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Factors Influencing Women's Access to Healthcare Services: A Literature Review of Selected Countries and Vietnam

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Abstract

The right to access health services is one of the fundamental human rights recognized in international conventions. Many countries around the world, including Vietnam, have been improving their policy systems to create an equal legal environment that strengthens women's access to health services. However, in many parts of the world, women from disadvantaged groups are often restricted in accessing these rights for various reasons. Many studies have been conducted to understand women's unmet health care needs and access to health services, as well as solutions that help them access health services more easily. This article focuses on analyzing the factors affecting women's access to health care services, such as individual factors, interpersonal factors, community-level factors, and system-level factors, through a review of studies in several countries and Vietnam. On this basis, the author proposes several recommendations to strengthen the access of Vietnamese women to health services.

Keywords:

Factors; influence; access; health services; women.

1. Introduction

Access to health services refers to timely access to health services that are affordable, accessible, and of acceptable quality to achieve the best health outcomes. Access to health services is a decisive factor in improving and maintaining physical and mental health, because timely and affordable access helps reduce the burden of medical conditions. Timely access to health services supports disease prevention and management and reduces secondary complications related to communicable and non-communicable diseases. Health plays an important role for women, enabling them to contribute more to the economy, education, and other fields. Evidence shows that access to health services significantly reduces morbidity and mortality and increases the effectiveness of reinvestment in other areas within the family and society. Therefore, ensuring equitable access is necessary because it can significantly reduce the related direct and indirect costs.

Nevertheless, many documents show that large disparities still exist in access to and use of health services. Gender inequality in access to health care for women in many countries

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has been confirmed by many studies. Economic barriers, knowledge, beliefs, support from family and community, geographical distance, and health service providers are common factors shown across many studies. Therefore, systematizing studies on the factors hindering women's access to health services is very necessary.

2. Research Methodology

2.1 Information Collection Methods

This literature review search, select, and synthesize studies on factors affecting women's healthcare access in Vietnam and selected comparative contexts. Literature was collected from major databases such as PubMed, Google Scholar and other resource articles. The search strategy combined keywords regarding target factors, influencing, women, access and geographic scope.

Eligible studies met predefined criteria: empirical or analytical research on access determinants, focusing on relevant contexts, and available in full-text English or Vietnamese; non-peer-reviewed or commentary pieces were excluded. Retrieved studies were synthesized using a socio-ecological framework across four levels: individual (economic, cultural, awareness), interpersonal (social norms, family support), community (geography, local infrastructure), and systemic (service delivery, quality). Findings indicate that researchers employed mixed methods—combining quantitative data with qualitative interviews, focus groups, and document analysis—to capture population-level trends alongside complex structural barriers.

2.2 Concepts

Access to health services

The concept of "access" has long been the subject of many debates in the research literature aimed at clarifying the factors that constitute access to health care services. However, the theoretical orientations on the factors that make up access to health care remain unclear in many respects. Descriptions in academic literature and public policy often limit the concept of access to the scope of affordability and geographical distance. This implies that access to health services basically revolves around issues of health insurance coverage and the distance from the service provider to the patient. According to researchers AD), these are "easy" solution-oriented measures for the regulatory agencies responsible for ensuring access, because they are easy to understand and relatively simple to measure. Developing the concept of access requires a broader perspective. A study by Mackinney AC (2016) described the concept of access in four approaches: definition, measures, barriers, and theoretical framework. Defining the concept of access basically means examining the different theoretical explanations that exist in current literature. Another study, by Donabedian A (1972), described access as the use of services rather than merely the presence of health facilities.

