4.2.1 Health insurance

The first government decree on social health insurance (SHI) was announced in 1992 (Decree No. 299/1992/HDBT), aiming to curb the increase in OOP spending. This scheme was specifically targeted towards civil servants, those employed within the formal sector, as well as other population groups including, pensioners and the disabled (Tien et al., 2011, Ekman et al., 2008). It covered all the eligible population by early 1993 and was implemented nation-wide in all provinces. The scheme is financed by payroll tax of 3% – the employer contributes 2% and the employee 1% (Tien et al., 2011). Moreover, to improve the accessibility of health services to the poor and other vulnerable groups, the Health Care Fund for the Poor (HCFP) was announced in 2002 through Decision 139. The fund covers an estimated 18% of the population, specifically directed towards the poor, ethnic minorities, and those living in disadvantaged communities (Tien et al., 2011, Ekman et al., 2008). Implemented in all provinces, authorities could choose to either enrol individuals in the health insurance scheme or to reimburse providers for free health services to those eligible. However, when initially implemented, the policy encountered several administrative difficulties, including, how to classify individuals as "poor". The pro-poor policy was further modified in 2005 to tackle these issues (Health Insurance Decree 63). Finally, a third compulsory insurance program is directed towards children aged below six years of age and covers approximately 11% of the population (Tien et al., 2011). Together, these three schemes are formally part of Vietnam's compulsory health insurance (CHI) program, with population coverage of the CHI steadily increasing from 43% in 2008, to 61.5% in 2014 (Mao et al., 2020). A voluntary health insurance scheme

(VHI) was introduced in 1994 and was targeted towards the dependents of those covered by the CHI, namely, students, school children, as well as those that are self-employed or work in the informal sector. However, the scheme has had little success in terms of population coverage, covering only around 11% of the population (Ekman et al., 2008).

The current health insurance scheme in Vietnam includes several dimensions that favour financial equity, including providing insurance coverage to a large proportion of poor households in Vietnam. As Ekman et al., (2008) also highlight, both the CHI and VHI schemes are associated with a number of positive impacts such as, increased healthcare utilisation and reduced out-of-pocket payments. Yet, the Vietnamese health financing system has also contributed to both poverty impacts and catastrophic effects. For instance, Mao et al. (2020) have shown that disparities in financial protection still exist *within* Vietnam; while the gap in catastrophic health expenditure (CHE) rates has decreased between the lowest and lower-middle income groups, the impoverishment due to health expenditure (IHE) rate is still high in these groups. Therefore, it is possible that poorer households are still experiencing financial hardship when accessing health services (Mao et al., 2020). Thoa et al., (2013) suggest that this could be due to indirect costs associated with seeking care (such as for travelling, accommodation, and food), particularly for those living in rural or remote regions of the country.

2.4.3 Maternal healthcare provision

Over the years, Vietnam has made substantial progress towards improving maternal health. Maternal mortality in Vietnam has declined from 233 per 100,000 live births in 1990, to 69 per 100,000 live births in 2009, and then to 46 per 100,000 live births in 2021 (WHO, 2021, Chuong et al., 2018). In 2021, about 96% of births in Vietnam were attended by a skilled health personnel, compared to 2000, where a little over a half (58.8%) of women were assisted by a skilled attendant during birth (WHO, 2021). Such progress, it has been argued, is the result of strong political commitment and effort by the Vietnamese Government which has issued numerous policies and strategies directed towards improving access to and utilisation of maternal health services: *National Master Plan on Reproductive Health, focusing on safe motherhood and neonatal care period 2011-2020*, *Strategy on population and reproductive health Vietnam 2011-2020 (Decision No 2013/QĐ-TTg)*, and *National guideline on reproductive health services 2016 (Decision No 4128/QĐ-BYT)* (Chuong et al., 2018, Khanh Chi et al., 2021). The

National Guideline emphasises the need for reproductive health services, but also the necessity to improve knowledge and behaviour associated with reproductive health, such as gender and sexual abuse. More broadly, the National Strategy outlined a plan to "renovate" the current network of services providing population and reproductive health care, including calling for the expansion of prenatal screening services (Khanh Chi et al., 2021).

While the World Health Organisation recommends at least eight antenatal care visits for a positive pregnancy experience, the National Strategy in Vietnam recommends at least three antenatal check-ups for uncomplicated pregnancies (Heo et al., 2020, WHO, 2016). The primary access point for women during pregnancy are CHCs, which register and manage all pregnant women in the commune (Ngo & Hill, 2011). They are typically staffed by at least one midwife and provide one-day, monthly antenatal check-ups that are subsidised by the state and therefore free of charge. CHCs may also assist with uncomplicated deliveries, as well as manage immunisations and support breastfeeding. Also based at local CHCs, are three-day semi-annual campaigns that are primarily targeted towards early detection and treatment of reproductive tract infections (including sexually transmitted infections) (Ngo & Hill, 2011). In the event of a complicated pregnancy or labour complications, such as obstetric haemorrhage, patients are referred to higher-level facilities. District and provincial hospitals manage high-risk pregnancies, perform caesarean sections, and care for premature or low birth weight babies (Heo et al., 2020). Alternatively, following Doi Moi*,* the private health sector supplements maternal health services offered by the public health system. As outlined above, private hospitals and clinics have a reputation for providing access to advanced medical technologies, including obstetric ultrasounds (Ngo & Hill, 2011, Gammeltoft & Nguyen, 2007). As work by Ngo & Hill (2011) reveals, the reduction of government subsidies for CHCs to develop out-dated and deteriorating facilities and support human resources is increasingly prompting women, in both urban and rural areas, to bypass their local CHCs in favour of higher-level facilities. It also encourages women to seek care at private facilities which have convenient opening hours, advanced equipment, and more competent staff. However, as I outline in a critical interpretive synthesis (CIS) below, such a shift is insufficiently reflected in or indeed engaged with in the current literature examining Vietnamese women's encounters with maternal health services.

2.5 Childbearing women's experiences of and interactions with the health system in Vietnam: A critical interpretive synthesis

In this sub-section, I present a critical interpretive synthesis (CIS) of childbearing women's experiences of and interactions with the health system in Vietnam. In this piece, I critically examine the current evidence on Vietnamese women's encounters with maternal health care, proposing three critiques of the existing scholarly literature. These critiques highlight the overwhelming focus of the current literature on women's experiences of maternity care in rural and mountainous regions of the country and with public maternity care services, as well as an emphasis on women's limited autonomy and agency. Drawing together these critiques within a synthesising argument, I call for future research to explicitly recognise Vietnam's shift towards for-profit care provision, as well as the societal changes and evolutions occurring in contemporary Vietnam. As such, the CIS informs this study's objective: to examine childbearing women's expectations of and interactions with the Vietnamese health system, in light of the social, economic, and health system transitions and changes occurring in post-Doi Moi Vietnam. This piece is under peer review for publication in an international health journal. Below, the most recent version submitted to the journal for peer review is presented. The supplementary material is included in Appendix D.

Abstract

Scholars have long argued that how one experiences care is shaped by one's context, and by evolutions in this context. Using Vietnam as a case, we critically interrogate the literature on women's care experiences with maternity care to unpack whether and if it engages with the major social, economic, and health system transitions in Vietnam, and with what consequences for equity. We conducted a critical interpretive synthesis of this literature in light of the social, economic, and health system transformations driven by the Doi Moi reforms. We offer three critiques: 1) an overwhelming focus on public maternity care provision in rural/mountainous regions of Vietnam, 2) narrow focus on women's ethnic identity, and 3) a misplaced preoccupation with women's limited autonomy and agency. We argue that future research needs to consider the impact of Vietnam's shift towards market-oriented care provision, and the broader societal and health system changes impacting both rural and urban areas, as well as ethnic minority and Kinh majority populations.

Introduction

Recent decades have been characterised by major economic transitions, globally, but particularly in many low- and middle-income countries (LMICs). Economic growth has contributed towards the rapid disappearance of 'low-income countries' in almost all regions around the world and, since 1990, the halving of the population living in extreme poverty (1). McPake et al. (1) argue that, as populations become more affluent, there is a growing demand for care that is of a higher-quality, and which meets people's increasing expectations. In this way, rising living standards, as a consequence of rapid economic growth, can shape how people experience and interact with their health systems. Inquiries examining peoples' experiences of health and healthcare draw on a long tradition of empirical and theoretical research (2). However, historically, both the empirical and theoretical scholarly literature have consistently overlooked the broader social, cultural, historical, and economic systems and structures that can shape how people experience their care (3). Particularly, how these systems and structures shape people expectations and experiences of their health system along temporal, spatial, and geographical dimensions (4-5). In this paper, we critically interrogate the evidence on women's experiences with maternity care, within the context of post-Doi Moi Vietnam. We employ a critical interpretive synthesis (CIS) approach to critically unpack to what extent rapid economic, societal, and health system changes, as a result of Doi Moi, are reflected in the current scholarly literature on women's care encounters. We use the case of women's experiences with maternity care in Vietnam to illustrate peoples' experiences with a health system in a country experiencing rapid economic and societal changes and shifts – changes that are akin to those impacting many LMICs (1).

Vietnam has been dubbed a 'transition tiger' – transitioning from a low- to a middle-income economy in a single generation (6-7). Such economic growth can be traced right back to Doi Moi – a series of social and economic reforms that prompted Vietnam's transition towards a socialist-oriented market economy (8-9). These reforms also brought about various health sector developments within the Vietnamese health system. Central among these, was the liberalisation of the healthcare market with the legalisation of the private sector (8-9). As Dao (10) recently argued, patrial-privatisation, liberalisation, as well as the influx of new medical technologies has changed the organisation of Vietnam's health system and, with that, peoples' interactions with the health system. The stratification of Vietnam's health system, as a result of Doi Moi, has created several

distinct, but overlapping "medical routes" (10). Primary care is delivered at commune health centres (CHC), with district health centres (DHC) and hospitals, as well as provincial and central hospitals offering more specialised treatment and care. However, recent reviews by the Ministry of Health reveal that many patients bypass CHCs, and even DHCs, in favour of higher-level provincial and central hospitals as they expect better quality of care at these facilities (11-12). Competing with public health services are private providers based in private hospitals or outpatient clinics. Similarly, patients are increasingly seeking care at private facilities and are willing to pay higher fees for perceived better quality of care. In particular, the private sector has been found to better respond to patients' expectations by having more competent staff, convenient opening hours, and advanced medical equipment (13).

During pregnancy and childbirth, women and their families are required to navigate these complex "medical routes", both physically and cognitively (10). Examining the pattern of reproductive health service utilisation in Vietnam, Ngo and Hill (13) found that, while CHCs continued to dominate the provision of antenatal care, urban women were more likely to seek care at private clinics. Yet, a significant proportion of women in rural areas (including ethnic minority women) were also found to visit private clinics during their last pregnancy. On the other hand, a review of ethnic minority health in Vietnam suggested that ethnic minority women's preferences for delivering at home were driven by distance, cost, cultural rituals associated with childbirth, as well as negative attitudes by health staff. Some scholars have however argued that such explanations are merely rationalisations – distance is relative and there is in fact low knowledge about these culturally-specific practices among health workers (14). There has yet been no comprehensive synthesis of the literature on women's experiences of and interactions with maternal health care in Vietnam. Particularly one which critically examines the care encounters of both ethnic minority and the majority Kinh women, and in light of the social, economic, and health system transitions initiated by Doi Moi. We conducted a critical interpretive synthesis (CIS) to engage with these knowledge gaps.

A critical interpretive synthesis (CIS) is an approach to synthesise a diverse body of evidence where the overall aim is interpretive, rather than aggregative (15). Several inquiries have used a CIS approach to critically review and synthesise the literature on health systems structures and processes, as well as the experiences and interactions of health system actors, including underserved populations (16-18). Our aim of this

synthesis was primarily interpretive – we sought to not only present, but critically unpack the current evidence on women's encounters with maternal health care in Vietnam. To facilitate an interpretive synthesis, the CIS approach emphasises critical appraisal, theory development, and methodological flexibility (15, 19). It is also guided by a highly iterative compass question, which is constantly refined in response to emerging findings (19). The refined compass question which directed our inquiry was: what are childbearing women's experiences of and interactions with the health system in Vietnam? To respond to this question, we first outline three critiques on how the current empirical literature examines childbearing women's experiences of their interactions with the Vietnamese health system. These critiques form the basis of our synthesising argument which outlines an agenda for future inquires seeking to interrogate childbearing women's care encounters in contemporary Vietnam.

Methods

Literature search and selection

A broad search of electronic bibliographic databases was conducted between November 2022 and April 2023. Medline, CINAHL, and PsycInfo databases were searched broadly using the following search terms: (Vietnam OR Viet Nam) AND (maternal* OR maternity OR reproductive* OR perinatal OR peripartum OR antenatal OR prenatal OR intrapartum OR delivery care OR postnatal OR postpartum OR pregnan* OR expectant* OR mother* OR childbirth OR childbearing). The reference lists of review pieces were also hand searched for any relevant literature (including grey literature) which the database search failed to capture.

Records captured by the initial database search were imported into an Endnote database. Duplicate records were removed and, as fig. 1 outlines, the titles and abstracts of each article were screened. We broadly included papers which examined women's experiences of and interactions with maternal health services in Vietnam. As such, we included studies which examined women's interactions with all levels of maternity care (antenatal, delivery, and postnatal care), at different tiers of the Vietnamese health system (commune, district, provincial, and national), and various health system actors, including both public and private providers. We also included studies which analysed healthcare providers and managers perspectives on maternal health care provision. However, we did exclude studies which examined: (1) breastfeeding practices, (2) access to and utilisation of abortion services, (3) Vietnamese migrants' experiences of maternal health care, (4)

child health and nutrition, (5) folic acid or iron supplementation during pregnancy, (6) various health conditions during pregnancy (such as HIV), (7) adverse pregnancy- and infant-related outcomes (still birth, low birth weight, birth defects), and (8) family planning services. We also excluded papers which merely measured women's access to and utilisation of maternal health services without providing an account of their experiences. Moreover, some papers examined women's experiences of both family planning and maternity care services. These papers were still included, with only data relating to women's interactions with maternity care analysed. Any uncertainty about the relevancy of papers was resolved by discussion between the authors.

Following initial screening of titles and abstracts, full-text records of included studies were retrieved. These records were then assessed for eligibility and quality, using Dixon-Woods and colleagues (15) appraisal prompts (19). This involved a two-step process of first considering a paper's methodological quality (using the five appraisal prompts) and then reflecting on its relevance and theoretical contribution to the emerging inquiry. Only one paper did not adequately report on the methodology for data collection and analysis but, as it offered key insights to the inquiry, it was ultimately included within the CIS. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) checklist guided the reporting of this CIS (see Supplementary file 1).

Data extraction and synthesis

Included papers were imported into QSR NVivo which facilitated data extraction and synthesis. Key characteristics of each paper were first entered into a data extraction proforma, included in Supplementary file 2. Consistent with the CIS approach as proposed by Dixon-Woods et al. (15), we adopted an inductive approach to analysis. Each paper was read several times and themes and sub-themes were coded. As Dixon-Woods et al. (15) propose, our review question served as a "compass rather than an anchor" during this process and was therefore constantly refined in response to the emergent themes. We constantly compared themes and sub-themes against data encountered in the papers to identify notable patterns. This process ultimately facilitated the development of our critiques and overall synthesising argument of the existing scholarly literature on childbearing women's experiences of and interactions with the Vietnamese health system.

Results

Search results and article selection

The electronic bibliographic database search identified a total of 2981 records (see fig 4.). Following the removal of duplicates (n=832), the titles and abstracts of the remaining papers (n=2149) were screened based on the exclusion criteria detailed above. As a result, 105 potentially relevant records were identified and the full-texts of these were examined. A total of 28 records were ultimately included within the CIS. A further three records were identified while reviewing the literature. Details of the included records are presented in Supplementary file 2.

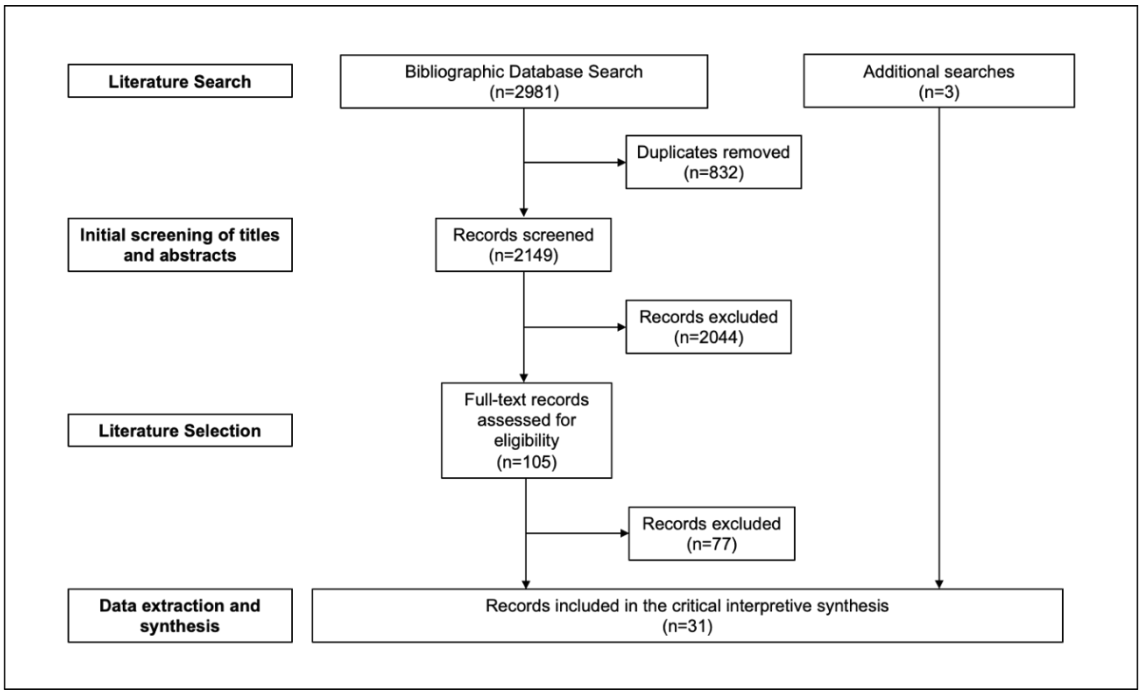

Figure 4: Literature search and selection

Childbearing women's experiences of and interactions with the health system in Vietnam

In this CIS, we aimed to critically unpack the existing evidence on childbearing women's experiences of and interactions with the Vietnamese health system. We sought to examine the experiences of both Kinh and ethnic minority childbearing women with different levels of the Vietnamese health system, as well as the perspectives of various health system actors. Yet, we found that the majority of included studies were from sites in rural and mountainous regions of Vietnam i.e., places where the only source of healthcare are the public services. Hence, there is an inevitably disproportionate examination of women's interactions with public maternity care services which overlooks Vietnam's

growing shift towards market-based provision of healthcare. Because the studies were largely from rural and mountainous regions where ethnic minorities reside, they focused on the care encounters of ethnic minority women. These papers principally focused on the "barriers" preventing such women's engagement with maternity care and, in this way, primarily problematise women's "ethnic minority identity". Finally, much of the literature appears to take a deficit perspective of women's autonomy and agency during pregnancy and childbirth – overlooking the multiple and complex femininities in contemporary Vietnam. Our critiques of the current empirical literature on childbearing women's encounters with the Vietnamese health system are outlined below.

Critique 1: A focus on maternity care provision in rural/mountainous regions of Vietnam

Of the 31 included studies, a total of 20 were conducted in rural/mountainous regions of Vietnam. These inquires principally sought to examine the accessibility and utilisation of maternity care in these areas, drawing on the perspectives of women (including but not limited to ethnic minority women), family members, healthcare professionals (doctors, midwives), mangers/directors of local CHCs, as well as other key informants (village health workers, members of the Women's Union). Across these studies, women residing in rural areas commonly reported a preference for seeking maternity care at CHCs – primary-level, public facilities located in each commune (13, 20-25). Childbearing women described that CHCs in rural areas were deficient in the most basic of amenities – there were few beds for patients, poor sanitation, and even a lack of clean water (13, 22, 26). Such facilities also failed to respond to women's expectations of convenient opening hours and short waiting times, as well as privacy and confidentiality. Many CHCs did not meet the National Guideline's recommendation of six separate service rooms – in some cases, there was only one room to accommodate the needs of all patients, including women in labour or those requiring a gynaecological examination (13, 27). Healthcare providers and managers working at CHCs described how such capacity- and infrastructure-related constraints adversely impacted their ability to respond these needs and demands of childbearing women (13, 27). Hence, we found that, in these studies, inevitably greater attention was paid towards women's, healthcare providers', and managers' experiences of accessing or providing maternity care specifically at these public facilities.

Yet, we noted that a few studies did describe how the privatisation and commercialisation of Vietnam's health system, prompted by Doi Moi, has impacted women's preferences for, and subsequent interactions with private providers – even in rural areas. For instance, Gammeltoft (28) suggested that "high-tech" medical equipment (such as obstetric ultrasounds) can serve as "revenue-generating services" for both public and private providers to "attract more patient" (13, 29-30). As a result, and as highlighted in a few studies, this has potentially contributed towards the overuse and commercialisation of obstetric ultrasounds in Vietnam. However, as Ngo and Hill (13) reveal, these revenue-maximising practices were rarely acknowledged by providers, though they recognised that women's increasing use of ultrasounds was a sign that, "…today, our lives have improved, social conditions have improved, and so people care more about their health. They also have more knowledge, culturally we have advanced". Private clinics, in particular, were perceived to respond to women's demands for high-quality ultrasounds and some studies revealed how this drove women's interactions with private providers (22, 28-31). For instance, in Heo et al.'s (32) study, women preferred visiting private providers for antenatal care due to flexible opening hours and access to high-quality, colour ultrasounds. Women reported that they were willing to pay for visiting private providers, and for colour ultrasonography, as they felt the cost was affordable (32). Heo et al.'s (32) study was situated in a rural district in Vietnam, but one that was also experiencing rapid urbanisation. Thus, it potentially serves as an illustrative example of how Doi Moi-related reforms are also gradually impinging upon the health system in rural regions of country (28-29, 31, 33). In fact, a study by McKinn et al. (22) revealed how even childbearing ethnic minority women residing in a rural district perceived the availability of ultrasounds as an incentive for visiting a private clinic – ultrasounds were not offered at CHCs. Given this, we call for a deeper engagement with and critical analysis of how Vietnam's shift towards market-oriented provision of healthcare has impacted childbearing women's care encounters. This particularly includes inquiries set in rural/mountainous regions of Vietnam which, as the aforementioned studies suggest, are not altogether untouched by market forces triggered by Doi Moi.

Critique 2: The problematisation of ethnicity

Many studies specifically examined the experiences of childbearing ethnic minority women's encounters with the health system. Within these inquiries, there was an inordinate focus on the "barriers" that prevented ethnic minority women from accessing

antenatal or delivery care from a health facility. Some ethnic minority communities, such as the Hmong, lived far from the public health facilities (23). The distance, coupled with expensive transportation and poor road conditions, were found to deter ethnic minority women from accessing care, particularly when giving birth (14, 34-35). If ethnic minority women did seek care, mostly at a local CHC, the facility was found to be poorly constructed and lacked essential resources, such as beds (described further above) (22). Some women reported experiencing negative attitudes from health staff and were unable to speak or understand the Kinh language – the official language of Vietnam (14, 27). Also presented as "barriers" in these inquires, were "vaguely-defined" traditional customs associated with pregnancy and birth (24). For instance, in the Hmong ethnic minority community, the placenta can be seen as a "crucial symbol of the cycle of mortal life" and is ritualistically buried following birth (34, 36). However, in Corbett et al.'s (34) study, giving birth in a hospital was found to potentially "disrupt" this traditional ritual. The lack of cultural sensitivity and language barriers among healthcare workers working within ethnic minority communities can lead to poor communication regarding health issues and further discourage care-seeking among ethnic minority women (24). More generally, some studies associated ethnic minority women's "shyness" with a hesitancy to seek care from a facility or to ask healthcare providers questions (27, 37). Yet, White et al. (24) found that the speed or ease of delivery was the most dominant explanation women provided for giving birth at home – "shyness" was rarely cited as an explanation. This study reveals the continuing practice of sitting, squatting, and kneeling delivery positions, and the presence of husbands and other support persons during home childbirth. The National Standard Guidelines on Reproductive Health however does not take into account any of these practices and preferences (38).

Within these inquiries, the overwhelming emphasis on the "barriers" that impede ethnic minority women's access to and utilisation of maternity care services, particularly those related to traditional customs or rituals, "implicitly place the onus of minority women to change behaviour and engage more comprehensively with services" (24). This problematic presentation was in fact reflected within a sub-section of a UNFPA (36) report which detailed, "the problem of ethnic minority groups and low usage of public birth facilities". There were even instances where health professionals were found to "blame" ethnic minority women who were referred to higher-level facilities for care: "ethnic people from mountainous and remote areas come here, and it is a big problem

because the total number of daily patients increases" (39). Several studies engaged with this problematic presentation of childbearing ethnic minority women as "obstacles" to service attendance which, as White et al. (24) argues, can be seen as conforming to mainstream stereotypes in Vietnam which enforce the "otherness" or "backwardness" of ethnic minorities. Such inordinate problematisation of childbearing women's "ethnic minority identity" in the literature, we contend, can shift the focus away from improving overall service capacity and quality. Particularly, as both Kinh and ethnic minority women alike could be the recipients of poor-quality care in rural/remote regions of Vietnam (as we have highlighted above) (39). This was emphasised in Binder-Finnema et al.'s (39) study in which a health professional suggested that "... there is no difference in wanting to provide healthcare to Kinh people or Thai people".

Moreover, the narrow focus on "ethnicity", we argue, overlooks how other social systems and structures can shape childbearing women's care encounters, including but not limited to, the encounters of Kinh women. A few studies analysed the care experiences of women with physical disabilities in both urban and rural Vietnam (33, 40-43). Such women faced numerous accessibility-related issues; toilets were not accessible for wheelchair use and there was an absence of ramps and lifts. As such, health facilities, particularly public hospitals, failed to meet women's needs and, in some instances, they experienced undignified treatment by health staff (41, 43). Another study, by Klingberg-Allvin et al. (44), unpacked the experiences of adolescent mothers, finding that such women "normalised" patronising and discriminative treatment by healthcare staff. We argue that the dominant focus on women's "ethnic minority identity" and the "obstacles" it elicits, not only conforms and entrenches prevailing stereotypes, but also overlooks the experiences of childbearing women with different lived experiences.

Critique 3: Childbearing women's limited autonomy and agency

Finally, throughout much of the literature, there is an emphasis on women's unequal decision-making power during pregnancy and childbirth. The Confucian belief-system foregrounded numerous inquiries, which is said to define the patriarchal Vietnamese family structure (25-26, 45). As such, the husband (and his family) may have a particular influence on women's decision-making relating their sexual and reproductive health. In several inquiries, influenced by Confucian patrilineal practices, women were pressured by their husbands and parents-in-law to have son (26, 22). This was exemplified in the study by McKinn et al. (22), where a woman indicated that she would continue to try and

have a son to fulfill her husband's wishes. This was against the advice of health professionals and prompted her to travel far to the provincial capital to determine the sex of her baby via ultrasound. The unequal decision-making power of women was even evident when it came to the choice of antenatal or delivery facility. In Duong et al.'s (20) study, a woman admitted, "his mother decided the whole thing" and, McKinn et al. (22) reported how an ethnic minority woman's parents advised her against visiting a CHC as they felt that one antenatal check-up was "enough". As such, some studies highlighted how women's limited decision-making power was particularly prevalent in ethnic minority communities where men, fathers, and patriarchs can be viewed as the 'gatekeepers' in prompting access to reproductive health services (22, 46). When it came to the care encounter itself, several studies revealed how women had limited autonomy when consulting with health professionals (22, 40-41, 30). Traditional gender roles and the high regard for the medical professional could indeed explain why women followed the advice of doctors without question. Yet, one study did point out that women can be torn between the advice of health professionals and family members (40). However, when deciding where to seek care, the preferences of family members seemed to prevail and, in some cases, the decision was taken out of women's hands entirely (22). Overall, much of the examined literature appears to take a deficit perspective of childbearing women's autonomy during pregnancy and childbirth and, in this way, potentially presents Vietnamese women as "powerless".

However, there were exceptions. As opposed to the findings above, Heo et al.'s (32) study revealed that women encountered few cultural and social barriers to accessing maternal and child health services. Women were reported to have a "high level to autonomy" and were able to make their own decision on where to seek care. These decisions were informed by drawing on formal and informal sources of information, such as the internet and older, experienced women, who were seen as trusted sources of knowledge (22, 32). However, some women conceded that the knowledge of other women was based on experience, while the advice offered by health professionals was science-based and, as a result, more reliable (25). These examples suggest that childbearing women in Vietnam may not in fact be passive recipients of healthcare, as the evidence above suggests; they appear to exercise their agency and autonomy in a variety of ways, particularly by drawing on the expertise of others to make an informed choice on where to seek care. Another source of knowledge may also be a woman's husband and a few studies revealed

instances of joint decision-making when it came to the birth. For instances, in the study by White et al. (24), a Thai ethnic minority woman reflected, "I discussed things with my husband, and we decided that if the delivery was easy, I would deliver at home. If the labour was difficult, I would go to the CHC." However, as Duong et al. (20) found, joint decision-making may suggest that traditional gender roles and structures still pose an obstacle to childbearing women's autonomy. While women were empowered to manage the family's finances, the ultimate decision on spending still resided with the husband. In this way, women were reluctant to independently make the final decision on where to seek care (20). These examples hint at the existence of multiple and complex femininities in contemporary Vietnam (47). However, this nuance, we argue, is overlooked by inquires which adopt a deficit perspective by solely examining the impact of patriarchal norms and conventions on childbearing women's autonomy and agency during pregnancy and childbirth.

Discussion and conclusions

In the three critiques outlined above, we aimed to critically unpack how the current literature examines childbearing women's experiences of and interactions with the health system in Vietnam. Drawing together the concepts emerging within these critiques, we propose the following overarching synthesising argument:

Vietnam's shift towards market-oriented provision of healthcare is insufficiently reflected in much of the current literature, which is primarily set in rural/mountainous regions of the country and examines women's encounters with public maternity care services. Moreover, the resulting dominant focus on the experiences of ethnic minority women not only inordinately problematises the 'ethnic minority identity' but obscures the experiences of the vast majority of Kinh women and the impact of other social structures and systems on their lives and care seeking behaviours. Finally, the presence of multiple, complex, and competing Vietnamese femininities, we suggest, is overlooked by studies which emphasise childbearing Vietnamese women's limited autonomy and agency. We argue that future inquires seeking to interrogate childbearing Vietnamese women's care encounters should explicitly take into account the social, economic, and health system transitions that currently define contemporary Vietnam.

The Doi Moi reforms had, and continue to have, a number of effects on Vietnam's health system, specifically, the exponential growth of the private healthcare sector. In 1993,

there were no private health services in the country. However, by 2008, the sector included 83 private hospitals and 30,000 private clinics (48-49). As a result, private health services accounted for 40% of total outpatient visits in 2010, and thus play a crucial role in healthcare delivery in Vietnam (50). Hospital auntonomisation polices have also underpinned the increasing shift of healthcare costs from the State to citizens. As Vo and Lofgren (9) have revealed, the rise of 'on-demand' or 'patient-requested' services (such as private service rooms and "high-tech" medical equipment) can strategically serve to maximise the revenue of providers (9-10). In this way, health system changes prompted by Doi Moi have increased both the heath care options available to service users, as well as the cost of care. As a result, and as Dao (10) recently proposed, several new "medical routes" have emerged. In the vast majority of included studies, which were set in rural/mountainous regions of Vietnam, there was inevitably a greater focus on childbearing Vietnamese women's (including ethnic minority women) experiences related to the "public" medical route. In these studies, women primarily sought care at local CHCs, despite such facilities failing to respond to their expectations of convenient opening hours and short waiting times, as well as privacy and confidentiality. For ethnic minority women, this could be due to the fact that they, as well as those from 'poor' households, are entitled for free check-ups and (basic) medicines at CHCs. In some cases, when there may be no early signs of pregnancy-related complications, reluctance to use the government healthcare services among some ethnic minority communities may be related to a strategy of "selective non-participation". The history of mistreatment by, and resulting mistrust towards, national governments may explain this, and such a finding aligns broadly with what has been called "the art of not being governed" (15). Yet, a few studies did shed light on how the growing privatisation and commercialisation of Vietnam's health system prompted childbearing women to alternatively embark on a "private" medical route, even for those residing in a rural district. In these studies, private clinics were found to be more responsive to women's needs and demands, especially with regards to having access to high-quality ultrasounds (22, 28-32). As evidence in Critique 1 suggests, Doi Moi-related reforms and its impact are not exclusively restricted to the health system in urban/suburban areas, nor to the care encounters of Kinh majority women. We argue and conclude that any future inquiry (regardless of setting or population group) seeking to examine the care experiences of childbearing Vietnamese women should consciously and explicitly consider the impact of Doi Moi on the organisation, practices, structures, norms, and activities of Vietnam's health system. But

also, how such health system reforms and changes shape what childbearing women expect from the health system and their subsequent decisions, choices, preferences, and interactions with health services.

More broadly, the Doi Moi reforms of the 1980s saw an increase in private and foreign investment which led to rapid economic growth, particularly in major cities, and encouraged rural-urban migration. These economic reforms have transformed Vietnam into a middle-income economy and has seen rates of absolute poverty rapidly fall (8). McPake et al. (1) have argued that, as people become more affluent, they expect care that is of a greater quality and cost. Indeed, Heo et al.'s (32) study showed how women were willing to pay the costs of visiting a private provider to meet their expectations of timeliness and high-quality ultrasounds. Even in this rural district, women felt such costs were affordable. In the study by Ngo and Hill (13), a health professional notably suggested that women's ability to access such advanced medical technologies is a sign that "social conditions have improved" and that Vietnam has advanced both culturally and in terms of the population's health and wellbeing. Moreover, there was evidence that, even in ethnic minority communities, ultrasounds were an incentive for women to visit private providers and generally served as a maker of high-quality care (22, 28-31). Yet within many inquiries, there was an overwhelming emphasis on the "barriers" that women's "ethnic minority identity" presents to the accessibility and utilisation of maternity care services. We argue that any examination of how childbearing women's "ethnic minority identity" shapes their experiences of and interactions with the health system, should explicitly consider the diversity and heterogeneity of ethnic minority groups in Vietnam. The narrow and sole focus on women's "ethnic minority identity", we contend, can reinforce and propagate prevailing stereotypes, while also potentially presenting all 53 ethnic minority communities as homogenous. This problematic presentation can ignore inequalities and disparities between and within ethnic minority groups too. For instance, the recent study by the World Bank (52) revealed that relative to other minorities, utilization of maternal health service is particularly low among the Hmông, Khơ Mú and Xơ Đăng. A 'one-size-fits-all' approach to ethnic minority health and wellbeing in Vietnam (24) is thus clearly problematic at many levels. Given these findings, we argue and conclude that future inquiries need to take into account the economic shifts currently afoot in contemporary Vietnam – both in urban and rural areas, as well as within ethnic minority and Kinh majority populations.

Specifically, future studies are needed examine how such economic transitions shape childbearing women's increasing expectations of care and their subsequent experiences of and interactions with the health system. For women, the economic transitions associated with Doi Moi have had a substantial impact on their participation in the labour workforce. For instance, by 1994, it was estimated that women workers comprised 53% of the total labour workforce (53). Today, Vietnam has maintained a particularly high female employment rate of 70% (54). The gendered impacts of Doi Moi prompted Werner (55) to argue that the economic restructuring of Doi Moi is not merely a series of economic reform policies but a "socially embedded process" that is shaped by many gendered components. One such impact of the economic reforms is that relations and workloads between men and women, both within the "public" and "private" spheres, are increasingly unequal; women not only have to maintain a "socialist work ethic" but must also attend to household duties (53, 55). These gender dynamics bear upon all aspects of social life, particularly, as we have revealed above, the household dynamics of seeking care. Much of the examined literature however referred to Confucian patrilineal practices and norms to highlight the unequal decision-making power and agency of childbearing women in Vietnam – women's decision on seeking care during pregnancy and childbirth is heavily influenced by the preferences of her husband and/or in-laws (20, 22, 26). However, other studies revealed that childbearing Vietnamese women are not simply "passive agents" in seeking care; they exhibited a "high degree of autonomy", encountering few cultural and social barriers to accessing maternal health services (22, 25, 32). We contend that this evidence points to the existence of diverse, multiple, and sometimes contradictory Vietnamese femininities. For instance, echoing work by Long et al. (53), Duong et al.'s (20) study found that, women appear to have greater control over financial resources within the household. Similarly, work by Do and Brennan (56) has highlighted the symbolic and practical power that women have over men within the 'domestic sphere', particularly in relation to the family economy, which they suggest has created even more complexity in the dynamics of power relations in contemporary Vietnam. Yet, as Duong et al.'s (20) study found, women can still be required to consult their husband before spending money and may be reluctant to make the final decision on where to seek care. Moreover, Do and Brennan (56) emphasise that power, as a dimension of gender, is often associated with patriarchy and 'formal power'. Their study, and the findings we outline in Critique 3, shed light on the idea of 'power outside the symbols of power'. Several studies showed how women drew on their 'informal power' to consult

with formal and informal sources of information, such as the internet and older, experienced women to decide where to seek care (22, 26, 32). We argue, as do Long et al. (53), that a focus on Confucian and/or patriarchal traditions alone does not sufficiently explain the complex and competing forms of femininities in contemporary Vietnam, which have arisen from the shift towards a market economy. Neither does the dominant and sole focus on women's "ethnic minority identity" adequately account for all that can shape the care encounters of ethnic minority women, as we highlighted in both Critiques 1 and 3. Our findings suggest that there is a need to better understand both the potential effects of intra-household dynamics and gender relations on childbearing women's access to and use of health services, especially, but not limited to, in ethnic minority communities. As such, we argue that future studies examining ethnic minority women's experiences of care should also consider how social and economic transitions have impacted ethnic minority women differently to Kinh majority women (57). Overall, we argue and conclude that future inquires seeking to interrogate childbearing women's care encounters in contemporary Vietnam need to engage with the social, economic, and health system transitions and changes that characterise Vietnam today.

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Chapter 3: Concept Mapping

3.1 Chapter overview

A responsive health system is one which is able to respond appropriately to peoples' "universally legitimate expectations" (de Silva, 2000). The concepts of 'expectations' and 'legitimacy' are therefore key for understanding, examining, and, ultimately, improving the responsiveness of health systems. Both concepts have been theorised in a variety of ways across disciplines – from social psychology to sociology, and from political science to the organisational literature. It is perhaps owing to this complexity that there remains a notable lack of theoretical engagement with the concepts of expectations and legitimacy within the health systems responsiveness literature. As such, several theoretical questions remain unaddressed – what corresponds to a legitimate expectation? Who determines what is a legitimate expectation? How can health systems actors best examine peoples' expectations of their health systems?

In this chapter, I tackle these questions by theoretically mapping the concepts of expectations and legitimacy as they are conceptualised broadly across disciplines, and, specifically, within the healthcare literature. In a peer-reviewed journal article published in Social Science and Medicine (Section 3.2), I draw on key insights from a conceptual review of the notion of expectations to propose an intersectional, translocational, and relational analytical framework for examining peoples' expectations of healthcare. This paper was also presented as a poster at the 7th Global Symposium on Health System Research (HSR 2022). Likewise, in a peer-reviewed journal article published in BMJ Global Health (Section 3.3), I critically examine how legitimacy is conceptualised in social psychology, political science, organisational studies, and in the health systems responsiveness literature. I then unpack the concept of 'legitimate expectations' and highlight the need for citizens to contest, negotiate, and participate in establishing legitimate expectations of their health systems. Below, I include the verbatim, final accepted version of these peer-reviewed manuscripts (supplementary material is included in Appendix E).

3.2 Peoples' expectations of healthcare: A conceptual review and proposed analytical framework

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Peoples' expectations of healthcare: A conceptual review and proposed analytical framework

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Abstract

Expectations shape how one experiences the healthcare one receives. In this paper we argue that the current conceptualisations of expectations within the healthcare literature have much to gain from the many recent and adjacent conceptual developments in other disciplines. The concept of expectations has been extensively studied across disciplines – we review the key texts on the subject in the business, management, social psychology, and sociology literatures to provide a conceptual overview and propose an integrative analytical framework for better understanding individuals' expectations in healthcare. We argue that peoples' expectations of a care encounter are usefully understood as being shaped by their social locations at particular points of time, which is at the intersection of multiple social structures and relations. Peoples' future expectations of care may also be influenced by the experiences of past and current care encounters, framed again by intersecting social structures and relations at that point in time. We demonstrate how an intersectional, translocational and relational analytical approach can allow researchers and practitioners to consider how peoples' social locations shape their expectations of care, not only within a given social environment, but at certain points in time and over time. We emphasise that, given the mobilities and mixing societies are experiencing globally, such an approach is particularly useful for understanding healthcare-related expectations and experiences of all.

Keywords: Expectations, healthcare, health systems responsiveness, migrants

Introduction

Expectations shape how one experiences the healthcare one receives. Expectations serve as the benchmarks by which patients assess systems performance during the care encounter and are central to both patient satisfaction and health system responsiveness (Mirzoev & Kane 2017). While the concept of expectations has been articulated and understood in a variety of ways within healthcare, it remains an area of continual debate (de Silva 2000), with conceptualisations primarily relating to patient satisfaction. It has also been argued that within the satisfaction-related literature, as well as the WHO responsiveness framework and other health service encounter frameworks, limited attention is paid to the various social, cultural, historical, and economic antecedents that shape people's expectations of healthcare (Mirzoev & Kane 2017). These calls beg the question - through what perspectives and approaches should peoples' expectations of healthcare be understood?

At another level, the rapidly growing literature on migrants (international, and rural to urban alike) and health also engages with issues of healthcare-related expectations, usually tacitly, but sometimes explicitly. However, insights from this literature remain marginally represented in the current conceptual understandings of people's expectations. For instance, the literature on expectations does not yet sufficiently engage with either the influence of pre- and post-migratory contextual factors (Hossin, 2020), or the migration trajectories and various phases including, pre-departure circumstances in the country-of-origin, destinations of long-term or short-term stay and return to country-of-origin for resettlement or temporary visits (Abubbakar et al. 2018, Gostin & Roberts 2015, Maskileyson 2019, Zimmerman, Kiss & Hossain 2011). All these phases of an individual's journey can have an impact on their healthcare-related expectations and experiences. We contend that the issues being articulated in the literature on migrant's health offer much value to the broader understandings of the healthcare experience and expectations – the migrant experience is important today more than ever given the high levels of population mobility within and across countries.

