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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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1. 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 et al., 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 and 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 and 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 and Jenkinson, 2005; Peltzer, 2009; Liabsuetrakul et al., 2012; Chao et al., 2017; Awoke et al., 2017; Ratcliffe et al., 2020; Kapologwe et al., 2020; Negash et al., 2022). 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 and Kane, 2017). Moreover, only a few studies, such as those by Bramesfeld et al. (2007), Bramesfeld 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 and 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

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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 and 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 and 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; Gammeltoft, 2007; Gammeltoft and 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.

2. 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 and 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 Koselleck (2004) and Luhmann's (1995) work on expectations within sociology. Koselleck (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). Koselleck (2004) uses the 'horizon' as a temporal metaphor to illustrate how expectations are essentially, "the future made present" (Lakin and 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 and Kane, 2023; Dornbusch and Scott, 1975, Johnson et al., 2006). These values, beliefs, and standards are *normative* – they are people's perceptions about how a health system should or ought to be (Lakin and 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.

3. Methods

3.1. 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 it has 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).

3.2. 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.

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 and 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).

Table 1
Participant characteristics.

Participant characteristics	N
Age, years	
<20	2
20–24	4
25–29	9
30–34	8
35–40	3
>40	2
Pregnancy status	
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	

3.3. 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.

4. 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'.

4.1. 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.

4.2. 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, Võ and Löfgren, 2019). 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 (Võ and Löfgren, 2019; Holmlund et al., 2020; Ngo and 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."* [25–29 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 and 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'.

4.3. 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.

4.4. 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; Koselleck, 2004; 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.

4.5. 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'.

4.6. *"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.

5. 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 and Kane, 2022; Mirzoev and 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 and 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 et al., 2007, Bramesfeld 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 and Nguyen, 2007; Heo et al., 2020; Holmlund et al., 2020; Ngo and 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 and 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, Ekman 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.

6. 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.

7. 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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CRediT authorship contribution statement

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

Declaration of competing interest

No declarations of interest.

Data availability

The data that has been used is confidential.

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