The last theoretical approach, proposed by Donabedian A (1972) and developed by Ricketts et al. (2005) as well as Mackinney AC (2016), views access as the process of building an effective, closely coordinated, and diverse framework of interaction between the factors affecting access and the characteristics of the health system. This approach places particular emphasis on the "framework" factor when describing access. The framework affecting access needs to consider the following factors: i. the temporal fit between the service schedule of the

health facility and the work/daily schedule of the patient; ii. the spatial distribution between service recipients and health facilities; iii. the social organizational characteristics of the area, including socio-economic class, gender, ethnicity, and the mental health status of the patient; and iv. the level of financing for health care, which will also affect access. (Azuh Dominic, 2019)

In Vietnam, Resolution 72-NQ/TW of the Politburo dated September 9, 2025, "On several breakthrough solutions to strengthen the protection, care, and improvement of people's health," sets the requirement on access to health services for the people as: to be given full, fair, and equal access to health services, with special attention to children, the poor, social policy beneficiaries, and ensuring gender equality.

Citing studies by many authors (Giang, 2023; Anh, 2023; Tuan, 2023) on the issue of barriers to accessing health services among other groups, who have thoroughly explained the content of the concepts: access to health services is the state of receiving and benefiting from health care services at health facilities, and barriers to access to health services are the difficulties currently preventing women from benefiting from health care services at health facilities. In this article, the factors affecting women's access to health services are understood as the limitations, difficulties, and challenges currently preventing women from benefiting from appropriate, timely, and effective health services at health facilities. The hindering factors include factors originating from the individual women using health services, including individual factors of economy, knowledge, and beliefs; interpersonal factors, including social norms and the environment supporting women's access to health services; community-level factors; and system-level factors, the availability of health services.

3. Research Results

Factors affecting access to health services are divided into individual-level factors, interpersonal-level factors, community-level factors, and system-level factors.

3.1 Individual-Level Factors

Individual-level factors affecting women's access to health services include economic status, knowledge, and beliefs.

Economic status: Poverty is one of the main barriers limiting women's access to health services. Although financial pressure also exists among men, it is more severe for women. In lower-middle-income countries, most women depend on their male partners and are therefore economically disadvantaged. In these countries, women mainly take on housework and childcare, while men are the main income earners for the family. Women who work and earn their own money are also not independent in accessing health services because they are often not allowed to spend without the consent of their husbands/partners. Therefore, women in lower-middle-income countries find it difficult to access health services unless they receive financial support from male family members.The study in Ghana by Abdul-Aziz Seidu (2020) was conducted on 9,370 women aged 15–49, using data from the 2014 Ghana Demographic and Health Survey. The outcome variable was defined as barriers in accessing health care, based on four questions about whether women faced difficulties related to financial issues, geographical distance, having a companion, and permission to seek medical care. The results showed that more than half (51%) of the women reported facing at least one type of barrier when accessing health services; those with higher education and those doing office work or

sales had a lower rate of facing barriers when accessing health care services. Similarly, women who listened to the radio at least once a week and watched television at least once a week had a lower risk of facing barriers in accessing health services. In contrast, widowed women had a high risk of facing barriers in accessing health care services. This study shows that individual factors and contextual factors play an important role in predicting barriers to accessing health care services in Ghana. The identified factors include age, marital status, employment, health insurance coverage, frequency of listening to the radio, frequency of watching television, wealth level, and area of residence. (Abdul Aziz Seidu, 2020)

The study by the group of authors Sufyan Habib et al., conducted in Saudi Arabia in 2022, examined the factors affecting the health system in that country through access to and use of primary health care centers in both urban and rural areas, and at the same time determined whether a gender gap exists in access to health services. The study subjects included both male and female citizens in the city of Makkah, KSA. The results of a survey of 529 participants showed that residents' access to the health service system in the region was at a good level, and there was a significant difference in access to health services between the gender groups of survey participants. According to studies by Ahmad (2013), providing free or low-cost health services will ensure equity in access. On the other hand, the research literature also expresses concern about the high cost of medicines and other health services for patients; Eide, A.H (2016) found that people with disabilities cannot buy medicines and pay for medical treatments due to poverty. A study conducted by Almubark et al. (2019) showed that about half of the population in Saudi Arabia has a low level of health literacy. Risk factors leading to a low level of health literacy include older age, low income and education level, having been married, and a moderate level of health service use. (Sufyan Habib, 2022)