In this paper, considering the above, we tackle the question - through what perspectives, cartographies, and approaches should peoples' healthcare-related expectations be understood? A comprehensive and nuanced understanding of healthcare expectations is essential for the provision of responsive healthcare and to better satisfy people's needs (and expectations). We argue that the current conceptualisations of peoples' healthcare-

related expectations can be improved by the explicit incorporation of the various contextual factors that shape such expectations. In this paper we engage with people's expectations broadly, and this includes those who are not ill and/or not seeking care and also those who are interacting with health services as patients. While we recognise that there are differences between the two categories, we focus on the commonalities and on the expectations of people generally — whether they are patients or not. In the following sections, we provide a conceptual overview of 'expectations' as articulated in the major disciplinary domains of business, social psychology, sociology, and healthcare. Though we refer to literature on expectations specifically within these major disciplines, we recognise that it is possible that the concept has been engaged with in other fields too. Throughout this review we will engage with some empirical examples from the healthcare literature (from different parts of the world) to illustrate key elements relevant to the conceptualisation of expectations of healthcare. Drawing on the insights from the conceptual review, we propose an integrative analytical framework for examining peoples' expectations of healthcare.

'Expectations' within Business and Social Psychology

In the organisational and management literature, expectations are defined in two broad ways. The first centres on behaviour, where an expectation is the subjective probability that a behaviour will lead to a specific outcome (Coye 2004). By contrast, Olson and Dover (1979) propose that expectations should be defined as beliefs, representing the link between an object or event and an attribute. They argue that in order to understand the formation and modification of expectations, one must consider the theoretical basis of belief formation. According to Fishbein and Ajzen (1975), beliefs may be *descriptive, informational,* or *inferential.* Individuals form *descriptive beliefs* by direct observation or personal experience and are therefore held with a degree of certainty. When the connection between an object and an attribute is drawn from a prior belief, it is said to be an *inferential belief.* As these beliefs are based upon perceived relations between beliefs, they are subject to personal influences such as personality characteristics. *Informational beliefs* are those in which another source (an intermediate or unknown other) makes the connection between an object and attribute and is maintained if the source is deemed credible. Due to the lack of grounding in direct personal experience, *informational* and *inferential beliefs* can be held with varying degrees of confidence. Coye (2004) utilises this model to understand customer expectations in service encounters. A customer

expectation is a belief about a future event that is the result of information gathered directly through personal observation, indirectly via information provided by others, or inferred by information or observation (Coye 2004). For instance, this notion of *descriptive* beliefs is evident in a study by Fair et al. (2020), in which migrant women had differing expectations of maternity care in their host country. This was found to have stemmed from their past healthcare experiences in their country-of-origin; some women feared being treated poorly due to poor experiences in their home country. Expectations about what would be an appropriate medical intervention during childbirth and pregnancy were also shaped by cultural beliefs and experiences in their home country's health system (Fair et al. 2020). The point being that peoples' future interactions with the health system may be shaped by past experiences (*descriptive beliefs*) and, in the case of *inferential* and *informational beliefs,* personal factors such as desires and personality characteristics.

Expectation States Theory, within Social Psychology, provides useful insights on expectations within social interactions that are goal-oriented (Ridgeway 1993). The theory contends that interactants form "performance expectations" which influence behaviour in a self-fulfilling manner. Crucially, social factors influence the formation of performance expectations and include status characteristics, social rewards, and behavioural interchange patterns (Correll and Ridgeway 2003, pp. 31). Specifically, status characteristics are the attributes in which people differ (such as race, gender, class, and educational attainment) and for which there are widely held cultural beliefs that differentiate the "greater social worthiness" of one category over the other (Correll and Ridgeway 2003, pp. 32). Fochsen et al. (2006)'s study in rural India illustrates how the status characteristic of gender can influence power disparities in the doctor-patient relationship and the 'performance expectations' of female patients. In Fochsen et al. (2006)'s study context, women were perceived as dependent, vulnerable and to have an "inferior status" both in society, as well as within the family. This meant that family members (such as the husband or in-laws) were involved in consultations to communicate the woman's illness to the practitioner and make 'appropriate' decisions regarding the woman's treatment. In this way, internal family hierarchies relating to gender, as well as age, differentiated the 'social worthiness' of female patients, shaping their 'performance expectations' from and within the healthcare encounter. (Fochsen et al. 2006).

Status Characteristics Theory on the other hand contends that beliefs about social characteristics shape performance expectations. The theory argues that for status characteristics to influence behaviour, they must be salient; the attribute must be socially significant for actors in the specific setting in order to influence performance expectations (Correll and Ridgeway 2003). Similarly, patients' interactions with the health system may be influenced by specific 'social' expectations. These expectations may present 'social accessibility' related barriers to health services, as was identified by Kane et al. (2018) in their study examining women's decisions to use maternal health services in South Sudan. They found that women's decisions to use such services were not solely related to quality or affordability but were influenced by certain social norms. Pregnancy was perceived as a matter of personal pride, and women were expected to dress well and be presentable in public places (such as the clinic). Fulfilling these salient 'social' expectations communicated to society that her pregnancy was celebrated and dignified by the family. However, women who were unable to present themselves in this way (because of missing husbands or having no family to provide for them) would forgo the use of antenatal health services, despite knowing the importance of such visits during and after pregnancy. Moreover, *Status Characteristics Theory* contends that multiple status characteristics, relating to gender, class, and ethnicity, may combine to form "aggregated performance expectations" (Correll and Ridgeway 2003, pp. 33). But also, that performance expectations formed in one encounter (based on status beliefs) shape expectations from future encounters. Nevertheless, this conceptualisation of expectations highlights a number of important considerations. Firstly, that beliefs relating to social status, which are relevant to a specific context, shape performance expectations in goal-oriented interactions. This indicates that the social context plays a key role in determining whether beliefs relating to social characteristics shape expectations. It also suggests that past experiences of encounters can shape one's performance expectations during a current encounter. Lastly, that social status characteristics can intersect to shape expectations during interactions.

Also, within Social Psychology, the concept of expectations is incorporated as a major consideration in the *Theory of Planned Behaviour* (De Jong 2000). Here, intention is the primary determinant of behaviour and is the product of both social norms (one's perceptions of what others think about the behaviour) and expectations (achieving a valued goal due to the behaviour). Thus, according to Ajzen (2005), social norms are the

main elements involved in translating expectations into behavioural intentions and subsequent action. The theory also identifies the role of background factors in facilitating or constraining behaviour. These factors may be *personal* (personality traits, values, or emotions), *social* (age, gender, ethnicity, or religion) or *informational* (experience or knowledge). Specifically, Ajzen (2005) concedes that a major facilitating factor is prior experience of engaging in a specific behaviour. But also, one's interpretation of others' experiences, whether they be those within immediate social networks or unknown others observed in the media. These factors are shaped by the broader social environment which, in turn, influences intentions and actions. In this way, individuals in different social environments can possess diverse beliefs about the consequences of a behaviour, the normative expectations of others and the obstacles that may prevent them from engaging in a behaviour (Ajzen 2005).

'Expectations' within Sociology

Luhmann (1995) has argued that the concept of expectations should have a central theoretical position within all social inquiry. In his social systems theory, Luhmann (1995) views environments as being excessively complex and various social systems as serving to reduce the complexity of these environments. Moreover, within each system, there may be sub-systems that reduce this complexity even further (Meyer, Gibson & Ward 2015). In the case of the health system, sub-system may include primary care, dentistry, and maternity care. A system's complexity is reduced by structuring the possibilities of its own experiences and actions and, in doing so, the system maintains meaning (Meyer, Gibson & Ward 2015). Specifically, Luhmann (1995, pp. 292) claims that social system structures are formed out of expectations, so much so that social structures are essentially "expectational structures". In this way, meaning for an action is constituted within a "horizon of expectation" (Kosseleck 2004, Faure 2017, pp. 2), and such expectations are pre-given and generalised. Structures of expectations are constantly re-activated, anticipating future actions and, in doing so, reducing the complexity of the system (Luhmann 1995). These understandings signpost the reciprocal relationship of expectations and experiences. People may have generalised and pre-given expectations of healthcare that are defined by the organisational processes, resources, policies, and actors of the health system, as well as the sub-systems they interact with. However, their expectations may also be defined by the social systems (and structures) they are part of and interact with and are also generalised and pre-given. We argue that these social

systems (and structures) on the one hand may constrain patients' 'horizon of expectations' relating to the health system. On the other hand, this very constraining may help to reduce the complexity of these systems, enabling patients to better inhabit and interact with and cope with these complex social systems.

The concept of "horizon of expectation" thus offers a potential explanation of how expectations are shaped and further demonstrates the reciprocal relationship of expectations and experience. Indeed, Koselleck makes the compelling point of: "no expectations without experience; no experience without expectation" (Koselleck 2004 pp. 257). Expectations refer to a future which is the product of both individual and collective experiences; such experiences represent one's interpretation of the past, as well as the present (Faure 2017). Koselleck (2004, pp. 259) uses the 'horizon' as a temporal metaphor, arguing that "person-specific and interpersonal", expectations are shaped and constituted by "hope and fear, wishes and desires, cares and rational analysis" and is, essentially, "the future made present". The 'horizon' we contend can also be understood as referring to what individuals can imagine as being possible for themselves, given their *habitus.* The *habitus* being the processes of thinking in which one's social position, social norms, cultural conventions, and the experiences one has as a social being, are internalised in the mind, along with the individual's own inclinations, preferences, and interpretations. Drawing on Bourdieu (1990 pp. 64), we argue that expectations are about "probable futures" that one can imagine for oneself; and that one's probable futures are imagined and "constituted in the prolonged relationship with a world structured according to the categories of the possible (for us) and the impossible (for us), of what is appropriated in advance by and for others and what one can reasonably expect for oneself". That is, life chances (experiences) are internalised and translated into specific expectations, which are subsequently externalised through actions that tend to reproduce the same life chances (Hinote 2015). Essentially, one's *habitus* is a result of one's socialisation throughout life, with one's expectations and actions reflecting what one is repeatedly subjected to. Therefore, expectations are socially constructed, collectively produced and are "transmitted and conveyed to offspring who see little evidence to contradict them" (Crossely 2001, pp. 91). As a result, one's 'horizon of expectations' may not only be influenced by one's *habitus,* one's own experiences, but also by the experiences of 'intermediate' others.

Importantly, Bourdieu proposes that one's *habitus* is a "structured structure" (Bourdieu 1990); it comprises of perceptual structures that generate deeply structured dispositions that reflect the characteristics of a particular class or social group. Therefore, it is also a "structuring structure" in that individuals perform the appropriate practices for that social position, perpetuating existing social arrangements (King 2000, pp. 423, Hinote 2015, pp. 478). This can explain how advantage or disadvantage, that are internalised as behavioural dispositions and translated into specific expectations, can reproduce structural inequities across generations. But what if social conditions change, as is the case with migration? Nowicka (2015, pp. 105) puts forth the notion that, in a new social context, one can experience a "tormented *habitus"*. When confronted with new practices or social norms, migrants can undergo increasing self-analysis which can result in a "cleft *habitus*", that navigates the disparities between the norms and practices acquired prior to and post-migration, or a "transformed *habitus"* which loses its past qualities. Hinote (2015) reiterates that, though *habitus* can influence multiple aspects of cultural consumption and is enduring, it is not completely static and is somewhat adaptable. In this way, actions, and the expectations that guide them, can be shaped by the social environment and the broader structures to which individuals are "inextricably linked" (Hinote 2015, pp. 478). As an illustration, a study by Maharaj and Bandyopadhyay (2013) revealed that Indian migrant women who had lived in Australia for several years recognised the importance of work and being financially independent in Australian society and embraced these roles other than the traditional role of the 'mother'. Though aware of the importance and recommendation of exclusive breastfeeding for six months, such women substituted breast milk for infant formula to accommodate for their return to work. The authors contend that these women attempted to adopt the individualistic 'Western model' of healthcare and motherhood and, in this way, perhaps experienced a "transformed *habitus"*. On the other hand, women who had recently migrated tended to embody the traditional gender role of 'mother', consonant with the 'Traditional' approach to mothering. Additionally, having no extended family in Australia meant that they relied on the advice of health professionals for the 'right' approach to breastfeeding (Maharaj and Bandyopadhyay 2013). Such women experiencing a "cleft habitus" had specific expectations of health professionals to provide the support and advice that was lacking due to the absence of extended family. Ultimately, women's independence versus reliance underpinned the two approaches to motherhood and healthcare, which shaped their expectations of health service providers. This example demonstrates that the changing

roles of migrant women in the new social context and over time can have varying influences on their healthcare-related expectations.

The social environment encapsulates institutionalised historical social and power structures, immediate physical surroundings, as well as cultural milieus (Barnett & Casper 2001). Given then that the social environment encompasses both cultural and structural elements, what role does culture play in the shaping of expectations? Anthropologists define culture as, "systems of meaning, knowledge, and action" (Nastasi et al. 2017). As a "system of meaning", culture enables individuals and communities to organise the multiple components of their world into a cohesive whole, via a process of construction through social interaction (Nastasi et al. 2017, pp. 137). As a "system of knowledge", culture permits normative behaviours which reinforce and transmit the constructed "meaningful" world over generations. As a "system of action", culture prompts individuals to act upon their world through which new meanings can be negotiated (Nastasi et al. 2017, pp. 137). At the collective level, culture represents a shared set of beliefs, values, and behavioural expectations. However, an individual's interpretations of this shared system may be influenced by experiences within different contexts that have varying cultural meanings (Nastasi et al. 2017). Thus, culture may play a role in the meaning associated with specific expectations which, in turn, prompts normative behaviours that maintain and transmit this constructed meaning. Importantly, this meaning is constructed via a process of social interaction and is shaped by one's experiences in varying contexts. Accordingly, Patterson (2014) insists that our understanding of how culture influences behaviour should be interactional; cultural structures do not autonomously influence social structures or human actors but, rather, interact *with* structural forces to enable and constrain human agency. Anthias (2011, pp. 205) corroborates this argument by explaining that it is difficult to distinguish the boundary between the cultural and non-cultural as, "all social practice is imbued with the cultural".

'Expectations' within the healthcare literature

Within healthcare, the importance of expectations is particularly salient in two bodies of scholarship – on patient satisfaction, and health systems responsiveness, overwhelmingly the former (de Silva 2000, Kravitz 1996). In their review of expectations as determinants of patients' satisfaction with health services, Thompson and Sunol (1995) identify four types of expectations: *ideal, predicted*, *unformed* and *normative.* The latter (which is

central to responsiveness) represents what users believe should or ought to happen. *Ideal* expectations refer to patients' aspirations or desires, however, *predicted* expectations, on the contrary, are those that are realistic and practical; they are what users actually believe will happen and are likely the result of personal experience. When users are unwilling or unable to articulate their expectations, they are known as *unformed* expectations. Kravitz (1996) has put forth a model of patients' expectations in relation to visit satisfaction or the care interaction. In this model, a patients' expectations of care are formed prior to the medical encounter but can be modified as the encounter proceeds. The model also incorporates possible determinants of patients' *a priori* expectations such as socio-demographic characteristics, biopsychosocial concerns, as well as past experiences with the health system and the practitioner. Another critical dimension of patients' expectations is content; patients' expectations can relate to health care structures, processes and/or outcomes (Kravitz 1996). For instance, patients can have specific 'structural' expectations relating to the health care facility, personnel, or organisational policies, however, these may be shaped by the patients' social situation. Pass, Kennelty, and Carter (2019) shed light on the barriers older adults with multiple co-morbidities experienced when accessing mental health services in rural Iowa. They found that while they could access primary care physicians who practiced locally, elderly patients had to travel some distance to access psychiatrists and therapists. Access was also difficult for patients who had limited mobility, could not travel independently, or could not afford to travel. Patients' 'structural' expectations of accessing mental health care were therefore structured at the intersection of social structures and processes relating to their age, social class, and co-morbidity status. Alternatively, expectations could also concern technical medical processes (diagnostic testing, therapeutic processes) or interpersonal processes (patient-practitioner interaction). Finally, patients can have expectations of the physical, psychosocial, and financial outcomes of their care (Kravitz 1996). Kravitz (1996), places satisfaction at the centre of his framework to distinguish between value expectations based in desires, necessities, entitlements, or importance (the emotional component), and probability expectations which are the probabilistic assessment and beliefs that something will occur (the cognitive component). Kravitz (1996) adds that expectations can be understood along three broad axes; whether they are defined as value expectations or probability expectations; whether expectations for health care are in general or related to a specific treatment or care encounter; and whether related to the structure, process, or outcomes of care.

Bandura's (1977, Crow et al. 1999) work on expectancies allows one to make a further, important distinction between self-efficacy expectations that patients as social beings have, or have of themselves, and outcome expectations that patients have from their care encounters. Oliver and Winer (1987), while writing about service encounters more generally (in non-healthcare settings) differentiate between *active* and *passive* expectations. They posit that *active* expectations, which are at a high level of consciousness, are influential in the decision to use certain services. On the other hand, *passive* expectations may only exist as generally true assumptions that are not processed until they are disconfirmed. In this way, individuals may be neither satisfied nor dissatisfied with the particular service until the interaction either confirms their *active* expectations or violates their *passive* expectations (Oliver and Winer 1987). While this literature engages with the notion of expectations broadly, its reference point relates primarily to satisfaction with services.

The concept of expectations is also incorporated within Larson et al. (2019)'s proposed framework for person-centred measures of health system quality and responsiveness. In this framework, patients' needs, expectations and values are influenced by modifiers such as facility characteristics (availability of services and resources and number of healthcare providers), patients' characteristics (sociodemographic characteristics and clinical history) and the type of service (preventative or emergency care). These factors are, in turn, dependent on the country and health system context. Ultimately, patients' expectations, needs and values shape their experiences of care in relation to effective communication, respect and dignity and emotional support, as well as health outcomes, patient satisfaction and confidence in the health system. Larson et al. (2019) maintain that patients' expectations are affected not only by factors related to the health system, but also by the broader societal, community and family contexts. This model has been adopted by Ratcliffe et al. (2020) in their examination of the experiences of women of reproductive age, measured with respect to the elements of health system responsiveness (dignity, autonomy, choice of provider, confidentiality, quality of amenities, communication, and choice of provider). Women who experienced more responsive care were more likely to be educated and have good access to care that was provided at a private facility. More importantly, woman who reported the highest responsiveness levels were also likely to indicate that care was excellent at meeting their needs (Ratcliffe et al. 2020).

On the other hand, but still related to the literature on person-centred care, is the literature on health systems responsiveness; recent and limited though it still is, it approaches the notion of expectations a bit differently. Health systems responsiveness is defined as "the outcome that can be achieved when institutional and institutional relationships […] respond appropriately to the universally legitimate expectations of individuals" (De Silva 2000, pp. 3). In this articulation, individuals in a particular society are considered to have specific expectations, in terms of how they should be treated both physically and psychologically, which that society chooses to regard as 'legitimate'. Thus, within responsiveness, there is an emphasis on *legitimate* expectations which are those that conform to recognised principles or accepted social norms and standards. De Silva (2000) argues that this differentiation is necessary as individuals may possess expectations of the health system that are unrealistic or unjustifiable. For example, a patient may consider a waiting period of six months for a given health condition the norm for a specific health system. However, people in another country may feel that a health system that requires this six-month waiting period is not a responsive health system. This reference to 'legitimacy' is primarily rooted in economic theoretical concerns around the rationing of finite resources, as well as the work on responsiveness and human rights. For instance, forced sterilisation and incarceration of individuals with communicable diseases are possible ways of improving population health, but they also impact patients' dignity and autonomy. Therefore, it is considered not legitimate to improve health at the expense of reducing responsiveness (Valentine et al. 2003). While the notion of legitimacy has attracted its fair share of criticism, it also refers to and highlights the importance of acknowledging the role of societal and individual characteristics and experiences in the shaping of healthcare-related expectations (De Silva 2000).

Noteworthy, however within the satisfaction-related literature, in the WHO responsiveness framework, and in other health service encounter frameworks (Mirzoev & Kane 2017) is the limited attention paid to understanding what shapes people's expectations of healthcare. This is despite the recognition that healthcare expectations can be influenced by many factors, including socio-economic status, age, health status and past experiences of interaction with the health system (Coulter & Jenkinson 2005). Similarly, Mirzoev and Kane's (2017) recent conceptual framework identifies two aspects which comprise health system responsiveness: people's initial expectations and the health system's response to these expectations. These aspects are the determinants of

people's experiences of their interaction with the health system, which Mirzoev and Kane (2017) locate at the centre of health system responsiveness. They observe that the seven elements of health system responsiveness are best understood by incorporating an understanding of the determinants of patients' expectations of their care encounter. Crucially, the framework also calls for the importance of taking into account the wider social, cultural, historical, and political contexts which shapes people's *active* and *passive* expectations of the health system.

Finally, the particular context of the health system and the ways in which this unique context also shapes patients' expectations of healthcare should be acknowledged. The affective state of a patient who is in pain is likely to be emotionally charged and this is not usually the case in other consumption experiences (Thompson and Suñol 1995). In this way, distress and uncertainty can have specific implications for patient's healthcare expectations relating to, for example, autonomy and trust. The nature of the patient-practitioner interaction can also mean that the public and private lives of patients are "laid bare" both in a physical and emotional sense. However, the degree to which this occurs and the healthcare expectations associated with this is influenced by various intersecting social structures at that point in time. Another consideration is the asymmetry of information that exists in the patient-practitioner relationship. Though individuals are increasingly expecting greater provision of information from practitioners, evidence indicates that information asymmetry can be more prominent in some specialities due to rapid advances in technical knowledge (Thompson and Suñol 1995). Also, as Coulter and Jenkinson (2005) revealed, the extent to which patients expected to be provided with information and involved in treatment decisions can be influenced by factors such as age and country of residence. Furthermore, healthcare encounters (particularly when considering chronic illnesses) can occur over an extended period of time and are not momentary (Thompson and Suñol 1995). This points to the notion that expectations are temporally defined, evolving, and developing as the healthcare interaction progresses. Therefore, individuals' expectations of healthcare are also shaped by these unique aspects of the healthcare encounter, that may differ from other service encounters, and which are also socially and culturally mediated.

An intersectional, translocational, and relational analytical framework for understanding peoples' healthcare expectations

In this section we draw upon the conceptual insights outlined so far to engage with the question - through what perspectives, cartographies, and approaches should peoples' healthcare-related expectations be understood? We propose an intersectional, translocational and relational analytical framework for understanding peoples' healthcare-related expectations. Figure 5 is a visualisation; in the following sections we elaborate the analytical approach by drawing on the theoretical literature.

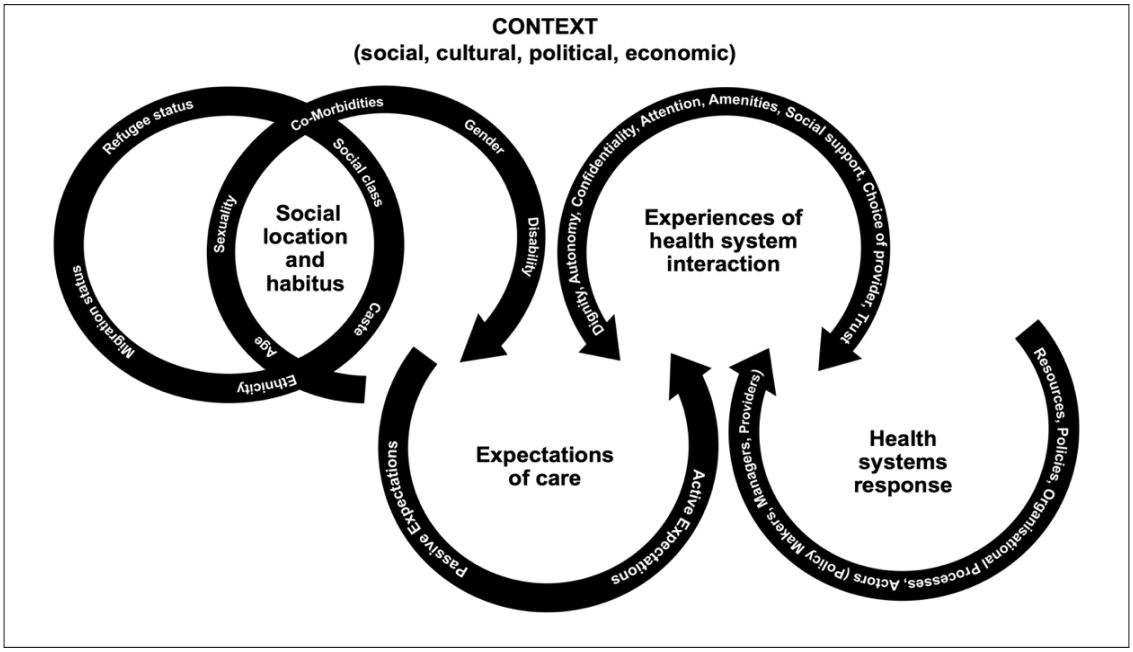

Figure 5: An intersectional, translocational and relational analytical framework for examining peoples' healthcare-related expectations.

Insights from the conceptual review

From the conceptual review, it is evident that the concept of expectations can be defined in a variety of ways. But, despite this variation, there remain some key overlapping facets of these conceptualisation which are discussed below. In the organisational literature, expectations have been defined as a belief or as the probability that a given behaviour will result in a specific outcome. According to Luhmann (1995) structures of expectations (that are pre-given and generalised) are constantly re-activated, anticipating future actions and, in doing so, reducing the complexity of social systems (Luhmann 1995). Furthermore, the concept of expectations can be usefully understood as embedded within Bourdieu's notion of *habitus,* the mechanism by which life chances are internalised and translated into specific expectations that guide one's actions (Hinote 2015). Within Social

Psychology's *Theory of Planned Behaviour* expectations are defined as one's perceptions of achieving a valued goal and, within *Expectations States Theory*, interactants form 'performance expectations' in goal-oriented interactions (Correll and Ridgeway 2003). In the healthcare literature, health system responsiveness centres on expectations that are *normative* (what should or ought to be) and *legitimate* (those that are justifiable). By contrast, patient satisfaction broadly encompasses *ideal, predicted*, *unformed* and *normative* expectations.

Nevertheless, there are some key overlapping features in these conceptualisations. Specifically, that multiple contextual factors contribute towards the formation and revision of expectations. This is evident within *Expectations States Theory,* where social status characteristics (such as race or class) are said to influence the formation of 'performance expectations' in goal-oriented social interactions (Correll and Ridgeway 2003). Moreover*, Status Characteristics Theory* proposes that multiple status characteristics can intertwine to form 'aggregated performance expectations' – within the healthcare context, these would apply to services users, individual providers, and institutions alike. But, in order to shape such expectations, social status beliefs must be relevant to the social context in which the interaction occurs (Correll and Ridgeway 2003). In the *Theory of Planned Behaviour,* Ajzen (2005) acknowledges that various personal, social and informational background factors facilitate or constrain behaviour through influencing expectations. These factors are shaped by the broader social environment, explaining how individuals in different social environments possess diverse expectations about the consequences of a behaviour (Ajzen 2005). Drawing on Luhmann (1995)'s work, it is possible to argue that expectations (which are pre-given and generalised) can be defined by the social systems (and structures) that individuals are part of and interact with. Such an understanding is not unlike the view that considers *habitus,* as a 'structured structure'. That is, one's *habitus* generates structured dispositions that are characteristic of specific social groups that are, in turn, translated into expectations. These expectations are externalised into behaviours that reproduce existing structured differences (Hinote 2015). Similarly, Koselleck points out that the broader social environment "grants background to individuals" which shape and revises their expectations (Faure 2017, pp. 3). Yet, within the healthcare literature, there is limited acknowledgement of the contextual factors which shape patients' *a priori* expectations of healthcare. Kravitz (1996) does acknowledge that initial healthcare expectations can be

influenced by socio-demographic characteristics and biopsychosocial concerns. But what these factors are and how they interact to shape healthcare expectations, is not focused on. Larson et al. (2019) also describe how patients' characteristics, such as sociodemographic factors and previous care-seeking behaviours, influence their expectations, needs and values which ultimately shape their care experiences. Alternatively, in their conceptual framework of health system responsiveness, Mirzoev and Kane (2017) articulate the wider social, cultural, historical, and political contexts which shape expectations of healthcare. Evidently, the broader social factors which influence patients' expectations of healthcare remain insufficiently understood and articulated.

Another common feature is the role of past experiences in the shaping of expectations. In many ways, these conceptualisations reveal the reciprocal relationship of expectation and experience; perhaps most clearly articulated by Koselleck's assertion of "no expectations without experience; no experience without expectation" (Kosseleck 2004, pp. 257). Luhmann (1995) reaffirms this notion by maintaining that, the outcomes of expectations restructure a repertoire of possible future actions. Social Psychology's *Status Characteristics Theory* also mentions that 'performance expectations' formed in one goal-oriented interaction can transfer to future interactions. Furthermore, within the services literature and according to Coye (2004), *descriptive* customer expectations (or beliefs) in service encounters can be formed by personal experience. A system of 'circular relations' also underpins the concept of *habitus,* in which life chances or experiences are translated into specific expectations that can reproduce the same life chances (Hinote 2015). Having said that, Bourdieu also alludes to the fact that expectations are socially constructed in that they are shaped and determined by what one is continually subjected to and experiences. This reveals that expectations are not only shaped by one's own experiences, but also by the experiences of 'intermediate' others (Crossely 2001). This notion is echoed within the *Theory of Planned Behaviour*; *informational* factors which shape behavioural expectations can include prior experience of engaging in the behaviour, as well as one's understanding of others' experiences. On the other hand, in the patient satisfaction literature, Kravitz (1996) identifies past experiences with the health system and practitioners as a possible important determinant of patients' expectations of healthcare. This influence of past experiences with the health system on patients'

expectations of healthcare, while salient and widely recognised, remains relatively under-studied.

An intersectional approach

The term "intersectionality" was coined by the legal scholar and black feminist theorist Kimberlé Crenshaw. Crenshaw (1991) stressed that black women's lives could not be extensively captured by analysing race or gender dimensions separately, as these systems of oppression are experienced simultaneously. An intersectionality approach therefore recognises that multiple social structures and processes intersect to produce social positions and outcomes (Anthias 2012). Above all, Crenshaw (1991) insisted that intersectionality can and should expand beyond examining the intersections between race and class to include social categories such as gender, age and colour. Patricia Hill Collins uses a Foucauldian framework to propose that gender, race and class are discursive means in the production of power (Anthias 2012). In Collins' view, intersecting oppressions linked to gender, race and class are organised through a "matrix of domination", which comprises structural, disciplinary, hegemonic and interpersonal power relations (Anthias 2012, pp. 126). Along these lines, it is possible to locate the intersections of social categories and the exercise of power within a range of social and institutional domains, such as the health system. Larsen et al. (2016) argue that an intersectionality informed approach is particularly suitable for health systems research as it can help unpack the complexities of the care encounter to understand and reveal the fluid and interconnected structures of power that characterise the care encounter.

According to Hill (1993), power relations (such as those that operate in the patient-practitioner relationship) relate to various *intersecting* social structures such as gender, social status (including class), and ethnicity, as outlined in Figure 5. Differences in power, structured along these intersections, produce inequalities which shape individual experiences (Anthias 2020). Thus, within an intersectional analytical approach and as illustrated in Figure 5, power relations associated with various intersecting social structures influences peoples' *active* and *passive* expectations of care which can, in turn, shape their experiences of a health system interaction. These experiences can relate to the various non-clinical aspects of the care encounter, as outlined within the WHO responsiveness framework. It follows then that peoples' expectations of healthcare professionals relating to, for example, autonomy in decision-making (as described by Fochsen et al. (2006) are shaped by intersecting systems of power. However, aside from

specific expectations relating to the doctor-patient relationship (such as those within the 'respect for persons' domain of responsiveness), individuals can also have expectations of the structural aspects of the health system as illustrated by Pass, Kennelty, and Carter (2019). Expectations of having timely access to a health care facility or good quality amenities are not only shaped by the context of the health system, but also by various intersecting social and cultural forces.

Existing conceptualisations recognise that one's spatial location plays a role in the shaping of expectations. For instance, in *Social Status Characteristic Theory,* status characteristics must be salient to a particular context in order to influence 'performance expectations' (Correll and Ridgeway 2003). Koselleck's notion of 'horizon of expectation' also implies that different social environments can shape one's interpretation of past experiences which, in turn, influences their expectations (Faure 2017). Furthermore, in Hinote's (2015) view, one's *habitus* is not completely static or unchangeable and can perhaps adapt to changes in social context. Lee (1997, pp. 133) corroborates this stating that, as the *habitus* "moves through time in response to changing objective conditions", it is in an ongoing state of evolution. It can therefore be argued that one's expectations are shaped by intersecting social structures and processes that exist within a particular social environment. This consideration is perhaps crucial for understanding the impact of migration on patients' expectations of care. Migration is a socio-spatial mobility; individuals can experience both geographical and social mobility as a result of the migration process. Power arrangements in the new social environment can reconstruct migrants' realities which can, in turn, shape both their expectations and experiences of healthcare (Thimm & Chaudhuri 2019).

A translocational and relational approach

Lupton (1997, pp. 206) points out that in a care encounter patients present themselves as, "a certain 'type of person' engaged in 'rational and 'civilised' behaviour consonant with her or his social or embodied position at the time". Therefore, apart from *spatial* social location, it is also vital to consider the effect of one's *temporal* social location on their healthcare expectations. Existing conceptualisations of expectations in the healthcare literature tend to centre on *spatiality,* and therefore have not explicitly focused on the notion of *temporality.* However, Luhmann (1995) does mention that expectations are "temporally bound", and Oliver and Winer also remark (1987) that existing definitions

appear to concur that expectations are associated with a particular point in the future. Similarly, temporality is also key to Kosselleck's notion of 'horizon of expectation'; one's representations of time are oriented from the present to the past or to the future. In this way, expectations (that determine the future or the "non-experienced") are shaped both by one's interpretations of past, as well as current experiences (Faure 2017, pp. 3, Koselleck 2004, pp. 259). Lee (1997) also stresses the temporal dimension of *habitus* by maintaining that it is in a constant state of evolution as it moves through time; arguing that the dispositions, expectations, and actions it generates are therefore *temporally* and *spatially* modified. Nevertheless, how expectations change, not only in response to changes in the social environment, but over time requires consideration. Floya Anthias (2020) suggests that a more nuanced interpretation of intersectionality is possible through adopting a *translocational* lens. Such an approach centres on one's social 'location' which is embedded within relations of hierarchy that vary according to time, place and scale (Anthias, 2020) Hence, the concept of *translocational positionality* incorporates the spatial, temporal and the scalar as 'place' within hierarchical social ordering (Anthias 2020). Critically, apart from changes in place and scale, the approach also takes into account temporality; considering social structures not only in relation to each other in time, but also *over* time (Anthias 2020). Through an intersectional and translocational approach, it is therefore possible to consider how peoples' social locations shape their healthcare expectations within specific social environments, at certain points in time and over time. Figure 5 illustrates how an individuals' expectations of care can be influenced by their social location, which is at the intersection of multiple social structures.

A translocational approach also has significant implications for understanding migrants' healthcare-related expectations; it allows one to examine changes in migrants' social locations pre- and post-migration and how these changes, in turn shape their expectations of healthcare. Understanding the care experiences of migrants is important now more than ever given that, in 2019, there were an estimated 272 million international migrants globally (IOM 2020). Major displacement events in recent years have also led to forced migration; experiences of trauma and loss of life can have a distinctive impact on the *habitus* of refugees, ultimately influencing their expectations of their host country's health system (Hossin 2020, Gostin & Roberts 2015, Zimmerman, Kiss & Hossain 2011).

Connected to this, is the need for the reciprocal relationship of expectation and experience to be acknowledged in this intersectional, translocational and relational analytical

approach. As demonstrated earlier and in Figure 5, a person's experiences of a particular care encounter can influence their future expectations of care. Patient's past healthcare interactions are framed by intersecting social structures and processes at that point in time. These healthcare experiences and the individuals' interpretation of these experiences shape their healthcare expectations during their current encounter (as revealed by Fair et al. 2020). In a sense, past healthcare experiences (particularly those of another country's health system) can broaden or limit one's 'horizon of expectations' relating to a current care encounter. However, and having said that, it should also be noted that peoples' expectations of healthcare can be shaped by their interpretation and understanding of others' (intermediate or unknown) experiences of a care encounter too. Figure 5 also indicates that an individuals' experiences of care can be influenced by the health systems response to their expectations. This response can be shaped by the various policies, organisational processes, and resources of the health system. It may also be influenced by the expectations of actors within the health system, such as health professionals, as is evident within Fochsen et al. (2006)'s study. Female patients were perceived as 'vulnerable and 'dependent' both by health professionals, as well as family members and this shaped their expectations of and ability to actively participate and make decisions during the care encounter. This highlights the need to consider the broader social and cultural context within which the care encounter takes place, and which also shapes the health system's response to individuals' expectations of care.

In this sense and given the above, we argue that the study of peoples' healthcare-related expectations requires one to deliberately engage with some of the limitations and concerns about the current models of intersectionality – the concerns highlighted by Brah (2005), Puar (2008) and Pedwell (2010) are particularly salient here. Echoing Brah (2005), Puar (2008, pp. 208) finds problematic the presumption (in intersectional models) that the axes of race, class, gender, sexuality, nation, age, religion are analytically separable; she argues that these axes are in fact interwoven and "merge and dissipate" over time, space, and bodies. Pedwell (2010, pp. 38-9) argues that inquiries into and analyses of the intersection must not only involve looking at multiple axes of differentiation; they need to do so such as to "avoid excluding particular subjectivities and experiences", and with constant awareness of "what kinds of knowledges, histories, practices and relations of power are legitimated or reified, and which are marginalised or occluded". In line with Brah (2005), Puar (2008), and Pedwell (2010), we contend that

taking *an explicitly relational approach* which involves clearly recognising that "categories of 'self' and 'other' are constituted relationally through intersectional processes in which multiple axes of social differentiation articulate" (Pedwell 2010, pp. 39), to one's inquiries and analyses allows one to engage with, if not fully address, some of the concerns around intersectional models. Relationality here is understood as to "signify the ongoing, contextually specific processes through which cultures, bodies, practices and subjectivities are (re)constituted and gain meaning through discursive-material encounters with other cultures, bodies, practices and subjectivities" (Pedwell 2010, pp. 41). A relational perspective recognises that social and cultural differences exist and are produced in relation to and in connection with constitutive 'others'; and that these differences are also contingent as they are socially and relationally produced, maintained, and evolve – they are not a given (Brah 2005, Puar 2008). A relational perspective thus inevitably requires one to engage with the constitutive other and with 'difference' - conceptualised as 'experience', as 'social relation', as 'subjectivity' and as 'identity' (Brah, pp. 14). Doing so as such allows one's inquiries and analyses to engage better with the differences (and asymmetries) encountered within care encounters – by all, in all care encounters, but particularly so in the encounters experienced by migrants.

Conclusion

Gaps in the understanding of the concept of expectations within healthcare have led to calls for researchers and practitioners to consider the various contextual factors that shape individuals' expectations of their interactions with the health system. Also, despite various calls for the need to recognise the dynamic and complex nature of modern migration, current conceptualisations of expectations within healthcare are yet to systematically draw on the research on the healthcare experiences of migrants. In response, drawing on a review of how expectations, and the shaping of expectations, is understood in different disciplines, we have proposed an intersectional, translocational and relational analytical framework for understanding peoples' expectations of healthcare. Within this approach, a patients' expectations of a health system interaction are shaped by their social location, the relational dynamics within these locations, as well as by their interpretation of past experiences of care. The framework considers both the *temporal* and *spatial* social locations of patients', echoing those current conceptualisations which indicate that expectations are *relationally, temporally,* and *spatially* defined and shaped. We contend that such an analytical framework would help

researchers, policy makers and practitioners to better take into account the antecedents and determinants of patients' expectations of care – for the former, in the inquiries they conduct, and for the latter in their efforts to improve the responsiveness of and satisfaction with the services they provide.

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3.3 What can one legitimately expect from a health system? A conceptual analysis and a proposal for research and action

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Abstract

In 2007, the World Health Organisation proposed the Building Blocks Framework and articulated 'responsiveness' as one of the four goals for health systems. While researchers have studied and measured health systems responsiveness since, several aspects of the concept remain unexamined, including, understanding the notion of 'legitimate expectations' – a notion central to the definition of responsiveness. We begin this analysis by providing a conceptual overview of how 'legitimacy' is understood in key social science disciplines. Drawing on insights from this overview, we examine how 'legitimacy' is understood in the literature on health systems responsiveness and reveal that there is currently little critical engagement with this notion of the 'legitimacy' of expectations. In response, we unpack the concept of 'legitimate' expectations and propose approaches and areas for reflection, research and action. We conclude that contestation, and ongoing negotiation of entrenched health system processes and norms which establish citizens' 'legitimate' expectations of health systems, is needed – through processes that ensure equitable and wide participation. We also call on researchers, in their capacity as key health policy actors, to trigger and initiate processes and help create equitable spaces for citizens to participate in establishing 'legitimate' expectations of health systems.

Summary box

- The idea of 'legitimate expectations' is a key feature of the definition of health systems responsiveness.
- There is limited critical engagement with the notion of the legitimacy of expectations within current literature on health systems responsiveness.
- Drawing on insights from across disciplines, we analyse and discuss the notion of a 'legitimate' expectation of a health system.
- While what is a legitimate expectation and what is not is a feature of social norms and shared beliefs, it is also the result of negotiation and contestation.
- It is vital that citizens can imagine, contest, and negotiate what to legitimately expect from their health system.
- Researchers and policymakers can help create equitable, regularised spaces for active citizen participation and contestation.

Introduction

In 2007, the World Health Organisation (WHO) proposed the Building Blocks framework which outlined four overall goals and outcomes of well-functioning health systems – improved health, social and financial risk protection, improved efficiency, and responsiveness (1). In response to this, and as a result of growing interest, an increasing number of publications have focused on the concept of responsiveness in the last 20 years (2). However, several scholars have also identified key theoretical shortcomings in existing understandings of responsiveness (2-4). The WHO (2000) defines responsiveness as, "the health system's ability to meet the population's legitimate expectations". The demarcation of 'legitimate' expectations within responsiveness, de Silva argues (5), is necessary to tackle the issue of divergence of expectations - people may have unrealistic or unjustifiable expectations of health systems which are not considered within articulations of health system responsiveness (5-6). While there are clear reasons for focusing on 'legitimate' expectations within responsiveness, there is very limited critical engagement with the notion of the 'legitimacy' of peoples' healthcare-related expectations within the scholarly literature.

The concept of legitimacy has been the subject of extensive theorisation and research in various disciplines and multiple theoretical and empirical contexts. However, the widespread application of legitimacy has layered the construct with multiple meanings and conceptualisations (7). This complexity could account for the lack of engagement with 'legitimacy' within the responsiveness literature (7). Consequently, we argue, as do Khan et al. (2), that several conceptual questions remain, such as what is a 'legitimate' expectation? Who decides what is a 'legitimate' expectation? But also, what denotes a *universally* legitimate expectation? In this analysis, we engage with key conceptualisations of legitimacy within the social sciences to respond to these questions and conceptual gaps. Ultimately, our aim is to tackle the question – what is a 'legitimate' expectation? In light of our findings, we argue that 'legitimate' expectations of health systems are social constructs which need to be negotiated, established, and revisited on an ongoing basis through a process of participation and contestation. We propose an agenda for reflection, debate, research, and action.