In Vietnam, the study by the group of authors Cao Ngọc Thanh et al. (2017) was a cross-sectional descriptive study conducted in the mountainous district of A Luoi, Thua Thien Hue province. A total of 381 ethnic minority women who gave birth in the 1 year up to the time of the study were invited to participate in a household survey. The study showed limitations in access to and use of maternity care services in ethnic minority mountainous areas of central Vietnam. Nearly 50% of ethnic minority women cannot read or write the common script. This becomes a barrier for them when accessing health services: because they are not proficient in the language, they are reluctant to interact with people of other ethnic groups and reluctant to go to public administrative places, where they must communicate but are unable to.

In Vietnam, the study by Ta Thi Thao (2020) used a qualitative research method, conducting focus group discussions with ethnic minority women and interviewing local officials working on ethnic affairs. In addition, the authors used secondary data from a national study on the socio-economic development of the 53 ethnic minority groups in Vietnam (2017). The results show that the livelihoods of ethnic minority communities currently lie mainly in agriculture and forestry. Employment among ethnic minority groups in industry, construction, and services remains limited, and the average per capita income of ethnic minorities is currently about 1.1 million VND/person/month, which is less than ½ of the national average. Most families are still poor, and the results show that both the direct and indirect costs of health services at health facilities are considered a barrier to full access to services. Although health insurance already covers services provided by health facilities, many ethnic minority women, especially the most disadvantaged, do not clearly understand the conditions for health insurance entitlement and how health insurance works. Health services also involve indirect costs that are not covered by health insurance, such as bus and taxi fares, etc., medicines, meals, costs for

accompanying people, and informal fees or envelopes for health workers in order to receive better services and care. These indirect costs are beyond the means of many ethnic minority families. (Ta Thi Thao, 2020).

Individual factors are women's knowledge and beliefs about diseases and their treatment. Most women living in low-income countries lack awareness of disease prevention and early detection. They often ignore symptoms at the mild to moderate stage and seek care only when the illness has become severe. They generally do not know about health promotion strategies or healthy lifestyles, so they go to health facilities only when facing serious conditions that require surgery or expensive medicines. In addition, misconceptions and harmful customs are very common. Mental disorders are often regarded as being caused by supernatural forces, so women turn to shamans/religious leaders to manage them. Similarly, they often turn to traditional healers instead of formal health facilities.

The study by Sreya Sanyal Puja and colleagues (2024) explored barriers to accessing women's health care services among disadvantaged women in Bangladesh and supported access through voice bot technology. The study sheds light on the barriers that prevent disadvantaged women from accessing health services in developing countries. The preliminary research pointed out the everyday challenges faced by this group of women, stemming from limited awareness, misconceptions, and a sense of hesitancy when seeking medical support. In addition, financial limitations and social prejudices further increase the difficulty of accessing timely health services. Clearly recognizing the disparity in access to health care between advantaged women and disadvantaged women is a key factor in achieving equity. Technology emerges as a feasible solution to help narrow the gaps caused by the above-mentioned problems, such as poverty or scarcity of resources. (Sreya Sanyal Puja, 2024)

According to the authors Sufyan Habib, although Saudi Arabia has gender norms regarding health-related behavior that interact with each individual's ability to seek treatment, which depends on financial resources, time, the availability of services, as well as the authority or ability to make decisions independently. Women are particularly vulnerable to poverty due to the disparity in income and assets between men and women. This makes it difficult to access essential healthcare services in many regions of the world. Azad et al. (2020) found this in their study; the results showed that women's ability to arrange extra cash (68.6%) was much lower than that of men (88.8%). Regarding gender discrimination in access to health care, the studies by Heise, L. (2019) confirmed differences between men and women in several health indicators, including access and affordability of costs. (Sufyan Habib, 2022)

A qualitative study in mountainous areas of Vietnam showed that ethnic minority women were "reluctant to ask because they could not speak the language," that health information was one-way and lacked cultural and linguistic adaptation, which reduced the use of antenatal/postnatal health services. (Hoang Thi Giang, 2025). Individual factors such as economy, knowledge, and beliefs have a very clear impact on women's access to health services, so support to strengthen women's capacity plays a very important role.

3.2 Interpersonal-Level Factors

Interpersonal-level factors include social norms and support from family and friends.

In addition to financial dependence, women in many low-income countries are also socially dependent on their partners. In general, they do not have the right to make their own decisions, and decisions related to their health are usually made by the male members of the family. To go for a medical examination, women must ask for permission. In some low-income countries, women are not allowed to travel alone for cultural and religious reasons, so they must be accompanied by a man. All these factors hinder women's access to health services.

A study by the author Linda Abou Abbas in Lebanon on the challenges of accessing health services for women and girls with disabilities participating in a humanitarian physical rehabilitation program. The study used an explanatory sequential mixed-methods design. The results showed that access to health services for women and girls with disabilities was limited across all five dimensions of adequacy, accessibility, affordability, appropriateness and availability, as well as their corresponding abilities. Although some challenges, such as transportation issues, financial limitations, inadequate infrastructure, and lack of information about available services, were common difficulties for both genders, the gender-specific barriers mainly included: social norms, safety concerns when going to health facilities alone, limited access to social information, economic disparities, the desire to be examined by female health workers, and the need for privacy during consultations. (Linda Abou-Abbas, 2024)

In Vietnam, many studies show that ethnic minority women aged 21–49 belonging to 12 ethnic groups have an average gynecological service utilization rate of 62.0%. This rate varies considerably among ethnic groups, from 36.5% among the Hmong to 87.7% among the Bru Van Kieu. This difference shows a clear inequality in access to and use of health services among different areas and ethnic minority groups (Lê Thị Kim Thảo, 2023). The UNICEF report (2021) on the implementation of the Sustainable Development Goals (SDGs) in Vietnam shows that the rate of pregnant women receiving 4 or more antenatal care visits reached an average of 88.2%. However, this rate drops sharply among women with low education levels and those from poor households, reaching only 10.6% among Hmong women. This result reflects a profound level of inequality in access to obstetric health services among population groups. (Antenatal Care – SDG Country Work 2021: Viet Nam Country Report)

The proportion of ethnic minority women giving birth at health facilities is significantly lower than that of Kinh women. On average, only about 63.6% of ethnic minority women give birth at health facilities, while this figure for Kinh women reaches 99.1%. Notably, 25 ethnic groups have a rate of facility-based births below 50%, reflecting a clear inequality in access to obstetric services. (UNICEF Report, Vietnam, 2015).

Support from family and friends**:** Support from family and friends is a decisive factor in access to health care. However, women in low- and middle-income countries lack this support. Families often try to handle illnesses with traditional folk methods at home. In addition, relatives and friends often have limited understanding of the serious consequences of not accessing health care in a timely manner.

3.3 Community-Level Factors

Community-level factors include support from community members and transportation conditions.

Support from community members**:** In many low-income countries, women are often regarded as weak and submissive. In male-dominated societies, women are deprived of basic rights, including equal access to education and health care. Community members provide little support to women who are ill. In addition, the stigma attached to diseases causes women to hide their illness to avoid being gossiped about.

Some other studies in Bangladesh conducted similar surveys from the perspective of developing countries. The study by Ahmed, et al (2022) highlighted the impact of the shortage of qualified health workers and their uneven distribution among regions on the poor in Bangladesh. Some other studies focus on inequality in maternal health care in low-income countries F. Misu, K. Alam (2017), while others emphasize the disparity in the use of medical treatments for common childhood illnesses in Bangladesh M. Khanam, E. Hasan (2018) (Sreya Sanyal Puja, 2024)