A conceptual review of 'legitimacy'

This analysis begins by providing a brief review of 'legitimacy' as it is conceptualised in what we identify as key theoretical work in social psychology, political science, and organisational studies. While the concept of 'legitimacy' has been incorporated within the broader health systems literature in various ways, we take a critical look at how the health systems responsiveness literature specifically engages with the concept.

'Legitimacy' in social psychology, political science, and organisational studies

Within their social psychological theory of "legitimation of interpersonal status hierarchies", Ridgeway and Berger (8) define legitimacy as a "process by which cultural accounts from a larger social framework" can be used to explain the "existence" of a particular social entity, regardless if that entity is a group, structure of inequality, or a position of authority. The central tenet here is that Ridgeway and Berger (8) distinguish between the "object" of legitimation at one level, and the broader beliefs, values, and norms that actors possess at a more encompassing, social level. Drawing on work from both social psychology and institutional theory, Johnson, Ridgeway, and Dowd (8) articulate the link between these two levels, showing how patterns of behaviour or beliefs are widely accepted into the broader cultural framework and become taken-for-granted social features. In the first stage (*innovation*) a new social innovation is created to address a need or desire at the level of actors (such as an organisation developing new procedures to meet policies). For an innovation to be accepted locally, local actors must believe that it is consonant with an existing, widely accepted cultural framework. As a result of being implicitly accepted, the innovation achieves *local validation*. Eventually, the new social innovation may diffuse into new, local situations and is adopted by actors in other contexts. As the new social object diffuses across contexts, it acquires widespread acceptance and is *generally validated*, becoming a "taken-for-granted" social innovation (8).

One of the most widely accepted definitions of legitimacy stems from the organisational literature (8). Suchman (9) describes legitimacy as, "a generalized perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed norms, values, beliefs and definitions". Here, as do Ridgeway and Berger (8), Suchman (9) emphasises the collective nature of legitimacy; it is a shared cognitive construct that is consistent with a cultural framework of beliefs, norms, and values that are generally accepted by a group as a whole (10). According to Suchman (9),

there are three primary forms of legitimacy within organisations: *pragmatic* (based on the audiences' self-interest), *normative* or *moral* (based on what is right) and *cognitive* (acceptance of an organisation as necessary or inevitable). Although each form of legitimacy is based on different "behavioural dynamics", they all involve a generalised perception that the activities of an organisation are appropriate and desirable according to a "taken-for-granted" set of norms, values, and beliefs (8). That being said, in their multilevel theory, Bitektine and Haack (10) approach organisational legitimacy from evaluators' perspectives. In this way, legitimacy is not seen as a "property" or "asset" of an organisation, rather a "judgement". Bitektine and Haack (10) propose that legitimacy is a cross-level construct, consisting of individual-level *propriety* and collective-level *validity* (8, 11). When assessing the "normative acceptability of an organisation" (*propriety*), the evaluator refers to a set of social norms against which the organisation's properties are compared and expectations are constructed. In a stable institutional environment, the choice of norm is "obvious"; it is a taken-for-granted set of norms. Again, Bitektine and Haack (10) echo existing conceptualisations by emphasising the "collective" nature of legitimacy through the notion of *validity* – the extent to which there is general consensus, within a collective, that an organisation is appropriate for its social context (10). Dornbusch and Scott (11) suggest that *validity* is reinforced by authorisation (support of higher authorities) and endorsement (support of one's peers). In this way, an individual evaluator's legitimacy judgement (*propriety*) is not only based on their perceptions of an institution's properties and behaviours, but also on their observations of collective legitimacy judgements (*validity*). That being said, "major environmental jolts" and changes in social norms, values, and judgements may provide the conditions for norm change, as well as institutional change (10). "Jolts" may also occur at the individual-level through major life-changing events, such as illness or job loss, altering a person's position perspective of the institutional field. Their altered perspective may create new expectations that could go unmet. This connects to recent work by Lakin and Kane (4) in which they argue that changes in one's social location can prompt the construction of a new 'horizon of expectation'.

Stillman (12), drawing on political science defines a government as being 'legitimate', "if and only if the results of governmental output are compatible with the value pattern of the society" (12, p. 39). Here, there is a parallel with conceptualisations in the organisational and social psychological literature which also stress the collective nature

of legitimacy. By "the value pattern of society", Stillman (12) refers to society's generalised criteria of desirability, standards of evaluation or normative properties which should be compatible with the results of a government's actions (or outputs). Importantly, a legitimate government can exercise power and influence society's values, while also assuring society and its members that their "value pattern" is respected. Weatherford (13) has elaborated upon this interaction between a government and its citizens and, the construction of governmental legitimacy, in his revised conceptualisation of legitimacy in political science. He distinguishes between macro, system-level properties (the formal structures and processes of political systems) and micro, individual-level properties (citizen's attitudes and actions). Notably, macro-level components of legitimacy include the *accountability* of governments to their citizens by allowing wide, effective public participation, *efficiency*, *procedural fairness,* and *distributive fairness.* Weatherford (13) further classifies the *accountability* and *responsiveness* of political systems as the representational procedures which link governments and their citizens. He emphasises that accountability mechanisms, such as regular elections, are crucial structures of legitimate governments.

'Legitimacy' in health systems responsiveness

The healthcare literature engages with the notion of 'legitimacy' in different ways, drawing on existing theorisations from institutional theory and political science. Work by Lockett et al. (14), for instance, drew on interpretations of 'legitimacy' within institutional theory, particularly by Suchman (9), to understand the dynamics of institutional change in the UK National Health Service. Lockett et al's. (14) study revealed that health system actors who have limited structural legitimacy – "the power that emanates from professional hierarchy" – are most willing to provoke change but are least able to do so. By contrast, those who have a combination of both structural and normative legitimacy – "the ability to convince others of "what ought to be"" – are the most able to promote institutional change. The concept is also linked to accountability; as theoretical work from political science highlights, accountability is a macro-level component of legitimacy and are the representational procedures which link governments with their citizens (12). In the health systems literature, social accountability suggests that political and governmental actors, as well as service providers are held to account by citizens for their decisions and actions (15). The link between social accountability and legitimacy is highlighted in a realist synthesis by Lodenstein et al. (16) in which they

reveal that the ability of citizen groups to engage in social accountability mechanisms is dependent on providers perceiving these groups as 'legitimate'.

That being said, we sought to understand how literature examining the responsiveness of health systems engages with the concept of 'legitimacy'. Specifically, how (and if) such literature articulates and defines peoples' 'legitimate' expectations of their health systems. Our search of the literature (for details, see Supplemental files 1 and 2) revealed that scholars appear to only engage with the notion of 'legitimacy' when defining health systems responsiveness. As Supplemental file 2 highlights, all included papers were of the consensus that responsiveness relates to the health system's (or indeed health system actors') ability to meet peoples' 'legitimate' expectations of care. However, only one paper, by Joarder et al. (17), drew on the work of de Silva (2000) to define 'legitimate' expectations as those that are based on ethical norms and values. De Silva's (5) work on responsiveness provides the first and, to our knowledge, the only articulation of a 'legitimate' expectation: "Legitimate can be defined as conforming to recognised principles or accepted rules and standards". De Silva (5) cautions that, while 'legitimate' standards and norms with an ethical basis (such as those related to dignity and respect) can be set without much debate, the setting of 'legitimate' norms related to infrastructure and access to care could be more difficult specify. Apart from this exception, no paper clarified or elaborated upon what demotes a 'legitimate' expectation. Thus, as Khan et al. (2) also recognise, there is yet no critical engagement with what is a 'legitimate' expectation and, in particular, who decides what is considered 'legitimate' expectations of responsive health systems.

A conceptual analysis of 'legitimacy'

In this section, we unpack the conceptual overview presented above to highlight the common facets of existing conceptualisations of legitimacy. We then respond to the question – what is a 'legitimate' expectation of a health system?

Insights from the conceptual overview

Several common facets in these conceptualisations of 'legitimacy' are evident. Primarily, that a 'legitimate' entity – whether that be an organisation, government, social innovation, judgement, or status order – is one that is based on a cultural framework of widely shared, *normative* beliefs and values on how things should or ought to be. In social psychology, Ridgeway and Berger (8) terms these belief as the "cultural accounts from a larger social

framework". Bitektine and Haack (10) also reveal that the "normative acceptability of an organisation" is evaluated against a "taken-for-granted" set of social norms. Moreover, Stillman (12) suggests that a government is deemed 'legitimate' if its output is consistent with "the value pattern of society"; society's generalised criteria, standards, or normative properties. Hence, as Ridgeway and Berger (8) put it, there is a distinction between the entity which is perceived as 'legitimate', and the cultural framework that people possess which is situated within the broader social environment. Connected to this, is the "collective" nature of legitimacy; that whether or not an entity is deemed 'legitimate' is dependent on general consensus of other actors, groups, or society in general (8-11). Dornbusch and Scott (11) suggest collective legitimacy judgements are particularly reinforced by the authorisation of higher authorities. That being said, in the political science, we see how 'legitimacy' of an entity is conferred through active citizen participation in accountability initiatives (12). Yet, it is important to note that perceptions of 'legitimacy' are not stable – changes to both individual- and collective-level social norms and values can prompt a revision in one's judgements of 'legitimacy' (10).

What is a 'legitimate' expectation of a health system?

Incorporating the above insights from the conceptual overview and analysis, we propose that a 'legitimate' expectation of a health system encounter is one which reflects and complies with widely shared norms, values, beliefs, and standards. These beliefs, values, and standards are *normative* – they are peoples' views about how a health system should or ought to be. Such 'legitimate' expectations are also collective in nature; though mediated by the views of individuals, they are ultimately collective and socially constructed, emerging through and depending on the presence of a social audience accepting of the encompassing framework of beliefs, norms, and values (8). The inclusion of the term 'universal', when specifying 'legitimate' expectations within responsiveness, can be viewed as an attempt to acknowledge this social construction and collective nature of the accordement of legitimacy (5). Echoing work by Bitektine and Haack (10), and Lakin and Kane (4), we also emphasise that peoples' 'legitimate' expectations of health systems are not static, but constantly evolving in response to "environmental jolts", and changes in peoples' social locations which prompt the re-construction of their 'horizon of expectations'. Aside from being *spatially* defined, and as Lakin and Kane also suggest (4), 'legitimate' expectations may also be *temporally* shaped by peoples' past and current experiences of their health system interaction.

But what are the norms, values, beliefs, and standards in the context of the health system? Can they provide an accurate reference for defining what is considered a 'legitimate' expectation? Norms or "accepted standards" may be institutionalised in the form of, for example, standards created by governments or public and private actors (such as the United Nations Global Compact) (5, 10). Within health systems, national safety and quality health service standards are developed to improve the quality of health service provision and protect the public from harm. For example, this can include policies and standards to ensure comprehensive care involving integrated screening and assessment, as well as systems and strategies around medication safety (18). Therefore, widely accepted standards such as these could provide an objective reference for defining peoples' 'legitimate' expectations of the various aspects of health system responsiveness. However, these standards vary across country and health system contexts, and, for this reason, de Silva (5) concedes that it can be difficult to set standards for a health system's infrastructure, as well as access to care. Therefore, how might one then go about establishing 'legitimate' expectations in a particular context? While this question has been directly and indirectly recognised and asked by many (including in the early conceptualisations of responsiveness), much needs to be done to tackle this question. In this paper, we have taken what we consider the first explicit step in this direction. In the sections that follow, we draw upon insights from political science and public policy to discuss how legitimacy is established in the public square through a process of participation and contestation, with the former itself being contested and negotiated.

Establishing 'legitimate' expectations through participation and contestation

Within political theory, Dhal (19) terms an 'ideal' democracy in which governments exhibit continuing responsiveness to the preferences of their citizens, as a *polyarchy* (19-21). The two main underlying dimensions of this ideal-type liberal democracy, Dhal (19) proposes, is contestation and inclusiveness (or participation). Contestation, within a democracy, exists when citizens have "unimpaired opportunities" to not only articulate their preferences, but to also communicate them to fellow citizens and the government via individual and collective action. However, these preferences must be given equal consideration in the actions of the government. On the other hand, participation is considered as the proportion of the population that is, "entitled to participate on a more or less equal plane in controlling and contesting the conduct of the government…" (20 p.633). In Dhal's (19) view, a central quality of a democracy is enabling minority groups

to communicate their preferences, as well as the presence of representatives to respond to these preferences. Establishing a "equal plane" for participation is therefore a subject of much debate and negotiation (20-21). For instance, those who are better educated have been found to vote more often that those who are less educated. In this way, the interests of this under-represented group may be overlooked in the creation of public policy (22). More broadly, this links to the notion of the "collective" nature of legitimacy - that the establishment of 'legitimacy' is dependent on general consensus or the endorsement of actors, groups, or society in general (8-12). More specifically, in political science, Weatherford (13) proposed that a key macro-level component of legitimacy is the accountability of governments to their citizens by allowing public participation. Therefore, 'legitimacy' can be established within systems or organisations through a process of contestation and participation. Within health systems, this may involve the 'elite' – politicians, policymakers, and managers – initially setting the boundaries for contestation (21). This is echoed within Dornbush and Scott's (11) articulations of organisational legitimacy, in which they argue that authorisation and endorsement of higher authorities is required for an organisation or organisational procedure to be defined as legitimate. However, Suchman (9) proposes that *normative* legitimacy within organisations is derived from actors who specify "what is right". Patients and citizen groups are these actors who specify their *normative* expectations of what should or ought to happen during their healthcare encounters (5). As Lodenstein et al. (16), Cleary, Molyneux and Gilson (15) and other scholars reveal, one such way is through the participation of citizens and citizen groups in social accountability initiatives. Hence, in order to define what is a 'legitimate' expectation of a health system, active citizen participation is vital. Thus, while authorities may set the standards for a health system's infrastructure and processes which specify *universally* 'legitimate' expectations, we argue that citizens, understood broadly, need to be able to contest and regularly revisit these standards of what counts as a responsive health system. This requires active and broad-based citizen participation in health policy and practice with, as Dhal (19) emphasises, an "equal plane" for participation.

Creating spaces for equitable participation and contestation

Arenas which promote opportunities for public participation can be usefully understood through the concept of *space.* A *space* for public participation can be bounded in time and dimension, with sealed or permeable boundaries between citizens and institutions

(23). “Invited spaces” are spaces created by institutions who “invite” citizens to contribute towards the shaping and implementation of policy. Some “invited spaces” may be transient and are only briefly opened for communication and participation. Others are more durable, regularised “invited spaces” for public engagement and participation (23-24). However, as with other participatory institutions, “invited spaces” often lack the conditions for equitable participation. This may be the case for “invited spaces” that have been transplanted onto institutional landscapes where entrenched structures and relations of privilege undermine equitable participation (25). For instance, Mohanty (26) shows how, in India, women’s participation in committees within the Integrated Child Development Scheme was shaped by gendered norms whereby they were viewed only as mothers rather than as individual citizens. She adds that though the state had created these spaces for participation, it had done little to “actualise” the spaces; women’s participation and agency in these spaces was structured within and constrained by the scheme officials’ assignment of a particular identity to the involved women (25-26). The point being that in as much as the presence of spaces for participation and contestation is important, it is important to not lose sight of the fact that such spaces are not “bounded” - they are inevitably embedded within, interact with and are influenced by existing structures, entrenched norms, and established social and organisational processes. That being said, several methods or approaches can strengthen or enhance equitable participation. Within the sphere of political participation, one such approach includes ongoing dialogue and awareness raising (24). As such, work by Cornwall has similarly highlighted that education can be key to both individual and collective empowerment of community groups – to enable such groups to “gain a voice” for engagement in and contestation of health-related concerns (23).

Therefore, we argue that the creation of durable, regularised “invited spaces” by healthcare institutions is a necessary, though not necessarily sufficient step, to enable citizens to contest the standards for a health system’s infrastructure and processes which specify the legitimacy of what citizens can expect from the system. This must involve all citizens, particularly minority or disadvantaged groups. For instance, the implementation of country-specific health policies, which set the standards for peoples’ ‘legitimate’ expectations, should not only involve the ‘elite’ who make decisions based on ‘universal’, professional criteria (27). At a global level, this translates into spaces and processes being such that the poorer and weaker LMICs can meaningfully participate in and contest the

development of recommendations and policies by powerful multilateral organisations, international non-government organisations, and donors (28). We also contend that, through active citizen participation and contestation, it is possible to understand how social structures, such as culture, gender, and socioeconomic status, intersect to shape peoples' expectations of a care encounter (4). This consideration is necessary for determining how expectations, whether they relate to a health system's infrastructure or the ethical norms of a care interaction, vary across contexts (5). Ultimately, we argue that active citizen participation and contestation is vital for specifying what can be considered *universally* 'legitimate' expectations of responsive health systems. However, in order to establish an "equal plane" for participation and contestation, we argue that these "invited spaces" need to be "actualised" (19, 26). This involves taking into account the impact that existing social structures and relations can have on restricting equitable participation and contestation in particular contexts and for certain social groups. In establishing "invited spaces" for contestation and participation, it is therefore vital that healthcare institutions actively create the conditions for equivalence to strengthen the participation of marginalised groups (25-26).

Participation and contestation across different political systems and realities

It is important to acknowledge that the above discussion around the establishment of legitimacy of expectations from a health system assumes and refers to an 'ideal' liberal democratic context where participation and contestation are seen as basic citizen rights and spaces for participation are many, are formalised, and tend to have constitutional bases (29). Political systems vary in their degree of political space for citizen participation and in the bases, processes, and platforms for citizens to participate in public discourse and policy. For instance, one can expect this to be different across single-party political systems and dictatorships as in parts of the Middle East, Latin American, and parts of East Asia, to two- or multi-party systems in liberal democracies in different parts of the world. Therefore, we argue that any scholarship that seeks to understand the nature of contestation and participation (including but not limited to health services-related matters) needs to explicitly take into account the political system context. While it is not within the scope of this analysis to examine how the processes of contestation and participation for establishing 'legitimate' expectations varies across political systems, we propose this as an area for future research. As an illustration, we look at the case of some countries in East Asia that have single-party polities. In these countries, understandings

of citizen participation (and contestation) in the public sphere are influenced by the doctrine of *'Minben'*, a distinctly paternalistic idea in which the power of the government is based on responding to the welfare of common people and not in extending autonomy or participation in government (30). Within the *Minben* doctrine, the scope of citizens' political participation is limited to conveying their concerns to political leaders, with leaders having the power and freedom to deviate from public opinion when implementing policy. In this way, governmental legitimacy is established through the outcomes of policy, rather than through fair elections, such as in liberal democracies (30). It is therefore important to recognise that, in such polities, prevailing political traditions may constrain or even prevent the creation of "invited spaces" for citizen participation and contestation in public policy. Moreover, peoples' expectations of their role could also be shaped by these cultural and political traditions, and they may in fact regard political leaders as, "guardians of their interests" (30, p.129). This, in turn, could influence their desire to contest and participate.

All processes, particularly the participatory processes for the social construction of, and agreement about what one might legitimately expect from and of a health system are at risk of becoming about pandering to "all" social norms, or worse, to being captured by powerful groups. These processes also risk the legitimation of unscientific and damaging medical treatments that may not be medically sound or appropriate from a health system point of view but might be widely preferred. For instance, how would the demand for antibiotics for common viral infections be processed? Or how would the widely shared preference to be seen/evaluated by a clinical specialist when a primary care provider might be better suited for the condition, be navigated? The point is that all processes for agreeing about what people can legitimately expect from and of a health system, require the explicit inclusion of safeguards against the reproduction and perpetuation of harmful and discriminatory social norms, and against the legitimation of scientifically and medically unsound or unsafe preferences. An inclusion that requires a delicate balance between democratic (where citizens decide) and epistocratic (where experts decide) concerns (31).

An agenda for reflection, research, action, and policy

In this section, we propose an agenda for reflection, research, action, and policy. Drawing on our findings from the conceptual review and analysis, we first outline areas for reflection and future research on 'legitimate' expectations of health systems – this is by

no means a comprehensive or complete set of questions. We also call on researchers in their capacity as key actors in health policy development, to trigger and initiate actions towards establishing 'legitimate' expectations of health systems.

Areas for future research: a call to action

Insights from this paper pave the way for the asking of a range of questions – the answers to which could ultimately help improve the responsiveness of health systems globally: What are 'legitimate' expectations of a health system? How is the legitimacy of an expectation established? Who defines what are 'legitimate' expectations? What are the perspectives of various health system actors i.e citizens (including, but not limited to patients), policymakers and practitioners, on what counts as legitimate expectations? Cross-country, comparative studies could also shed light on how 'legitimate' expectations vary across contexts, overtime and in response to major "environmental jolts". But also, how peoples' past and current experiences of their interactions with health systems, and with other social and political institutions and systems, shape what they consider as 'legitimate' expectations. What strategies can optimally improve citizens' understanding about health and health service provision? The organisational studies literature reveals the role of authority figures and endorsements by such figures in establishing legitimacy within organisations (11). Future research could examine the key actors (from within and outside the health system) involved in the authorisation and endorsement of these expectations. Finally, drawing from the political sciences literature, we have argued that 'legitimate' expectations are ideally established through a process of participation and contestation. This requires the presence of or the establishment of spaces where citizens can participate, question, and contest normative health system processes and be involved in healthcare related decision-making. Studies are needed to examine: What, if any, are the processes of and spaces for participation and contestation in different health system contexts? And how effective, and inclusive are these? But also, how can health systems create the conditions to strengthen the participation of marginalized groups in these processes and spaces (25-26)? Another question that follows is - what else i.e., alongside instituting participatory processes, do health systems need to do, to become better responsive to the various populations they serve? We have acknowledged that participation and contestation can primarily refer to the context of liberal democracies, and that processes and spaces for citizen's participation in public policy and planning, will vary across political systems. We contend that there is a need for studies to

understand the nature and varieties of contestation and participation for establishing 'legitimate' expectations from health systems across different political system contexts.

We also call on researchers as key actors in the health policy and systems arena to initiate inquiries, trigger processes towards, and help create spaces for equitable and meaningful participation, contestation, and ongoing negotiation of entrenched processes and norms which currently define 'legitimate' expectations in their health systems. There is room for action and real possibilities for achieving meaningful change in such an enterprise as there are instances where the legitimacy or not of care-related norms and expectations have been vigorously contested, resulting in incremental social and policy change. One such example is the international- and national-level response, across the range of polities, to the care needs of people who inject drugs (32). An evidence-informed, combination approach involving needle and syringe programs, opioid substitution therapy, HIV testing and counselling and antiretroviral therapy (ART), is now an established and socially accepted approach to providing care to people who inject drugs. However, it took decades of patience, participation, and diligent contestation before countries and societies came to recognise this approach as being socially legitimate and acceptable. While criminalisation, long-term prison sentences, compulsory treatment, even the death penalty (32), remain part of the formal law in many contexts, the broader policy and social environment increasingly recognises injection drug users' expectations of having timely access to respectful, non-discriminatory healthcare as being 'legitimate'.

Conclusion

As constraints around availability and accessibility of health services increasingly get loosened in low- and middle-income country contexts, scholars, policymakers, and practitioners in global health are increasingly interested in and focusing on improving the responsiveness of health systems to the needs and expectations of the populations they serve. In this analysis, we have unpacked an important element of the definition of health systems responsiveness – the notion of 'legitimate expectations' – an element, that though central to the definition, has hitherto not received much critical attention. We highlight the need for research which seeks to understand how 'legitimate' expectations are established, through what forms of participation and contestation, in various political system contexts. We also highlight the potential role researchers can play to initiate processes and help create spaces for equitable and meaningful participation, contestation,

and ongoing negotiation of entrenched processes and norms which currently define 'legitimate' expectations from health systems.

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Chapter 4: Research approach and methodology

4.1 Chapter overview

In this chapter, I outline the approach to this inquiry and the methodology employed. I begin by presenting the rationale for this inquiry, its place within the RESPONSE project, and the research questions and objectives I tackle. Drawing on theoretical insights from the conceptual mapping exercise in Chapter 3, I outline the theoretical approaches that framed this inquiry. Then, I briefly describe the study site – the rural northern province of Bắc Giang. Here, I reflect on my observations while travelling through Bắc Giang and, in Section 4.3.2, provide an overview of the health system in this province. I also describe maternity care provision specifically within the district of Hiệp Hòa and the communes of Đông Lỗ and Đoan Bái, which were the designated sites of participant recruitment. I then detail my "immersion" within the field of inquiry, which did not only begin with the fieldwork in Bắc Giang, but while working as a research assistant on RESPONSE and as a result of my interactions and discussions with key Vietnamese scholars in the field. I describe the processes and activities of participant recruitment, data collection, and analysis, before reflecting on the ethical considerations of the study.

4.2 Rationale for this study

As I highlight in Chapter 1, several empirical and theoretical gaps remain in the current scholarly literature on health systems responsiveness. The responsiveness of country health systems has primarily been examined through survey-based inquires which use adapted versions of the WHO health systems responsiveness questionnaire (Coulter & Jenkinson, 2005, Peltzer, 2009, Liabsuetrakul et al., 2012, Chao et al., 2017, Awoke et al., 2017, Ratcliffe et al., 2019, Kapologwe et al., 2020, Negash et al., 2022). However, within these inquiries, peoples' expectations, which shape their experiences and evaluations of their health system interactions, are given little consideration (Mirzoev & Kane, 2017). Theoretically, the concept of health systems responsiveness is the least well-understood health system goal. In particular, and as I also point out in Chapter 1, this includes limited explicit engagement with and understanding of what is a legitimate expectation – a notion that is central to health systems responsiveness. To tackle this theoretical gap, in Chapter 3, I mapped the concepts of expectations and legitimacy, within various disciplinary domains and as they relate to health systems responsiveness. Moreover, as Mirzoev and Kane (2017) emphasise, in the WHO responsiveness framework and other analytical frameworks which follow, there is limited recognition of the broader and evolving social, political, cultural, economic, and historical conditions which define what people expect from their health systems.

As I outline in Chapter 2, global political, economic, and health system transitions and changes have characterised recent decades. Since 2003, the number of low-income countries has declined and the proportion of the world's population living in extreme poverty has halved (McPake et al., 2020). Asian economies, in particular, have experienced significant economic growth which has led to a rapid disappearance of low-income countries in these regions (McPake et al., 2020). These economic transitions have, in some ways, been driven by the macro-economic, neo-liberal policy turn of many countries around the world. Thus, sustained and rapid economic growth, alongside the shift towards neoliberalism, has seen an increasing demand for better quality health care which meets peoples' increasing expectations (McPake et al., 2020, Bloom et al., 2014). This demand has created significant "market opportunities" within the health sector. For-profit providers have therefore "filled the gaps" the public health sector has left or is unable to meet in many LMICs, particularly in relation to the accessibility and availability of health services (Bloom et al., 2014, McPake et al., 2020). In this way, and as I explain

in Chapter 2, these economic, political, and health system transitions and changes have transformed the nature of care provision and, with that, how people seek and experience healthcare.

That said, to my knowledge, no study, as yet, has systematically examined peoples' expectations of their health systems, and how these are shaped by broader and evolving economic, social, cultural, and political systems. But also, how these expectations drive peoples' engagements (decision, choices, preference) and interactions with health systems. There is also a notable absence of research which unpacks what shapes the legitimation of peoples' expectations of their health systems (Khan et al., 2021). This is despite the notion of legitimate expectations being so central to health systems responsiveness. This study seeks to bridge these empirical and theoretical gaps in the current scholarly literature on health systems responsiveness by providing insights from maternal health care in Vietnam. As I discuss in Chapter 2, in the last two decades, Vietnam has been one of the fastest growing economies, globally (The World Bank, 2022). Such growth has been spurred on by the Doi Moi reforms, a series of economic and social policies implemented in the 1980s and 1990s (Witter, 1996, Dao, 2023). Within the health system, the Doi Moi reforms saw the official recognition of the private sector, as well as the introduction of user fees within public health facilities, as a result of hospital authorisation policies (Võ & Löfgren, 2019, Dao, 2023). Yet, as I argue in the CIS presented in Chapter 2, these social, economic, and health system transformations are insufficiently reflected in the current scholarly literature on women's experiences with maternity care. In particular, there is an overwhelming focus on women's encounters with public maternity care services which does not adequately capture Vietnam's shift towards market-oriented care provision.

In this inquiry, I examine childbearing women's expectations and experiences of care, in light of the social, political, economic, and health system transitions and changes occurring in post-Doi Moi Vietnam – changes which reflect those occurring within other LMICs. In doing so, I aim to identify the implications for improving health systems responsiveness, globally, but particularly in LMICs. More specifically, and as I explain below, it also seeks to achieve Objective One of the REPONSE project in Vietnam – "to conduct an in-depth analysis of how health systems responsiveness is understood and

enacted by key health systems actors, and to what degree the local health system in Vietnam responsive to these expectations" (Mirzoev et al., 2021).

4.3 The RESPONSE Study

RESPONSE is collaborative project involving a consortium of partners from Hanoi University of Public Health (HUPH), University of Melbourne (UoM), University of Ghana, the University of Leeds, and London School of Hygiene and Tropical Medicine (LSHTM). The multi-country project uses a mixed-methods, theory-driven design to co-produce, implement, and evaluate context-sensitive interventions to improve health systems responsiveness to the mental health needs of pregnant women in Ghana and Vietnam (Mirzoev et al., 2021). Pregnant women were identified as the priority group due to their vulnerability associated with the intersection of their gender, age, ethnicity, socioeconomic status, and mental health needs. The project has five main objectives, each with specific research questions (detailed below). I began as an active research assistant (RA) on RESPONSE in April 2020 and was involved in all aspects of the project. However, I worked closely with and supported colleagues at HUPH to achieve Objective One of the RESPONSE project in Vietnam: *to conduct in-depth analyses of how health systems responsiveness is understood and enacted by key health systems actors, and to what degree the local health systems are responsive to these expectations*.

Study objectives	Specific research questions
1) Conduct in-depth analyses of how health systems responsiveness is understood and enacted by key health systems actors, and to what degree the local health systems are responsive to these expectations	1. How is health systems responsiveness understood and enacted by key health systems actors in LMICs? a. What do people, especially from vulnerable groups, expect from a responsive system and how do these shape their engagements with their health systems? b.What being responsive means to key actors on the 'systems' side (providers, managers, policymakers), and how do these shape their practices? 2. To what degree the local health systems organise themselves to be responsive to actors' expectations? a. How do systems contexts, structures and processes facilitate or constrain its responsiveness?
2) Co-produce, implement and evaluate context-sensitive interventions to improve health systems responsiveness to neglected health needs of vulnerable groups	
3) Develop an empirically-based and theoretically-grounded model of complex relations between the contexts, the mechanisms and the outcomes of the interventions to improve health systems responsiveness	3. Which co-produced interventions can improve health systems responsiveness to neglected health needs of vulnerable groups? a. How does improving responsiveness affect the use of mental and maternal healthcare? b. In what way responsiveness depends on, and contributes to, other health systems goals?
4) Develop transferable best practices for scalability and generalisability of the pilot-tested interventions	4. Which transferable best practices can be developed for future health systems strengthening? a. What adaptations will be required to apply the interventions to other health areas? b. In what way can the model be adapted to improve responsiveness in other contexts?
5) Strengthen research capacity at individual, organisational and systems levels, through extending existing collaborations into strong South-South and South-North exchange and learning within and between Ghana, Vietnam and UK	

Figure 6: RESPONSE study objectives and research questions (Mirzoev et al., 2021)

In this way, the associated fieldwork and study I present in this thesis aimed to examine what childbearing women in Vietnam expect from the health system and how these expectations shape their engagements, experiences, and interactions with the health system. In doing so, it is presented as a case study for understanding what people expect from responsive health systems in LMIC-contexts (research question 1a). The study plan, including methods for recruitment and data collection, was developed with, and approved by RESPONSE researchers at HUPH to meet Objective 1 of the project. Data analysis was conducted alongside both RESPONSE and HUPH researchers. The plan also received approval by the rector of HUPH and I was officially invited as a RA to work on the study and conduct fieldwork for a period of three months.

4.4 Research questions and objectives

In this study, I set out to tackle two questions, which broadly aligned with Objective 1 of RESPONSE:

1) What shapes childbearing women's engagements, experiences, and interactions with the health system in Vietnam?
2) What are childbearing women's expectations of the health system in Vietnam?

To respond to these questions, I was guided by three main objectives:

1) Examine childbearing women's engagements (decisions, choices, and preferences), experiences, and interactions with the Vietnamese health system
    1.1) Analyse what shapes their engagements (decisions, choices, and preferences), experiences, and interactions
2) Explore childbearing women's expectations of the Vietnamese health system
    2.2) Examine what shapes their expectations
3) Identify the implications of the findings for improving health systems responsiveness, globally, but particularly in low- and middle-income country-contexts.

This study is set within the context of post-Doi Moi Vietnam – a country that has experienced rapid social, economic, and health system shifts and transitions. Therefore, as indicated above, I present insights from maternal health care in Vietnam to illustrate peoples' interactions with a health system that is gradually transitioning towards market-based provision of care – changes akin to those taking place within other LMICs.

4.5 Theoretical approaches framing the inquiry

Inquiries examining peoples' experiences of health and healthcare, including but not limited to those relating to health systems responsiveness, draw on a long tradition of empirical and theoretical research. This research uses a variety of theoretical and methodological approaches to examine the care experience (Ziebland et al., 2013). In this inquiry, to explore childbearing women's engagements, experiences, and interactions with the health system in Vietnam (Objective 1), I drew on Archer's (2003) and Chalari's (2009) work on the "internal conversation". Building on Archer's (2003) initial theorisation, Chalari (2009) proposes that peoples' deliberations on their actions and experiences occurs through their internal conversation – the inner dialogue that people have with themselves. It is through such internal conversations that people weigh up what is most important to them – their ultimate concern – and decide on an appropriate course of action to tackle this concern (Fuller, 2013, Archer, 2003). It is through this process that individuals process internal and external stimuli and externalise an appropriate response (Chalari, 2009). Thus, it is possible for one to glimpse individuals' internal conversation through eliciting their "self-talk" or "thinking aloud" – the external conversation individuals produce when they vocalise their thoughts to themselves (Chalari, 2009). Though, as Chalari (2009) proposes, the process of "mediation" allows one to selectively choose which part of the internal conversation they will share with others, when they will do it, in what way, and for what reasons. However, it is important to note that society is a key 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). I drew on these theoretical insights to uncover and analyse women's 'internal conversations', in which they make sense of their experiences of their interactions with the Vietnamese health system (Section 5.2). Importantly, this approach allowed me to shed light on the key determinants influencing their actions and experiences – their needs, legitimate expectations, concerns, choices, and decisions. As such, expectations emerged as a particularly powerful, unseen determinant influencing women's choices and decision and motivating their interactions with the health system during pregnancy and childbirth.

Given this, in Objective 2 of this inquiry, I sought to uncover childbearing women's expectations of the Vietnamese health system and to examine what shaped these expectations. This examination was informed by key theoretical insights emerging from

the conceptual mapping of the literature on expectations and legitimacy I conducted in Chapter 3. Health systems responsiveness centres on understanding peoples' normative expectations of care – what people expect should or ought to happen during a care encounter. Therefore, I drew on Thompson and Suñol's (1995) articulation of expectations, within patient satisfaction, to distinguish between women's ideal (aspirations or desires), predicted (realistic expectations shaped by experience), normative (what should or ought to be), and unformed (inarticulate expectations) expectations of care. The intersectional, translocational, and relational framework I propose in Section 3.2 framed and guided the overall analysis of Vietnamese women's expectations of their health system. Building on conceptualisations of intersectionality, the framework draws on Anthias' (2020) work on translocational positionality. Central to the approach is the notion of a social 'location' which incorporates the spatial, temporal, and scalar as 'place' within social hierarchical positioning. As such, I adopted this theoretical approach to examine how Vietnamese women's social, spatial, and temporal 'locations' shaped and defined their expectations of care (Objective 2.1). Embracing a translocational approach therefore allowed me to go beyond merely examining how various social structures independently shape women's expectations of care, to also giving importance to temporality, spatiality, and geography. This consideration was particularly important for capturing how (and if) past and ongoing social, economic, and health system shifts, as a result of Doi Moi*,* temporally and socially defined what women expected from the health system during pregnancy and childbirth. Moreover, whether (and if) these shifts and changes were apparent within rural regions of the country and how this might spatially and geographically shape women's expectations of care.

The notion of expectations being temporally defined is echoed within Koselleck's (2004) and Lunhmann's (1995) conceptualisations of expectations in sociology. Koselleck (2004) proposes that meaning for an action is comprised within a 'horizon of expectation' – 'horizon' being a temporal metaphor to show how expectations are "the future made present". Luhmann (1995) postulates that expectations are pre-given and generalised and, as such, structures of expectations may be constantly re-activated, anticipating future actions and, in this way, reducing the complexity of systems. This can include the health system, where people may have pre-given, generalised expectations of health system process and practices. As I define in Section 3.3, expectations that are based on generalised, widely accepted norms, values, beliefs, and standards can be consider as

'legitimate' – a consideration that is central to health systems responsiveness. All these theoretical insights foreground my examination of childbearing women's 'horizon of expectations' of the health system within the context of post-Doi Moi, rural Vietnam (Section 5.3). Within this analysis, I further aimed to understand what makes these expectations 'legitimate' for them.

The theoretical and methodological approaches outlined above are elaborated further in the findings section within the published and "in-progress" pieces presented in Sections 5.2 and 5.3. This elaboration is with a view to avoid repetition, given that this is a "thesis with publications".

4.6 Methodology

4.6.1 Study sites

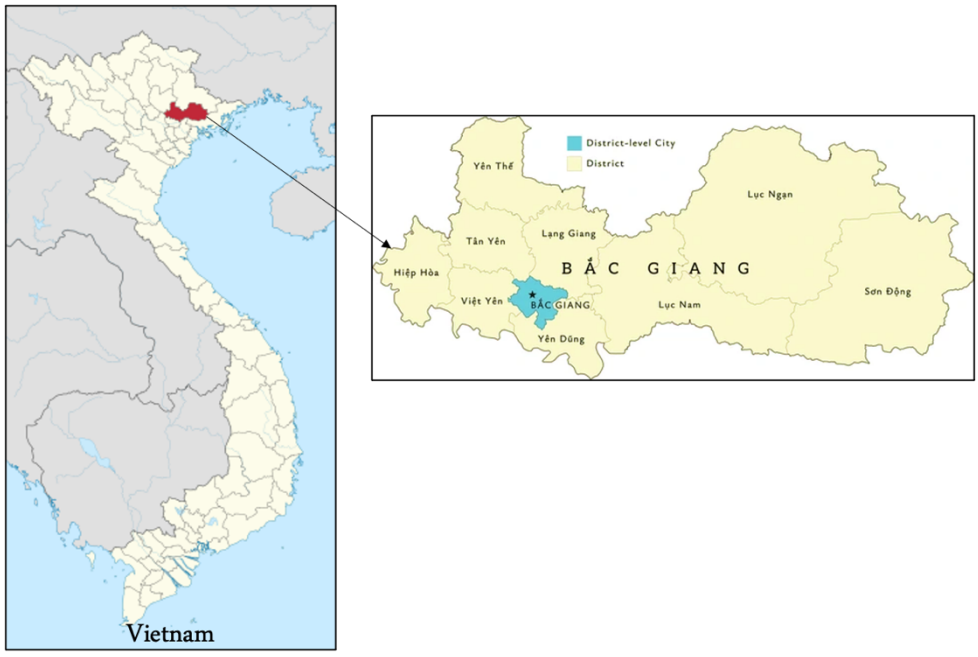

Figure 7: Map of study sites. Images adapted from Wikipedia (2011) and Shutterstock (2024).

The province of Bắc Giang was purposively selected as the study site for the RESPONSE project and for this study. The province is located 50 km to the north of Hanoi and is situated in the northern midlands and mountainous regions of Vietnam. Bắc Giang has experienced rapid industrialisation in recent years, attracting migrants from neighbouring provinces (Mirzoev et al., 2021). Hence, the province was identified as the RESPONSE study site due to the presence of both rural and industrialised areas. Within Bắc Giang,

the district of Hiệp Hòa was selected as the site for implementation of the context-sensitive interventions co-produced by RESPONSE. Participants for this study were similarly recruited within the district of Hiệp Hòa, specifically within the communes of Đông Lỗ and Đoan Bái.

According to the population and housing census in 2019, approximately 1.8 million people reside in Bắc Giang across 10 districts and 209 communes (General Statistics Office, 2020). The majority of the population – around 1.5 million – live in rural regions of the province. However, while travelling within Bắc Giang during the field trips, I found it difficult to clearly distinguish between the rural and urban areas. It seemed to me that the industrialisation zones were gradually encroaching upon the rural areas of the province; factories and urbanised areas with shop-lined roads were often interspersed with farms and rice fields. It was only when we travelled to the very edges of the province, did houses become scattered and the roads less developed. However, even in these areas, there were signs of construction and development. Travelling through Bắc Giang, I saw several large, newly built industrial parks which, I was told, manufactured electronic products for Samsung and Apple. Like small cities, these industrial parks were spread throughout the countryside amid the rice fields and farms. In this way, industrialisation in Vietnam, has fuelled the export of manufactured goods, including electronics. The sector has been found to disproportionately employ women – women accounting for approximately 80% of electronics manufacturing workers in Vietnam (a trend I too observed among the participants interviewed). As such, current trends of internal migration point to the increasing feminisation of the phenomenon, with women compelled to migrate to urban and industrialised areas of the country for work (Vo, 2021). I also observed multiple garment and ceramic factories throughout the countryside, but the buildings were significantly smaller and older, perhaps reflecting the shift in manufacturing in Vietnam towards telecommunications and computer equipment (DFAT, 2021). To me, there were no observable differences between the communes of Đông Lỗ and Đoan Bái; one commune seamlessly blended into the other. However, as I discuss further below, there were marked differences in the size and infrastructure of the CHCs.

The 2019 census also reveals that, while the majority of the population in Bắc Giang are of Kinh ethnicity (the major ethnic group in Vietnam), around 14% of the population are ethnic minorities, specifically from the Nùng, Tày, and Hoa ethnic minority groups (General Statistics Office, 2020). As a communist nation, Vietnam is often misleadingly

referred to as an “atheist nation”, and the 2019 census shows that the majority of the population claim to have “no religion”. However, as Chung (2023) highlights, major shifts in policies towards religion, as a result of Doi Moi, has led to the emergence of a new religious landscape in contemporary Vietnam. This has seen the revitalisation of major religions, particularly Buddhism. Travelling through Bắc Giang, I noted several Buddhist pagodas and statues sometimes revealing, as Chung (2023) described, the “contradictory tendencies” happening to Buddhism, specifically in the north of Vietnam. For instance, it was not uncommon to see the figure of Hồ Chí Minh alongside other subjects of worship within family alters.

4.6.2 The health system in Bắc Giang

Bắc Giang Provincial Hospital is the highest-level public hospital in the province. As with other provincial hospitals in Vietnam, Bắc Giang Provincial Hospital is intended to respond to complex health needs, with multiple in-patient and out-patient departments. In terms of maternal health care, the provincial hospital is the referral point for women with complicated pregnancies, such as those who are older and/or have existing health conditions. Along with district-level facilities, the provincial hospital also preforms caesarean sections and manages complex deliveries. While commune- or district-level facilities can directly refer patients to the provincial hospital, one is also able to independently seek care at such a facility. Consequently, as other studies also highlight, Bắc Giang Provincial Hospital was often described by the women we interviewed as being overcrowded, noisy, and lacking in privacy (Hoa et al., 2019). Moreover, for those who lived in the outskirts of Bắc Giang, the provincial hospital was located far away from their homes. Women in our study described how, as a result, their only option was to seek care at Hiệp Hòa District Hospital or, in one case, the district hospital of Bắc Ninh province (the neighbouring province to Bắc Giang).

Hiệp Hòa District Hospital and Health Centre similarly attends to peoples’ complex health needs, but at the district-level. While health system reforms in 2005 sought to separate the district hospitals from health centres throughout Vietnam, in Hiệp Hòa, this separation had not occurred, and both facilities were located in the same ‘complex’. As women described during the interviews (and the maternal and child health officers confirmed), Hiệp Hòa District Hospital had recently undergone a substantial renovation, including constructing a nine-floor building with a separate maternity department. Part of

this re-development also involved the construction of "on-demand" service rooms – fee-paying private rooms which contained certain "extra" amenities, such as air conditioning, a TV, fridge, and water heater. Despite these developments, the district hospital still only has access to a black and white ultrasound machine. In order for services at the hospital to be covered by health insurance, patients are required to present their insurance cards upon arrival. As the fieldwork progressed, it became clear that the rate of reimbursement from health insurance can vary. For example, reimbursement does not take into account fee-paying amenities (such as on-demand rooms), but patients identified as "poor" (via the Health Care Fund for the Poor scheme) can receive up to 100% reimbursement of their care. Visiting the district hospital is particularly vital for childbearing women who are factory workers and beneficiaries of the "50-leave" regime; a scheme enabling women to receive 50% of their salary for three months prior to birth, and up to six months following the birth. To benefit from this scheme, women are required to visit the district hospital to confirm their pregnancy and obtain the official documentation for their employer. However, in order to do so, they are required to have a valid social health insurance card, specifically registered at Hiệp Hòa District Hospital.

Directly across from Hiệp Hòa District Hospital and Health Centre, is Hùng Cường Hospital, a private, district-level facility. Though Hùng Cường is labelled as a private hospital, the interviews suggested that, aside from offering fee-paying antenatal check-ups and services (such as 4D and 5D colour ultrasound), the facility also accepts health insurance (for example, for black and white ultrasounds). When I visited Hùng Cường (as part of the RESPONSE consortium meeting, see below), I noticed that it was not as large as Hiệp Hòa District Hospital, however, the manager showed us construction that was underway to expand the hospital and include more beds for in-patients. Hùng Cường was also located directly opposite Hiệp Hòa District Hospital which, to me, highlighted that factors other than distance clearly also played a role in shaping women's preferences for seek care from this private hospital. Aside from Hùng Cường Hospital, several smaller private clinics, some operating out of homes, are spread throughout the district.

At Hiệp Hòa District Hospital with the managers of Đông Lỗ, Đoan Bái, and Hương Lâm CHCs

CHCs provide acute and chronic care and treatment to the residents of each commune within Hiệp Hòa. The CHC of Đông Lỗ is a double-storey building with a small, uncovered waiting area. When I visited at the beginning of September 2022, I found that the building was noticeably old and weather-beaten; parts of the building were crumbling and there seemed to be only one toilet, for both male and female patients' use. Within the building there were designated rooms for patient consultations, vaccinations, as well as for pregnancy check-ups and deliveries. The CHC manager explained that nine years ago, approximately 40 women would give birth at the CHC in one month. Currently, it is less than 10. Due to poor demand, the CHC staff now use the delivery room for antenatal check-ups. Another room, I was told, was for performing patient ultrasounds but I noted the absence of an ultrasound machine. There was also a small pharmacy for patients to purchase medications, only some of which can be covered by health insurance. While at Đông Lỗ's CHC (I was there for several hours), I noticed that only one patient visited the centre. Similarly, at the CHC of Đoan Bái, there was a notable absence of patients. However, upon entering, it was clear that Đoan Bái's CHC was significantly larger and more developed; the waiting area was extensive and there was even a children's playground. Indeed, the CHC manager informed us that it was a "level 2" CHC – the only "level 2" CHC in Hiệp Hòa. The centre contained several rooms for consultations and vaccinations, a delivery room, as well as isolation rooms for COVID-19 patients. Moreover, we were told that it is the only CHC in the district to have a colour ultrasound

machine (even the district hospital only offered black and white ultrasounds) and, as result, around 40 pregnant women a month visit the centre solely for ultrasounds. The upper-level of the centre contained an office with several computers (as opposed to a single computer at Đông Lỗ's CHC) and employed a total 10 health staff.

Đông Lỗ CHC waiting area and admission

Delivery room in Đông Lỗ CHC

Đoan Bái CHC waiting area

Delivery room in Đoan Bái CHC

Colour ultrasound machine in Đoan Bái CHC

4.6.3 Approaching the field of inquiry

My "immersion" in the field did not only begin with the fieldwork in Bắc Giang, which I detail in the following Section. Here, I will detail all the activities, experiences, and interactions that contributed towards and informed my understanding of the field of inquiry – the social, economic, and health system context of Vietnam and Bắc Giang province. As I detailed earlier, I began as a research assistant (RA) on RESPONSE since the start of the project in April 2020. As an RA, I was involved in all aspects of the project, but particularly with supporting the Vietnam country team which, at the outset, was decided to be a "paired partner" with team members from the University of Melbourne. Working closely with the Vietnam team also allowed me to pose well-defined research questions that would achieve Objective One of RESPONSE in Vietnam (see Sections 4.4).

My involvement in RESPONSE began by supporting project partners at LSHTM with a realist synthesis of the literature on responsiveness, which would complement the policy reviews conducted by the Ghana and Vietnam teams. This would occur in Phase One of REPONSE, which also involved conducting a community survey, as well as interviews and focus groups to identify peoples' expectations of responsive health systems (as was

the aim of this study) (Mirzoev et al., 2021). Insights gained through these activities would inform theory development and, ultimately, the development of the context-sensitive interventions. I supported the team at LSHTM to synthesis the findings of the literature search and identify gaps for additional database searches. Such an exercise contributed towards my understanding of the current theoretical and empirical literature on health systems responsiveness, particularly the prevailing gaps and shortcomings of current conceptualisations of responsiveness (as I highlight earlier in Chapter 1).

Concurrently, and informed by the realist synthesis, the teams in Ghana and Vietnam began work on the first iteration of the program theories that would guide intervention development. I worked with partners at LSHTM to compare the program theories developed for the two contexts. I then supported the organisation of an online workshop, during which all project partners, including myself, worked on mapping and refining the program theories, in light of evidence generated from the realist synthesis and policy analyses. To inform further iterations of the program theories developing in Ghana and Vietnam, I supported another literature search conducted within the Mental Health Innovation Network database. The aim of this search was to identify interventions conducted in other LMICs targeted towards those with mental- and/or maternal mental health-related needs. I then worked together with the team at LSHTM and the University of Leeds to draw together insights from all the literature and policy reviews conducted thus far to inform the development of a stakeholder consultation topic guide. Stakeholder consultations were conducted as part of Phase Two of RESPONSE which involved the co-production of the interventions in Ghana and Vietnam (Mirzoev et al., 2021). However, it is worth nothing that progression through the phases of theory development, intervention co-production and implementation, and evaluation occurred at different time periods in Ghana and Vietnam.

In Vietnam, intervention co-production processes began at the beginning of 2022. As part of the package of interventions that were to be implemented was the Vietnamese version of the 20-item Self-Reporting Questionnaire (SRQ-20). The tool would be implemented within the primary care-level in Bắc Giang province (within CHCs and DHCs) to detect common mental disorders (CMDs) among pregnant women. I supported Vietnam project members with the development of a validation study that sought to evaluate the SRQ-20 tool's reliability, factorial structure, and performance in detecting common mental disorder (CMD) symptoms. I drew on key literature identified from the initial literature

reviews, conducted as part of Phase One, to develop the background and discussion sections of the paper. The paper was published in the International Journal of Women's Health in April 2022. During this time, the Vietnam country team also worked on analysing the data from the in-depth interviews and focus groups conducted within Phase One. I supported partners at LSHTM and University of Leeds with a search of the theoretical literature on the concepts of stigma and health service integration, that would inform the Vietnam team's analysis. The analysis culminated in the development of two papers, one offering perspectives on the integration of maternal mental health at the primary care-level in Vietnam, and the other examining how mental health-related stigma influences the care-seeking behaviour of pregnant women. The former is currently under review in the journal Health Policy and Planning, and I worked with Vietnam team members to write the background and discussion sections of the piece, drawing on literature identified from the initial literature reviews. I also supported the overall editing process of the paper and served as the corresponding author for the submission process. The second paper is currently in the final stages of development. Working with the Vietnam team on these papers allowed me to familiarise myself with the existing Vietnamese literature on maternal health, as well as the broader policies in place directly targeting maternal health care, as well as those that indirectly related to health systems responsiveness. These insights informed the CIS, as well as the overviews I present in Sections 2.3, 2.3.2, and 2.3.3 of Vietnam's health system, health policies, and maternity care service provision.

In March 2023, I attended the first RESPONSE project workshop held in Hanoi, Vietnam. The aim of this workshop was to refine the program theories developed in the two contexts, plan intervention evaluation (particularly of the interventions already implemented in Vietnam), and progress academic and non-academic outputs. During this workshop, I supported Vietnam team members with the development of academic outputs (especially those mentioned above) and with the refinement of the program theories. I also worked with Ghana team members to analyse the findings on mental health-related stigma arising from the Phase One fieldwork. These discussions informed my planning of a paper that would compare how maternal mental health-related stigma operates within the two contexts of Ghana and Vietnam. This comparative paper is currently in the initial stages of development. The field trip to Bắc Giang province provided me with another opportunity to immerse myself within the field of inquiry. While I had previously visited

the CHC of Đông Lỗ, I had not had the opportunity of visiting inside Hiệp Hòa district centre and hospital, nor the private hospital of Hùng Cường. During this field trip, we were given a tour of these hospitals by the managers, and I was able to compare the infrastructure of each facility, while also comparing my own observations with women's accounts – I reflect on these observations above. I attended the second project workshop in Accra, Ghana, in December 2023 and supported both Ghana and Vietnam team members with advancing academic outputs. The field trip to Ningo PramPram district allowed me to compare primary-level maternity care provision in Ghana and Vietnam, particularly with respect to accessibility and availability. It became clear to me the extent to which the expansion of the private health sector in Vietnam has significantly improved the availability of maternity care services, even for women in rural regions. While, on the other hand in Ghana, women in rural areas were dependent upon poorly equipped community-level maternity care clinics. Ultimately, working as an RA on RESPONSE enabled me to deepen my understanding of the context of Vietnam – how Vietnam's health system, as well as its broader social and economic context, differs to that of other LMICs (particularly Ghana).

My understanding of the field of inquiry was also shaped by my interactions and informal discussions/conversations with notable Vietnamese sociologists, anthropologists, and health system scholars. I met with Dr Liem Nguyen on several occasion during my time in Hanoi and we spoke about health care provision in Vietnam and the changes that have occurred in recent decades. I also had the opportunity to meet with Dr Vu Manh Loi, a senior researcher within the Vietnam Academy of Social Sciences and director of the Institute of Sociology. As I highlight earlier in the CIS and within Section 2.4, much of the current literature, foregrounded in Confucianism, overwhelmingly stresses the limited autonomy and agency of Vietnamese women. During our discussion on gender dynamics in contemporary Vietnam, Dr Loi stressed that, the history of patriarchy notwithstanding, "the Vietnamese woman is not completely powerless", and that Vietnamese women still wield significant power within the family system. Dr Loi also reminded me that Confucian traditions and practices may not always be influential in shaping women's decision-making power. I also worked closely with Prof. Huong Thu Nguyen from Vietnam National University of Social Science and Humanities; her insights on Vietnam's ethnic minority groups were key to developing the synthesising arguments within the CIS. My informal discussions with these scholars allowed me to critically

interrogate the current literature on women's care encounters and to explicitly take into account the social, gender, and health system shifts and changes occurring in contemporary Vietnam.

4.6.4 Fieldwork

Fieldwork for the study occurred over an 11-week period from the 1st of September till the 15th of November 2022. After arriving in Hanoi, I spent the following two weeks working with Dinh Thu Ha (a bilingual public health researcher at HUPH) to engage with key stakeholders at the provincial health system-level in Bắc Giang, as well as at the district level in Hiệp Hòa. These stakeholders included the Head of the Department of Human Resource Management at Bắc Giang Provincial Department of Health, the Vice Head of Hiệp Hòa District Health Centre, as well as the managers of the three CHCs we had planned to recruit participants from (Đông Lỗ, Đoan Bái, and Hương Lâm). During these meetings, we discussed the tentative plan for the fieldwork and sought advice and guidance on recruitment and data collection. We also discussed the inclusion criteria for recruitment, specifically indicating that we aimed to recruit women who were currently pregnant and those who had given birth within 12 months. Moreover, we made it clear that we wanted to speak to a diversity of women, in terms of age, ethnicity, number of children, occupation, who they lived with, as well as potentially those who were single mothers or had a disability. This diversity was important for capturing how women's social locations differentially shaped their expectations and experiences of maternity care. These stakeholder meetings were conducted entirely in Vietnamese, and Dinh Thu Ha constantly translated the conversations to English for my understanding.

Dinh Thu Ha and I made a total of nine field trips to the province of Bắc Giang – four to the commune of Đông Lỗ and five to Đoan Bái. Majority were "full-day" field trips – beginning with the first interview at 8am in the morning and completing the last at around 4pm. During full-day field trips, we were able to complete a total of four in-depth interviews. However, for three out of the nine field trips, it was only possible to visit Bắc Giang in the morning and, in these cases, only two in-depth interviews were conducted. The drive from Hanoi to Bắc Giang took approximately one and a half hours, but we used this time to prepare for the upcoming interviews in the morning, and to de-brief on the way back to Hanoi in the evening. At midday, we often had lunch with staff from the CHCs (and sometimes their families) who assisted with recruitment and data collection.

This informal setting allowed me to build relationships with these key stakeholders, as well as to observe and ask about the various practices and beliefs of Vietnamese culture I wanted to know more about. More importantly, these moments gave me an opportunity to ask them questions about the study participants that I had prior to, or after, conducting the in-depth interviews. I found that the CHC staff had particularly close relationships with many of the women and their families, developed through their prior interactions particularly during past pregnancies. In this way, the CHC staff were an important source of knowledge not only for understanding the nature of maternity care provision in Bắc Giang, but also to build a picture of women's lived experiences.

Dinh Thu Ha explaining details of the study with a participant before conducting an interview at Đông Lỗ CHC

Talking with a participant and her family after an interview

4.6.5 Recruitment

Working with the maternal and child health officers in each CHC, I purposively recruited insight-rich participants with a diversity of lived experiences. Women who were currently pregnant and those who had recently given birth up to one year were deemed eligible for participation in this study. The period of one-year postpartum was selected to limit recall errors and reconstruction of the childbirth experience which can occur over time. Several studies have sought to examine women's perceptions and recall of the childbirth experience and have shown that, while women can remember their experiences clearly at five years postpartum, they tend to construct a more positive perception of the experience over time (Conde et al., 2008, Takehara et al., 2014). While we proceeded to recruit participants with this consideration in mind, an anonymous peer reviewer for one of the papers helpfully pointed out that 'false' memories can be just as revealing of peoples' expectations. As such, in the peer-reviewed publications presented in Sections 5.2 and 5.3, as well as within the broader 'limitations' section in this thesis, I do not note 'recall errors' as study limitations. As discussed above, the inclusion criteria were outlined during the initial stakeholder meetings with CHC and district-level staff. Following these initial conversations, the maternal and child health officers obtained a list of all pregnant women in their respective communes and suggested a number of participants who met the inclusion criteria. From this list, Dinh Thu Ha and I worked to purposively selected participants for initial contact, beginning recruitment in Đông Lỗ. The maternal and child health officer then facilitated initial communication with these potential participants via phone, outlining the details of the study and requirements for participation. If the woman agreed to participate, the maternal and child health officer organised a time and location for the interview, according to the woman's preference and convenience. All potential participants freely consented to participate when contacted by the maternal and child health officer and also agreed to proceed with the interview when I met them in person and provided further details of the study. Only one participant was not able to be contacted during the fieldwork and, in this case, the maternal and child health officer arranged an interview with another participant who expressed interest in the study.

After completing the 23rd interview and conducting an initial analysis of the data, I noticed that women's experiences of childbirth and delivery care were particularly lacking; the majority of participants recruited up until that point had been women who were currently pregnant. To fill this analytical gap, I decided to begin a further round of recruitment,

specifically for women who had recently given birth. As a result, a total of 28 participants were recruited for the study – 14 from the commune of Đông Lỗ and 14 from Đoan Bái. As analytical saturation had been reached following the 28th interview in Đoan Bái, no participants were recruited from the third commune of Hương Lâm. The point at which analytical saturation was reached was assessed and decided during the regular de-briefing sessions between my collaborator Dinh Thu Ha, my supervisor Professor Sumit Kane, and myself. I however acknowledge that analytical saturation is a contested concept – there is a degree of ambivalence in its conceptualisation and use across qualitative research (Saunders et al., 2017). Saunders et al. (2017) argue that some of the uncertainty around the concept can be resolved if researchers consider saturation as a "matter of degree" rather than something that is "attained". While, in this study, I did decide on the point at which analytical saturation had been reached, the "degree" of saturation was actively discussed as data collection proceeded. This, as I indicate above, led to a further round of interviewing to gain a deeper understanding of women's experiences of childbirth and delivery care. Given the ambiguity surrounding saturation, scholars have put forth alternative approaches for guiding participant recruitment. For instance, Malterud et al. (2016) recommends the use of "information power" – the notion that the more information a sample holds, relevant to the study, the fewer participants needed.

4.6.6 Study participants

Participant characteristics	N	%
Age, years		
<20	2	7.1
20-24	4	14.2
25-29	9	32.1
30-34	8	28.6
35-40	3	10.7
>40	2	7.1
Pregnancy status		
Currently pregnant	16	57.1
Postnatal	12	42.9
Marital status		
Married	27	96.4
Divorced	1	3.6
Ethnicity		
Tay	1	3.6
Thai	1	3.6
H'mong	1	3.6
Kinh	25	89.3
Years of school		
1-6	2	7.1
7-12	17	60.7
Post high school	9	32.1
Occupation		
Factory worker	12	42.9
Teacher (kindergarten)	3	10.7
Business owner/worker	7	25.0
Unemployed (housewife)	2	7.1
Office worker	2	7.1
Farmer	1	3.6
Cleaner	1	3.6
Number of children		
0	4	14.2
1	3	10.7
2	9	32.1
3	8	28.6
4	3	10.7
5	1	3.6
Total		**100**

Table 2: Participant characteristics

As mentioned above and as table 2 highlights, I recruited a diversity of participants in terms of age, ethnicity, education level, number of pregnancies, as well as other unique lived experiences, such as single motherhood. We recruited a total of 28 participants, 16 of whom were currently pregnant, ranging from as few as 17 weeks pregnant to a total of 39 weeks. Additionally, a total of 12 women had recently given birth – from two weeks to 12 months postpartum. While most women recruited were aged between 25 and 34 years old (60.7%), two first-time mothers were 18 years of age, and a further two participants were older than 40. Most women had between two to three children (32.1% and 28.6%, respectively). Four women were pregnant with their first child (14.2%) and one woman had a total of five children, having given birth to two sets of twins. This

woman recognised that she was in a particularly unique situation compared to other women and having had five children, she now felt "close to her ancestors". According to the General Statistics Office, a little over half (59.5%) of women in Bắc Giang who were pregnant gave birth to their second child in 2019. These statistics were further stratified by education level which revealed that most of these women (41%) had a lower-secondary education (General Statistics Office, 2020). There is consensus with what we observe nationally, with 52.5% of women also giving birth to their second child in 2019.

As discussed previously, Vietnam has a notably high literacy rate, even in rural regions. Looking at the national profile, 22.6% of women have completed primary school, while 31.3% have a lower-secondary education. What we observe specifically in Bắc Giang somewhat reflects the national picture – the General Statistics Office suggests that 41.1% of women in Bắc Giang have a lower-secondary education (General Statistics Office, 2020). This corresponded to the fact that all women in this study, except two, had at least a secondary-level education. A further nine women interviewed (32.1%) had a post-high school education, two of these had completed a university degree. One notable exception was a 51-year-old pregnant woman (she had shared that she had conceived late, and through in-vitro fertilisation) who worked as a farmer. She was mindful of her low education level and, during the interviews, constantly compared her situation to that of her "more knowledgeable" daughters. Unsurprisingly, given the industrialisation of Bắc Giang and the general trend in Vietnam towards the export of manufactured goods, most women interviewed (42.9%) were factory workers, mainly employed by Samsung (Vo, 2021). That being said, other participants had a range of occupations, working in both public and private sectors as kindergarten teachers, farmers, small business owners, sales assistants, and office workers. Only two women were unemployed, indicating that they were "housewives". Majority of participants were married with only one participant indicating that she was officially divorced – she was a single mother of three children, having recently given birth to twins. During the interviews, she explained that her older child currently lived with her ex-husband and she found it difficult to be separated from him. Majority of recruited participants were of Kinh ethnicity, the dominant ethnic group in Vietnam, however, three participants were from minority ethnic groups (Tay, Thai, and H'mong) (General Statistics Office, 2020).

4.6.7 Data collection

Data were collected through both semi-structured, individual interviews and participant observations. The interviews were conducted by Dinh Thu Ha in Vietnamese, who translated the questions and women's subsequent responses back to me in English. Most interviews were conducted in women's homes, according to their preference, and at a time that was convenient for them. However, one interview was conducted in Đông Lỗ's CHC and, for two women who were small business owners/workers, the interviews were conducted in their shops situated at the front of their homes. Visiting women's homes was a valuable opportunity for me to get a sense of their living conditions and their interactions with family members who were present. With permission, I was able to take photos of them, their families, and their homes to capture and document these conditions. At home, women appeared to be more relaxed, and we were able to take our time to build rapport before beginning the interviews. The maternal and child health officer, who facilitated recruitment, introduced us to the participants (and other family members who were present) and we were often invited to tea while we conversed.

Outside a participant's home

A participant's single-room home

The details of the study were verbally explained to participants, and they were given the opportunity to ask any questions. In some instances, women's family members, who were present at the time, asked questions about the research. I noted that these questions were usually raised by older family members – women's mothers, fathers, or in-laws. They also directed certain questions towards me, and I found that sharing aspects of my life allowed me to build a rapport with the participants and their family. Women were asked to voluntarily sign a consent form for participation in the study, prior to commencing the interview. They were also asked for their permission for the interview to be audio recorded – all participants consented and therefore all interviews were audio recorded using a digital recorder. The date, time, and location of the interviews, as well as participants' consent to proceed with the interview, was also audio recorded prior to the interview. Extended family members, particularly the woman's mother or mother-in-law, often looked after their child/children while we conducted the interviews in a private room. Some women had recently given birth, and, in these instances, they watched over their baby while we spoke. In some cases, it was necessary to pause the interview to allow for women to settle or breastfeed their baby. Other times, it was not possible to conduct the interviews in a private room and, as a result, women's family members were nearby.

An interview guide directed each interview, which was developed in consultation with project partners at HUPH and was continually refined as data collection progressed and in response to the daily de-briefing sessions (the third and final version is included in Appendix C). As the interview guide outlines, women who were currently pregnant were

asked to reflect on their encounters with ANC services – where they seek ANC, what influenced this decision, and to describe and reflect upon their experiences with and, a priori expectations of, ANC. They were then asked to describe what they expected from the care they would receive during birth. Women who had recently given birth were also asked to reflect on their experiences of delivery care. If not discussed, we prompted women to discuss their expectations and experiences of care in relation to the elements of health systems responsiveness (see Chapter 1). In particular, we prompted women to explain and justify why they had certain expectations and why these expectations were particularly important to them. These prompts were crucial for understanding what women legitimately expected from the health system during their pregnancy and childbirth, as well as what shaped this legitimation.

Interviews are often perceived as the "gold standard" of data collection in qualitative research (Sandelowski, 2002). They provide researchers with "rich" qualitative data to understand participants' experiences, how they articulate and describe those experiences, as well as the "meaning-making" associated with those experiences (Castillo-Montoya, 2016). However, Sandelowski (2002) argues that qualitative researchers can hold a "naïve" view of interviewing as a "deceptively" simple method of data collection. Such a view can mean that researchers are at risk of overlooking the "constructed nature" of an interview. That is, that participants can strategically use the interview to present and justify themselves and their actions. Sandelowski (2002) suggests that this requires one to consider the multiple and shifting identities of participants that can account for the contradictions and inconsistencies in their accounts of their experiences (Sandelowski, 2002). With this in mind, we encouraged women to reflect on certain contradictory expectations, the subsequent trade-offs they made when seeking care, and the reasons for the various decisions and choices made, prior to and during the care encounter. In doing so, women's explanations shed light on how various intersecting and competing social, economic, cultural, and gender structures shaped their expectations, choices, and decisions, as well as their eventual interactions with and experiences of their care encounters. Moreover, and as I highlight below, these prompts encouraged women to "think aloud" and engage in "self-talk" through which women's internal conversations could be elicited.

Sandelowski (2002) also proposes that, to achieve robust, "full-bodied" qualitative research, researchers are required to make full use of their "bodies and senses". This is

particularly the case when conducting participant observations – taking into account sounds, sights, emotional tensions, and the "feel of culture". While Dinh Thu Ha conducted the interviews, I recorded my observations and reflections in a field notebook. I paid close attention to women's attitudes and non-verbal cues – when they smiled or laughed, or if they seemed anxious or frustrated. I also reflected on their relationships and interactions with other family members who were present. For instance, I noted that women who were particularly young were closely followed and accompanied by their mothers-in-law. These women appeared hesitant to speak on their own and remained mostly silent while their mother-in-law spoke and asked questions about the study. Yet, in private during the interview, their attitude changed – they appeared uninhibited and were particularly keen to share their thoughts and experiences. I also described women's homes, as well as the notable sights and experiences I encountered while travelling through Bắc Giang. This included making note of the various health facilities I visited, comparing my reflections with women's accounts.

At the end of each day of fieldwork, Dinh Thu Ha and I debriefed on each interview – we discussed notable findings, observations relating to women's living situations and interaction with other family members, as well as any required refinement to the interview guide and questions asked. These sessions were audio recorded so that they could be listened to at a later date to inform data analysis. On a weekly basis, debriefing sessions were also held between Dinh Thu Ha, Prof Sumit Kane, and myself, to discuss emerging insights, as well as to assess and decide when analytical saturation was reached. A total of 28 in-depth interviews were conducted – 16 with women who were currently pregnant and 12 with those who had recently given birth.

4.6.8 Analysis

As Tavory and Timmermans (2014) propose, an abductive analytical approach offers a way to "nurture theory construction" without "locking it into predefined conceptual boxes". In this way, it tackles key shortcomings of inductive and deductive approaches to analysis. Central to an inductive analytical approach is Grounded Theory which, as Glaser and Strauss propose, seeks to build theory "from the ground up". That is, without referring to or engaging with existing theory during the process of analysis (Tavory and Timmermans, 2014). Yet, Glasser and Strauss noted that, in order to generate novel theoretical insights, the researcher must possess a level of "theoretical sensitivity" – a

broad familiarity with existing theories. This contradiction is a central critique of employing an inductive approach to qualitative analysis (Tavory and Timmermans, 2014). On the other hand, in theory-driven research, deductive analysis requires researchers to compare data with an overarching theoretical framework (Meyer & Lunnay, 2013). This can however mean that data which falls outside of the a priori theoretical framework is often ignored or remains unanalysed. As Meyer and Lunnay (2013) argue, abductive inference allows researchers to overcome this critique by analysing data which falls outside the theoretical frame, leading to the formation of nuanced theoretical insights. Moreover, as Tavory and Timmermans (2014) point out, the "ready-made" categorisation emerging from deductive inference can also "obliterate" the multifaceted personal and professional lives of the researcher. This includes the sophisticated theoretical background that a researcher brings to an inquiry. As such, if the goal of analysis is indeed to encourage novel theorisations, Tavory and Timmermans (2014) emphasise that it is crucial to take into account the theoretical lenses researchers have cultivate and been sensitised to. Thus, an abductive analytical approach emphasises the use of "theories" – a deep knowledge and familiarity with a broad range of theories is deemed essential for generating innovative theoretical contributions. As I detail in Section 6.7.1, drawing on a rich complexity of theoretical constructs is also key for conducting rigorous qualitative research. In view of these considerations, I adopted an abductive approach to the analysis of data generated from the in-depth interviews. This was with a view to not only frame the data within exiting theoretical frameworks (as is the case in deductive inference), but to also extend these theories in novel ways (Tavory and Timmermans, 2014).

In order to begin analysis, the interview recordings first had to be transcribed into Vietnamese and then translated into English by professional translators. The transcripts were constantly checked by Dinh Thu Ha for accuracy and minor amendments were made. Finalised transcripts were imported into QSR NVivo for analysis. Data analysis occurred concurrently with data collection – I began with an initial reading of each interview transcript as I received them. This allowed me to develop a preliminary understanding of the data and to also modify data collection accordingly. For instance, as I discuss above, it became clear during data collection that there was insufficient data relating to women's experiences of childbirth and delivery care and this resulted in a further round of recruitment of women who had recently given birth. During this initial

process of familiarising myself with the data, I also took notes on emerging patterns and referred to observations within my field notebook to contextualise each interview. The transcripts were then read again but, this time, I began coding each transcript using QSR NVivo (Tavory and Timmermans, 2014).

As per abductive inference, the codes were formulated based on both the data, as well as relevant theoretical frameworks and constructs (I outline these in detail in Section 4.5). This included existing conceptualisations of health systems responsiveness, such as those proposed by de Silva (2000) and by Mirzoev and Kane (2017). For example, within the broader code of 'antenatal care', sub-codes included, 'amenities' and 'timeliness' – established components of responsiveness (de Silva, 2000). However, 'provider competency' and 'high-quality ultrasounds' were sub-codes which emerged from the data and are not designated elements of health systems responsiveness. The intersectional, translocational, and relational analytical framework (Section 3.2) framed and guided the overall analysis of women's expectations of the health system during their pregnancy and childbirth (study objective 1, findings detailed in Section 5.3). This included constructing a broader code on women's social locations, with sub-codes on various social structures such as gender, age, culture, and socioeconomic status, as well as on temporality and spatiality. Under these sub-codes, were women's accounts which highlighted how these social structures impinged upon and coloured their expectations of care. I was also theoretically sensitised by existing conceptualisations of the concepts of expectations and legitimacy, which I unpack in Chapter 3. As I also describe in Section 4.5, the examination of women's engagements (decisions, choices, preferences), interactions, and experiences with the health system (study objective 2, findings detailed in Section 5.2) was informed by the work by Chalari (2009), Archer (2003), Fleetwood (2008), and Fuller (2013). This enabled me elicit women's internal conversation by identifying and analysing the instances when women "thought aloud" or engaged in "self-talk" during which they made sense of their care experiences and sought to justify their various choices and decisions. Eliciting women's internal conversations allowed for an examination of not only women's *actual* experiences of their interactions with the health system, but also the causal influences or mechanisms – their concerns, needs, expectations, choices, and decisions. Once codes and sub-codes were identified, they were mapped to identify overarching themes and connected sub-themes. Patterns which emerged were used as triggers to explore other relevant theoretical literature, particularly in relation to the

broader social, economic, and health system context of post-Doi Moi Vietnam. This included drawing on the work of Võ and Löfgren (2019), Witter (1996), and Ekman et al., (2008), as well as Werner (2002).

4.6.9 Ethical considerations

In this sub-section, I will detail the procedural, situational, and relational ethical considerations of this inquiry (Tracy, 2010). In terms of procedural ethics, ethics approval for RESPONSE 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 the governing review ethical review boards of the University of Leeds and the London School of Hygiene and Tropical Medicine (ref 22981) (see Appendix A). As I detail in Section 4.3, I was invited by the HUPH team to work on data collection and to conduct fieldwork for a period of three months to achieve Objective One of RESPONSE in Vietnam (see Appendix B). The fieldwork received overall approval by the rector of HUPH and the study plan was developed with HUPH RESPONSE researchers. Prior to commencing the data collection, Dinh Thu Ha and I met with and obtained approval for the fieldwork from the Head of the Department of Human Resource Management at Bắc Giang Provincial Department of Health, the Vice Head of Hiệp Hòa District Health Centre, as well as the managers of the three CHCs in Đông Lỗ, Đoan Bái, and Hương Lâm. Separately, we met and worked with the maternal and child health officers working in the CHCs of Đông Lỗ and Đoan Bái to obtain their support with participant recruitment and data collection.

At the initial meeting with women who expressed interest in the study, Dinh Thu Ha explained the study's details and what their participation would involve. Participants were also assured of the strict confidentiality of their personal details and that these would not be reported. It was also made clear to participants that participation in the study was entirely voluntary – that they were free to not answer questions they were not comfortable to or to withdraw entirely from the study at any moment. In outlining participants' involvement in the study, Dinh Thu Ha explained that they would be invited to participate in a 30-60 minute interview which would be audio recorded using a digital recorder, with their consent. She also briefly explained the types of questions that would be asked and that I would also be present during interview and would be taking notes. These considerations were detailed within a plain language statement, which was shared with

participants to read, and they were given the opportunity to ask any questions. This also included allowing other family members, who were present during this time, to raise any questions they had about the study. If participants agreed to proceed with participating in the study, they were asked to sign a consent form (see Appendix C). As I have outlined previously in Section 4.3.6, Vietnam has a notably high literacy rate, and this trend was reflected in Bắc Giang. All study participants were literate and could provide written informed consent for participation. The written consent forms were kept in a safe place during the fieldwork and were stored under lock and key at HUPH.

Interviews were conducted at a time and location that was convenient for the study participants. As outlined in Section 4.3.7, most interviews were conducted in women's homes, expect for one that took place in a private consultation room in Đông Lỗ's CHC. As I discuss further below, most of these interviews were conducted in a private setting, however, in some cases, this was not feasible. Prior to commencing the interview, consent to audio record was sought – all participants consented to the interview being audio recorded. The date, time, and location of the interviews, as well as participants' consent, was audio recorded before beginning the interview. The digital audio recordings of each interview were uploaded onto a password-protected personal computer at the end of each day of fieldwork. The digital files of the audio recordings were shared securely through Google Drive with access restricted to Dinh Thu Ha, Professor Sumit Kane, and myself. The interview transcripts (which had been transcribed and translated) were also shared securely through Google Drive and saved on a personal computer and on the University of Melbourne's One Drive, both of which were password protected. The field notebook in which I recorded my reflections and participant observations was stored securely with me under lock and key. No identifying material, such as participants' names, phone numbers, places of work, or addresses, were recorded. All interview transcripts were de-identified – Dinh Thu Ha and I reviewed each interview transcript for any identifying material, and these were removed. No identifying material is reported in this thesis, or any publications associated with this study. These procedural ethical considerations are in line with the ethical approvals obtained for the RESPONSE project from the ethical review boards in Vietnam, LSHTM, and University of Leeds.

With regards to situational ethical issues – the ethical practices that emerge due to the study's context – it was not always possible or feasible to conduct the interviews in an entirely private setting. Family members, particularly the woman's mother or mother-in-

law, often looked after their child/children while we conducted the interviews in a private room. However, in some cases, it was not possible to conduct the interviews in a private room and, as a result, women's family members were often nearby. For instance, some women needed to watch over their children during the interview and, as such, the discussion had to take place in an open setting to enable them to do so. On two occasions, interviews were conducted with women who were small business owners/workers and, at their request, the interviews were held in their shops. That being said, no customers were present during these discussions. Another situational ethical consideration that we were particularly mindful while conducting the interviews was the possibility that women might experience some distress when recounting their experiences of pregnancy and/or childbirth. In two instances, women showed some visible signs of distress – one woman was recounting the death of her eldest son, and the other was reflecting on a miscarriage she experienced before her current pregnancy. Dinh Thu Ha paused the interview and asked if the participants felt able to proceed with the interview and if they would like any support from a family member. Both participants expressed that they were "okay" and were willing to continue with interview.

Relational ethical considerations involve recognising and valuing, "mutual respect, dignity, and connectedness between researcher and researched, and between researchers and the communities in which they live and work" (Tracy, 2010). We respected women's decision to participate or not in the study and allowed women to freely decide on a time and location of the interview which would work best for them. As a "cultural outsider" (see Section 6.5), I sought advice and guidance from Dinh Thu Ha as to the customs and practices that would convey respect to those I interacted with. Throughout the research, I was mindful of also maintaining a respectful working relationship with Dinh Thu Ha, respecting her decisions and contributions to the study.

Collaborative research between institutions can pose a range of ethical challenges, including the need to accommodate specific research practices, processes, and cultures that may vary between research institutions (NHMRC, 2020). In developing the proposal for the RESPONSE project, all key actors collaboratively identified important ethical issues that may arise during the project and the appropriate management strategies. These are outlined in the study protocol for the RESPONSE project (Mirzoev et al., 2021). The RESPONSE project is implemented according to robust research governance practice standards at LSHTM (and the University of Leeds), a key consideration of collaborative

research projects. This includes regular engagement between project partners and policymakers and practitioners, quality assurance through regular peer-reviewing, as well as equal opportunities for all researchers involved in the project. With this in mind, authorship and publication agreements were formulated, with the inputs of all project partners, and these were adhered to in the publications arising from this study.

Chapter 5: Findings

5.1 Chapter overview

In this Chapter, I present this study's findings along three broad lines. The first, sought to tackle the first research question and objectives 1 and 1.1 – to analyse childbearing women's engagements (decisions, choices, and preferences), experiences, and interactions with the Vietnamese health system. These findings are presented in the form of a manuscript which has been submitted to an international health journal and is currently under peer-review. The verbatim, final version of the manuscript that is under peer-review is included in Section 5.2. The findings outlined in this manuscript have also been presented in the form of an oral presentation at the 2024 Qualitative Health Research Network (QHRN) Conference. In Section 5.3, I present study findings which respond to the second research question and objectives 2 and 2.2 – to explore childbearing women's expectations of the Vietnamese health system and to examine what shapes these expectations. These findings are detailed within a peer-reviewed journal article, published in Health & Place. Below, I include the verbatim, final accepted version of this peer-reviewed journal article. Finally, in Section 5.4, I analyse the overarching findings on Vietnamese women's autonomy and agency during their pregnancy and childbirth.

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

Presented below, is the final version of a manuscript titled: "Childbearing women's experiences of and interactions with the health system in post-Doi Moi Vietnam". This manuscript is currently under review in an international health journal. As I outline in Section 4.5, the piece draws on theoretical insights from Archer (2003) and Chalari (2009) to uncover women's 'internal conversations' in which they reflect upon and make sense of their maternity care-related experiences. In doing so, it sheds light on the unseen, causal influences of women's care experiences – their needs, expectations, concerns, choices, and decisions – and how these are constrained or enabled by broader structural and cultural forces in post-Doi Moi Vietnam. The findings reveal the need for health system actors to consciously consider the society and health system-level evolutions and changes when researching or developing interventions for improving health systems responsiveness. Moreover, the findings also reveal that the Vietnamese women in this study were not merely passive agents in the act of seeking care as the current literature disproportionately seems to suggest, but were calculative, and wield significant agency – I reflect on the implication of this finding in Section 6.4 of this thesis. Hence, the findings presented in this manuscript aimed to engage with the study's first research question: what are childbearing women's engagements (decisions, choices, preferences), experiences, and interactions with the health system in Vietnam?

Abstract

How people experience their interactions with their health system is central to the notion of a responsive health system. Experiences may be 'personal', but 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, we use and illustrate the use of 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. Drawing on in-depth interviews with 28 pregnant and postpartum in a rural province of Vietnam, we demonstrate how this approach can shed light on the unseen, often causal influences of people's needs, expectations, concerns, choices, and decisions – which are, in turn, constrained or enabled by broader structural and cultural forces. Vietnam has undergone major social and economic shifts in the last two decades that have changed the organisation and structure of Vietnam's economy, society, and health system. Our findings reveal how the preferences, demands, and expectations of the Vietnamese have likely thus evolved and, with that, their experiences of their interactions with their 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.

Keywords: Health systems responsiveness, Healthcare experiences, Expectations, Maternal health, Vietnam

Introduction

How people experience their interactions with health systems are central to the notion of health systems responsiveness (Mirzoev & 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 (WHO, 2000). However, Gartner et al. (2022) have argued that 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. People's experiences of their interaction with health systems, as it relates to responsiveness, has typically been examined through the WHO health systems responsiveness questionnaire (Coulter & Jenkinson, 2005, Peltzer, 2009, Liabsuetrakul et al., 2012, Chao et al., 2017, Awoke et al., 2017, Ratcliffe et al., 2019, Kapologwe et al., 2020, Negash et al., 2022). While a number of studies shed light on the antecedents and determinants of peoples' care experiences, and their needs, concerns, and expectations, few locate and understand peoples' expectations and 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 & Jenkinson, 2005, Mirzoev & Kane, 2017).

In this paper, we present a novel analysis and account of how the wide-ranging social, economic, gender, and health systems transitions, that have occurred in Vietnam in the last two decades, shape pregnant women's experiences of their interactions with the health system. We unpack how these transitions and changes have shaped women's needs, concerns, expectations, choices, and decisions. 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.

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 transforming 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 2018, Ekman et al. 2008, 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 aspect of social life but, as our recent review has shown, can shape how childbearing women interact and engage with the Vietnamese health system (Anonymised, 2023). 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 2018, 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 2018). 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 2018). 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 (WHO, 2018). Our recent analysis of the literature (Anonymised, 2023) 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, Anonymised, 2023). 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 (Anonymised, 2023). 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 femininities 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. In this study, we tackle these gaps by engaging with the question: what are childbearing women's engagements (decisions, choices, preferences), experiences, and interactions with the health system in post-Doi Moi Vietnam?

Theoretical framing

Chalari (2009), drawing on the work of Archer (2003), proposes an analytical approach for understanding and making sense of 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 delineate, 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). In this way, individuals can process and analyse internal and external stimuli, and externalise an appropriate response (Chalari, 2009). 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. It is important to note, however, 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). Analytically, identifying and unpacking these modes of 'internal conversation' can provide a rich "theoretical canvas" through which one can reveal different 'types' of structured agency.

In this study, we use and illustrate the use of a novel approach that draws on the work of Chalari (2009) to uncover and analyse women's 'internal conversations', in which they make sense of their experiences of their interactions with the Vietnamese health system. We demonstrate how this approach can also shed light on the unseen, causal influences on their actions and experiences – their needs, legitimate expectations, concerns, choices, and decisions.

Study setting

This study was conducted as part of the broader --- project which aims to improve health systems responsiveness to the neglected health needs of vulnerable populations in Ghana and Vietnam (Anonymise 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 --- project as it has experienced rapid industrialisation in recent years (Anonymise 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 district, some which also provide certain insurance-covered services. Participant recruitment occurred within the district of Hiệp Hòa.

Recruitment of study participants and data collection

Recruitment and data collection were conducted from September to November 2022 by ---- and ---. 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 ad 12 had recently given birth.