The lack of suitable means of transportation in rural areas is a major obstacle. Long distances make women reluctant to go for medical examinations regularly. Some other studies by the author Sreya Sanyal Puja in Saudi Arabia used primary data to survey the availability of health facilities, health care-seeking habits, factors affecting access to health services, behavior in complying with medical regulations/recommendations, and delays in accessing different health services. The results showed that factors related to access to health services differed significantly between the gender groups of survey participants. Access to health services is an important determinant of health and economic sustainability. Many studies have demonstrated that the availability of health facilities within accessible range helps improve health. emphasizes the importance of individual characteristics in health care-seeking habits, rather than focusing only on potential barriers from the system. Previous studies have also indicated that people in Saudi Arabia often seek health services only when they are already ill. (Sufyan Habib, 2022)

In Vietnam, ethnic minority women are still facing many barriers in accessing health services, such as geographical distance, language limitations, shortage of health workers at the grassroots level, and cultural and social prejudices. A report by the United Nations Population Fund (UNFPA) shows that maternal mortality and child malnutrition in ethnic minority regions remain significantly higher than the national average. The maternal mortality ratio in ethnic minority regions still ranges from 100 to 150 per 100,000 live births, which is 2 to 3 times higher than the national average of about 46 per 100,000 live births. For example, the Hmong group has a maternal mortality ratio 7 times higher than that of the Kinh. Ethnic minority children are still seriously affected by malnutrition, with a markedly higher stunting rate, and nearly 1/3 of ethnic minority children are stunted6. In addition, the mortality rate among children under 1 year old in ethnic minority communities can be as high as 2.2%, many times higher than the national average. (United Nations Population Fund).

Community support and transportation conditions are factors hindering women's access to health services, especially among women in difficult economic circumstances, in remote and mountainous areas, and among ethnic minority groups in low- and middle-income countries.

3.4 System-Level Factors

System-level factors include the availability of services and health service providers, the role of the medical profession, and effective policies.

Another study by the author Genevieve Jeffrey, reviewing studies in the United Kingdom, shows that the health gap between genders in the UK remains a worrying problem for both public health and the economy, reflecting systemic inequalities in access to and outcomes of health care between men and women. Although women often report higher rates of illness than men for many types of conditions, the health system has historically been built on male-centered models; this leads to delays in diagnosis, suboptimal treatment effectiveness, and women's health care needs not being fully met. Studies indicate that, although women are often more proactive in seeking medical care, structural and socio-economic barriers, such as financial limitations, family caregiving responsibilities, and workplace policies, continue to hinder their access to timely and appropriate care. Furthermore, women from low socio-economic groups and disadvantaged communities also face a double inequality in health, thereby highlighting the intersection of gender, income, and ethnicity in shaping health outcomes. (Genevieve Jeffrey, 2025)

Gender inequality in access to health services has attracted the attention of many researchers in both developing and developed countries and is being analyzed from many different aspects. Many studies conducted in the past on concepts of gender, as well as descriptions of gender roles, have often been separated from specific historical contexts and social realities. Access to health care includes four components: health coverage, disease prevention services, timely access to health services, and the presence of a professionally competent workforce. The proportion of women using services is higher than that of men, which may reflect common patterns of health care utilization. However, studies on the use of health services in Muslim communities show that women often have lower utilization rates. The cause is usually that they remain dependent on men in making health care decisions, and women are often not allowed to go to health facilities or meet health workers by themselves (Shaikh, B.T, 2025). Waqas, 2021, pointed out that empowering patients brings positive health outcomes, such as enhanced decision-making rights, freedom of choice, and the ability to take responsibility.

According to the authors, although Saudi Arabia has a large-scale health system, more than 4% of women do not use this service and go to the hospital for the first time only when they are in labor. Empowered women are better able to protect their own health. Women may lack information or resources to protect their health due to limited education, low income, unequal control over household resources, and restrictions on mobility. It is expected that improving gender equality in income and education will help women gain more knowledge about disease prevention and have better access to health services for themselves and their children. Dhaher, 2017 studied gender discrimination in access to health services among 151 women in the southern region of Saudi Arabia. The study showed that the majority of women (94.2%) faced at least one barrier when accessing health services. These problems ranged from seeking female health workers (72.2%) to asking for their husband's consent (25.2%). Furthermore, the data showed that women in this region had difficulty traveling because they were not allowed to drive (51.7%); they were also hesitant to go for medical examinations by

themselves (53%). Saudi Arabia would be able to access health services more easily if there were greater freedom of movement. (Sufyan Habib, 2022)