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**

Table 1: Participant characteristics

Semi structured, in-depth interviews were conducted in Vietnamese by ---, who was supported by -- 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 had 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 ---, ---, and ---. 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 --- (Ethics approval decision number 33/2022/YTCC-HD3) and --- (ref 22981).

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 ---, 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), 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 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 *real* unseen, causal influences or mechanisms – their concerns, needs, expectations, choices, and decisions. To further shed light on broader social and institutional contexts which shaped these causal mechanisms, 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.

Results

'Internal conversations' seemed to serve many purposes for the women in our study. It was a means to test and moderate the 'legitimacy' of their own expectations and concerns, to unpack and make sense of 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 needs, expectations, and experiences within broader individual, relational, social, and institutional contexts which, in turn, enabled or constricted their decisions, choices, and actions. Below, we unpack childbearing women's 'internal conversations' relating to their interactions with the health system in Vietnam. We do so according to specific elements of care women discussed during the interviews, including but not limited to the elements of health systems responsiveness. Throughout, we use these

reflexive deliberations as a "theoretical canvas" to uncover the different 'types' of structured agency exhibited by Vietnamese women.

High-quality ultrasounds, short waiting time, and distance to facility

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 us 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 (WHO, 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 an important contextual feature in Vietnam (Vo & Lofgren, 2018). 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 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' (WHO, 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).

Privacy and dignified treatment

Within health systems responsiveness, privacy during medical examinations is an essential feature of 'dignity' and 'dignified care' (WHO, 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 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 the overcrowded, noisy conditions of the public hospitals, 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 were both enabled by 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 & 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).

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' (WHO, 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 experiences were often related relative to other 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: "Preeclampsia? 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 because 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 institutional conditions, particularly within the public health system, may indirectly push women down "private" medical routes which, as Vo and Lofgren (2018) 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' (Anonymised, 2023, Do & Brennan, 2015). 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'.

Decision-making related to Caesarean Sections

During the interviews, some women who had recently given birth reflected on their experiences of having a caesarean section delivery. Women's accounts revealed different 'types' of structured agency, which were framed 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' (WHO, 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 fetal 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 fetal 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" [DB-3010-1]. 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 forthcoming work highlights (Anonymised, 2023) 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.

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 & Kane, 2017). We believe that, by utilising this novel approach, one can also methodologically uncover the potentially unseen, causal influences on 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, both constrain and enable women's 'legitimate' expectations, decisions, and choices.

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 how the overcrowded, noisy conditions of public hospitals 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 & Kane, 2022, Mirzoev & 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 causal mechanism influencing women's choices and decision 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 related to privacy and confidentiality, for receiving prompt and respectful care, and what they saw

as high-quality ultrasounds. 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 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 was 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 care experiences and expectations, as well as the views 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.

Women's 'internal conversations' also offered a 'theoretical canvas' which uncovered the different types of structured agency women exhibited in our study during pregnancy and childbirth. The vast majority of current literature on childbearing Vietnamese women's care encounters emphasises women's unequal decision-making power (Anonymise, 2023). 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. 2021, 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 considers them, and selectively chooses 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). As we (Anonymised 2023) argue in our recent work, in the Vietnamese context, this reflects the existence of multiple, complex, and contradictory Vietnamese femininities. Future inquiries examining women's care encounters should explicitly take into account how these complex gender dynamics and multiplicities in gender identities shape women's decision-making power and agency in the context of post-Doi Moi Vietnam.

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 causal influences 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.

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5.3 "We can't expect much": Childbearing women's 'horizon of expectations' of the health system in rural Vietnam

An examination of childbearing Vietnamese women's care encounters in Section 5.2 revealed that expectations were powerful causal mechanisms that influenced women's care-seeking decisions and choices, and their subsequent interactions with the Vietnamese health system. Below, is an in-depth examination of childbearing women's 'horizon of expectations' of the health system in rural Vietnam. Framed by an intersectional, translocational, and relational analytical approach, this examination sought to respond to the study's second research question – what are childbearing women's expectations of the health system in Vietnam? The findings are presented in peer-reviewed journal article published in Health & Place. The piece reveals that women's horizon of expectations included, having access to modern equipment (such as high-quality ultrasounds), short waiting times for appointments, detailed consultations, and respectful treatment by providers. These expectations were shaped by their social, spatial, and temporal locations. Women also viewed these expectations as legitimate, which were authorised and endorsed by for-profit providers' normative, revenue-maximising practices. The findings emphasise the need for researchers and health system actors to better consider the impact of market forces on responsive care provision – a need I engage with in Section 6.3 of this thesis.

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"We can't expect much": Childbearing women's 'horizon of expectations' of the health system in rural Vietnam

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Abstract

In this inquiry, we unpack women's 'horizon of expectations' of the health system of rural Vietnam. Through interviews with 28 pregnant and postpartum women we reveal how women's 'horizon of expectations' was shaped at the intersection of their social, temporal, and crucially, spatial locations, various competing and sometimes contradictory social forces, and the evolution and changes occurring in the Vietnamese health system. We call on researchers and health system actors to better consider the impact of market forces on healthcare provision, globally, but particularly in low- and middle-income country contexts.

Keywords: Health systems responsiveness, Expectations, Healthcare experiences, Maternal health, Vietnam

Highlights

- Responsiveness centres on understanding peoples' 'legitimate' expectations of their health system.
- Healthcare-related expectations are shaped at the intersection of social, temporal, and spatial 'locations'.
- Expectations are also shaped by social norms, and market-driven practices and forces in the health system.
- There is a need for health system actors to consider the impact of market forces on responsive care provision.
- Active citizen participation and contestation is also needed to establish 'legitimate' expectations of care.

Introduction

Health systems responsiveness has been defined as, "*when institutions and institutional relationships are designed in such a way that they […] respond appropriately to the universally legitimate expectations of individuals*" (de Silva 2000).A responsive health system is fundamentally important as it relates directly to human rights – it safeguards the rights of patients to receive healthcare which meets their needs and expectations (Gostin, Hodge, & Valentine, 2003, de Silva, 2000). Given this, improving health systems responsiveness is widely agreed as being a goal for all health systems (and governments) (WHO, 2000). Central to understanding and examining health systems responsiveness, is the concept of expectations. Within the responsiveness literature, de Silva (2000) stresses that responsiveness centres on specifically examining peoples' "legitimate expectations" (de Silva, 2000). The demarcation of peoples' 'legitimate' expectations those that conform to recognised principles, or accepted norms or standards – is deemed necessary to overcome the issue of "divergence of expectations", where people may have "unrealistic" or "unjustifiable" expectations of their health systems (de Silva, 2000). Yet another dimension involves consideration of peoples' *normative* expectations – what people expect should or ought to happen during a care encounter. This contrasts with the notion of patient satisfaction, which also seeks to understand peoples' *ideal* (aspirations or desires)*, predicted* (realistic expectations shaped by experience)*,* and *unformed* (inarticulate expectations) expectations of care (de Silva, 2000, Thompson & Suñol, 1995). However, as Lakin and Kane (2022) and Mirzoev and Kane (2017) have pointed out, within the World Health Organisation (WHO) responsiveness framework, there is limited consideration of the broader social, cultural, economic, political, and historical systems and structures that shape and define peoples' care-related expectations. They have also argued that there is limited theoretical engagement with and understanding of what makes an expectation 'legitimate' (Lakin & Kane, 2023, Khan et al. 2021). Therefore, the concept of expectations, as it applies to responsiveness, continues to be an area of debate and discussion.

Empirically, the responsiveness of country health systems has been widely examined through survey-based inquires which use a version of the WHO health systems responsiveness questionnaire (Coulter & Jenkinson, 2005, Peltzer, 2009, Liabsuetrakul et al., 2012, Chao et al., 2017, Awoke et al., 2017, Ratcliffe et al., 2019, Kapologwe et al., 2020, Negash et al., 2022). To evaluate health systems responsiveness, respondents are

asked to rate their experiences of their encounter with the health system with respect to the domains of dignity, confidentiality, autonomy, basic amenities, prompt attention, access to social support networks, and choice of provider (WHO 2000). In these inquiries, however, peoples' diverse expectations (including but not limited to the domains of responsiveness), which shape their experiences and subsequent evaluations of their care encounters, are given little consideration (Mirzoev & Kane, 2017). Moreover, only a few studies, such as those by Bramesfeld, Klippel et al. (2007), Bramesfeld, Wedegartner et al. (2007) and Coulter and Jenkinson (2005), have shed light on how peoples' expectations of care can be shaped by factors such as one's culture, as well as the hierarchical relations between the patient and provider. To our knowledge no study yet, globally, has conducted an in-depth examination of peoples' expectations of their health systems, as well as the antecedents and determinants of these expectations. Similarly, there is an absence of inquiries that unpack what shapes and defines the 'legitimation' of peoples' expectations of their health systems (Lakin & Kane, 2023, Khan et al., 2021). This is despite the concept of 'legitimate expectations' being so pivotal to our understanding of health systems responsiveness.

Addressing these theoretical and empirical gaps are important, now more than ever, as the focus of scholars and policymakers in many low- and middle-income countries (LMICs) is increasingly shifting from addressing the accessibility and availability of health services, towards improving health systems to meet peoples' increasing expectations (McPake et al., 2020). Such a shift, among other things, is likely in response to rapid economic growth and development which has contributed towards significant improvements in the availability of health services in these contexts, including the expansion of the private healthcare sector (McPake et al. 2020). Moreover, evidence suggests that, as populations become more affluent, there is a growing demand for care that is of a higher quality which meets peoples' increasing expectations (McPake et al. 2020, Ekman et al. 2008, Mirzoev et al. 2021). Nowhere has such rapid economic growth been more evident, than in Vietnam – one of the fastest growing economies of the last two decades. The country has experienced significant economic and social reforms since a series of policies, known as *Doi Moi,* were implemented in the 1980s and 1990s. (Witter, 1996, Dao, 2023). *Doi Moi* transformed Vietnam's economy from a centrally-planned economy to what has been called "market socialism", prompting rates of absolute poverty to fall. In this way, *Doi Moi* has had profound social and gender impacts too and has

therefore also been viewed as a "socially embedded process" (Werner, 2002). For instance, as a result of *Doi Moi,* Vietnam has maintained a particularly high female employment rate of 70% (Banerji et al., 2018, Long et al. 2000). Yet, this has meant that the workloads between men and women are increasingly unequal, both within households and in society – women not only have to maintain a "socialist work ethic" within workplaces but must also simultaneously conform to Confucian traditions and practices still prevalent within their "private spheres" (Werner, 2002). Within the health sector, as a result of *Doi Moi,* hospital autonomisation policies were introduced which gave varying degrees of autonomy to public health services in terms of finance, personnel, and organisation. This prompted the introduction of user fees within public health facilities for various services, such as for the use of advanced medical technologies (Witter, 1996, Ekman et al., 2008, Võ & Löfgren, 2019). *Doi Moi* also saw the official recognition and legalisation of the private health sector which, as work by Ngo and Hill (2011) have revealed, has been found to better respond to patients' expectations with more convenient opening hours and advanced medical equipment. As such, in 2010, private health facilities accounted for 40% of total outpatient visits in Vietnam (WHO, 2018). In this way, the growth of market-oriented care provision, as a result of *Doi Moi,* has prompted a gradual shift of financial responsibilities from the State onto health care facilities and households (Dao, 2023).

These social, economic, and health sector reforms have specific implications for what women legitimately expect from the Vietnamese health system during childbirth and pregnancy. However, the impact of these changes on childbearing women's expectations and experiences of care in post-Doi Moi Vietnam, is insufficiently reflected in the current scholarly literature. Much of the current literature examines women's experiences of maternity care in rural and mountainous regions of Vietnam and/or the experiences of ethnic minority women (McKinn et al., 2019, White et al., 2012, Binder-Finnema et al., 2015, Huong et al., 2021, Graner et al., 2010, Ngo & Hill, 2011). In these studies, there is inevitably a greater focus on childbearing Vietnamese women's interactions with and experiences of public health services, despite such facilities failing to respond to their expectations of convenient opening hours and short waiting times, as well as privacy and confidentiality. That being said, a few studies have revealed how Vietnam's shift towards market-oriented care provision has prompted childbearing women to seek care at private health facilities to meet their increasing expectations (Holmlund et al. 2020, Gammetoft,

2007, Gammeltoft & Nguyen, 2007, McKinn et al. 2019, Heo et al., 2020). This was found to even be the case for those residing in rural areas of the country who felt that the additional costs of visiting private providers were affordable (Heo et al., 2020). Nevertheless, no study has examined Vietnamese women's expectations of their health system during pregnancy and childbirth, in light of the social, economic, and health transitions and changes in post-Doi Moi Vietnam. Particularly within rural regions of the country which, as the evidence suggests, is not untouched by the impacts of Doi Moi.

Therefore, in this study we respond to the question: What are childbearing women's expectations of the health system in rural Vietnam? We also ask: What shapes childbearing women's 'legitimate' expectations of care? We use the case of maternity service use in rural Vietnam to illustrate how peoples' 'legitimate' expectations of their health systems are shaped and defined by broader and intersecting systems and structures within their unique social environment. In light of our findings, we discuss the implications for researchers, policymakers, and practitioners working on health systems responsiveness, globally, but particularly in LMIC contexts.

Theoretical framing

Lakin and Kane (2022) recently synthesised the conceptual literature on expectations in healthcare contexts and proposed an intersectional, translocational, and relational analytical approach for examining peoples' expectations of care. In their work, they build upon the conceptualisation of intersectionality proposed by Crenshaw (1991) which recognises that multiple social structures (such as gender, class, and age) intersect to produce social positions and outcomes. Drawing on the work of Anthias (2020), Lakin and Kane (2022) argue that a more nuanced interpretation of intersectionality is possible by adopting a *translocational* lens. Such an approach centres on the notion of a social 'location' which sees social positioning as embedded within intersecting power structures and relations, that vary according to time, place, and scale. A *translocational* approach therefore moves beyond an intersectional lens by incorporating the spatial (encompassing the social, cultural, economic, and political structures and relations tied to 'place'), temporal, and scalar (across distances) as 'place' within social hierarchical positioning (Lakin & Kane, 2022, Anthias, 2020). In this way, Lakin and Kane (2022) propose that such an approach allows scholars to examine how peoples' expectations of their health systems are shaped by their social 'locations' within specific social environments and

contexts, as well as at particular points in time. This consideration explicitly links to Kosselleck's (2004) and Luhmann's (1995) work on expectations within sociology. Kosselleck (2004) suggests that meaning for an action is constituted within a "horizon of expectation" and that such expectations are pre-given and generalised (Faure, 2017). Kosselleck (2004) uses the 'horizon' as a temporal metaphor to illustrate how expectations are essentially, "the future made present" (Lakin & Kane, 2022). In this way, structures of expectations may be constantly re-activated, anticipating future actions and, in doing so, reducing complexity of systems (Luhmann, 1995). Reducing the complexity of social systems, as Lakin and Kane (2022) argue, can allow one to better inhabit, interact with, and cope with such systems, including the health system. Another key dimension of health systems responsiveness is the specific focus on peoples' 'legitimate' expectations of their health systems. A recent theoretical analysis has shown that 'legitimacy' is established based on a social and cultural framework of widely accepted, norms, values, beliefs, and standards (Lakin & Kane, 2023, Dornbusch & Scott, 1975, Johnson, Dowd & Ridgeway, 2006). These values, beliefs, and standards are *normative* – they are people's perceptions about how a health system should or ought to be (Lakin & Kane, 2023). These theoretical insights foreground our inquiry on childbearing women's 'horizon of expectations' of the health system within the context of post-Doi Moi rural Vietnam. Within this analysis, we aim to specifically examine what makes these expectations 'legitimate' for them.

Methods

Study setting

This study is part of a broader, multi-country study, RESPONSE (Mirzoev et al., 2021) which aims to analyse health systems responsiveness to the needs of the populations they serve. The study site was Bắc Giang – a mountainous province 50 km to the east of Hanoi, located in the northern midlands and mountainous areas of the country. The province was purposively chosen because experienced rapid industrialisation in recent years (General Statistics Office 2020); within Bắc Giang, the district of Hiệp Hòa was chosen for the recruitment of study participants. Bắc Giang has a provincial hospital, as well as district hospitals that manage high-risk pregnancies and caesarean sections. The primary access point for reproductive care are Commune Health Centres (CHC), which provide free, insurance-covered antenatal check-ups, gynaecological examinations, and family planning services. In addition to these public services, a number of private clinics and

hospitals are spread throughout the district, some offering certain insurance-covered services. Delivery in public hospitals (district and provincial) is free, however, as we reveal below, women are required to pay for certain services (such as, staying in a private room following delivery).

Recruitment of study participants and data collection

Fieldwork (conducted by DTH and KL) occurred over a period of three months from September to November 2022. Within the Hiệp Hòa district, participants were purposively recruited from two communes, Đông Lỗ and Đoan Bái. Women who were currently pregnant, or those who had given birth within one year, were eligible for participation in the study. Identification and recruitment were facilitated by the CHC in each commune; the research team worked closely with the maternal and child health officers in each CHC to obtain a list of all registered pregnant and postpartum women in the commune. To capture a diversity of participants in terms of age, occupation, education level, and number of children, eligible participants were purposively selected from this list and contact was facilitated by the maternal and child health officer. All women who were approached freely consented to participate in the study. A total of 28 women, 16 of whom were currently pregnant and 12 who had recently given birth, participated in the study. Participant characteristics are outlined in Table 1.

Participant characteristics	N
Age, years	
<20	2
20-24	4
25-29	9
30-34	8
35-40	3
>40	2
Pregnancy status	
Currently pregnant	16
Postnatal	12
Marital status	
Married	27
Divorced	1
Ethnicity	
Kinh	25
Tay	1
Thai	1
H'mong	1
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	

Table 1: Participant characteristics

Semi structured, in-depth interviews were conducted with study participants. The interviews were conducted in Vietnamese by DTH, who was accompanied and supported by KL during the process. All interviews, but one (which was conducted at the CHC), took place in women's homes. Interviews lasted between 30 to 60 minutes and were digitally recorded with participants' consent. For women who were currently pregnant, we asked them to reflect on their expectations of maternity care (both antenatal and delivery care) generally, as well as their current experiences of antenatal care. For women who had recently given birth, we also asked them to describe their experiences with delivery care. We did initially prompt women to discuss their expectations of maternity care generally, but also asked them to reflect on expectations specifically relating to elements of health systems responsiveness. For instance, prompting women who had recently given birth to reflect on how they initially expected to be treated by the doctors during their delivery. Following the interviews, a de-briefing session was held at the end of each day of fieldwork and on a weekly basis (between DTH, KL, and SK) to reflect upon the interview process and to discuss preliminary interpretations and emerging findings. Data was collected until analytical saturation was reached and no new insights emerged, this was assessed during the regular debriefing discussions between DTH, KL, BTH, and SK (conducted at the end of each day of fieldwork/data collection). 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).

Data analysis

Interview recordings were transcribed verbatim to Vietnamese and these transcripts were translated to English. During this process, the transcripts were constantly checked by DTH, a Vietnamese bilingual researcher, for accuracy. An abductive analysis of the transcripts was conducted. Per Tavory and Timmermans (2014), an abductive analytical approach aims to develop novel theorisations based on identifying surprising evidence which does not fit within existing theoretical understandings. Analysis began with an initial reading of the interview transcripts to develop a preliminary understanding of the data. The transcripts were then coded using QSR Nvivo, with the codes informed both by the data, as well as insights from existing theoretical literature. Lakin and Kane's (2022) intersectional, translocational, and relational framework guided and framed coding and the overall analysis. The analysis was also 'theoretically sensitised' by existing

conceptualisations of the concepts of 'expectations' and 'legitimacy' detailed above. The codes were then mapped to identify themes and sub-themes. Patterns that emerged were used as 'triggers' for exploring other relevant theoretical literature which resulted in further refinement of themes and sub-themes.

Results

Findings are presented along two broad lines. The first, sheds light on women's 'horizon of expectations' of the health system in rural Vietnam. The second, reveals how this 'horizon' was potentially constrained by women's *social, temporal,* and *spatial* 'locations'.

Childbearing women's 'horizon of expectations' – *normative, ideal,* and *predicted* expectations of care

The study initially set out to examine childbearing women's *normative* expectations of the health system in rural Vietnam, which are central to health systems responsiveness – what women expect should or ought to happen during a care encounter. However, women also often reflected upon their *ideal* (aspirations or desires) and *predicted* expectations of care. They discussed their wants, wishes, and hopes, and also, what their 'ideal' antenatal or delivery care would be like. Shaped by past interactions with the health system, women also shared their *predicted* expectations; practical, anticipated experiences and outcomes. Described below are women's 'horizon of expectations' – their *normative, ideal,* and *predicted* expectations relating to the various elements of care they consistently reflected on and deemed important throughout pregnancy and childbirth. We reflect upon how women's 'horizon of expectations' was defined at the intersection of social structures, and the norms and practices of the Vietnamese health system.

Modern equipment and accurate diagnosis

When asked about their expectations of care, women consistently reflected on how they expected to be cared for by competent doctors who accurately diagnosed any issues affecting their baby. This, to them, was dependent on the presence of modern equipment, particularly a 4D or 5D colour ultrasound machine, which often served as a 'marker' of high-quality care. Women discussed these *ideal* and *normative* expectations without prompting, suggesting that they were perceived as legitimate, reasonable expectations to have of any facility providing maternity care.

"For the clinics, I want good doctors who can diagnose well ... my child's condition. The clinics need to be clean and have modern equipment so that when I have a pregnancy check-up, I lie down there, they do an ultrasound for me, and I can clearly see my child's image on the screen." [30-34 years old, postnatal].

"First of all, it has to be clean and well-equipped. When I go there, 4D ultrasound would be clearer, while at hospital, with black and white ultrasound, I am no doctor, so to me it's all blurry […] I couldn't [see] and couldn't understand. With 4D, I can see clearly the face and body parts of my baby. I would be able to see things clearer and sharper" [25-29 years old, postnatal].

The *Doi Moi* reforms have slowly unleashed market forces in the health system and prompted the proliferation of private providers in Vietnam (Thoa et al., 2013, Vo & Logren, 2018). As such, private providers are known to respond to patients' expectations through the provision of "patient-requested" services – an approach that concomitantly serves as a "strategic instrument" for maximising revenue (Vo & Logren, 2018, Holmlund et al., 2020, Ngo & Hill, 2011). Women in our study were acutely aware of this and, as the quotes above highlight, legitimately expected these services. Hence, market forces, particularly for-profit providers' normative practices to maximise revenue, endorsed and shaped what women consider as 'legitimate' expectations of care. User fees applied for women visiting a private facility for antenatal check-ups, and additional fees were charged for other services, such as ultrasounds and tests – the average cost of colour ultrasonography in Bắc Giang was 200,000 VND (equivalent to 8.4 US dollars). Women felt that these fees were affordable and, as the following quotes illustrate, were willing to pay such fees for better quality care that met their particular expectations. Hence, almost all women in our study, except one, decided to have their routine pregnancy check-ups at private facilities.

> *"Of course, going to a private clinic, I would expect it to be better than the (public) hospital. At the hospital, even the equipment and amenities are not as good as the ones at the private clinic, since they invested in them to have more customers. Of course, the price would be higher, but going there, we also expect better results, so it's fine even if it is more expensive."* [25 to 29 years old, currently pregnant].

> *"No need for me to say, you would know already. Public could never be as good as private, to be honest… I mean, we wouldn't feel as comfortable as we do in private clinics. When I was there, I had to follow their regulations, since they serve many people … have to understand and accept it."* [Over 40 years old, currently pregnant].

Women who had previous pregnancies also spoke about how their expectations of having a good quality ultrasound have evolved over time; they perceived that having a higher-quality ultrasound was more important during their first pregnancy to reassure them about the health of their baby.

> *"But when I was pregnant with my first child, I prefer colour ultrasound. I did have those kinds of expectations the first time I had a baby … being able to see the baby's face."* [25-29 years old, currently pregnant].

The above quotes illustrate how normative, revenue-maximising practices of providers have shaped what women have come to see as 'legitimate' expectations (i.e., having access to high-quality ultrasound during antenatal check-ups) (Lakin & Kane, 2023). Moreover, the findings suggest that providers' market logic-based practices are, in turn, also driven by and intersect with women's needs and expectations. However, we also see how women's expectations are *temporally* defined – they can evolve for women over time, depending on whether they are experiencing their first or a subsequent pregnancy, and what their experiences were in the past. These expectations were clearly also shaped by a desire for and the possibility of seeing one's baby's 'face'.

Waiting time and detailed consultation

Vietnam has maintained a high female employment rate of 70% and, as such, all but two women in our study were working full-time (Banerji et al., 2018). For some women who were factory workers, there was a degree of flexibility as they were able to stay at home during the pregnancy while receiving 50% of their income (beneficiaries of what is known as the "50-leave" scheme). Other women who were business owners or teachers were unable to take leave and had to organise their maternity appointments around their work schedule. Nevertheless, women still had to attend to household duties and childrearing responsibilities, which was expected of them as wives and mothers. Moreover, though some women remained at home during the pregnancy, they were reliant on (and expected) their husbands (who were also working full-time) to accompany them to their antenatal

check-ups. Women described relying on their husbands for support and reassurance during check-ups, and some women, particularly first-time mothers or those who were younger, expressed a reluctance to go for check-ups on their own. However, it was also a gendered expectation with some women believing that it was the "duty" of their husbands to accompany them. Therefore, women's *social* locations, at the intersection of these competing economic, social, and gender structures, shaped their expectation of a short waiting time at the private health facilities they visited – many reflecting on this specific expectation without prompting.

"For us, since we are still working, we would want them to be quick. Really, everyone wants it to be quick. Long waiting time would [make] me anxious..." [30-34 years old, currently pregnant].

"Since I have several small children, and my husband also has a business, so I want to make use of the time and go home to do housework." [30-34 years old, postnatal].

One woman in particular had noticeably poorer living conditions compared to the other women interviewed. She explained how she had moved far from home to marry and, due to patrilineal cultural practices rooted in Confucian traditions, did not have much support of her husband's family as he was the youngest son. She expected to be accompanied by her husband to appointments, but this often competed with his work hours. When asked what she expected from a health facility during her pregnancy, she replied: *"I just wanted it to be quick so we could go back home."* [25-29 years old, currently pregnant]. This was her only expectation, shaped by her *social* location at the intersection of competing cultural practices, gender roles and expectations, as well as economic pressures (she wanted to return home quickly as her husband had to get back to work).

Another view about what constitutes good quality, responsive care, that shaped expectations (and demands), for most women, was having a long, detailed consultation during their check-up: *All in all, if they explain it to me in such a manner, I will… I will have a better impression [of the facility], of course. As for places where they just finish the ultrasound and say "There is no problem, honey. Everything is good.", I won't be as impressed as where they explain to me in more detail."* [30-34 years old, postnatal].

Some women, reflecting aloud noted that there was a contradiction in expecting to wait a short time for their appointment, while also expecting a long, detailed consultation. As the following excerpt illustrates, they noted that this may not, in fact, be reasonable

expectations to have: *"I just hope that every time I go to the doctor, he will check a little faster so I can take my turn because sometimes I have to spend a long time, you know…Everyone has that psyche because having to wait an hour or even an hour and a half for an appointment would make anyone impatient, wouldn't it? For me, that's how I feel. As for the patients being checked, they would probably want to be checked more thoroughly. [Laugh]"* [30-34 years old, currently pregnant].

A short waiting time was a widely-shared, 'legitimate' expectation of the women interviewed, defined by their *social* location, at the intersection of competing and contradictory social, economic, and gendered structures. It was determined by their (or their husband's) work commitments which, in the current context of Vietnam, can be seen as a normative social and economic necessity. This expectation also intersected with and was also driven by women's gendered roles as wives and mothers, and the normative expectations and practices associated with these roles. The quotes above also reveal how the 'legitimate' expectation of a short waiting time often contradicted other 'unreasonable' expectations (such as a long consultation), as well as competed with women's gendered expectation of having her husband's presence and support during appointments.

Attitude of doctors and other health staff – being treated with respect

Women expected doctors and other health staff to treat them gently and respectfully both during their check-ups, as well as the birth. Thinking aloud, one woman said**,** "*their attitude was shown through their facial expressions. When I came in, they smiled, they spoke softly…"* [35-40 years old, postnatal], indicating that respect was conveyed by the way providers spoke to them, their tone, body language, and facial expressions**.** In fact, as the following quote further illustrates, being treated respectfully by providers and other health staff was perceived by women as a 'legitimate', universal expectation of any patient, regardless of their socioeconomic circumstances: *"When someone goes to a hospital, you know, they would like to be warmly welcomed whether they have money or not. As long as patients visit a hospital, health workers should be more welcoming to them."* [30-34 years old, postnatal].

Another woman, who worked in customer service, compared the health service-encounter to other service-encounters where the consumer is expected to be "well-served". This, as she argues in the following excerpt, inevitably shaped her expectations of how she should

be treated as a patient: "*Well, just like how I work. I think it's important that the customer is well-served. So, when I was in their shoes, it was the same. I'm also a saleswoman, you know."* [20-24 years old, currently pregnant].

For some women, being treated respectfully during their care encounters was an *ideal* expectation, as they were aware that family members and friends had experienced disrespectful treatment while giving birth. Therefore, they "hoped" to be treated gently – for women, an indicator of respectful care – all the while knowing that this might not be the case: *"I hope the doctors will give me a gentle delivery. Because many people who cry too much during their deliveries are often scolded. I think it is very sad if it turns out that way. So, I want doctors to be gentle, encouraging ... and to support me to deliver when I am experiencing labour pain."* [30-34 years old, currently pregnant]. For this woman, her expectation was influenced by the experiences of her friends: "*Well, some of my friends told me that after coming back from their deliveries. For me, I have never seen anyone yelling at me when I delivered. So, I'm also very worried about that because when I'm in labour pain, I can't control my emotions."* [30-34 years old, currently pregnant].

Some of the study participants did report experiencing disrespectful treatment during their past and/or current pregnancies, which ultimately *temporally* shaped their *ideal* and *normative* expectations of care. One woman was unaware that she was pregnant and was scolded by a "really difficult" doctor for not knowing. She explained how she *ideally* expected a gentle doctor during her delivery but, if this was not the case, she would just have to accept it: *"I would like to meet a nice, gentle doctor. But even if it is a difficult doctor, then I still have to accept it. Otherwise, when my stomach was in so much pain, who would save me."* [25-29 years old, currently pregnant]. Her reflection also seems to suggest that she feels like being 'at the mercy' of the doctor who needs to 'save' her. When asked why she felt she had to accept disrespectful treatment, she described how she was "used to it" as it was something she experienced during her previous pregnancies, as well as at home.

One woman who had given birth at the provincial hospital felt that the attitude of the doctors and health staff did not meet her expectations but, *"...for the services from government's service provider, that kind of attitude is really common."* [25-29 years old, postnatal]. As opposed to public health services, women generally observed that they were more likely to be treated respectfully by private providers, which was all the more

reason to seek care at private facilities. These findings suggest that private providers were well informed about these expectations and responded accordingly by improving their attitudes towards service users. This indirectly implies the commodification of respectful care; women who are able to afford it can "pay" to be treated respectfully by providers to fulfil this 'legitimate' expectation. Again, women were acutely aware of this and expected it: *"For private hospital, they now attract more patients because of their attitude."* [35-40 years old, postnatal].

Women did expect to be treated respectfully during their care encounters. However, as highlighted above, some women experienced disrespectful treatment, some had heard about such experiences, and, for some, not being treated respectfully was something that happened at home generally too. These "common" experiences, structured variously, led to an overwhelming feeling among women that they had to accept that the care they received, specifically at public health facilities, would not meet these expectations. In this way, we witness the reciprocal relationship of expectation and experience; women's future expectations of their treatment during delivery were *temporally* and *socially* shaped by both their own experiences during past and current care encounters, as well as those within their social network (Lakin and Kane, 2022, Kosselleck, 1995, Faure, 2017). Yet, some women reflected that private providers treated them with a greater deal of respect and this consideration also swayed their decision to seek care at private facilities. In this case, we see again how women's needs, expectations, and subsequent actions can have a causal effect on care provision, particularly by private providers who may also be driven by the wish to maximise revenue.

Privacy and quality of amenities

Only when prompted, did women discuss their expectations of privacy during their antenatal check-ups. This could be because it was widely understood that private facilities in the district lacked privacy – women described only a curtain separating them from others during check-ups. This was in contrast to the district or provincial hospital, where antenatal consultations were conducted in a private room. Nevertheless, almost all women continued to visit private clinics during their pregnancy, revealing that they were perhaps willing to forgo privacy in favour of other expectations being met. As the following quote highlights, women did describe how the facility they visited did not meet their expectations of privacy. However, they felt that they just had to accept it given that it was

the "norm": *"For me, it lacked privacy…Most of the clinics around here are the same, so I didn't really have any other choices."* [25-29 years old, postnatal].

In the following excerpt a woman, who had had antenatal check-ups in Taiwan, before returning to Vietnam to give birth, describes how her care encounters in Taiwan *spatially* and *temporally* shaped her future expectations of privacy in clinics in Hiệp Hòa: *"In Taiwan, there would only be 1 patient and 1 family member accompany them in a private room. There wouldn't be people sitting and looking at you like that. So, for my expectation, I would expect them to do the same, but since it's only a private clinic, so they couldn't meet that expectation"* [30-34 years old, postnatal]. The quote suggests that now, as a result of her experience, she possibly perceives privacy during check-ups as a 'legitimate' expectation that should be fulfilled.

Likewise, some women did not discuss their expectations relating to the quality of amenities (such as the toilet and the waiting area), unless prompted to do so. For instance, when one woman was asked whether she expected the facility she visited to have good quality amenities, she responded: *"No. Generally, I didn't expect that, since I came for the check-ups, so I just want the doctor to check me up, welcome me. So, I don't really need or think of those things. It's not necessary."* [30-34 years old, currently pregnant]. Hence, for many women, these may not have been perceived as particularly crucial expectations which had to be met by the facility they visited.

These quotes illustrate how usual practices and norms in the Vietnamese health system shaped what women saw as 'legitimate' expectations of care, potentially limiting their 'horizon of expectations'. This was emphasised by the fact that women did not discuss, in our interviews, their expectations of privacy, or the quality of amenities, unless prompted to do so. Yet, in the example above, we do see how a woman's interactions with a health system in a different context can *spatially* and *temporally* shape her future 'legitimate' expectations of care and, in doing so, potentially broaden her 'horizon of expectations'.

"We can't expect much"

Though many women we interviewed felt that the care they received generally met their initial expectations of care, they often demurred that maternity care services in rural Bắc Giang could not compete with those in big cities, like Hanoi. As the following quotes reveal, women did expect better quality care, but were quick to concede that, as women

living in a rural area, it was perhaps not a reasonable expectation to have. We see how women's 'legitimate' expectations are *spatially, socially,* and *geographically* determined, shaped by intersecting social and economic systems and structures that exist within their unique social environment of rural post-Doi Moi Vietnam.

> *"Me? For us people in rural area, that's quite enough. I have never gone to places like big hospitals, so I wouldn't know, and cannot compare."* [30-34 years old, currently pregnant].

> *"About that, we can't expect much. Because, most of the time, I expect that… Because we're all civilians here, in this rural area, so, it's not… as good as in Hanoi or large facilities… If it were improved, it would be better. But for now, it's kind of okay."* [20-24 years old, currently pregnant].

Though content with the care she received throughout her pregnancy and delivery, one woman reflected on how someone with a higher income in her small town might yet expect better services: *"Since I live in the rural area, so I find (i.e., I get) the equipment as well as the way the doctors care for me. Personally, I feel really content. Otherwise, other people with higher living standard might expect better services, then I don't know. Personally, I just think that it's ok"* [30-34 years old, currently pregnant].

Several women also discussed how they had heard from friends, or had seen on social media, what private hospitals in Hanoi were like: *"I saw online that private hospitals are tidier and clearer, their employees welcome and provide guidance for the patients enthusiastically, unlike here. Here, we just get a number and wait for our turn."* [30-34 years old, currently pregnant]. The same woman reflected on whether the care she received during her pregnancy met her initial expectations: *"Since we are in the rural area, we can only have that much check-ups. Since we have never been to bigger hospitals in Hanoi, so we wouldn't know how much better their services are. In the rural area, we just go for check-ups, and they would just give us the result like that."* [30-34 years old, currently pregnant].

As the above quotes highlight, almost all study participants were quite reflective, and many were often quick to qualify their 'legitimate' expectations by emphasising that the care they received was, *"quite okay already".* It almost seemed that many of the women interviewed were actively limiting their 'horizon of expectations' – i.e., setting limits to what all they legitimately expected from the health system during pregnancy and

childbirth. They seemed to believe that such moderation was necessary as they lived in a rural area and thus, it was reasonable to have and expect lower standards of care. Drawing on Luhmann (1995), Lakin and Kane (2022) have argued that by constraining one's 'horizon of expectations', patients may be able to better interact, and ultimately cope with, complex social systems, such as the health system.

Discussion

There is a notable absence of inquires which unpack people's expectations of their health systems, and how broader social, cultural, economic, and gender structures and systems shape these expectations (Lakin & Kane, 2022, Mirzoev & Kane, 2017). In this paper we have critically analysed women's 'horizon of expectations' of the health system in rural Vietnam, drawing on key theoretical work on the concepts of 'expectations' and 'legitimacy'. In doing so, we have also taken the first tangible steps in unpacking what makes certain expectations 'legitimate', in particular contexts, and how people explain this legitimation – a dimension of responsiveness which has been largely overlooked in inquires thus far (Lakin and Kane, 2023).

Lakin and Kane (2023) have defined 'legitimate' expectations of health systems as those that comply with a cultural and social framework of "widely shared norms, values, beliefs, and standards". They go further to emphasise that such values, beliefs, and standards are *normative* – they are people's perceptions of how a health system should or ought to be. In this study, women's 'horizon of expectations' included, having access to modern equipment (such as high-quality ultrasounds), short waiting times for appointments, detailed consultations, and respectful treatment by providers. Majority of women talked about these expectations without prompting, suggesting that these particular elements of care were important to them. As such, women perceived these expectations as 'legitimate', taken-for-granted expectations, which were authorised and endorsed by private providers' *normative*, revenue-maximising practices (Lakin & Kane, 2023). Moreover, the findings also revealed that providers' actions to maximise revenue were potentially, in turn, also driven by their awareness of such expectations. However, in seeking care which fulfilled these 'legitimate' expectations, women were potentially willing to forgo other expectations, such as privacy and quality of amenities. In this way, women's 'horizon of expectations' was shaped, but also restricted by the structures, norms, and practices of the Vietnamese health system.

By using a *translocational* approach, we have also uncovered how childbearing women's 'horizon of expectations' was *socially, temporally* and *spatially* defined (Anthias, 2020). In particular, that this 'horizon' was both shaped and restricted by their *social, temporal* and *spatial* 'locations', which were at the intersection of competing social, economic, gender, and cultural systems and structures, in the context of rural post-Doi Moi Vietnam. Though they generally conveyed contentment with the care they received, it was clear that women were expressing a limited 'horizon of expectations'. As residents of a rural region in Vietnam, women were acutely aware of their *spatial* and *geographical* location, which they associated with a lower standard of living. Thus, they seemed to feel it necessary to actively limit what they 'legitimately' expected from the health system. We echo Lakin and Kane's (2022) conjecture that by, constraining their 'horizon of expectations', childbearing women may have been able to better interact, and ultimately cope with the complexity of the Vietnamese health system, as well as other intersecting social systems they are a part of and interact with. We show how a *translocational* approach to inquiry and analysis can allow researchers and practitioners to examine how peoples' expectations are shaped by intersecting social structures, within specific social environments and settings, as well as a particular points in time and over time. This nuanced approach allows one to go beyond merely examining how structures, such as age and culture, independently shape peoples' care-related expectations, towards also considering the temporal, spatial, and geographical determinants (Bramesfeld, Klippel et al., 2007, Bramesfeld, Wedegartner et al., 2007, Coulter & Jenkinson, (2005). As such, we call for further research to understand how peoples' *social, temporal* and *spatial* 'locations' shape, but also constrain, what they can legitimately expect of health systems, in different contexts, for various populations groups, and over time.

It is possible that what we have observed in this context of for-profit care provision in Vietnam, is the commodification and commercialisation of responsive care. That is, those who are able to afford it, can pay for health services that are more responsive to their needs and expectations. The notion of health systems responsiveness was proposed over two decades ago when accessibility and availability of health services were constraints (de Silva, 2000). As McPake et al. (2020) have argued, there have been substantial economic transitions in recent decades both, globally, and specifically, in Asia. Our findings have highlighted that, even in a rural region of Vietnam, many childbearing women found user fees affordable, and this was reflected in the fact that all women,

expect one, sought care from private providers. This finding is similarly reported in a few studies conducted in both rural and urban contexts in Vietnam (Gammeltoft, 2007, Gammeltoft & Nguyên, 2007, Heo et al., 2020, Holmlund et al., 2020, Ngo & Hill, 2011). We argue that there is a need for researchers, practitioners, and policymakers, globally, to re-think current understandings of responsiveness. That is, to take into account for-profit care provision, which can mean that people are able to "pay" for responsive care. In contexts such as Vietnam, this has potentially given rise to the commodification of responsive care. It is also worth noting that the elements of care referred to by women in our study did not align with the domains of responsiveness as proposed by the WHO (2000); while short waiting times and respectful treatment are aspects of 'prompt attention' and 'dignity', modern equipment and detailed consultations are not acknowledged within the WHO's domains of responsiveness. Moreover, while 'choice of provider' was not explicitly mentioned by women, it appeared as a cross-cutting feature of most of the elements of care women discussed – meeting their expectations of modern equipment and short waiting times, for instance, prompted their choice of a private provider. Our findings suggest that the aspects of care women consistently reflected on and deemed important were both a function of the norms and processes of Vietnam's market-based health system, as well as their unique *social, temporal,* and *spatial* locations. Further research is therefore needed to critically unpack the WHO-proposed domains of health system responsiveness – to examine peoples' perceptions of what constitutes a responsive health system (including but not limited to these domains) and how such perceptions vary across contexts and for different population groups.

Moreover, we argue that there might be some benefit in re-visiting the notion of 'legitimacy' within responsiveness. While the WHO demarcated 'legitimate' expectations to tackle the issue of divergence of expectations, we have shown that what is considered a 'legitimate' expectation is in fact personally, socially, and locationally determined. We argue that this finding reinforces calls for the need to establish what can be considered a 'legitimate' expectation through a process of active and ongoing citizen participation and contestation. As Lakin & Kane (2023) propose, this requires health system actors to enable and "create equitable process and spaces for citizens, particularly minority and disadvantaged groups, to contest the norms and structures that specify their 'legitimate' expectations of responsive health systems". We also extend upon Lakin and Kane's (2023) conceptual understanding of legitimacy to suggest that future scholarly

work (particularly work conducted in market-based health system contexts) should explicitly acknowledge the role that market-driven activities and processes can play in defining what one legitimately expects from a health system. We, however, note that the expansion of for-profit care provision in Vietnam, as a consequence of rapid economic growth under *Doi Moi,* while improving access, may be at the expense of health equity. Prior to *Doi Moi,* healthcare used to be free, however, access to care is now increasingly dependent on one's financial means. In this way, the financial burden associated with health care can contribute towards income-related inequalities in access to and utilisation of healthcare in Vietnam. In particular, access to responsive care which meets peoples' increasing healthcare expectations (Ekman et al. 2008, Thoa et al. 2013). In 2016, in Vietnam, the income of the highest-income group was 9.8 times higher than that of the lowest income group. The rich-poor divide is greater in rural areas and for ethnic minority groups (General Statistics Office, 2021, Ekhman et al., 2008). Further research is needed to critically examine how all expectations and their legitimation – at individual, social, and health system-levels alike – can *spatially* and *socially* differ between urban and rural contexts, and across social and economic strata groups, globally.

Study limitations

This study was conducted in one rural province in Vietnam and, as such, we acknowledge that our findings do not necessarily describe the 'legitimate' expectations of *all* childbearing Vietnamese women. We recognise that health sector changes instigated by *Doi Moi* may have impacted health system structures, processes, and activities differently in remote/mountainous regions, as well as in urban areas of the country. Moreover, while we did endeavour to recruit women with a diversity of lived experiences, we recognise that, in this study, we may not have documented *all* the ways that various social forces intersect, compete, and/or contradict each other to shape what childbearing women 'legitimately' expect from the Vietnamese health system.

Conclusion

As many LMICs experience rapid economic growth and urbanisation, scholars and policymakers are increasingly concerned with improving health systems to meet peoples' needs and expectations. Yet, few studies have unpacked peoples' legitimate expectations of their health systems – a notion central to health systems responsiveness – as well as the antecedent and determinants of these expectations. In this paper, we take the first explicit step by revealing childbearing women's 'horizon of expectations' of the health

system in rural Vietnam. We show how this 'horizon' was both shaped and restricted by their *social, temporal* and *spatial* 'locations', at the intersection of various competing and sometimes contradictory social forces. Moreover, normative, revenue-maximising practices, which can be traced right back to the *Doi Moi* reforms and the proliferation of for-profit care provision in Vietnam, also defined what childbearing women 'legitimately' expected from their health system. In view of our findings, we call on key health system actors to consider the impact of market forces on responsive care provision in their efforts to improve health systems responsiveness, globally, but particularly in LMIC-contexts. Such efforts should also explicitly consider the impact on income-related inequalities in access to and utilisation of responsive healthcare.

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5.4 Women's autonomy and agency in contemporary Vietnam

While this inquiry did not explicitly intend to examine Vietnamese women's autonomy and agency during their pregnancy and childbirth, it emerged as an overarching finding from the fieldwork. Therefore, in this section, I reflect on the question: what does the empirical data reveal about women's autonomy and agency in contemporary Vietnam? Findings are discussed along three broad lines: "I decide", restricted agency, and joint decision-making. Drawing on relevant theoretical literature, I seek to uncover what new insights can be inferred about the complex gender dynamics present in contemporary Vietnam. I reflect on the implications of these findings for research and policy in Chapter 6 of this thesis.

"I decide"

Gender, as a social institution, is influenced by numerous historical and socio-economic factors, changing according to social shifts. In Vietnam, gendered ideologies and norms have been coloured by Confucianism and Confucian traditions, as well as by the rise of Socialism and, later, the Doi Moi reforms (Drummond & Rydstrøm, 2004). These three distinct social and economic movements, and moments in time, have had, and continue to have, an impact on Vietnamese women's autonomy and agency in all private and social spheres. During their pregnancy and childbirth, women in this study were faced with a number of decisions – where to go for their antenatal check-ups, where to deliver their baby, as well deciding on the various tests and procedures that they were offered and/or required to do. Drummond and Rydstrøm (2004) suggest that patrilineal Confucian practices can endow the husband (and his family) with "self-evident power" within the domestic sphere and, as a result, they can have greater decision-making power. Yet, when asked about how they navigated the decision-making process during their pregnancy and childbirth, many women were emphatic that they made their own decisions: *"I will usually be the one to decide where to have check-ups, how to give birth […] I am one for equality."* This woman went on to explain that this was possible as, *"...my husband is really easy going, and would let me decide, so I just go ahead."* [30–34 years old, postnatal].

Another woman reflected: *"Just my choice, no one forces me […] I make all of the decisions myself. I would go to have check-up wherever I wanted ... For example, I want to go to Bac Giang Women's and Children's hospital. Just now, my mother-in-law said*

that for this one, I should go to the district hospital. Then I said no, I would go back to my commune to give birth. Then they said that I could give birth wherever I wanted. Since it is for me to decide, as it would affect my wellbeing, my child" [20–24 years old, currently pregnant]. These examples reveal that there existed room, or perhaps some women were given the room by their husbands and in-laws – those who may traditionally have greater decision-making power – to make their own decisions related to pregnancy and childbirth.

Within health care spaces, some women reflected on the importance of making their own decisions about their care, regardless of what health professionals recommended. This is nicely illustrated in the following excerpt where a woman said that it was about her right to bodily autonomy: "*Even if the doctor told me something, I would need to listen to my own body."* [over 40 years old, currently pregnant]. As such, some women discussed how they expected healthcare providers to consult them about treatment options and procedures to inform their decision-making. The same woman went on to describe a situation where this was evident: *"For example, when I went for the ultrasound at week 12, in order to measure the nuchal translucency to see if the baby had Down syndrome, the doctor did tell me that since my age was high...but I rejected having that test"*.

Apart from her right to bodily autonomy, she explained how cost was the main reason why she opted against doing the test for Down's Syndrome: "*I also discussed with my husband, but he said that it depended on me, and I didn't want to pay that cost so I didn't do it [...] For me, I could afford it, but it is still something I need to consider."* [over 40 years old, currently pregnant]. Werner (2004) argues that today's generation of Vietnamese women – those who I encountered in this inquiry – represent the first generation of Doi Moi. Due to the social and economic changes brought about by Doi Moi, Vietnamese women's roles and identities have undergone major changes. Their roles are no longer confined to the domestic spheres of childbirth and childrearing but have shifted towards achieving economic stability for their families. As such, this example shows how a woman's concern for her family's economic condition was a key factor that shaped her decision to reject an important screening test.

Another woman's story also conveyed the symbolic and practical power that women can have within the domestic sphere in relation to the family economy (Do & Brennan, 2015). This woman recently lost her only son which motivated her to "seek a new one" to carry

on the family lineage. As she was 51 years old, she said, she chose to conceive via In Vitro Fertilisation (IVF): *"After my 3 daughters got married and had children of their own, and my youngest son lost his life in an accident, I nearly broke down. But after I checked out of the hospital, people motivated me to seek a new one".* [over 40 years old, currently pregnant].

She further reflected on the poor economic condition of her family and the drastic measures she was willing to take in order to afford IVF: *"To be honest with you, we don't really have that much money, but we do have lands. For us, if we were short of money, I was willing to sell some of our lands."* [over 40 years old, currently pregnant]. This woman's story is illustrative of the pressure that women can place upon themselves to uphold certain Confucian ideals and traditions, in this case, preserving the family's lineage. However, it is also revealing of the power and control she possessed over not only her life choices, but also the family's economy – it suggests that she was a major, if not the primary decision-maker on economic matters within her family too. In this way, it points to the competing and contradictory gender and cultural norms Vietnamese women are encountering.

The above quotes highlight that some women did have the capacity and were empowered to make their own decisions during their pregnancy and childbirth, both within private and public spheres. In doing so, they actively challenged what has long been accepted as a traditional gender norm of Vietnamese men being the primary decision-makers. The quotes also illustrate how broader economic and social shifts in Vietnam have potentially reconstructed Vietnamese women's roles and the power they possess over the family economy. Yet, as Do & Brennan (2015) argue, this power is still undervalued by men and can even be ignored by women due to prevailing cultural beliefs which bestow Vietnamese men with "self-evident" power.

Constrained agency

Elements of Confucianism have been present in Vietnam for two thousand years (Whitmore, 2023). Whitmore (2023) however suggests that Vietnamese Confucianism has remained distinct from Chinese Confucianism as it has been adapted according to the various shifts and changes occurring in Vietnamese society and polity. Confucianism forms a broad cultural element within Vietnamese society through traditions including, patrilineal (sons carry the family lineage and inheritance), patrilocal (married couples live

with or close to the husband's family), and patriarchal kinship (male family members have the greater decision-making power) (Whitemore, 2023, Do & Brennan, 2015). As such, within the Confucian doctrine, human reproduction is generally viewed as an important function and responsibility of women (Drummond and Rydstrøm, 2004). In this study, it was evident how certain Confucian traditions constrained women's agency, and this was especially apparent when it came to the decision of having another child. While we asked women to reflect on their experiences of their current pregnancy, many women were quick to explain that they would be having another baby, particularly if the current child was a girl. In line with patrilineal practices, having a son was deemed necessary to carry on the family lineage.

"They are both girls. This time is a girl, too, so I must continue." [30–34 years old, currently pregnant].

On the other hand, some women discussed how they felt pressured to have another child, regardless of the child's gender, to fulfil the wishes of their husband or in-laws: *"I listen to my husband's advice. Honestly, I didn't want any more children, because we already had 2 sons, but my husband still wants to have more. He wants to have a daughter, but we end up with another son."*. When asked if she felt that it was important for her to make her own decisions, she responded: *"If I am the one who make the decision, then I would feel respected"* [20–24 years old, currently pregnant]. As this excerpt reveals, while women wanted to make their own decisions on having more children, some had to ultimately submit to the will of their husbands. As Drummond and Rydstrøm (2004) suggest, this could broadly relate to the Confucian ideal of maintaining a "harmonious family life" through a wife's obedience to her husband.

One woman indicated how her in-laws did not initially force her to have another baby, *"The parents would not risk telling me to do so because I have given birth a lot already. So, they wouldn't take the risk."* However, once she was pregnant, *"[…] they forced me to give birth […] It wasn't because it was a girl. They just wanted me to give birth more. Because there were few people in the family, they forced me to have more children. That was the case here. It wouldn't matter whether I gave birth to a boy or a girl"* [30–34 years old, postnatal]. This woman's story reveals that while on the surface Confucian norms may not be visible, they can still be powerful enough to influence women's

decisions about having children. It is also broadly reflective of how such norms constrain Vietnamese women's agency and autonomy generally.

That said, women did reflect on how times and traditions have evolved and changed; one woman said: *"Actually, people have become better, changed for the better. In the past, then most would, like in my husband's hometown, or my aunt's hometown, people would think very different from each other [...] My aunt stopped at the third child, and that was it, even if she didn't have a son."* [30–34 years old, currently pregnant]. This quote serves as a reminder that today's generation Vietnamese women have potentially come of age under very different social and cultural experiences (Werner, 2004). While Vietnamese women have been politically and economically liberated to a certain extent (and I discuss above), as a result of the revolutionary movement and Doi Moi, the above evidence still suggests that their reproductive autonomy and agency can still be constrained by prevailing Confucian traditions and practices (Werner, 2004).

Joint decision-making

Many women discussed the need for seeking advice from significant others – health professionals, other women, their husbands – before making decisions during their pregnancy and childbirth. One woman reflected on this: *"There were all 3 factors. There were things that were my decisions [...] I also consulted the doctors as well as their advice on [YouTube], that I researched myself. I also discussed with my husband about those matters […] There are things that I feel comfortable making decisions, but I also usually talk and ask for my husband's opinions."* [30–34 years old, postnatal].

Admitting to their deficiencies in knowledge and/or experience, women actively sought the expertise of knowledgeable others. For instance, one spoke about how, during the birth, most of the important decisions were made by her sister who was her confidant, and also much more experienced: *"When I gave birth, most of the decisions were made by my sister […] since my sister has experiences, while I didn't know anything, so it would be more reasonable for her to make the decisions in my place."* [30–34 years old, postnatal].

While women appreciated the experienced-based knowledge of other women, they saw health professionals as a source of science-based knowledge and "formal power" closely associated with figures in authority (Do and Brennan, 2015). Many women explained how a lack of medical knowledge meant that they did not have capacity to make informed decisions about their care. For these women, their decisions and actions, as the following

quote reveals, were therefore based on and guided by the advice of health professionals: *"Sometimes the doctor tells me to do something, and since we didn't know better, we just do what we were told to do […] Since we don't really know how it is, so we just follow the doctor. For example, if the doctor tells us to do the blood or urine test, since we don't know, we just follow what they say.* [35–40 years old, currently pregnant]. In this way, many women expected health professionals to examine them carefully during their check-ups, give them advice about the pregnancy, and respond to any of their concerns.

Do and Brennan (2015) point out that formal power is often embodied through masculinity. As I discuss above, in Vietnam, Confucian traditions and norms can endow men and their family with self-evident power. This might explain why some women also felt the need to consult their husbands before making any decisions: *"We discuss together to make a decision […] I think it's necessary to discuss and make the decision together rather than do it on my own."* [25–30 years old, currently pregnant]. One woman spoke about how she actively discussed with her husband on where she would seek care during her pregnancy: *"So, I and my husband discussed together to see which place is better. We also considered the distance from our house to the clinic. It has to be close and convenient for me to travel."* [30–34 years old, currently pregnant]. When asked if she would take advice from others, such as her mother-in-law, she replied: *"In that case, well… If my mother-in-law asked me to go to someone's place because she thought they had a very good service, I would try it out. No problem! I would still have a choice."*. As the following quote suggests, though some women sought advice from others, they had the capacity to and did make their own decisions.

The examples above point to, what Do and Brennan (2015) have called, the "paradox of power" that Vietnamese women encountered during their pregnancy and childbirth in both public and private spheres. While some women had the capacity to make their own decisions on their care, others were still beholden to or felt the need to at least doff their hats to those with formal power. Making joint decisions with such significant others potentially offered women a means to navigate the complex gender dynamics and power relations evident in contemporary Vietnam. More broadly, one could also argue that there is an inevitability to the involvement of family members in these important 'family' decisions – and that this is a universal norm of sorts.

Chapter 6: Discussion

6.1 Chapter overview

In this section, I reflect on the key insights emerging from this inquiry. I begin by analysing how women's expectations were powerful determinants of their care-seeking choices and decisions, and which motivated their subsequent actions and interactions with the Vietnamese health system during pregnancy and childbirth. Then, in Section 6.2.2, I discuss how applying a translocational lens to analysis can be a particularly useful approach for examining how peoples' expectations of their health systems are shaped by their social, spatial, and temporal locations. Another significant finding was the role of market dynamics in shaping the legitimation of women's expectations of care. This, I argue, reflects the increasing role of the market in responsive care provision – a shift that is reflected in other LMICs too. Therefore, in Section 6.2.4, I advocate for a nuanced and expanded conceptualisation of health systems responsiveness which reflects the shift, in many LMICs, towards market-driven care provision. I then reflect on specific findings which highlight the autonomy and agency of childbearing women in post-Doi Moi Vietnam – findings that are insufficiently reflected in the current scholarly literature on Vietnamese women's care encounters. Knitting together these insights, I propose an agenda for researchers, policymakers, and practitioners working on health systems responsiveness, as well as for those seeking to improve the care of childbearing women in Vietnam. I then critically reflect on this thesis as a scholarly enterprise, in particular, the role of positionality and self-reflexivity within the broader inquiry. This follows a discussion on some of the possible limitations of the study, in light of the eight "big-tent" criteria for high quality qualitative research. I conclude this thesis with some final reflections on the way forward.

6.2 Unpacking the study's findings

This inquiry has bridged significant theoretical and empirical gaps on the notion of health systems responsiveness by presenting nuanced insights from childbearing women's encounters with their health system in Vietnam. I have shown how women's expectations of their health system are particularly powerful determinants of their health system interactions, shaping their care-seeking decisions, choices, and actions. I have critically and comprehensively explored childbearing women's legitimate expectations of care, uncovering how these expectations are personally, socially, and locationally determined. In doing so, I have demonstrated how a translocational analytical approach allow scholars to examine how peoples' expectations of their health systems are shaped by their spatial, temporal, and geographical locations. The findings also shed light on how women's legitimate expectations of care are defined by market-driven practices and forces evident within the Vietnamese health system. As such, it highlights the increasing role of the market in the provision of responsive care, particularly in emerging economies like Vietnam. This finding, I argue, calls for health system actors to advance a nuanced and contemporaneous conceptualisation of health systems responsiveness – one which explicitly acknowledges the expansion of for-profit and market-driven care provision. More specifically, the findings illustrate the complex and multiple gender identities present in post-Doi Moi Vietnam. In the sections that follow, I disentangle each of these key findings and outline an agenda for future research, policy, and practice.

6.2.1 Determinants of people's health system interactions and experiences

How people experience their interactions with their health systems is central to health systems responsiveness. As I discussed in Chapter 1, Mirzoev and Kane's (2017) conceptual framework perhaps best illustrates this, defining responsiveness as "an actual experience of people's interaction with their health system", with respect to the elements of: dignity, autonomy, confidentiality, prompt attention, access to networks, quality of amenities, and choice of provider (WHO, 2000). It is this experience which either validates or negates service user's initial, legitimate expectations and, in so doing, shapes their overall perception of the responsiveness of their health system. Yet, while current responsiveness frameworks have acknowledged both the 'people' and 'health systems' side of this interaction, as Mirzoev and Kane (2017) suggest, the interaction itself has received limited scholarly attention. Existing empirical literature on health systems

responsiveness examines people's health system interactions using the WHO health systems responsiveness questionnaire – a tool based on the initial WHO conceptualisation of responsiveness (Coulter & Jenkinson, 2005, Peltzer, 2009, Liabsuetrakul et al., 2012, Chao et al., 2017, Awoke et al., 2017, Ratcliffe et al., 2019, Kapologwe et al., 2020, Negash et al., 2022). As such, and as I also highlighted in Chapter 1, such inquiries fail to sufficiently capture how broader and interconnecting social, cultural, political, economic, and historical systems and structures shape peoples' expectations and perceptions of responsive health systems (Mirzoev & Kane, 2017). In view of this, in this study, I set out to first understand childbearing women's engagements (decisions, choices, and preferences), experiences, and interactions with the Vietnamese health system. Crucially, I aimed to examine how the broader social, economic, gender, and health system evolutions, occurring in post-Doi Moi Vietnam, shaped these engagements, experiences, and interactions.

The resulting findings from this analysis, which are presented in Section 5.2, bring to attention the powerful role of 'expectations' in determining one's health system interactions and experiences. In Section 3.2, my conceptual review of the notion of expectations revealed the reciprocal relationship of expectation and experience – as articulated by Koselleck (2004), "no expectation without experience; no experience without expectation". Connected to this is Koselleck's (2004) notion of a "horizon of expectation", a temporal metaphor to demonstrate how expectations are essentially the "future made present" and are the result of individual and collective experiences. Informed by Archer's (2003) and Chalari's (2009) work the "internal conversation", the analysis I presented in Section 5.2 reveals how, apart from women's preferences, needs, and concerns, expectations emerged as unseen determinants which influenced their choices and decision and motivated their interactions with the health system during pregnancy and childbirth. In particular, women seemed to trade-off certain expectations – such as those relating to privacy and confidentiality – in favour of other, more pertinent expectations. These included receiving prompt and respectful maternity care, as well as high-quality ultrasonography. To meet these expectations, most women concluded that the only course of action was to embark down private or on-demand medical routes (Dao, 2023). These empirical findings provide an important evidence base, supporting those from the conceptual analysis (Section 3.2) which reveal expectations as key determinants of peoples' experiences of their health system interactions, particularly (as I develop

further below) those that are considered legitimate (Mirzoev & Kane, 2017). In this way, and as I outline below in Section 6.3, there is a need for future research examining the patient experience to explicitly consider expectations as key determinants of peoples' healthcare-related choices, decisions, actions, and interactions. This is particularly warranted for research examining health systems responsiveness – currently, only a few inquiries shed light on the antecedents and determinants of peoples' care experiences in relation to responsiveness (Bramesfeld, Klippel et al., 2007, Bramesfeld, Wedegartner et al., 2007, Coulter & Jenkinson, 2005, Mirzoev & Kane, 2017).

The findings detailed in Section 5.2 also illustrated how broader social and institutional contexts, within post-Doi Moi Vietnam, enabled or constrained women's choices, decisions, and actions. Archer (2003) suggests that, via the internal conversation, people delineate and deliberate about what is most important to them – their ultimate concern – and decide on an appropriate course of action (Fuller, 2013). Alderson (2021) however argues that one needs to be mindful of the structural and cultural powers which can impinge upon individuals and operate as constraints or enablements of their actions. Within the context of post-Doi Moi Vietnam, intersecting social, economic, and gendered powers acted as both enablements and constraints of women's interactions with private providers. Women were required to juggle full-time employment with childrearing and household responsibilities (unpaid work) and these intersecting gendered and economic expectations left them little time to attend antenatal check-ups. To overcome these constraints, women preferentially sought care at private facilities, which were often located close to their homes and/or workplaces and had shorter wait times. Their interactions with private providers were also prompted by meeting their expectation of high-quality ultrasonography, as well as other on-demand services (such as a private room following birth). As I discuss further below, such expectations and demands were shaped by market-driven practices and activities of for-profit providers, an important contextual feature of the Vietnamese health system. While meeting these institutionally-defined expectations were key enablers of women's engagements with private providers, some women explained that their care-seeking decisions were contingent upon (and constrained by) their poor economic situation. However, despite these findings, the CIS I conducted in Section 2.5 revealed that few inquiries explicitly consider how the privatisation and commercialisation of Vietnam's health system, prompted by Doi Moi, has impacted women's preferences for, and subsequent interactions with private providers

(Gammeltoft, 2007, Gammeltoft, 2007, Ngo & Hill 2011, Holmlund et al., 2020, Edvardsson et al., 2015, Heo et al., 2020). As such, in Section 6.3, I outline the need for researchers, policymakers, and practitioners to explicitly consider how evolving social and economic conditions, both within and external to the health sector, can shape peoples' interactions with and experiences of their health systems, across countries and for different population groups (Mirzoev & Kane, 2017, McPake et al., 2020). This particularly includes inquiries examining peoples' care experiences in relation to health systems responsiveness which, as I point out above, currently fail to consider the contextual determinants that impinge upon peoples' interactions with the health system (Mirzoev & Kane, 2017).

6.2.2 A novel approach to examine peoples' expectations of care

As the findings from the analysis in Section 5.2 confirm, peoples' expectations of care are powerful determinants of their health system interactions. They thus serve as the benchmarks against which service users assess the responsiveness of their health systems (Mirzoev & Kane, 2017, de Silva, 2000). Yet, the concept of expectations continues to be an area of debate, particularly with respect to its conceptualisation within health systems responsiveness. In particular, existing analytical frames of health systems responsiveness fail to take into account the various cultural, social, and economic antecedents that shape people's expectations of care (Mirzoev & Kane, 2017). To tackle the ambiguity surrounding the notion of expectations in responsiveness, in Section 3.2, I theoretically mapped existing conceptualisations of expectations across various disciplinary domains. Drawing on these theoretical insights, I proposed that peoples' expectations of their health systems can be usefully understood and examined by utilising an intersectional, translocational, and relational analytical framework. The approach builds on the work of Anthias (2020) and incorporates the spatial, temporal, and scalar as 'place' within social hierarchical positioning. As such, it allows researchers and practitioners to consider how peoples' social locations, which are at the intersection of multiple structures and relations, shape their expectations of care within specific social environments, as well as in time and over time. Therefore, the analysis I presented in Section 3.2 addressed key theoretical gaps in the concept of expectations within health systems responsiveness and further demonstrates the theoretical significance of this inquiry (Mirzoev & Kane, 2017, de Silva, 2000).

The intersectional, translocational, and relational framework guided and framed my overall examination of childbearing women's expectations of the health system in post-Doi Moi Vietnam, which I presented in Section 5.3 (Objective 2). Specifically, I aimed to analyse what shaped the legitimation of these expectations (this is discussed further in Section 6.2.3). In doing so, and to my knowledge, this is the first study to comprehensively examine people's expectations of their health systems. The findings from this analysis revealed women's horizon of expectations of the Vietnamese health system which included, high-quality ultrasonography, short wait times, detailed consultations, and respectful providers. Crucially, the findings revealed how this 'horizon' was both shaped and restricted by women's social, spatial, and temporal locations, which were at the intersection of competing social, economic, gender, and cultural forces, within the context of post-Doi Moi Vietnam. As I discussed in Section 2.3, scholars have viewed the economic restructuring of Doi Moi as not merely a series of economic policy reforms, but a socially embedded process with many gendered components (Werner, 2002). Therefore, as a result of the Doi Moi reforms, Vietnamese women may not only be expected to follow a "socialist work ethic" within the public sphere, but also abide by Confucian traditions and practices within the private family sphere (ISDS, 2015). The findings in Section 5.3 confirmed these assumptions, illustrating how the gendered and economic impacts of Doi Moi influenced what childbearing women expected from their health system. For instance, women's expectation of a short waiting time for their antenatal appointment was defined by intersecting and competing social, gender, and economic forces – by their (or their husband's) work commitments, as well as their gendered roles as wives and mothers and the expectations associated with these roles.

On the other hand, the findings also revealed how women's social, spatial, and temporal locations restricted their horizon of expectations. As residents of a rural region, women seemed to associate their spatial and geographical locations with a lower standard of living and, as a result, appeared to actively limit what they expected from the Vietnamese health system. This key finding echoes Luhmann's (1995) view that, to reduce the complexity of systems, people constantly re-activate structures of expectations which anticipate their future actions. Similarly, by constraining their horizon of expectation, childbearing women may have been able to better interact with and cope with the complexities of the Vietnamese health system. As I outline below in Section 6.3, these

findings highlight the need for health system actors to explicitly consider how peoples' expectations of their health systems are socially, spatially, and temporally defined. But also, how their social, spatial, and temporal locations can restrict or limit what they expect from health systems. As the analysis in Section 5.3 has revealed, this can result in service users actively limiting their expectations and potentially accepting and tolerating a lower standard of care. These important considerations are currently overlooked in existing conceptualisations of health systems responsiveness, as well as empirical inquiries, which fail to account for the intersecting and competing social, cultural, and economic antecedents that colour people's expectations of care (Mirzoev & Kane, 2017). Further research is therefore needed to examine how peoples' social, temporal, and spatial locations both shape and constrain what they expect from their health systems – for different contexts, for various population groups, and over time.

The analysis in Section 5.3, also demonstrated how an intersectional, translocational, and relational framework can be a useful heuristic device for generating novel and nuanced insights into peoples' expectations of their health systems. As I reflect below in Section 6.5, this further demonstrates the heuristic significance of this study. Drawing on the work of Anthias (2020), the approach extends upon the original conceptualisation of intersectionality, allowing one to consider the temporal, spatial, and geographical determinants of peoples' expectations of care. It therefore goes beyond merely examining how various social structures, such as culture, age, socioeconomic status, independently shape what people expect from their health system. As I discuss above, such an approach can also allow scholars to consider the reciprocal relationship of expectation and experience – how past care experiences can shape peoples' future expectations of care (Koselleck, 2004). In this study, this consideration, uncovered how women's experiences of disrespectful treatment during past pregnancies, as well as the experiences of those in their social network, temporally shaped how they expected to be treated during their current pregnancies; women ideally expected to be treated respectfully, while knowing and accepting that this would not be the case, specifically at public health facilities.

6.2.3 The legitimation of expectations

Responsiveness centres on examining peoples' legitimate expectations of care. The reason for the demarcation of legitimate expectations, as explained by de Silva (2000) and Murray and Frenk (2000), is to overcome the issue of "divergence of expectations" –

expectations that may be “frivolous” or “unjustifiable”. Despite a clear justification for focusing on legitimate expectations within health systems responsiveness, several theoretical questions persisted. Particularly, what are legitimate expectations? And, who exactly decides what is considered a legitimate expectation? In Section 3.3, I conducted a conceptual analysis of the notion of legitimacy with a view to address these current theoretical shortcomings. Knitting together key insights from social psychology, political science, and the organisational literature, I defined a legitimate expectation of a health system as: “one which reflects and complies with widely shared norms, values, beliefs, and standards”. I argued that such beliefs, values, and standards are normative in nature – they are peoples’ perceptions on how a health system should or ought to be.

I drew upon these theoretical insights within the analysis in Section 5.3 to uncover what makes childbearing women’s expectations of the Vietnamese health system legitimate for them. As a result, this is also the first study to investigate and explain what makes certain expectations legitimate, in a given context, and how people explain this legitimation. A key finding was that, apart from being socially, spatially, and temporally defined (as I explain above), the legitimation of women’s expectations of care was also coloured by the normative market-driven practices and activities prevalent within the Vietnamese health system. As I discussed in Section 2.4, the Doi Moi reforms of 1980s and 1990s saw the gradual diffusion of neoliberal, market-driven policies and strategies within the Vietnamese health system, prompting the growth of the private sector, as well as the covert privatisation of the public health system through the introduction of user fees via Decision 45 (Võ & Löfgren, 2019, Dao, 2023). This saw public health facilities charge fees for specific services and goods including, bed occupation, X-rays, and other high-tech equipment. As Võ and Löfgren (2019) found in their institutional analysis, for-profit providers can use these “patient-requested” services as a “strategic instrument” to maximise their revenues. As such, within the Vietnamese health system and as a result of the Doi Moi reforms, market-driven practices have potentially become the ‘norm’ and women’s accounts clearly reflected this. Specifically, the analysis (Section 5.3) revealed how the normative market-driven practices of for-profit providers meant that women legitimately expected access to modern equipment, particularly a 4D or 5D colour ultrasound machine during their pregnancy. They viewed the presence of such equipment as a marker of high-quality care and, to meet this legitimate expectation, women preferentially sought care from private providers (as I uncovered in Section 5.2). While

user fees applied for visiting private providers, as well as for access to colour ultrasonography, women were still willing to pay these costs to meet these expectations they regarded as legitimate.

While, as I argued within the CIS in Section 2.5, current literature has disproportionally examined maternity care provision in rural Vietnam, a few studies do highlight how the privatisation and commercialisation of Vietnam's health system has impacted women's preferences for, and subsequent interactions with, private providers. Work by Gammeltoft (2007) and others, for instance, has revealed how high-tech medical equipment, including obstetric ultrasounds, can serve as "revenue-generating services" for both public and private providers to increase patient numbers (Ngo & Hill, 2011, Gammeltoft, 2007, Holmlund et al., 2020). This has potentially resulted in the overuse and commercialisation of obstetric ultrasounds in Vietnam, with women undergoing ultrasound examinations more than is medically warranted – a finding reported in the study by Edvardsson et al. (2015). This was found to even be the case in rural regions where, as the study by Heo et al., (2020) has shown, women were willing to pay the costs for such services. This is consistent with what I observed in Bắc Giang – a rural province but, as I explain in Section 4.6, one that is experiencing rapid industrialisation. Currently, there is no available evidence on the difference in clinical outcomes for women receiving standard antenatal care and those purely receiving obstetric ultrasounds during their pregnancy in Vietnam. However, as Edvardsson et al. (2015) report, the commercialisation of obstetric ultrasounds in Vietnam can result in the replacement of antenatal care visits and clinical examinations with ultrasounds. In line with findings in Edvardsson et al.'s (2015) study, women in this study seemed to perceive the ultrasound as a 'complete check' of their pregnancy. However, there is a risk that pregnancy complications, such as gestational diabetes and pre-eclampsia, may be overlooked as they develop over the course of the pregnancy. There is a need for providers, both within the public and private system in Vietnam, to ensure that childbearing women adhere to the WHO recommendation of at least eight antennal care visits to reduce perinatal mortality and improve women's experience of care (WHO, 2016).

More broadly, I argue that these findings are potentially indicative of the commercialisation and commodification of responsive care. In emerging economies such as Vietnam, the shift towards for-profit care provision means that it is possible for service users to pay for care which better responds to their legitimate expectations (I expand upon

this point in Section 6.2.4). As I outlined in Section 2.4, this could partly explain the current trends of high out-of-pocket (OPP) expenditure in Vietnam (World Bank, 2022). The poor regulation of the private sector can mean that service users are at risk of being "strategically manipulated" by private providers who may seek to increase their profits by charging higher fees (Nguyen & Wilson, 2017). There is a need to create and implement systems and/or instruments to regulate private health activities and service quality. It is important to be mindful that the financial burden related to health care can contribute towards or exacerbate income-related inequalities in access to healthcare in Vietnam and indeed globally – a burden which is disproportionately felt by those in low-income groups who reside in rural areas of the country and/or have ethnic minority status (General Statistics Office, 2021, Ekhman et al., 2008).

The findings reported in Section 5.3 also reveal how market-driven practices and forces can potentially shape what women perceive as a *responsive* health system. While women freely spoke about their legitimate expectations for high-tech equipment, only when prompted did women discuss their needs relating to privacy, confidentiality, and quality of amenities – key elements of the WHO conceptualisation health systems responsiveness (WHO, 2000). As I analysed in Section 5.3, this was despite a lack of privacy being a common feature at private health facilities, which contributed towards "uncomfortable" situations and experiences for some women. In this way, by seeking care at private health facilities, women were potentially willing to forgo their privacy in favour of other legitimate expectations being met – expectations that were coloured by profit-maximising strategies of for-profit providers. While women did discuss their expectations and experiences relating to certain elements of responsiveness, such as prompt attention and dignity, access to high-tech equipment is not currently a designated element of responsiveness. Moreover, the analysis also revealed 'choice of provider' as a cross-cutting feature of women's health system interactions. As I reflected in Sections 5.2 and 5.3, meeting their legitimate expectations of prompt attention and dignity motivated many women's decision to seek care from private providers. The findings suggest that the elements of care women discuss were both a function of their social, temporal, and spatial locations within their given social environment, as well as the norms and practices of the Vietnamese health system. As I outline below, there is therefore a need for researchers, practitioners, and policymakers, across country-contexts, to critically examine people's perceptions and views about what constitutes a responsive health system, beyond the

WHO-proposed domains. Moreover, in view of these findings, I build on my current conceptualisation of legitimate expectations I proposed in Section 3.3, to argue that future scholarly work should explicitly consider the role that the market and market logic can play in shaping peoples' legitimate expectations of care. This is particularly the case for work conducted in market-based health system contexts, where market-driven practices and activities may be the 'norm' (see Section 6.3). Such work is necessary to uncover how provider-induced demand for high-tech medical equipment or other on-demand services can contribute towards unreasonable expectations and demands of service users. But also, as I have observed, can result in service users forgoing privacy, confidentiality, and other elements of responsive care in favour of meeting other, institutionally-defined expectations.

But how does one go about establishing what can be considered legitimate expectations of health systems? While the question had been raised by scholars previously, prior to this study, a suitable approach to establish the legitimacy of peoples' expectations of care was missing (Khan et al., 2021). Responding to this omission, in Section 3.3, I called for the need to establish legitimate expectations of health systems though the creation of regularised, equitable spaces for participation and contestation. Such spaces, I proposed, can allow for citizens to contest the standards and norms for a health system's infrastructure and processes, upon which the legitimacy of their expectations is based. Importantly, such spaces need to be 'actualised' – to consider the social structures which may impinge upon and restrict equitable participation and contestation (Mohanty, 2007). This is essential for the inclusion of minority and marginalised populations – those who, as I discuss above, may be disproportionately burdened by the rise of for-profit and market-logic driven care provision. Therefore, the participation of disadvantaged groups in such processes is necessary to understand the consequences of the rise in market-driven care provision for health equity. As I outline in Section 6.3, I call upon key health system actors to establish the processes required to create durable, regularised spaces to allow all citizens to actively contest the norms, standards, and practices which specify their legitimate expectations of responsive health systems.

6.2.4 The role of the market in health systems responsiveness: A conceptualisation for an age of economic transitions

A notable finding of this inquiry was the role of the market and market logic in influencing women's legitimate expectations of care, as well as driving their subsequent interactions with for-profit providers to meet these expectations. As I explained earlier, this is potentially the result of the gradual privatisation and marketisation of Vietnam's health system under the Doi Moi reforms. More broadly, Vietnam's health system changes reflect the global political shift towards neoliberalism which has promoted a transition towards covert or outright privatisation of health care in many LMICs (Sanders, 2023). Yet, current conceptualisations of health systems responsiveness do not account for the role of the market in responsive care provision. That is, how the rise of for-profit care can mean that service users are able to choose and pay for care which better responds to their expectations. In the section that follows, I present an analysis piece which seeks to address this omission by advocating for a nuanced, contemporaneous, and expanded conceptualisation of health systems responsiveness which reflects current political, economic, and health system shifts. This piece is currently under review in an international health journal and, included below, is the final version which has been submitted to the journal.

Abstract:

We critically interrogate the current conceptualisation of health systems responsiveness in light of ongoing political, economic, and health system transitions occurring in many low- and middle-incomes countries (LMICs), and call for a nuanced, contemporaneous, and expanded understanding of the concept. We begin by unpacking the economic and health systems transitions that LMICs have experienced in the last two decades, specifically the shift towards neoliberalism. We discuss the impact of these transitions, particularly, the rapid growth in for-profit care and the covert or outright privatisation of public health services, on health care provision. We then demonstrate how analytical frameworks about health systems responsiveness do not yet sufficiently reflect the role of the market in responsive care provision. In light of this, we make a case for explicitly recognising the role of the market logic in both shaping peoples' expectations of their health systems and the health system's response to these expectations, globally, but especially in LMICs.

Keywords: Health; health inequalities

Introduction

Over two decades ago, the World Health Organisation (WHO) proposed responsiveness as a key intrinsic goal of national health systems (WHO, 2000). Responsiveness corresponds to the health systems ability to meet peoples' legitimate expectations of their health system (Murray & Frenk, 2000). It is therefore considered a fundamentally important health system goal which helps safeguard the rights of patients to receive healthcare which meets their needs and expectations (Murray & Frenk, 2000). Yet, responsiveness continues to be the least well understood of the four agreed health system goals, with several scholars highlighting numerous conceptual shortcomings of existing frameworks (Mirzoev & Kane, 2017, Khan et al., 2021, Lakin & Kane, 202, Lakin & Kane, 2023). Mirzoev and Kane (2017) have argued that current frameworks of responsiveness (including the widely used and well accepted WHO conceptualisation) consistently overlook broader political, historical, and socioeconomic contexts. In this way, existing conceptualisations of responsiveness fail to sufficiently consider how evolving social and economic conditions, both within and external to the health sector, impact health system functioning, as well as peoples' interactions with and expectations of their health systems (Mirzoev & Kane, 2017, Lakin & Kane, 2022, McPake et al., 2020).

The transition to and towards middle-income status (or 'economic transition') is just one of a series of shifts and changes impacting many countries in recent decades (Mirzoev & Kane, 2017, McPake et al., 2020, Jahan et al., 2014). In many ways, these economic transitions have been driven by the ideas of market capitalism and the macro-economic, neo-liberal policy turn of many countries around the world. These policies were coined "neoliberal" as they liberalised and notionally liberated major markets (including the health care market) from government control, among other things, with the aim of rapidly expanding access to care, and to growing national economies. These economic transitions, within the context of neoliberal globalisation, have also led to and shaped the expansion of the private sector in many LMIC health systems, significantly improving the availability and accessibility of health services in these contexts (McPake et al., 2020, Sanders et al., 2023). This has seen a new paradigm emerge — that the market could (and some argue that it should) also provide care to poorer populations living in LMICs. Here we argue that this paradigmatic shift and these economic and political transitions and changes, are insufficiently reflected or acknowledged within current conceptualisations of health systems responsiveness. This is in some ways unsurprising given that the notion of responsiveness was proposed by the WHO over two decades ago, primarily with the public health sector in mind. Addressing this conceptual gap is important now more than ever as scholars and policymakers increasingly focus on and work towards improving health systems responsiveness, globally, and in LMIC-contexts (Mirzoev & Kane, 2017, Khan et al., 2021, Lakin & Kane, 2022, Lakin & Kane, 2022).

In this analysis, we argue for a nuanced, contemporaneous, and expanded conceptualisation of health systems responsiveness which reflects current and ongoing global political, economic, and health system transitions. We begin by unpacking economic transitions that have specifically impacted LMICs in the last two decades, driven by the shift towards neoliberalism, and the subsequent impact on healthcare provision. We then demonstrate how economic transitions such as these are not sufficiently accounted for in current conceptualisations of health systems responsiveness. In light of this, we call upon health system actors to recognise the impact of market logics and processes on the responsiveness of care provision, globally, but particularly in LMICs.

Political, economic, and health system shifts in recent decades

By the early 1980s, a major economic recession accelerated the global drift and shift towards neoliberalism – the new political, economic, and social arrangements emphasising the potential of market relations and logics as a way to organise social relations and institutions (Sanders et al., 2023). Some of the elements of neoliberalism included privatisation, a reduction of government control over private industry, as well as a "government deficit reduction" which saw cuts in public services. These neoliberal policies aimed to grow national economies and, in the decades that followed, contributed towards rapid economic changes and transitions. In 2000, sixty-six countries were classified as having 'low-income status', while a further fifty-five were 'lower-middle income' countries. Among those classified as low-income were countries such as India, Vietnam, Indonesia, and Bangladesh – now known as the Asian 'tiger economies' (McPake et al. 2020, World Bank, 2022). As such, when the World Health Report (which proposed responsiveness as an independent goal for health systems) was published in 2000, 40.8% of the global population were living in low-income countries (World Bank, 2019).

These political and economic changes and transitions also saw a paradigm shift in health care provision. A strong public health system had initially been seen as the only viable option to provide care to underserved populations in LMICs. The neoliberal turn within the political economy meant that the view that the market could be a mechanism to provide care to all citizens came to be increasingly accepted (Sanders et al., 2023). On the other hand, sustained and rapid economic growth in many LMICs has also seen an increasing demand for better quality health care which meets peoples' increasing expectations (McPake et al., 2020, Bloom et al., 2014). This includes the emergence and expansion of the middle class, with the necessary purchasing power to make private health care feasible and profitable (Sanders et al., 2023). This demand has thus created significant market opportunities within the health sector. And the market or the market logic is an increasingly important feature of health systems across countries. By 'market logic', we refer to the various actions and interactions relating to competition, reputation, and revenue and profit maximisation occurring within healthcare-providing institutions (Kane et al., 2021). The market logic has impinged upon global health systems through the adoption of various neoliberal policies such as, liberalisation, the application of user fees and cost-recovery in public health services, as well as creating competition between providers (Sanders et al., 2023). In particular, the reduction in public funding for health

care services has prompted a transition towards covert or outright privatisation of health care in many LMIC health systems (Sanders et al., 2023, Bloom et al., 2014).