In traditional societies, acceptability (appropriateness and receptiveness) is regarded as an important determinant of access to health care services. The attitudes of health workers and the quality of care are two main issues causing gender discrimination in health services. Many studies have shown both positive and negative attitudes affecting people's access to health services (Scheffler, 2017). These positive views are partly influenced by strong efforts to raise health workers' awareness of the need to enhance the acceptability of services and meet the health needs of clients with disabilities (Grut, L, 2015). However, some studies show that negative attitudes from health workers, such as discrimination and stigma, have created significant barriers to accessing health services, and many authors point out that discrimination arises from cultural differences between service users and health workers (Van Roo, 2012). According to the authors Van Hees et al. (2015), in some cases, gender discrimination in access to health services also stems from patients having low self-esteem and refusing to explain or share their health condition with health workers. (Sufyan Habib, 2022)

The provision and availability of health facilities are important factors affecting women's access to health care services. Many studies have identified availability as a factor influencing access to health services on a broad scale. The authors emphasize that the availability of resources is essential for accessing health services, including human resources, health infrastructure, and health care services. Many researchers have found that the shortage of health workers has hindered the delivery of health care services, and differences in the provision of health services between different locations have led to gender discrimination in the health sector. Some studies also note prejudice arising from the shortage of supply and resources (Scheffler, 2017). They also emphasize the importance of patients having the necessary resources available. (Sufyan Habib, 2022)

The issue of gender discrimination in access to health care and its relationship with mental health has been explored by many researchers; they found that gender affects the experience of being discriminated against and pointed out that men have a higher rate of perceived discrimination than women. Individual and social perceptions that undervalue the role of women have a significant impact on gender inequality in the health sector. Compared with men, women are more heavily affected by factors such as economic insecurity, lower social status, and limited access to education. Gender norms, which shape women as family caregivers and men as economic breadwinners, can also affect health. The importance of addressing gender disparities in access to health care has been widely recognized in the research literature, with evidence showing that doing so helps reduce mortality and morbidity in both men and women; this was also mentioned in The Lancet's 2019 series on Gender Equality, Norms, and Health, as well as the report of The Lancet Commission on Women and Health in 2015 (Barros, A.J, 2012). (Sufyan Habib, 2022)

The study by the author Yingyi Zhang, in 2022 in Beijing, China, focused on women's health care needs and their access to health facilities in urban areas. The study had two main objectives: to analyze the density, spatial distribution, and services of health facilities in the Yuetan area of Beijing, and to explore women's health care needs as well as the changes in health facilities that they require. This study emphasizes the need to address women's specific health care needs in health facilities, aiming toward equality and understanding. The study

conducted in the Yuetan area (Beijing) showed that the current health facility system is facing many challenges in density, spatial distribution, and service quality. Unbalanced health planning, together with the shortage of health care services dedicated to women, has limited access to health facilities. In addition, the study conducted a questionnaire survey as well as qualitative and quantitative data analysis on more than 400 female residents. Women's health care needs were identified, including gynecological services and the dissemination of health knowledge, among many other needs. Women's satisfaction with current health facilities was also surveyed; the results showed that a significant proportion of women were not satisfied with the existing system. Based on the above analyses of health facility supply and women's needs, the study proposed three strategies to improve access to health services, including: (i) optimizing the spatial distribution of health facilities; (ii) providing specialized health services for female patients and clients; and (iii) strengthening close coordination between health facilities and the community of female residents. These strategies contribute to improving the health facility system and enhancing the quality of life and health of women at every stage of life. (Yingyi Zhang, 2022).