Among other things, private providers "fill the gaps" the public health sector has left or is unable to meet, particularly in relation to the accessibility and availability of health services (McPake et al., 2020, Sanders et al., 2023). The case of India is aptly illustrative of this. In the late 1980s, India experienced a push towards liberalisation and, from 1991 onwards, there was a significant reduction in government expenditure and investment in health care which has contributed towards a poorly functioning public health system (Kane et al., 2022, Bagchi, 2022). This has driven the growth of the private health sector, which currently dominates health care provision (Datta & Chaudhuri, 2022, Kane et al., 2022). Private sector growth has been stimulated by successive governments in different ways, such as through the exemption of taxes and duties on drugs and high-tech medical equipment, as well as by encouraging the establishment of "super speciality hospitals" to provide high-quality care (Bagchi, 2022). As Bagchi (2022) explains, these liberalisation policies and health sector reforms, which occurred throughout the 1990s and 2000s, saw a shift towards the commodification of health care in India. Hospitals had now become "commercial enterprises" and patients were now "clients". Therefore, as Datta and Chaudhuri (2022) point out, in a health system context where the main payment method is fee-for-service and out-of-pocket payments are the norm, patients are particularly susceptible to provider-induced demand. That is, to maximise revenue, for-profit providers may be motivated to, for example, provide non-essential services which the public services would ordinarily not, or, to provide high-end services which the public sector is not able to provide (Sanders et al., 2023, Bloom et al., 2014, Adams et al., 2019, Ahmed et al., 2013). Adams and colleagues (2019) revealed how private sector actors utilise various "market strategies" to increase patient footfalls and flow, improve client satisfaction, and, ultimately, derive profit, such as 'patient discounts' and 'commission for referrals'. This may also include investing more heavily in human resources or infrastructure developments which can improve aspects of responsiveness, such as access to basic amenities and prompt attention (Bagchi, 2022). As a result of these market-driven activities and processes, private providers have been found to, expectedly, better respond to patients' needs and also expectations (Bagchi, 2022, Datta & Chaudhuri, 2022). This could account for the fact that, in India, and irrespective of economic status, people prefer to seek care at private health facilities due to perceived better quality, more responsive

care (Bagchi, 2022, Datta & Chaudhuri, 2022). As such, it is estimated that an overwhelming 62% and 75% of inpatient and outpatient cases in India are treated in the private sector, with private sector care utilisation being high across all income groups (Datta & Chaudhuri, 2022). That said, a substantial proportion of indebteness in India is directly attributable to peoples' preference for seeking care at private hospitals (Kastor & Mohanty, 2018). Like many other LMICs, the Indian private health sector serves different economic classes, including the poor who are especially dependent on private informal healthcare providers (Bagchi, 2022, Datta & Chaudhuri, 2022, Kane et al., 2022). As Mackintosh (2003) argues, commercialisation and marketisation restructures the logics of health care provision – it reconfigures internal hierarchies and the determines those who it treats, as well as those it excludes. In fact, this expansion of for-profit care provision in countries such as India, while improving availability and quality (and responsiveness), may be at the expense of health equity and sometimes quality.

McPake and Hanson (2016) emphasise that private sector providers are highly heterogenous with respect to their size, objectives, and quality of care provided. Non-for-profit private providers, such as large, non-governmental organisations (for example, BRAC in Bangladesh) or smaller scale, faith-based providers, may also be integrated within national health systems alongside the for-profit private and public sectors (Ahmed et al., 2013, Võ & Löfgren, 2019). While not-for-profits explicitly aim to serve the public, like the for-profit sector, they too are exposed to market forces and operate through market logics. It is therefore important to note that the survival of the not-for-profit sector may also depend on revenue generation which, in turn, might affect the "behaviour" of the sector at large (Võ & Löfgren, 2019). In certain contexts, we also see the covert entry of market logics within the public health system, particularly as a result of what is called the 'autonomisation' of public health services. Autonomisation reforms and policies seek to reduce direct governmental control over public hospitals and facilities and thereby induce their exposure to market and market-likes forces (Xu, 2011). The experiences of China and Vietnam are aptly illustrative of these evolutions. In China, economic reforms have been in motion for over three decades, transforming the country's economy from being centrally-planned, to one that is a mixed-market with a significant private sector (Duckett, 2020). "Neoliberal-looking", pro-market policies and reforms in the 1980s and 1990s saw the partial commercialisation of healthcare and the Chinese health system, formally publicly provided, subsequently transition towards a mixed health system (Kane

et al., 2021). As tax-based public funding of the public sector fell, a system of 'fees for services' was introduced to enable public health facilities to recover their costs (Kane et al., 2021). As such, work by Kane et al., (2021) in Shanghai has shown how public facility managers' actions and decisions were partly driven by competition and a concern for their reputation, all of which ultimately had an impact on the profit generated by the facility (i.e., the market logic) (Kane et al., 2021). The Doi Moi reforms of 1986 similarly saw Vietnam embark on a path of "market socialism", transitioning towards what has been termed a "socialist-oriented market economy". This shift towards neoliberalism has seen the country balance liberalisation, privatisation, and marketisation, with the maintenance of central controls (Xu, 2011 Võ & Löfgren, 2019). Within the health system, Doi Moi-related reforms including hospital autonomisation, have led to the diffusion of neoliberal market strategies within the public health system (Klingler-Vidra, 2014). Hospital autonomisation policies, introduced in 2002, granted varying degrees of autonomy to public service delivery units in terms of personnel, organisation and management of service provision, and finance. As Võ and Löfgren (2019) have analysed, such policies have encouraged public providers to charge fees for 'high-tech' diagnostic equipment and other "on-demand services" which, they argue, can serve as a "strategic instrument" to maximise providers' revenues within the public health sector (Võ & Löfgren, 2019). Importantly, Võ and Löfgren's (2019) analysis reveals that public facility mangers were acutely aware of patients' demands and needs for "advanced services" and responded accordingly by investing in these technologies to generate profit and become "financially autonomous" (Võ & Löfgren, 2019). As we discuss further below, these market strategies can also, in turn, shape and define what people come to 'legitimately' expect from their health system. Nevertheless, health system shifts and reforms in contexts such as Vietnam and China, have led to the market logic becoming a key institutional logic within public health systems too.

The point being that as LMIC health systems increasingly embrace for-profit care provision, it is possible for service users to choose and pay for care which better responds to their needs and expectations. That is, with the rise of for-profit and market-logic driven care provision across LMIC health systems, people can legitimately expect, demand, and get, responsive care. After all, the fundamental logic of the for-profit market is that the customer is king. Yet, as we discuss below, current conceptualisations of health systems

responsiveness do not sufficiently engage with or reflect this role of the market in responsive care provision.

Shortcomings in current conceptualisations of responsiveness

In her work, which lays the foundation for the WHO's conceptualisation, de Silva (2000) clarifies the 'scope' of health systems responsiveness. While patient satisfaction centres on peoples' interactions with specific health care settings, responsiveness evaluates the health system "as a whole". This, we contend, includes the private, for-profit health sector. However, neither de Silva's report (2000), nor the resultant WHO conceptualisation (2000) acknowledges how 'levels' of responsiveness may vary between the public and private sectors of national health systems (Khan et al., 2021). That said, market logics and processes are tacitly considered, to some extent, within certain responsiveness frameworks that have followed. Within their conceptual model, for instance, Robone et al., (2011) include 'health system organisation' as a key environmental characteristic influencing the responsiveness of health systems which, in turn, is a determined by the political process within countries. This component relates to the way a health system uses its resources, such as the proportion of total health care expenditure consumed by the public health sector. Notably, Robone et al., (2011) acknowledge that health care quality is dependent upon market incentives – as private providers depend on payments from service users, they are more likely, than public providers, to respond to patients' expectations of care. Nevertheless, despite this exception, no other health systems responsiveness framework or conceptualisation acknowledges the role of the market in shaping responsive care provision.

Several empirical inquiries confirm these assumptions. For instance, Negash et al., (2022) recent study examined the responsiveness of primary care facilities in Ethiopia, finding that patients utilising private clinics reported higher levels of responsiveness. They postulate that this could be because private facilities' need to "maximise revenue" – and therefore, to increase demand and maximise profit, private providers need to be more responsive to service users' expectations. Similarly, Peltzer's (2009) analysis found that the degree of responsiveness of publicly provided health care in South Africa was significantly lower compared to private health care. Private clinics have been found to outperform public clinics by having shorter wait times and better treatment of patients, albeit with a cost of more than 27% per visit (Palmer et al., 2003). Similarly, recent research from Vietnam shows that what women legitimately expected from the health

system was shaped by for-profit providers practices to maximise revenue (Lakin et al., 2024). These legitimate expectations included having access to high-quality, colour ultrasonography and other on-demand services available within private health facilities, but also accessible within the public health system to those who could pay. Women from all economic strata were willing to bear the cost of consulting for-profit private providers as these providers were willing to meet their particular (albeit medically unwarranted) expectations (Lakin et al., 2024). Work by Gammeltoft (2007, 2007) and others (Holmlund et al., 2020, Ngo & Hill, 2011) has revealed how obstetric ultrasounds, in particular, can serve as "revenue-generating services" for both public and private providers to increase patient numbers. They argue that such market strategies have contributed towards the overuse and commercialisation of obstetric ultrasounds in Vietnam. We suggest that these findings are also broadly indicative of the commercialisation and marketisation of responsive care.

How all then does the market logic shape providers' practices and what people can legitimately expect of their health systems? The neoliberal turn has brought about the commercialisation of health care – and, to generate profits, providers need to cater to and invest in meeting their customers' expectations and to satisfy their demands – sometimes inappropriate and unreasonable demands that can be detrimental to individual and population health too (Lakin & Kane, 2023, Sanders et al., 2023). Market-oriented provision of health care involves the patient's role transforming from a 'service user', to that of a 'purchaser' or 'customer' who comes to expect to be served in line with what she is paying. As an illustration, in a study amongst women in a rural province of Vietnam, women generally believed (and expected) that they would be treated respectfully by private providers, as opposed to providers working within the public health system (Lakin et al., 2024). It also became clear that private providers where acutely aware of these expectations and responded appropriately by improving their attitudes towards service users (Lakin et al., 2024) In this instance, respectful care was utilised by for-profit providers as a market strategy to attract service users. As such, women directly associated the act of paying for a service with the outcome of receiving respectful maternity care. These market-driven practices shaped what women legitimately expected from the health system – if one could pay for it, one legitimately expected (and received) respectful treatment by providers, and, ultimately, more responsive care (Lakin et al., 2024).

As Lakin et al. (2023) have argued, legitimate expectations, as they relate to health systems responsiveness, are those that reflect and align with widely shared and accepted norms, values, beliefs, and standards. These are situated within and shaped by the broader social, cultural, political, and economic context (Lakin & Kane, 2022, Lakin & Kane, 2023). In this way, in countries which have experienced a neoliberal turn within the political economy, along with rapid and sustained economic growth, we have observed market-driven practices and strategies become the norm within health systems. In India, the domination of the private health sector has resulted in out-of-pocket payments for health care services become the norm (Datta & Chaudhuri, 2022). This may even be the case within the public health system in certain countries, like in China and Vietnam, where there has been covert entry of neoliberal or "neoliberal-looking" market strategies (Xu, 2011, Duckett, 2020). In view of this, we argue that peoples' assignments of legitimacy to their expectations of care, as well as being personally, socially, and locationally determined, are also coloured by these normative, market-driven logics and practices in health systems – and as such deserve to be included in the analytical frames used to study health systems responsiveness (Lakin & Kane, 2022, Lakin & Kane, 2023).

An expanded conceptualisation of responsiveness for an age of economic transitions

Political and economic transitions have drastically changed the nature of care provision, particularly in LMICs, since the WHO proposed the notion of responsiveness in 2000. Yet, these changes are not sufficiently captured within current analytical frameworks of responsiveness, which reflect the thinking of two decades ago that LMIC health systems are largely publicly financed. In this section, we argue for an expanded conceptualisation of health systems responsiveness – one which explicitly recognises the role of the market logic in both shaping peoples' legitimate expectations of their health systems and the health system's response to these expectations. We reflect upon the implications for future research examining the responsiveness of health systems globally, but particularly in LMICs.

De Silva defines responsiveness as the outcome achieved when, "institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals" (de Silva, 2000). As we have highlighted above, the expansion of market-driven care provision, underpinned by the shift towards neoliberalism in many countries around the world, has meant that healthcare-providing institutions and institutional relationships are now

increasingly driven and shaped by the market and market logic (Sanders et al., 2023). That is, by the various actions and interactions relating to competition, reputation, and profit maximisation (Kane et al., 2021). This has required for-profit providers to be acutely aware or cognisant of service user's (or customer) expectations, in order to appropriately respond to their demands with a view to, ultimately, make a profit. As we have highlighted above, the role of the market in shaping the health system's response to service user's expectations has been considered, often tactility, within certain responsiveness frameworks (Robone et al., 2011). Therefore, we argue that there is a pertinent need for analytical frames of responsiveness to explicitly acknowledge how the market logic shapes the health system's response to peoples' expectations of care – how it influences health system's resources, policies, organisational arrangements, as well as the actions and interactions of health system actors (Mirzoev & Kane, 2017). Such a conceptualisation must also recognise the role the market can play within the not-for-profit and public health sectors of national health systems where, as we have shown above, there may be the covert entry of market logics and processes (McPake & Hanson, 2016). On the other hand, as we have also demonstrated above, peoples' legitimate expectations of their health systems can also be shaped by the normative, market-driven activities and logics of for-profit providers, aside from being socially, personally, and locationally determined (Lakin & Kane, 2022, Lakin & Kane, 2023). This means that if one can pay for it, one can legitimately expect and receive responsive care. While this consideration has been captured in some empirical inquiries, it is also missing from existing conceptualisations of health systems responsiveness (Negash et al., 2022, Peltzer, 2009, Palmer et al., 2003). Extending upon Lakin and Kane's (2023) conceptualisation of legitimate expectations, we call for frameworks of responsiveness to consider how the market logic defines peoples' legitimate expectations of care. But also, how these expectations, in turn, shape their care-seeking decisions and choices, and subsequent health system interactions and experiences (Mirozev & Kane, 2017).

That said, in order to sufficiently advance this expanded conceptualisation of health systems responsiveness, several questions need to be raised and addressed. For instance, there is a need to unpack how the market logic shapes provider behaviour – those at the forefront of care provision – and with what consequences for responsiveness to the service user. As Mackintosh (2003) suggests, a distinguishing feature of the commercialisation and marketisation of health care is changing patterns of behaviour. In this way, there is a

need to unpack how providers, in different health system contexts, utilise market incentives to generate profit, across for-profit and not-for-profit health sectors, while appearing highly responsive. But also, how provider-induced demand for unnecessary services, high-tech medical equipment, drugs, or other potentially unscientific and damaging medical treatments can contribute towards unreasonable expectations and demands of service users while appearing to be highly responsive (Lakin & Kane, 2023)? Similarly, how does the market logic shape the actions and decisions of managers and administrators who set the standards, norms, and create the processes that guide service provision? More broadly, how does the neoliberal turn in the political economies of countries around the world shape the decisions of policymakers and politicians who set key political priorities which define the overall direction of health systems development, prioritisation, and crucially resource allocation? Future empirical work is also needed to unpack how exactly the market logic shapes what people legitimately expect from their health systems (including but not limited to the elements of health systems responsiveness) and how this influences their subsequent encounters with health systems, particularly with the private health sector. The diffusion of neoliberal market strategies, both within public and private health sectors, has gradually shifted the financial burden from the State onto service users. While there has been rapid and sustained global economic growth and development in recent decades, current trends reveal that economic burdens are disproportionately felt by those residing in rural areas, as well as regions, such as in Sub-Saharan Africa and the Middle East, currently facing climate- and conflict-related threats (World Bank, 2021). In this way, the expansion of for-profit care provision, while improving access and responsiveness, may be at a detriment to health equity. As Mackintosh (2003) argues, commercialisation of health care, while being 'sold' as a policy for improving equity, "has generally acted to embed inequality in new forms". We therefore call for further research to examine the costs (direct and indirect, monetary, and non-monetary related) associated with people's pursuit for responsive care – in various regions around the world and for different population groups, but particularly the poor.

Conclusion

The last two decades have been characterised by rapid economic growth in many regions of the world, spurred on by the shift towards neoliberalism. This has seen a paradigmatic shift towards market-oriented care provision. As such, service users are now able to choose and pay for care which better responds to their demands and expectations. In this

analysis, we have highlighted how this shift is currently absent from existing analytical frameworks of health systems responsiveness. In light of this, we call for an expanded and contemporaneous conceptualisation of health systems responsiveness – one which sufficiently captures the impact (both, positive and not so positive), of market logics and processes on the responsiveness of care provision. To sufficiently advance this nuanced conceptualisation, we have outlined a research agenda for scholars working on examining and improving the responsiveness of health systems globally, but particularly in LMICs.

Author contributions

Both authors were involved in the conceptualisation of the paper. KL conducted the initial analysis and developed the first draft of the paper. Both authors revised it critically for intellectual content and approved the final version to be published. SK provided overall supervision. Both authors agree to be accountable for all aspects of the work.

Data availability statement

The data that support the findings of this study are derived from public domain resources.

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Declaration of Interest

The authors declare no competing interests.

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6.2.5 Improving the responsiveness of the Vietnamese health system

As defined in Section 1.1, health systems responsiveness is the outcome that can be achieved when health care institutions are able to respond appropriately to peoples' "universally legitimate expectations" (WHO, 2000). As I outline in Section 5.3, women in this study generally felt that the Vietnamese health system met their initial expectations of care. These mainly related to modern equipment (particularly high-quality ultrasonography), short waiting times, and detailed consultations. However, closer examination of women's accounts (detailed in Section 5.2) revealed elements of their care experiences which did not meet their initial expectations, especially with regards to privacy, respectful treatment, and autonomy.

Privacy during care is one of the "respect for persons" domains of responsiveness put forth by the WHO (2000). Women did not initially discuss their expectations relating to privacy but, when prompted, they described instances when they felt their privacy was compromised. These "uncomfortable" and "awkward" experiences occurred during antenatal check-ups at private facilities, where women were separated from other patients (including male patients) by a curtain. Following birth at public district and provincial hospitals, women reported recovering in a room with up to eight patients. Such findings potentially signal the need for structural and organisational changes, within both public and private health facilities in Vietnam, that can facilitate the privacy and confidentiality of patients. For instance, constructing separate, closed consultation rooms or limiting the number of patients recovering in post-delivery rooms. However, it did emerge that women could pay for an "on-demand" private service room after giving birth at both the district and provincial hospitals. Expectedly, some women's decision to choose such a service, which facilitated their privacy, was constrained by their poor socioeconomic situation. In this way, access to privacy (and responsive care) following birth is potentially constrained by and contingent upon women's socioeconomic circumstances. Creating and instituting regulatory systems can be one strategy to control and manage the revenue-maximising practices of for-profit providers in Vietnam. More effective regulation of for-profit care in Vietnam can be important for addressing income-related inequalities in access to care which is responsive to peoples' expectations, such as those relating to privacy.

‘Respectful treatment’ is a feature of the domain of ‘dignity’ within the WHO-proposed responsiveness framework (WHO, 2000). As described in Section 5.3, being treated respectfully by doctors and other health staff was perceived by women as a ‘legitimate’, though ‘ideal’, expectation. Yet, women reported instances of being treated disrespectfully by providers at public health facilities, leading to the perception that such treatment was the ‘norm’. These findings call to attention the need for providers, specifically within the public health system in Vietnam, to be cognisant of service user’s, including but not limited to childbearing women’s, expectations of respectful, dignified care – what ‘respect’ entails and how it can be conveyed to individuals during their care encounters (as some women described in Section 5.3). This may require further support for and training of health care workers in the provision of dignified care to women throughout their pregnancy and during childbirth. In this study, women did not formally raise their concerns with providers or facility mangers about experiencing disrespectful treatment. As Thi Thu Ha et al. (2015) reveal, poor implementation of the MoH regulation on complaints (Decision N44/2005), as well as patients’ limited knowledge of the complaint system, can hamper the collection and handling of patients’ complaints within public hospitals in Vietnam. Moreover, perceptions of their lack of power can prevent patients from making formal complaints about poor treatment in the first place. Addressing these issues can be vital for ensuring the Vietnamese health system is accountable to service users, including but not limited to childbearing women, and responsive to their expectations of respectful care.

Finally, women’s accounts revealed that health professionals, at times, only consulted their husbands when it came to deciding on a caesarean section. As a result, some women underwent a caesarean section despite their preference for a normal childbirth. The element of autonomy, within the WHO responsiveness framework, relates to the ability of an individual to act autonomously when making decisions regarding their health. This includes the right to choose what interventions they do or do not want to receive (Murray & Frenk, 2000). As such, the findings of this study showed that women’s autonomy was, in some cases, compromised when they were not able to autonomously choose to have, or not to have, a caesarean section. Similar findings have been reported in a study by Nguyen et al. (2022) that was conducted with women with physical disabilities in Vietnam. The analysis in Section 5.2 revealed that women’s decision-making power and autonomy was potentially restricted by prevailing cultural norms of the husband being

the primary decision-maker within the Vietnamese family. This points to the need for health system actors to be cognisant of how such social and cultural structures and norms shape patient autonomy and consent procedures within health care institutions. These considerations can be incorporated into training and education programs for health care providers in Vietnam. More broadly, as I proposed in Section 3.3, the creation of durable, regularised spaces for citizen participation can be vital for the ongoing contestation and negotiation of entrenched health system norms which define what citizens 'legitimately' expect form their health systems.

6.2.6 The paradox of power encountered by women in contemporary Vietnam

An overarching finding, which emerged during the fieldwork, as well as in the CIS, related to Vietnamese women's autonomy and agency during pregnancy and childbirth. As such, in Section 5.4, I analysed the relevant empirical data with a view to uncover new insights on the complex gender dynamics and relations evident in contemporary Vietnam. Below, I draw together these findings and reflect on the implications for future research and policy in Vietnam.

As I discussed in Chapter 2, three distinct social and economic movements in the history of Vietnam – Confucianism, the rise of Socialist Marxism, and the Doi Moi reforms – have had, and continue to have an impact on Vietnamese women's autonomy and agency. Vietnamese Confucianism – which is distinct from Chinese Confucianism – is a broad cultural element of Vietnamese society (Whitmore, 2023). Within the private sphere, prevailing Confucian traditions can mean that Vietnamese women are required to do the majority of work (unpaid) within the household while, in the public sphere, maintain full-time employment. In this way, Vietnamese women can be fondly referred to as "Generals" or "Ministers" of the "interior", with such a title, as Do and Brennan (2015) argue, reflecting the confinement of Vietnamese women's power to the "hidden" or "interior" of the domestic sphere (Drummond & Rydstrøm, 2004). As the analysis in Section 5.3 revealed, aside from engaging in full-time employment, women were expected to fulfil their duties as wives and mothers by attending to household and childrearing responsibilities. This left them little time to attend antenatal check-ups and, as a result, they expressed a need for visiting health facilities close to their homes and/or workplaces which had short waiting times – needs private providers capitalised on. This saw most women embark down the private "medical route", revealing how women's care-

seeking decisions and choices, apart from being shaped by the market forces and relations within the Vietnamese health system, were also constrained by gender and cultural norms (Dao, 2023). Confucian traditions also constrained women's agency through their decision of having another child, as I uncovered in Section 5.4. Even while they were pregnant, women explained that they would be having another child, especially if the current baby was a girl, as having a son was necessary to carry on the family lineage (in accordance with patrilineal practices). More broadly, women reflected upon the expectation of their in-laws, which was sometimes not explicitly conveyed, to "give birth more". While these findings suggest that Confucian gender and cultural norms prevail in private, domestic spaces, several instances highlighted how such forces also persist within health care spaces, as a number of studies have also found (Werner, 2004, Drummond & Rydstrøm, 2004, McKinn et al., 2019, Nguyen et al., 2022, Nguyen et al., 2023, Holmlund et al., 2020). This finding was especially apparent in the analysis in Section 5.2, where women's autonomy was compromised when the decision on having a caesarean birth was, at times, taken out of their hands entirely. This was facilitated by the health professional, who only consulted the husband when seeking a decision.

Yet, one woman pointed to her right to bodily autonomy and that, ultimately, she would need to "listen to [her] own body", irrespective of what the health professional advised. Other women also challenged the long accepted traditional gender norm of Vietnamese men being the primary decision-makers. Many women were clear that they made their own decisions, and their stories reveal that this was, at times, facilitated by their husbands and in-laws who gave them the capacity to do so. Rydstrøm and Drummond (2004) argue that Vietnam's economic progress under Doi Moi has brought about significant societal change which has encouraged new ways of enacting oneself as a gendered person. Contemporary Vietnamese women have come of age under very different social and political experiences, most of them representing the first generation of Doi Moi (Werner, 2004). Werner (2004) thus suggests that the present generation of Vietnamese women are mainly oriented towards achieving economic stability for their families, reflected in Vietnam's high labour force participation rate (Banerji et al., 2018). This trend is evident in Bắc Giang, as well as amongst the study participants I recruited – all but two women were employed full-time (General Statistics Office, 2020). In the analysis in Sections 5.2 and 5.4, it emerged that women's concern for their family's economic position shaped the various decisions and choices they made. For instance, in Section 5.2, a woman

weighed up the cost of using an on-demand room after giving birth, ultimately deciding to stay in a normal room to "save some money for the family". As this and other accounts suggest, some women appeared to be the major (if not the primary) decision-maker when it came economic matters within the family. Such examples not only signal the informal or hidden power women possess over the family economy, but also a shift in women's roles from the domestic spheres of childbirth and childrearing towards achieving economic stability for their families.

That being said, many women drew on several trusted sources of knowledge to make informed decisions during their pregnancy and childbirth, as is evident in a number of studies (McKinn et al., 2019, Huong et al., 2021). Particularly, women perceived health professionals as sources of science-based knowledge which, to them, can be more reliable than the experience-based knowledge of other women (Graner et al., 2010). Women's reliance on the science-based expertise of health professionals was a finding that similarly emerged in the analysis in Section 5.2. Such a need appeared to stem from their perceived lack of "formal power" by way of not having medical knowledge, but also a concern for the health of their baby (Do & Brennan, 2015). Another source of knowledge and formal power can be a woman's husband and some studies have revealed instances of joint decision-making when it came to the birth (White et a., 2012). Likewise, the findings in Section 5.2 and 5.4 revealed how women felt it necessary to make decisions together with their husband, not only in relation to the birth but generally in their lives too. While there is an inevitability to the involvement of family members in these important 'family' decisions, such findings could point to the "paradox of power" experienced by women in contemporary Vietnam. Though women appeared decisive, independent, and capable in both public (health care) and domestic spheres, their agency remains structured and constrained by cultural and gendered expectations and norms. Making a joint decision therefore potentially offered a means for women to navigate the complex gender dynamics and power relations present in Vietnam today. As Do and Brennan (2015) argue, the clashes between the forces of Confucianism, Socialism, and market Socialism has given rise to a contradictory set of gender identities, norms, and relations in contemporary Vietnam (Werner, 2004). While I examined an intimate aspect of women's autonomy and agency (i.e. during pregnancy and childbirth), these findings emphasise the need for future research to examine the paradox of power Vietnamese women encounter both within private and public spheres. As the CIS highlights, this paradox is

insufficiently engaged with in the current healthcare literature which predominantly focuses on the impact of patriarchal Confucian traditions on Vietnamese women's unequal decision-making power. There is also room for health policies, those related to maternal and reproductive health care and broadly, to be reimagined and to take into account these evolutions in decision-making.

6.3 Implications for research, policy, and practice

The findings from this inquiry have called to attention several important areas for future research, policy, and action, globally and specially in Vietnam. Below in Table 3, I outline an agenda for researchers, policymakers, and practitioners working on health systems responsiveness, as well as for those seeking to specifically examine and improve the care of childbearing women in Vietnam. These recommendations are also outlined in detail in the respective peer-reviewed and "in-progress" pieces included in Sections 3.2, 3.3, 5.2, 5.3, and 6.2.4.

Topic	Agenda for future research, policy, and practice

Health systems responsiveness	• Consider 'legitimate expectations' within conceptualisations of responsiveness, and in empirical inquiries examining the responsiveness of country health systems
	• Analyse the WHO-proposed domains of health system responsiveness
	  • Examine peoples' perceptions of responsive health systems, not limited to these domains
	• Advance a nuanced conceptualisation of responsiveness which acknowledges the role of the market
	  • Examine how the market logic shapes peoples' expectations of care
	  • Examine how the market logic shapes the health system's response to these expectations - how it shapes the behaviour of healthcare providers, managers, administrators, and policymakers
	  • Consider the implications for health equity

The patient experience	• Engage with 'expectations' as key determinants of peoples' health system interactions • Examine how past care experiences temporally shape peoples' future expectations of care • Examine how evolving social, economic, and political conditions shape peoples' engagements, experiences, and interactions
Legitimate expectations	• Consider the perspectives of health system actors on what are legitimate expectations of health systems • Examine how peoples' social, temporal, and spatial locations shape what they legitimately expect of health systems • Examine how the market logic shapes peoples' legitimate expectations of care • Understand and trigger the processes to create durable and equitable spaces for citizens to contest legitimate expectations of responsive health systems

Topic	Agenda for future research, policy, and practice
	• Examine how these processes differ across health system contexts and political systems

Vietnam-specific	• Consider structural and organisational changes, within public and private health facilities, to facilitate patient privacy and confidentiality
	• Training of health care workers on the provision of dignified care and patient autonomy
	• Strengthen and increase awareness of complaint handling systems
	• Engage with the growing shift towards market-oriented provision of care
	  • Create and institute regulatory systems and instruments for for-profit providers
	  • Consider the consequences for health equity
	• Examine how women's autonomy and agency operates within and across private and public spaces
	• Analyse the multiple and contradictory gender roles and norms present in post-Doi Moi Vietnam

Table 3: An agenda for future research, policy, and practice

6.4 Positionality and self-reflexivity

Vietnam has had a brutal history of French colonial rule. The period of French colonialism (1859-1954) saw the country exploited for its natural resources and "cheap labour", while citizens endured the regime's taxation policies, racial prejudice, and limited access to education and health care (Ashwill & Diep, 2005). The oppression of colonisation has had, and continues to have, broad implications, including for global health research. The history of Western researchers claiming ownership over non-Western views and knowledge can mean that, for those who have been oppressed by colonisation, research can be perceived as a "dirty word" (Thambinathan & Kinsella, 2021). This has spurred calls for the "decolonisation of research" – giving importance to and centring the world views of non-Western individuals and understanding research from "othered" perspectives. While this study was not framed by a decolonisation lens, I did engage with a key practice of decolonisation research – critical self-reflexivity. Self-reflexivity is also central to conducting high-quality qualitative research. Tracy (2010) describes self-reflexivity as the practice of being "honest" with one's self, one's research, and one's audience. Reflexivity is particularly central to "etic" approaches to research, in which the researcher makes sense of an event or phenomenon as an "external observer" or "outsider", albeit with a view to ultimately understand "insider" perspectives (Darling, 2016). However, adopting a purely "etic" approach to research can mean "cultural nuances" may be overlooked by researchers who are "outsiders" (Darling, 2016, Olive,

2014). Thus, reflexivity, at all stages of research, is key for "outsider" researchers to consciously reflect on and make sense of their observations, interactions, and experiences. Within decolonisation research, critical self-reflexivity can be important for addressing power dynamics in research, while being aware of the epistemological assumptions that impinge upon one's view of the world. Within research, this has implications for the questions that researchers pose, as well as the answers that they seek (Thambinathan & Kinsella, 2021).

Even before entering the field, researchers can practice self-reflexivity by being introspective and examining their biases, motivations, shortcomings, as well as their positionality (Tracy, 2010). I began this study as new postgraduate in Public Health from the University of Melbourne. For me, embarking down the "public health" route was quite a deviation (and a challenge), having previously completed a Bachelor's degree in Science. Therefore, being a relatively new qualitative researcher at the time of the fieldwork, I felt that I was still learning and developing the skills required to conduct good qualitative research. Having never been to Vietnam, I also felt significant pressure to learn the cultural beliefs and customs in a relatively short period of time. Of course, this was not to mention not knowing Vietnamese, which I thought might prove to be a challenge when it came to building a rapport with the study participants. However, as I reflected on all these limitations before beginning the journey to Hanoi for the fieldwork, I considered some of my motivations too. I wanted to tell an interesting story of Vietnamese women's care encounters. A story that provided a glimpse into the complexity of contemporary Vietnam which, as yet, had not been sufficiently captured in the scholarly literature. Ultimately, I wanted to do justice to the experiences of the women who would share their stories with me.

As one moves into the field, self-reflexive practices evolve; researchers examine their impact on the scene, noting their thoughts and experiences, as well as others' reactions to them (Tracy, 2010). I maintained a field notebook throughout the fieldwork, reflecting on my observations, thoughts, and experiences during the interviews, as well as in the evenings when I returned to Hanoi. As I explain in Section 4.6.7, robust, "full-bodied" qualitative research is produced when researchers make full use of their "bodies and senses" (Sandelowski, 2002). Central to this practice, is the notion of positionality – recognising how perceptions, biases, and multiple, intersecting identities operate within the space occupied by the researcher and participant(s). In this way, positionality is

determined by, "where one stands in relation to 'the other'" (Bourke, 2014). As a mid-20-year-old migrant with British-Indian ancestry, I have always been acutely aware of my distinct identity within Australian society. To my surprise, I found that my identity was actively challenged by several people I encountered in the field. For one, I was not seen as an Australian – several people I met bluntly told me so. More importantly, not being a mother or having my own lived experience of pregnancy and childbirth was a point that was raised by several of the women I met. Therefore, these encounters made me acutely aware of my position as an outsider – not only was I perceived as a cultural outsider, but an outsider with regards to motherhood too. In one instance, while we engaged in friendly conversation after an interview, a woman passed me her baby to carry and was amused at my inexperience of holding her child. She asked Dinh Thu Ha how old I was and, upon realising we were the same age, she laughed saying, "I am the same age as you and have three children. You are not even married!" (18th October 2022). I recorded this encounter in my field notebook that day, noting that it was symbolic of the differences in social locations between me and the women participants. These "axes of difference" did not only relate to culture, but motherhood too (Pedwell, 2010). This encounter also prompted me to reflect on the power and importance accorded to motherhood in this context, which I might have easily overlooked given my own cultural biases. In this way, Dinh Thu Ha served as a cultural insider throughout the fieldwork and during analysis, helping me to navigate and understand such "cultural nuances" (Darling, 2016). As I described previously in Section 4.6.3, my discussion with Vietnamese anthropologists and sociologists were also key to informing my understanding of the social and cultural context of contemporary Vietnam. As Thambinathan and Kinsella (2021) point out, utilising cultural insiders or brokers can be a key practice within decolonising research to promote understanding of alternative (or "othered") perspectives. Nevertheless, there is a need for qualitative researchers to consciously apply decolonising methodological practices to future research, especially research situated in countries that have a history of colonialism like Vietnam (Thambinathan & Kinsella, 2021).

6.5 Reflections and limitations

In this section, I critically reflect on this thesis as a scholarly enterprise. Specifically, I consider the quality of the research undertaken, in light of the "eight "big-tent" criteria

for excellent qualitative research", proposed by Tracy (2010). I hold these criteria up as a mirror against the research conducted and ask: what could have been done differently? In responding to this question, I reflect upon the limitations of this inquiry.

Tracy (2010) suggests an eight-point conceptualisation of qualitative inquiry, drawing on criteria previously proposed by notable qualitative scholars such as, Lincoln and Guba (1985) and Creswell (2007). These criteria, Tracy (2010) argues, are "unique" and even "provocative" as they outline the eight "universal hallmarks" of high-quality qualitative methods. These criteria include: worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethical, and meaningful contribution. In this way, the conceptualisation distinguishes between the end-point goals of high-quality qualitative research and the various means, practices, and methods by which these goals are achieved. Below, I critically reflect on how the methods and practices I employed throughout the research and fieldwork facilitated the achievement of each "eight big-tent" criterion.

6.5.1 Meeting the eight "big-tent" criteria for high-quality qualitative research

In Section 4.2, I make a case for the worthiness of this inquiry which, I argue, is not only highly relevant and significant, but timely too. As I highlight, recent decades have been characterised by major economic transitions which have, in turn, spurred on a rapid expansion in for-profit private healthcare provision in all LMIC health systems. Such shifts and changes can have specific implications for what people 'legitimately' expect from their health system. Yet, current conceptualisations of health system responsiveness (and the resulting empirical literature) fail to sufficiently consider how these evolving social and economic conditions shape peoples' expectations of and experiences with their health systems (Mirzoev & Kane, 2017, McPake et al. 2020). Using the case of maternity care in Vietnam, in this study, I sought to tackle these empirical and theoretical gaps. I argue in Section 4.2, that such an endeavour is significant and important, now more than ever, as numerous scholars increasingly focus their efforts on improving the responsiveness of country health systems, particularly in LMIC contexts (Mirzoev et al., 2021, Khan et al., 2021). However, Tracy (2010) argues that it is research which exhibits "critical intelligence" – which challenges existing ideas and assumptions – that is consider "worthwhile", "significant", and "evocative". In this study, I sought to demonstrate this "critical intelligence" by challenging and building upon existing conceptualisations of

health systems responsiveness. In Sections 3.2, and 3.3, I critically examined the concepts of legitimacy and expectations as they relate to health systems responsiveness. Moreover, in Section 6.2, I proposed a nuanced conceptualisation of health systems responsiveness – one which takes into account the role of the market. In this way, this study has theoretical significance – it extends and builds on current disciplinary knowledge and understanding of health systems responsiveness. It also has heuristic significance by proposing and demonstrating novel approaches for examining peoples' expectations and experiences of their health systems. As I discussed above, such approaches can be applicable for research conducted in various health system contexts and for different population groups (Tracy, 2010). Therefore, while this study presents the unique case of maternity care use in Vietnam, the findings have theoretical and practical relevance and value across a variety of care contexts. This contributes towards the study's resonance with scholars, policymakers, and practitioners both globally, and in Vietnam (Tracy, 2010).

This study is also significant and timely for the context of Vietnam. As a consequence of Doi Moi, Vietnam has experienced dramatic social, economic, and health system shifts. However, as I highlighted earlier within the CIS in Section 2.5, such changes are insufficiently reflected in the current scholarly literature, particularly the literature examining childbearing women's care encounters. This study's findings demonstrate the growing privatisation and commercialisation of Vietnam's health system, particularly in rural areas of the country. These findings have thus challenged the existing narrow focus on public maternity care provision in rural Vietnam. Moreover, the study's findings (specifically Section 5.2) have highlighted the multiple, diverse, and contradictory gender roles and norms existing in contemporary Vietnam. In this way, I have tackled current assumptions, in the existing scholarly literature of Vietnamese childbearing women's limited autonomy and agency. It is through these means that I have demonstrated the relevancy, significance, and timeliness of this inquiry within Vietnam.

High-quality, rigorous qualitative research is defined by rich complexity with respect to theoretical constructs, data sources, contexts, and samples (Tracy, 2010). I began this inquiry (Chapter 3) with a detailed and critical look at two constructs that are central to the notion of responsiveness – expectations and legitimacy. I analysed how each construct was conceptualised and theorised in various disciplines with a view to define and

understand the concepts within health systems responsiveness. This culminated in the development of the intersectional, translocational, and relational framework for examining people's expectations of care (Section 3.2). In Section 3.3, theoretical insights from key disciplinary domains also informed the theorisation of what constitutes a legitimate expectation. These theoretical insights informed both the interview guides, which guided the inquiry, as well as the abductive analysis of data collected during the fieldwork. Moreover, as I outlined in Section 4.5, the work of Archer (2003) and Chalari (2009) on the 'internal conversation' underpinned the analysis of women's engagements (decisions, choices, preferences), experiences, and interactions with the health system. In this way, and as I discussed in Section 4.5, this study was foregrounded and framed by numerous theoretical lenses.

Rigour was further ensured by using appropriate procedures and practices for collecting and analysing data. I kept a field notebook throughout the fieldwork, recording my observations of participants and the context, as well as critically reflecting on the interview process. I also reflected on my positionality (see Section 6.4) and the affect my presence could have on the interview, as well as my interpretations of the data. Being self-reflexive about my own values, biases, and perceptions was essential for the sincerity of the study (Tracy, 2010). A de-briefing session was held at the end of each day and on a weekly basis to reflect on emerging findings, as well as the interview process. During these de-briefing sessions, we also discussed the suitability of recruited participants, as well as decided on analytical saturation and the cessation of data collection. Transcription and translation of the interviews was checked by Dinh Thu Ha (a bilingual Vietnamese researcher) for accuracy and, together, we discussed and resolved any discrepancies. Once, I completed the preliminary analysis of the interview data, my interpretations were actively discussed with Professor Sumit Kane and Dinh Thu Ha. These discussions informed subsequent rounds of data analysis. Throughout the study, I maintained a clear audit trail of all these research decisions and activities which allowed me to transparently describe the recruitment, data collection, and analysis processes in this thesis and resulting publications.

These practices mentioned above are also part and parcel of ethical research, another criterion of high-quality qualitative research. Within this study, I followed procedural ethical practices – the RESPONSE project (and this fieldwork) received ethical approval

from the relevant institutional review boards (see Sub-section 4.6.9) (Tracy, 2010). Informed consent was obtained from all participants and data were collected in a manner to ensure their privacy. All data collected during the fieldwork were anonymised and stored securely. In the field, I was also actively conscious of situational ethical issues, such as participants' distress during the interviews, and the steps that should be taken in such an event. Finally, I also sought to also maintain "ethical self-consciousness" (relational ethics) by being mindful of the impact of my words and actions on others, including both participants and other researchers involved in this study.

I approached data analysis with the aim of providing a thick description of Vietnamese women's care encounters, as is evident in Sections 5.2 and 5.3. In particular, and as Tracy (2010) calls for, I focused on showing how various social, cultural, economic, and gender structures and forces shaped women's expectations and experiences of the health system in Vietnam. This was essential for not only highlighting the complexity of women's care experiences, but for also situating these accounts within the context of post-Doi Moi, rural Vietnam (Tracy, 2010). To further support the credibility of the study, data were collected from both participant observations and in-depth interviews, and from two communes within the province of Bắc Giang. As I discuss above, several theoretical frameworks also underpinned the inquiry. Therefore, the triangulation of data sources, study sites, and theoretical lenses were all methods and practices through which I could demonstrate the credibility of this inquiry (Tracy, 2010). Finally, Tracy (2010) proposes that good quality qualitative research is meaningfully coherent. Throughout this inquiry, I sought to align research design and data collection and analysis, with the overarching theoretical framework and research objectives.

6.5.2 Study limitations

In light of the above reflections, I now consider: What could have been done differently? Tracy (2010) suggests that one of the key questions that qualitative researchers should ask themselves while reflecting on the rigour of their study is: Did the researcher spend enough time in the field to gather interesting and significant data? The fieldwork was completed over an 11-week period, and I felt that this allowed me sufficient time to gather enough data to meet the study's objectives and sufficiently answer the proposed research questions. Moreover, with the support and guidance of Dinh Thu Ha, I was able to understand and navigate the various cultural beliefs and customs within a relatively short

period of time. Spending more time in the field, however, could have allowed me to develop a deeper understanding of such beliefs, as well as the various social and economic forces that operated within Bắc Giang. Such "immersion" might have helped me form a more complete picture of life in a rural province in Vietnam and provide further nuance to the analysis I conducted. However, as I discussed in Section 4.6.3, my immersion in the field of inquiry did not only begin with the fieldwork in September – it began earlier working as a research assistant on RESPONSE and through the various discussions and interactions I had with key scholars in the field. My ongoing involvement in RESPONSE and with supporting the Vietnam country team was essential for developing my understanding of the social, economic, and health system context of Vietnam which informed the way I approached this inquiry. Together, the fieldwork and my immersion in the field through these interactions, experiences, and activities allowed me gather interesting data and present significant findings. That being said, my informal discussions with notable Vietnamese scholars mainly occurred during the later stages of the fieldwork. If these discussions were had earlier, they could usefully have informed the way I approached data collection, particularly the kinds of questions asked during the interviews. This could have involved, for instance, asking specific questions to develop a deeper understanding of women's role and position within the household.