In Vietnam, the study on the causes of limited access among ethnic minority women by the author Thảo in 2020 showed that the distance from home to health facilities is generally relatively far, especially far for some ethnic groups such as the Mong, Cong, and La Hu. On average, the commune health station is 3.8 km from home, and the hospital is 16.7 km away, which makes ethnic minority women unwilling to seek medical examination and treatment (Ta Thi Thao, 2020)

Most health systems tend to benefit women who have advantages in society more than women in difficult circumstances. Thus, the challenges related to equitable access to health services are two-sided: challenges from the side of service provision (the health system) and challenges from the side of those who need to receive services (patients or clients seeking services) V. T. Nguyen (2012). The two sides of the challenge interact with each other: if the health system does not provide sufficient means, infrastructure, medicines, human resources, and health services appropriate to local culture, women and their families may not use those services. At the same time, the fact that people have little demand for high-quality services can lead to difficulties in mobilizing resources as well as political commitments to improve the limitations of the current health system. (Ta Thi Thao, 2020)

Lack of quality and affordable health facilities in rural areas is a major barrier; in many places there are no health facilities, or if there are, they lack both professional staff and basic equipment. The 2019 study by the group of authors Azuh Dominic on the determinants of women's access to health care services in sub-Saharan Africa showed that access to health care services directly leads to the use of these services, but when people cannot access life-saving health care services due to a number of barriers, the use of those services will be limited. The study by the author and colleagues examined socio-economic barriers to women's access to health care services in sub-Saharan Africa; the study measured the components of women's access to health care, including the availability of health services; the use of health services; and decisions about health services. The results showed that the availability of health services helps improve women's access to health care facilities in Africa. The availability of nurses and midwives, together with the provision of services such as sufficient hospital beds, improves the quality of health care services for women in the region and will help increase access to services. (Azuh Dominic, 2019)

Socio-economic factors such as population density worsen health outcomes in Africa, reflecting the high population density of most African communities and the sparse distribution of health care facilities in these areas. The ability to make independent decisions in financing access to health services, measured by women owning bank accounts, participating in the labor force, attaining basic education, and being heads of household, is very important in enhancing women's access by reducing maternal mortality and the rate of anemia among non-pregnant women. Most notably, among all the determinants of access considered, the use of health services and/or affordability had the most important impact on health outcomes in Africa. (Azuh Dominic, 2019)

Lack of policies that empower women's access to health care, or, where policies exist, their implementation is merely formal. A large number of studies focus on gender inequality that still exists in developing countries such as Bangladesh, affecting women's physical and mental health. y. The studies by the author M. Islam, in 2019, and N. Sultana, M.M.H. Khan in 2008 showed that maternal health outcomes and access to health care services in South Asian countries are influenced by socio-economic factors. The research literature also clearly shows that limited access to financial resources contributes to delays in accessing health care services (W.H. Organization, 2010). In addition, traditional household work such as childcare, meal preparation, etc., along with other family obligations, has prevented them from devoting time to taking care of their own health (Sreya Sanyal Puja 2024).

Vietnam's guarantee of the right of women to access health services holds a particularly important position in social security and gender equality policy, as recognized in the 2013 Constitution and the 2023 Law on Medical Examination and Treatment. For women, especially groups that often live in remote and mountainous areas with limited economic conditions, infrastructure, and educational levels, the right to access health services is not only a matter of welfare but also an indicator reflecting the level of equitable and inclusive development of the country. Ensuring this right clearly demonstrates the State's responsibility in narrowing regional, gender, and ethnic gaps, toward the goal of "leaving no one behind" in the spirit of Vietnam's Sustainable Development Strategy and the United Nations Sustainable Development Goals. This not only carries humanitarian and human rights value, but also contributes directly to human resource development, improving population quality, and the endogenous capacity of ethnic minority communities.

When women receive better health care, they are more capable of working, studying, raising children, and participating actively in social life; this creates a spillover effect in reducing maternal mortality, improving reproductive health, and raising awareness of disease prevention and nutrition. Promoting equitable access to health care is also evidence of the realization of substantive gender equality, affirming the role of ethnic minority women in the process of national development and strengthening the great national solidarity bloc.