Study participants were selected from two communes within one rural province in Vietnam and, as such, I acknowledge that the findings do not necessarily describe the expectations and experiences of *all* childbearing Vietnamese women. However, if the fieldwork had been conducted over a longer period, it might have been possible to recruit participants from other communes in Bắc Giang. In particular, it could have allowed for the recruitment of those with other lived experiences, such as women with disabilities or those from ethnic minority groups not included in this study (only three participants were from ethnic minority groups). Such diversity could have contributed to the complexity of women's care experiences. Nevertheless, the narratives presented in this study offer a nuanced insight into what Vietnamese women legitimately expect from the health system during their pregnancy and childbirth and how this drives their interactions with maternity care services. It is also important to recognise that the health sector changes instigated by Doi Moi may have impacted health system processes and activities differently in rural/mountainous regions, as well as in urban and suburban areas of Vietnam. It is essential, therefore, for future research to examine how peoples' expectations and

experiences of the health system in Vietnam, across mountainous, rural, urban, and peri-urban regions, have been differentially shaped and defined by Doi Moi.

Finally, it is important that the transcripts analysed included a "technically" and "conceptually" accurate translation of participants' accounts. During the translation process, it is possible that this "conceptual equivalence" may be lost and, with that, the true meaning of the participants words (Squires, 2009). To manage this, the transcripts were constantly checked for both technical and conceptual accuracy by Dinh Thu Ha and myself. This involved paying particular attention to context-specific names and terminology, such as the names of the various facilities women visited, which was important for distinguishing whether they were public or private providers.

6.6 Final conclusions – the way forward

There is an ever-increasing need to understand what people expect from their health systems. Particularly in low- and middle-income country contexts, which continue to experience rapid social, economic, and health system shifts. Health systems responsiveness, while a fundamentally important health systems goal, is poorly understood both conceptually and empirically. In this thesis, I have tackled significant gaps in current understandings of health systems responsiveness by presenting nuanced insights on childbearing women's encounters with the Vietnamese health system. The findings highlight some key considerations for researchers, policymakers, and practitioners working on improving the responsiveness of their country health systems.

Chief amongst these, is the need to critically and comprehensively examine peoples' legitimate expectations of their health systems – across contexts and for different populations groups. Such an examination should explicitly consider how evolving social, economic, and political conditions, both within and external to the health system, shape what people expect from their health systems. At an individual level, this includes unpacking how peoples' legitimate expectations are shaped by their social, temporal, and spatial locations. As such, peoples' perceptions of what constitutes a legitimate expectation varies across country and health system contexts. It is therefore important for health systems actors to initiate the processes for creating equitable, regularised, and durable spaces for citizens to participate and contest the norms and standards which specify the legitimacy of expectations. More broadly, this study has demonstrated the need for a nuanced and contemporaneous conceptualisation of health systems

responsiveness which explicitly acknowledges the role of the market in shaping responsive care provision. To advance this conceptualisation, future scholarly work is required to examine how the market logic shapes both peoples' expectations of care and the health system's response to these expectations – globally and particularly low- and middle-income countries. Such work must explicitly consider the implications of growing for-profit care provision on health equity.

Vietnam is a country in transition. However, the existing literature, particularly on childbearing women's care encounters, still reflects the thinking of three decades ago before the advent of Doi Moi in the 1980s. It is thus essential for future scholarly work to consider the impact of Vietnam's shift towards market-oriented care provision, as well as the broader societal and economic shifts and changes instigated by Confucianism, Socialist Marxism, and the Doi Moi reforms. While elements of these changes may be distinct to the context of Vietnam, I contend that they are broadly reflective of and have important implications for understanding the impact of those occurring within other LMICs.

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Appendix A: Ethics approvals

MINISTRY OF HEALTH
HANOI UNIVERSITY OF PUBLIC HEALTH

No.: 149/2020/YTCC-HD3
Subject: Ethical Approval

SOCIALIST REPUBLIC OF VIETNAM
Independence – Freedom - Happiness

Hanoi, April 14th, 2020

DECISION
On Ethical approval for research involving human subject participation

THE CHAIR OF THE ETHICAL REVIEW BOARD FOR BIOMEDICAL RESEARCH
HANOI UNIVERSITY OF PUBLIC HEALTH

- Based on decision No. 651/QĐ-ĐHYTCC by the Dean of Hanoi School of Public Health on the Issuing Regulation of the Institutional Ethical Review Board of Hanoi School of Public Health; June 26th, 2015;
- Based on Decision No. 560/QĐ-ĐHYTCC by the Dean of Hanoi School of Public Health on Establishment of The Institutional Ethical Review Board of Hanoi School of Public Health; May 16th, 2016;
- Based on Decision No. 58/QĐ-ĐHYTCC by the Dean of Hanoi University of Public Health about the member replacement of The Institutional Ethical Review Board of Hanoi University of Public Health; January 15th, 2018;
- Based on the minutes of meeting to review ethics application No. **020-149/DD-YTCC** dated April 14th, 2020,

DECIDED:

Article 1. Grant ethical approval for ethnographic study project:

- Study Title: **Improving health systems responsiveness to neglected health needs of vulnerable groups in Ghana and Vietnam**
- Principal Investigator: **Bui Thi Thu Ha,** Hanoi University of Public Health
- Research site: Quang Ninh province, Vietnam
- Project time: from 01/4/2020 to 31/12/2023
- Data collection time: from 15/4/2020 to 30/11/2020
- Review type: Expecdited review

Article 2. This decision is effective from **14/4/2020** to **31/12/2023**

Article 3. Principal Investigator must report to IRB (The Institutional Ethical Review Board) any change and risk associated with closing the research. Active research projects are subject to random inspection by the IRB of HUPH

CHAIR OF HUPH IRB
(Signature and full name)

[redacted]

Ha Van Nhu

SECRETARY
(Signature and full name)

[redacted]

Nguyen Thi Minh Thanh

Tolib Mirzoev

From: Rachel De Souza [Medicine]
Sent: 14 August 2020 11:36
To: Tolib Mirzoev
Cc: Medicine and Health Univ Ethics Review; Anna Cronin de Chavez
Subject: MREC 19-051 Conditional Approval

Importance: High

Dear Tolib

MREC 19-051 - Improving health systems responsiveness to neglected health needs of vulnerable groups in Ghana and Vietnam

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and on behalf of the Chair, I can confirm a conditional favourable ethical opinion based on the documentation received at date of this email and *subject to the following condition/s which must be fulfilled prior to the study commencing:*

- **The full link to the Research Participant Privacy Notice** https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Research%20Ethics.aspx **should be added to the Participant Information Sheet so the address can be copied if required. The Chair felt should suffice for the study as it is being undertaken overseas, therefore you may not wish to provide the document in full however this is optional**

The study documentation must be amended where required to meet the above conditions and submitted for file and possible future audit.

Once you have addressed the conditions and submitted for file/future audit, you may commence the study and further confirmation of approval is not provided.

Please note, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.

Please retain this email as evidence of conditional approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx or contact the Research Ethics & Governance Administrator for further information on FMHUniEthics@leeds.ac.uk if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Best regards
Rachel
On behalf of Dr Naomi Quinton, co-Chair, SoMREC

~~~~~~

Rachel de Souza, Lead Research Ethics & Governance Administrator, The Secretariat, Room 9.29, Level 9, Worsley Building, Clarendon Way, University of Leeds, LS2 9NL, Tel: 0113 3431642, r.e.desouza@leeds.ac.uk
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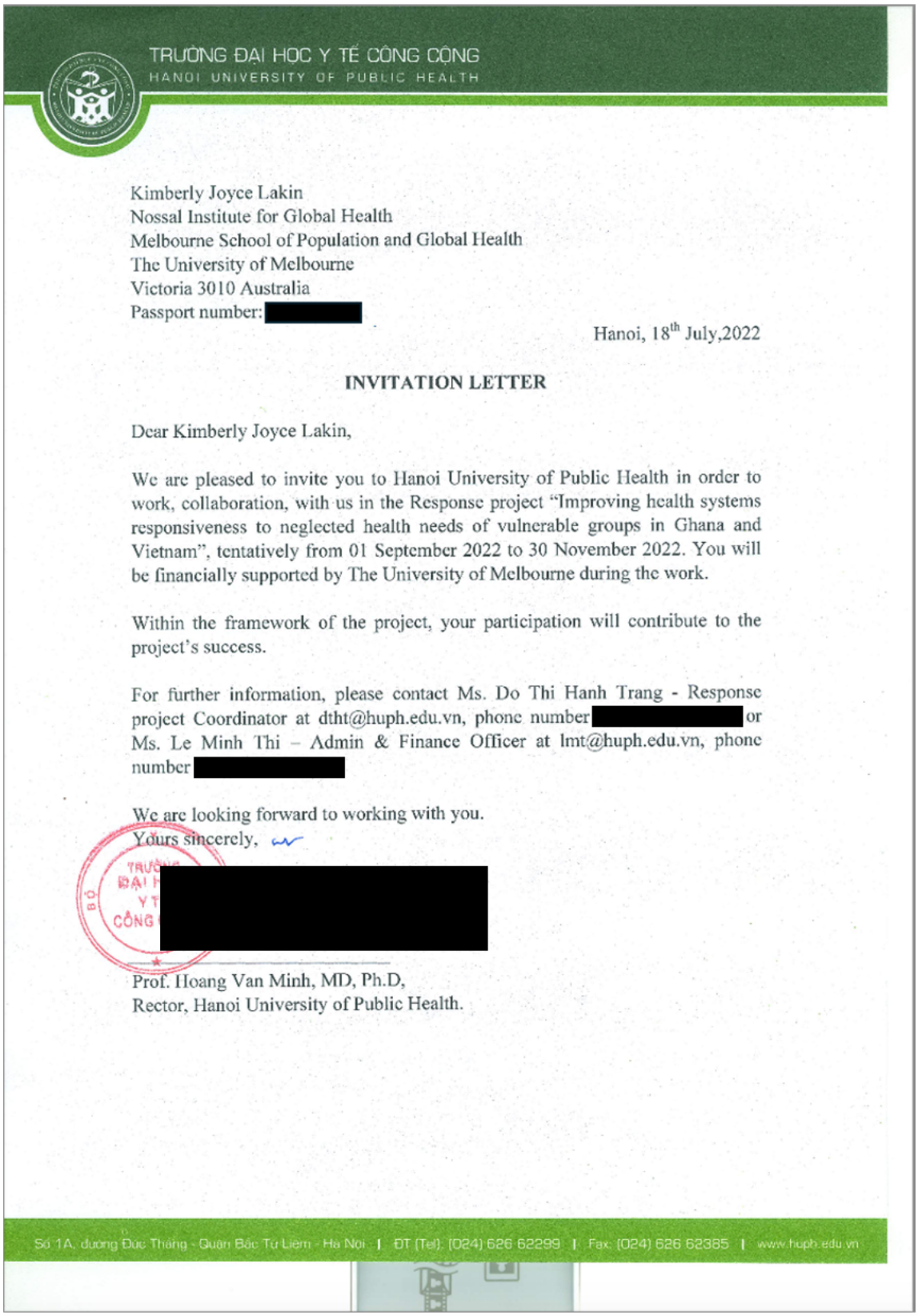
Appendix B: HUPH invitation letter



TRƯỜNG ĐẠI HỌC Y TẾ CÔNG CỘNG
HANOI UNIVERSITY OF PUBLIC HEALTH

Kimberly Joyce Lakin
Nossal Institute for Global Health
Melbourne School of Population and Global Health
The University of Melbourne
Victoria 3010 Australia
Passport number: [redacted]

Hanoi, 18th July,2022

INVITATION LETTER

Dear Kimberly Joyce Lakin,

We are pleased to invite you to Hanoi University of Public Health in order to work, collaboration, with us in the Response project "Improving health systems responsiveness to neglected health needs of vulnerable groups in Ghana and Vietnam", tentatively from 01 September 2022 to 30 November 2022. You will be financially supported by The University of Melbourne during the work.

Within the framework of the project, your participation will contribute to the project's success.

For further information, please contact Ms. Do Thi Hanh Trang - Response project Coordinator at dtht@huph.edu.vn, phone number [redacted] or Ms. Le Minh Thi – Admin & Finance Officer at lmt@huph.edu.vn, phone number [redacted]

We are looking forward to working with you.
Yours sincerely,

[redacted]

Prof. Hoang Van Minh, MD, Ph.D,
Rector, Hanoi University of Public Health.

Số 1A, đường Đức Thắng - Quận Bắc Từ Liêm - Hà Nội | ĐT (Tel): (024) 626 62299 | Fax: (024) 626 62365 | www.huph.edu.vn

Appendix C: Interview guide

INTERVIEW GUIDE	
I am Ha and I work at Hanoi University of Public Health. This is Kimberly and she is an academic from the University of Melbourne, Australia. We are conducting research on pregnant women's expectations and experiences of maternity care in Vietnam. Would you be willing to share your experiences with us? We will ask you a few questions and this will take about 30 to 45 minutes. Do you consent to have this interview recorded? Anything that you share during this interview will be strictly confidential and we can stop this interview at any time. *This is **NAME OF INTERVIEWER** and_. We are here with _ in **NAME OF COMMUNE**. Today is the **DATE**. We have shared/read out the participation information sheet with/to _ who has consented to participate in this study and for this interview to be recorded.*	
QUESTIONS	**PROBE**
Social situation 1) Can you please introduce yourself?	**PROBE FOR:** Name, age, level of education, current occupation, current living arrangements.
Antenatal care 2) Where do you/did you go for your antenatal care appointments (commune health services, district health centres/hospitals or provincial hospital) or private? Why did you select that facility? What influenced your decision? 3) Before your pregnancy, what were your initial expectations of antenatal care? Why are these important to you? 4) So far, what expectations have been met? What expectations have not been met? 5) What were/are your experiences of antenatal care?	**PROBE FOR:** Privacy/confidentiality (appointments conducted in a separate room), autonomy (making decisions during care), treatment by healthcare providers and other health staff, waiting time and distance to health facility, quality of amenities (cleanliness of rooms), support of family members (husband/parents/in-laws).
Delivery care and childbirth 6) Where did you deliver your baby? Why did you deliver in that facility (*If already had a baby*)?	**PROBE FOR:** Privacy/confidentiality (appointments conducted in a

7) What were/are your initial expectations of delivery care? Why are these important to you? 8) So far, what expectations have been met? What expectations have not been met (*If already had a baby*)? 9) What were your experiences with delivery (*If already had a baby)?*	separate room), autonomy (making decisions during care), treatment by healthcare providers and other health staff, waiting time and distance to health facility, quality of amenities (cleanliness of rooms), support of family members (husband/parents/in-laws).
<u>Pregnancy and motherhood</u> 10) What are/were some changes you experienced in your life during your pregnancy? Did/have you stopped working? Did/have family members come to stay with you? Did you have to move to live with someone else? Did you hire someone to support you? Why did you decide to do so? Are there any beliefs which influenced your decisions?	**PROBE FOR:** Cultural practices followed during pregnancy/childbirth and postpartum period

Appendix C: Participant Information and Consent form

RESPONSE

Tăng cường tính đáp ứng của hệ thống y tế đối với nhóm đối tượng dễ bị tổn thương tại Việt Nam và Ghana

GIẤY ĐỒNG Ý THAM GIA NGHIÊN CỨU

Cấu phần nghiên cứu: Phỏng vấn định tính đối với phụ nữ mang thai và phụ nữ sau sinh 12 tháng

	Đánh dấu x nếu đồng ý
Tôi xác nhận đã được giải thích về nghiên cứu và hiểu các thông tin về nghiên cứu, cũng như có cơ hội hỏi các câu hỏi về nghiên cứu.	
Tôi đồng ý tham gia nghiên cứu một cách tự nguyện và tôi có thể rút khỏi nghiên cứu bất kì thời gian nào trong quá trình thu thập số liệu. Tôi cũng có quyền từ chối trả lời các câu hỏi mà tôi không thoải mái trả lời. Các dữ liệu tôi cung cấp nếu không được đồng ý sẽ phải hủy .	
Tôi cho phép các thành viên của nhóm nghiên cứu có quyền truy cập vào các câu trả lời ẩn danh của tôi. Tôi hiểu rằng các phản hồi của tôi sẽ được giữ bí mật và thông tin cá nhân của tôi sẽ không được thể hiện trong các kết quả báo cáo.	
Tôi đồng ý cho dữ liệu được thu thập từ tôi sẽ được lưu trữ và sử dụng trong nghiên cứu có liên quan trong tương lai dưới dạng ẩn danh.	
Tôi hiểu rằng các nhà nghiên cứu khác sẽ chỉ có quyền truy cập vào dữ liệu này nếu họ đồng ý giữ bí mật thông tin theo yêu cầu trong biểu mẫu này.	
Tôi đồng ý ghi âm cuộc phỏng vấn.	

Mã số cuộc phỏng vấn:……

Họ và tên người tham gia phỏng vấn: ……...

Địa điểm nghiên cứu:……..……..

Người tham gia phỏng vấn kí tên:

Thời gian phỏng vấn: Từ …….h…….. phút đến ……..h……. phút ngày / /2022

Họ và tên nghiên cứu viên thực hiện phỏng vấn: ……..

Appendix D: Supplementary material for Chapter 2

Supplementary File 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Checklist

PRISMA Checklist			
Section	**Item**	**Checklist item**	**Page number it is reported**
TITLE			
Title	1	Identify the report as a systematic review.	
ABSTRACT			
Abstract	2	Provide a structured summary that includes: background (objectives), methods (eligibility criteria, information sources,), results (included studies and synthesis), discussion (limitations and interpretation), funding and registration.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	2
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	2
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	3-4
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	3
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	3
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	3-4
Data collection process	9	Specify the methods used to collect data from reports, and if applicable, details of automation tools used in the process.	4
Data items	10	List and define all outcomes for which data were sought. List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources).	N/A
Critical appraisal[§]	11	Quality of studies critically appraised by prioritising likely relevance of the paper over methodological quality.	3-4
Effect measures[‡]	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13	Describe the processes used to decide which studies were eligible for each synthesis and the methods used to synthesise results.	3-4
Reporting bias assessment [§]	14	Describe any methods used to assess risk of bias due to missing results in a synthesis.	N/A
Certainty assessment[§]	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram. Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	4
Study characteristics	17	Cite each included study and present its characteristics.	4
Critical appraisal studies	18	Present assessments of the critical appraisal for included studies.	3-4
Results of individual studies[‡]	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of synthesis[‡]	20	Summarise and present results of synthesis conducted in the form of a synthesising argument.	4-9
Reporting biases[§]	21	Present assessments of risk of bias due to missing results.	N/A
Certainty of evidence[§]	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A

DISCUSSION			
Discussion	23	Provide a general interpretation of the results in the context of the other evidence. Discuss the limitations of the evidence included in the review and the review processes used. Discuss implications for practice, policy and future research.	9-12
OTHER INFORMATION			
Registration and protocol	24	Registration information of review and/or protocol	N/A
Support	25	Sources of financial or non-financial support for the review.	13
Competing interests	26	Declare any competing interests of review authors.	13
Availability of data	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	13

§The term "critical appraisal" is used instead of "risk of bias" in items 11 and 18 as Dixon-Woods et al. (2006) propose an alternative approach to quality assessment than which is used in conventional systematic reviews. This approach prioritises the likely relevance of a paper over methodological quality. Items 14, 15, 21 and 22 are therefore not applicable.

‡ As opposed to conventional systematic reviews, the aim of a CIS is the development of a synthesising argument: a critically informed integration of evidence from across the studies in the review. As a result, items 12 and 19 are not applicable.

Adapted From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372: n71. doi: 10.1136/bmj. n7

Supplementary File 2: Data Extraction Proforma

Record	Publication year	Objectives/ aims	Type of source	Methodology	Participant characteristics	Setting (rural, semi-urban, urban)	Level of the health system examined (private, commune, district, provincial, national/central)
Binder-Finnema, P., Lien, P. T., Hoa, D. T., & Malqvist, M.	2015	Identify underlying structural barriers to equitable maternal health care in Nghe An province, Vietnam.	Research article	Qualitative (focus group discussions)	1) Kinh, Thai and Tho ethnic minority mothers, 2) Maternal healthcare providers	Rural Nghe An province (Kinh or ethnic minority communities)	Various levels of maternity care
Corbett, C. A., Callister, L. C., Peterson Gettys, J., & Hickman, J. R.	2017	To provide an ethnographic view of the perspectives on birthing of Hmong mothers living in the highlands of Vietnam.	Research article	Ethnography	Hmong women (given birth in the last 17 months)	Rural Hmong villages in Sapa	Various levels of maternity care
Duong, D. V., Binns, C. W., & Lee, A. H.	2004	To investigate factors that influence the utilization of delivery services at the primary health care level in rural Vietnam	Research article	Mixed-methods (survey, focus groups and in-depth interviews)	Women who have recently given birth	Rural Quang Xuong District, Thanh Hoa Province	Commune-level
Duong Thi Thuy, D., Tolib, M., Canh Chuong, N., & Ha Thi Thu, B.	2018	Reports findings of implementation research that aimed to increase the acceptability of village-based ethnic minority midwives (EMMs) by local communities in Vietnam.	Research article	Mixed methods (questionnaire, in-depth interviews and focus groups)	1) Ethnic minority midwives, 2) Relatives of pregnant women, 3) Community representatives, and 4) health managers	Rural, highland regions of Dien Bien and Kon Tum	Community-level
Edvardsson, K., Graner, S., Thi, L. P., Åhman, A., Small, R., Lalos,	2015	To explore Vietnamese obstetricians' experiences and views on the role of obstetric ultrasound	Research article	Qualitative (in-depth interviews)	Obstetricians and sonographers	Rural, urban, and suburban regions of Northern Vietnam	Various levels of maternity care

A., & Mogren, I.		in relation to clinical managemen t of complicated pregnancy.					
Gammelt oft, T., & Nguyen, H. T.	2007	Examine the use of obstetric ultrasonogra phy in routine antenatal care in Hanoi, Vietnam.	Research article	Mixed-methods (observations, survey and individual interviews)	1) Pregnant women 2) Doctors providing ultrasound s 3) Senior doctors and 4) Ministry of Health officials	Hanoi	National level
Gammelt oft, T.	2007	To show how Hanoian women's paradoxical stances toward ultrasound imaging can be explained through a consideratio n of embodied and historically generated experiences within everyday local worlds.	Research article	Ethnography	Mothers of young children	Inner and outer districts of Hanoi	Various levels of maternity care
Graner, S., Mogren, I., Duong le, Q., Krantz, G., & Klingber g-Allvin, M.	2010	Explore the perspectives and experiences of midwives, assistant physicians and medical doctors on the content and quality of maternal health care in rural Vietnam.	Research article	Qualitative (focus group discussions)	Midwives, Medical doctors and Assistant physicians	Rural Bavi district	Commune and district level
Graner, S., Klingber g-Allvin, M., Duong le, Q., Krantz, G., & Mogren, I.	2013	Explore perceptions and experiences among pregnant women in rural Vietnam with respect to pregnancy-related risks and maternal health care.	Research article	Qualitative (focus group discussions)	Kinh and Muong ethnic minority pregnant women	Rural Bavi district	Commune and district level
Ha, B. T. T.,	2017	To provide information	Research article	Cross-sectional	Various key informants	Hospitals in Hanoi, Hue	National level

Huong, N. T. T., & Duong, D. T. T.		on the prenatal diagnostic (PND) services provided in three major regional PND centers in Vietnam.		(document review and in-depth interviews)	(hospital manager, physician, technician and midwife)	city and Ho Chi Minh City	
Heo, J., Kim, S. Y., Yi, J., Yu, S. Y., Jung, D. E., Lee, S., Jung, J. Y., Kim, H., Do, N., Lee, H. Y., Nam, Y. S., Hoang, V. M., Luu, N. H., Lee, J. K., Tran, T. G. H., & Oh, J.	2020	Examine current maternal, newborn and child health service utilization patterns at a district level.	Research article	Qualitative (in-depth interviews and focus group discussions)	1) Women who recently gave birth 2) Healthcare professionals and managers/ directors of CHS	Rural district of Quc Oai (now experiencing rapid urbanisation)	Commune and district level
Holmlund, S., Lan, P. T., Edvardsson, K., Ntaganira, J., Graner, S., Small, R., & Mogren, I.	2020	To explore Vietnamese midwives' experiences and views on the role of obstetric ultrasound in relation to clinical management, including ethical aspects.	Research article	Qualitative (focus group discussions)	Midwives working at district and national level hospitals	Urban, semi-urban and rural parts of Hanoi	District to national levels
Holmlund, S., Lan, P. T., Edvardsson, K., Ntaganira, J., Graner, S., Small, R., & Mogren, I.	2022	To explore Vietnamese midwives' experiences of working in maternity care.	Research article	Qualitative (focus group discussions)	Midwives working in hospitals within district, provincial and national level hospitals	Urban, semi-urban and rural parts of Hanoi	District, provincial and national levels
Huong, N. T. T., Anh, H. P., Hao, M. T. T., & Huyen, N. T. H.	2021	To examine the current knowledge, attitudes, and practice of parents about maternal care in a mountainous region of Cao Bang province.	Research article	Qualitative (in-depth interviews and focus group discussions)	Both Kinh and Mong ethnic minority parents (including pregnant women or mothers)	Mountainous region of Cao Bang province	Various levels of maternity care
Klingberg-Allvin, M., Binh,	2008	Explores married Vietnamese	Research article	Qualitative (in-depth interviews)	Women younger than 20 who were either	Rural district north of Hanoi	Various levels of maternity care

N., Johansson, A., & Berggren, V.		adolescents' perceptions and experiences related to transition into motherhood and their encounter with health care services.			pregnant or had newly delivered.		
McBride, B., O'Neil, J. D., Hue, T. T., Eni, R., Nguyen, C. V., & Nguyen, L. T.	2018	To evaluate a low-cost mobile health (mHealth) intervention to improve access to maternal, newborn and child health (MNCH) services and health equity among EMW living in remote areas.	Research article	Qualitative (in-depth interviews)	1) Ethnic minority women, 2) Husbands, 3) Healthcare workers, and 4) Mangers	Thai Nguyen (mountainous) province	Various levels of maternity care
McKinn, S., Linh Thuy, D., Foster, K., & McCaffery, K.	2017	To explore how ethnic minority women experience communication with primary care health professionals in the maternal and child health setting.	Research article	Qualitative focused ethnography (focus group discussions)	Women who were currently pregnant, or who had been pregnant in the previous five years	Rural Tuan Giao district in Dien Bien Province	Various levels of maternity care
McKinn, S., Linh, D. T., Foster, K., & McCaffery, K.	2019	To explore the nature of maternal health literacy among ethnic minority women in a low-resource setting in Vietnam	Research article	Qualitative (focus group discussions)	1) Thai and Hmong ethnic minority women (currently pregnant, mothers or grandmothers) 2) Key informants	Rural Tuan Giao district in Dien Bien province (large ethnic minority population)	Various levels of maternity care
McKinn, S., Linh, D. T., Foster, K., & McCaffery, K	2019	1) How and why ethnic minority women currently use and do not use maternal healthcare services, 2) Identify the factors that influence	Research article	Qualitative (in-depth interviews)	1) Health professionals from CHS 2) Thai and Hmong ethnic minority women (currently pregnant, mothers or grandmothers)	Rural district in Dien Bien province (high ethnic minority population)	Commune and district level

		ethnic minority women and their families in their decisions to seek maternal healthcare services, and the barriers and facilitators to preventive care seeking			3) Village health worker and village midwife		
Ngo, A. D., & Hill, P. S.	2011	To explore the challenges faced by local CHSs in three provinces of Vietnam and the extent to which they had achieved universal access to community-based primary reproductive health care in the context of an increasingly commercialised health market.	Research article	Qualitative (in-depth interviews and focus group discussions)	1) Heads of CHS 2) Midwives 3) Women patients	Thai Nguyen (mountainous), Thua Thien Hue (urban, rural and mountainous areas) and Vinh Long (rural)	Commune level
Nguyen Thi Hoai, T., Wilson, A., McDonald, F., & Thu, N. T. H.	2015	To examine the impact of motivation on maintenance of professional competence among maternal health workers in Vietnam.	Research article	Mixed-methods (survey and in-depth interviews)	Maternal healthcare workers from CHCs and district hospitals	Five rural districts of two northern mountainous provinces of Vietnam	Commune and district level
Nguyen, A., Liamputtong, P., & Horey, D.	2019	To explore the reproductive health care experiences of people with physical disabilities in Vietnam.	Research article	Qualitative (in-depth interviews with the use of drawing and photo elicitation methods)	Men and women with physical disabilities	Ho Chi Minh City	Various levels of reproductive care (only data relating to maternity care was coded)
Nguyen, T. V., King, J., Edwards, N., & Dunne, M. P.	2021	To explore the lived experiences of women with physical disabilities through	Research article	Qualitative (in-depth interviews)	Women with physical disabilities who had given birth in the previous three years	Northern provinces of Hanoi and Thai Binh	Various levels of maternity care

		their pregnancy journeys, using an intersectional lens.					
Nguyen, T. V., King, J., Edwards, N., & Dunne, M. P.	2022	To explore the relative influence of health staff, family, friends, and the women themselves on key decisions about childbirth of women with physical disabilities in northern Vietnam.	Research article	Qualitative (in-depth interviews)	1) Women with physical disabilities who had given birth in the previous three years 2) Maternal healthcare providers	Northern provinces of Hanoi (urban) and Thai Binh (rural)	Various levels of maternity care
Nguyen, T. V., King, J., Edwards, N., & Dunne, M. P.	2022	To explore how maternal healthcare access was experienced by women with physical disabilities in Northern Vietnam.	Research article	Qualitative (in-depth interviews)	Women with physical disabilities who recently gave birth	Hanoi city (urban) and Thai Binh province (rural)	Various levels of maternity care
Nguyen, T. V., Edwards, N., & King, J.	2023	Explores perspectives and experiences of maternal healthcare providers in the delivery of services to women with physical disabilities in Northern Vietnam.	Research article	Qualitative (in-depth interviews)	Healthcare providers working in both public and private facilities	Hanoi city (urban) and Thai Binh province (rural)	Various levels of maternity care
Thi Hoai Thu, N., McDonald, F., Witter, S., & Wilson, A.	2018	To explore how district level reforms impact the organisation of maternal health care delivery at district and commune levels.	Research article	Qualitative (in-depth interviews)	Health staff and managers involved in the provision of maternal health services from commune to the central levels	Rural districts in Bac Giang and Lao Cai	Commune and district levels
Van, T. V., Ngoc, H. L., & van Schie, T. J.	2004	To determine the barriers to the use of maternal care and family planning (services by the disadvantaged Kinh people and	Research article	Mixed methods (survey, in-depth interviews and focus groups)	Mothers with at least one child under the age of 5 year Health staff, Managers	Remote and mountainous area of Nam Dong District in Central Vietnam	Various levels of family planning and maternity care (only data relating to maternity care was coded)

		Katu ethnic minority people					
White, J., Oosterhoff, P., & Huong, N. T.	2012	To enhance understanding of childbirth practices and maternal health-seeking behaviour among local Thai and Hmong villagers.	Research article	Qualitative (secondary data from literature review and primary data from focus group discussions)	Thai and Hmong ethnic minority women	Ha Giang and Dien Bien provinces (one remote Hmong village, one Thai village and one Kinh village)	Various levels of maternity care
United Nation Population Fund (UNFPA).	2007	To document reproductive health knowledge and behaviour of the ethnic minority community in mountainous provinces	Research article	Qualitative (in-depth interviews and focus groups)	1) Reproductive healthcare providers 2) Clients 3) Mass community organisations (Women's Union, Youth's Union)	Rural provinces of Hoa Binh and Ha Giang	Various levels of reproductive care (only data relating to maternity care was coded)
United Nation Population Fund (UNFPA).	2008	To explore reproductive health services provided to ethnic minority people living in three communes located in mountainous and remote districts of Binh Dinh province	Research article	Qualitative (in-depth interviews, focus groups, observations)	1) Ethnic minority women in the reproductive age group 15-45 2) Providers of reproductive health care	Three communes in rural districts of Binh Dinh province	Various levels of reproductive care (only data relating to maternity care was coded)

Appendix E: Supplementary Material for Chapter 3

Supplemental file 1: Search Strategy

Database	Search strategy	Limits	Date searched	Hits	Total of records screened (titles and abstracts)	Number of duplicates removed	Total (after screening titles and abstracts)	Total number of full-texts examined	Total number of records included
EBSCOHost (CINAHL, Medline)	"legitima*" AND "responsive*"	2000 till present * English	14/03/2023	139	256	25	39	25**	18
Pubmed	"legitima*" AND "responsive*"	2000 till present * English	14/03/2023	117					

*We limited the search for empirical literature from 2000 till present to take into account that the concept of health systems responsiveness was proposed by the WHO in World Health report 2000.

**Seven full-text records were excluded: the English versions of two could not be found, and five were found to not specifically focus on health systems responsiveness

Supplemental File 2: Papers Reviewed

Record	Aim	Reference to legitimacy
Achstetter, K., Köppen, J., Hengel, P., Blümel, M., & Busse, R. (2022). Drivers of patient perceptions of health system responsiveness in Germany. Int J Health Plann Manage, 37 Suppl 1, 166-186. https://doi.org/10.1002/hpm.3570	To analyse patient-side determinants that affect perceptions and assessments of health systems responsiveness.	*"HSR is defined as the degree to which a system responds to the non-medical **legitimate** expectations of the population in its interaction with the health system."*
Alavi, M., Forouzan, A. S., Moradi-Lakeh, M., Ardakani, M. R. K., Shati, M., Noroozi, M., & Sajjadi, H. (2018). Inequality in Responsiveness: A Study of Comprehensive Physical Rehabilitation Centers in Capital of Iran. Health Serv Res Manag Epidemiol, 5, 2333392818789026. https://doi.org/10.1177/2333392818789026	To identify whether there is any inequality in meeting the legitimate expectations of people with physical disabilities who attend the comprehensive rehabilitation centres (CRCs) in Tehran based on their socioeconomic situation.	*"Responsiveness refers to meeting the **legitimate** expectations of people who interact with the health system."*
Asefa, G., Atnafu, A., Dellie, E., Gebremedhin, T., Aschalew, A. Y., & Tsehay, C. T. (2021). Health System Responsiveness for HIV/AIDS Treatment and Care Services in Shewarobit, North Shewa Zone, Ethiopia. Patient Prefer Adherence, 15, 581-588. https://doi.org/10.2147/ppa.S300825	Assess the health system responsiveness of HIV/AIDS treatment and care services and associated factors in the public health facilities of Shewarobit town, Ethiopia.	*"Health System Responsiveness is the key objective of the health system used to fulfil patients' universal **legitimate** expectations."*
Bramesfeld, A., Klippel, U., Seidel, G., Schwartz, F. W., & Dierks, M. L. (2007). How do patients expect the mental health service system to act? Testing the WHO responsiveness concept for its appropriateness in mental health care. Soc Sci Med, 65(5), 880-889. https://doi.org/10.1016/j.socscimed.2007.03.056	To evaluate the WHO responsiveness concept regarding its applicability to mental health care systems.	*"Responsiveness seeks to relate patients' experiences to a common set of standards, which patients **legitimately** expect when coming into contact with the system."*
Bramesfeld, A., & Stegbauer, C. (2016). Assessing the performance of mental health service facilities for meeting patient priorities and health service responsiveness. *Epidemiol Psychiatr Sci, 25*(5), 417-421. https://doi.org/10.1017/s2045796016000354	Engages with the gap in studies which recognises patients' preferences as outcomes when assessing health systems responsiveness, particularly within mental health care.	*"Health service responsiveness measures distinct patient experiences with non-medical health issues […] It thus seeks to put patients' experience in relation to a common set of standards, of what patients' **legitimately** expect when coming in contact with the system and its services."*
Bramesfeld, A., Wedegärtner, F., Elgeti, H., & Bisson, S. (2007). How does mental health care perform in respect to service users' expectations? Evaluating inpatient and outpatient care in Germany with the WHO responsiveness concept. BMC Health Serv Res, 7, 99. https://doi.org/10.1186/1472-6963-7-99	Utilise the concept of responsiveness to evaluate the performance of mental health care in a catchment area in Germany.	*"Responsiveness relates to the system's ability to respond to service users' **legitimate** expectations of non-medical aspects."*

Record	Aim	Reference to legitimacy
Fiorentini, G., Ragazzi, G., & Robone, S. (2015). Are bad health and pain making us grumpy? An empirical evaluation of reporting heterogeneity in rating health system responsiveness. Soc Sci Med, 144, 48-58. https://doi.org/10.1016/j.socscimed.2015.09.009	Examines the influence of both the patients' state of health and their experiences of pain on their reporting style on responsiveness.	*Responsiveness concerns a system's ability to respond to patients' **legitimate** expectations regarding the non-health enhancing and non-financial aspects of health care."*
Gromulska, L., Supranowicz, P., & Wysocki, M. J. (2014). Responsiveness to the hospital patient needs in Poland. Rocz Panstw Zakl Hig, 65(2), 155-164.	To describe the patients' opinions on treatment they received in hospital.	*"Health system responsiveness is defined as non-medical aspect of treatment relating to the protection of the patients' **legitimate** needs and expectations…"*
Joarder, T., George, A., Ahmed, S. M., Rashid, S. F., & Sarker, M. (2017). What constitutes responsiveness of physicians: A qualitative study in rural Bangladesh. PloS one, 12(12), e0189962. https://doi.org/10.1371/journal.pone.0189962	To explore the perceptions of outpatient users and providers regarding what constitute responsiveness in rural Bangladesh.	*"…responsiveness is defined as the 'social actions by health providers to meet the **legitimate** expectations of patients'"*
Joarder, T., George, A., Sarker, M., Ahmed, S., & Peters, D. H. (2017). Who are more responsive? Mixed-methods comparison of public and private sector physicians in rural Bangladesh. Health Policy Plan, 32(suppl_3), iii14-iii24. https://doi.org/10.1093/heapol/czx111	Uses mixed-methods to compare responsiveness of public and private physicians in rural Bangladesh.	*"Responsiveness of physicians (ROPs) reflects the social actions by physicians to meet the **legitimate** expectations of health care users".*
Joarder, T., Islam, M. A., Islam, M. S., Mostari, S., & Hasan, M. T. (2022). Validation of Responsiveness of Physicians Scale (ROP-Scale) for hospitalised COVID-19 patients in Bangladesh. BMC Health Serv Res, 22(1), 1040. https://doi.org/10.1186/s12913-022-08413-4	To validate the existing ROP-Scale to measure the responsiveness of hospital physicians during the ongoing COVID-19 pandemic in Bangladesh.	*"…Responsiveness of Physicians (ROP) refers to the social actions by physicians to meet the **legitimate** expectations of healthcare users"*
Joarder, T., Mahmud, I., Sarker, M., George, A., & Rao, K. D. (2017). Development and validation of a structured observation scale to measure responsiveness of physicians in rural Bangladesh. BMC Health Serv Res, 17(1), 753. https://doi.org/10.1186/s12913-017-2722-1	To develop a scale for measuring responsiveness of physicians in rural Bangladesh, by structured observation method.	*"De Silva [6] argued, 'legitimate expectation' is aligned with the concept of 'normative expectations'. She defined 'legitimate' as, '…conforming to recognized principles or accepted rules and standards' (p. 04), and suggested **legitimate** expectations be determined based on ethical norms and values."*
Lunevicius, R., & Rahman, M. H. (2012). Assessment of Lithuanian trauma care service using a conceptual framework for assessing the performance of health system. Eur J Public Health, 22(1), 26-31. https://doi.org/10.1093/eurpub/ckq184	To describe and assess the trauma service of Lithuania using a conceptual framework for assessing the performance of health systems.	*"The **legitimate** expectations of the community—respect of persons in terms of dignity, autonomy, confidentiality, client orientation—do not correspond with the responsiveness of the trauma service."*

Record	Aim	Reference to legitimacy
Negash, W. D., Atnafu, A., Asmamaw, D. B., & Tsehay, C. T. (2022). Does Health System Responsiveness Differ between Insured and Uninsured Outpatients in Primary Health Care Facilities in Asagirt District, Ethiopia? A Cross-Sectional Study. Advances in Public Health, 1-10. https://doi.org/10.1155/2022/3857873	To evaluate the health system responsiveness among insured and uninsured outpatients in primary healthcare facilities and determine the association between health insurance and health system responsiveness among outpatients.	*An effective designation of health facilities improves the facility's ability to respond to patients' **legitimate** expectations."*
Negash, W. D., Tsehay, C. T., Yazachew, L., Asmamaw, D. B., Desta, D. Z., & Atnafu, A. (2022). Health system responsiveness and associated factors among outpatients in primary health care facilities in Ethiopia. BMC Health Serv Res, 22(1), 249. https://doi.org/10.1186/s12913-022-07651-w	To assess health system responsiveness and associated factors among outpatients in primary health care facilities, Asagirt District, Ethiopia	*"From these goals, health system responsiveness (HSR) is defined by the World Health Organization (WHO) as "how well the health system meets the **legitimate** expectations of the population for the non-health enhancing aspects of the health system"".*
Rahman, M. H. U., Singh, A., & Madhavan, H. (2019). Disability-based disparity in outpatient health system responsiveness among the older adults in low- to upper-middle-income countries. Health Policy Plan, 34(2), 141-150. https://doi.org/10.1093/heapol/czz013	Uses data from the Study on Global Ageing and Adult Health conducted in China, Ghana, India, Mexico, Russia and South Africa during 2007–10 and examines the disability-based disparity in outpatient HSR among the older adults in the abovementioned countries.	*"The concept of HSR can also be envisaged as a tool to study the response of health system for the nonmedical, **legitimate** expectations of a population in its interactions with the health system."*
Ramos, L. M., Quintal, C., Lourenço, Ó., & Antunes, M. (2019). Unmet needs across Europe: Disclosing knowledge beyond the ordinary measure. Health Policy, 123(12), 1155-1162. https://doi.org/10.1016/j.healthpol.2019.09.013	Discusses the ordinary measure of responsiveness (prevalence of unmet needs in the whole population) based on the level of healthcare needs among the population.	*"Unmet healthcare needs (or foregone healthcare) is a widely used intermediate indicator to evaluate healthcare systems attainment since it relates to health outcomes, financial risk protection, improved efficiency and responsiveness to the individuals' **legitimate** expectations."*
Tremblay, D., Roberge, D., & Berbiche, D. (2015). Determinants of patient-reported experience of cancer services responsiveness. BMC Health Serv Res, 15, 425. https://doi.org/10.1186/s12913-015-1104-9	To report on patients' perceptions of cancer services responsiveness and to identify patient characteristics and organizational attributes that are potential determinants of a positive patient-reported experience.	*"The 2000 World Health Report [7] has paved the way for PREMs, putting service users' **legitimate** expectations at the forefront of health systems responsiveness."*