A 2019 study on the use of health services and some related factors among women aged 18-49 in Phong Dien district, Can Tho city showed that most patients chose to use health services at private doctors, health centers, and provincial hospitals. The highest reason patients chose to go to private doctors for medical examination and treatment was convenience of travel (74.7%); for health centers, it was mostly because of the place of health insurance registration (85.1%); for provincial hospitals, most patients chose them because of trust in professional expertise (61.5%) and the place of health insurance registration (62.5%). This result is similar

to an earlier study by the author Cao Thanh Việt, in which convenience of travel (28.4%) was the leading reason patients chose to visit private health care, while trust in professional expertise (37.5%) and the place of health insurance registration (34.5%) were the two most frequently chosen reasons for seeking care at provincial hospitals. (Le Trung Hieu, 2019).

The access of women to health services is affected by many factors, as the above studies clearly show: the level of availability of services, the professional qualifications of health workers, and policies that support and create conditions for women. Differences between countries in economic, social, and political conditions and the status of women have an important influence in determining women's access to health services in those countries. In Vietnam, barriers to women's access to services in mountainous and remote areas, such as social norms, economic conditions, transportation, awareness, and the availability of health workers, remain major difficulties that clearly affect women's ability to take care of their health.

Conclusion

A review of domestic and international studies shows that women's access to health services is affected by the combined impact of a multi-layered system of barriers. Starting at the individual level with limitations in education, finances, and health awareness, these barriers continue to spread to the interpersonal level through economic dependence. At the community level, cultural norms and harmful customs, the lack of social support networks, and geographical distance in disadvantaged areas further aggravate inequality. Finally, at the system level, shortcomings in health costs, unbalanced resource allocation, complicated procedures, and the availability of health workers are institutional bottlenecks that directly hinder women from enjoying the right to health care. Recognizing this comprehensive picture not only affirms the urgency of multisectoral intervention solutions but is also an important scientific basis for policymakers to shape more equitable and comprehensive health policies in the future.

Drawing on studies from other countries, solutions to strengthen women's access to health services in Vietnam require a comprehensive strategy, designed to respond flexibly to the specific characteristics of both rural and urban areas, closely combining the strengthening of health system capacity with the improvement of social security policies. For rural and mountainous areas, the focus is on strengthening the grassroots health network through local personnel and promoting telemedicine to eliminate both geographical and cultural barriers. Improve the quality of health care services. Strengthening human resources for women's health care, including both quantity and professional capacity, through capacity-building training for health workers in women's health care.

Meanwhile, in large cities, barriers to women's access to health care generally do not lie in geographical distance but stem from time pressure, high service costs, and the risk of hospital overcrowding. To address this situation, solutions for urban areas need to focus on developing family medicine models and standardized private clinics close to the community, and on extending flexible consultation hours at public hospitals so that women who work, or who are self-employed, can more easily obtain medical examinations. At the same time, cities need to promote digital transformation through online appointment booking applications, delivery of results via mobile applications, and online mental health counseling. Occupational health programs in industrial zones and enterprises also need to be tightened to ensure that female workers receive periodic health check-ups and full screening for occupational diseases.

Financial support policies need to focus on expanding universal health insurance coverage, providing 100% support for premium contributions for women from poor households, ethnic minorities, and informal female workers. The State needs to issue specific policy packages, including free periodic health screening for women in disadvantaged areas.

Health services need to be as safe, effective, reasonable, and equitable as possible, based on the customs, cultural values, and diverse expectations of different groups of women. The Government needs to ensure that poor and disadvantaged women have access to health insurance and understand how to use it. There should be guidance on the use of insurance and easier access to health insurance.

Communication activities need to be carried out continuously and tailored to different groups of women, using social media to spread knowledge about proactive health care and mental health for young urban women, while using loudspeaker broadcasts and community gatherings in rural areas, thereby promoting the companionship of men and society in protecting women's health comprehensively.

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