

Obstacles to Accessing Healthcare and Safety Services for Minority Women and Girls in Vietnam in Relation to Sustainable Development Goals

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Abstract: Vietnam, as a developing country, is actively striving to achieve the Millennium Development Goals (MDGs) by 2030. Despite notable progress, particularly in promoting gender equality, significant challenges remain, especially in access to healthcare and safety services for women and girls. This study is based on comprehensive survey data from a national gender equality research project conducted between 2018 and 2021, encompassing 2,894 household questionnaires across six mountainous provinces with a high population of ethnic minorities. The research findings indicate that ethnic minority women and girls in Vietnam continue to be among the most vulnerable groups, facing numerous challenges due to cultural traditions, gender biases, and socio-economic conditions prevalent in mountainous regions. Many ethnic minority women and girls remain illiterate, and some are unable to speak or understand the national language, severely restricting their access to healthcare services, particularly reproductive healthcare. Language barriers also hinder effective communication with healthcare providers, often leading to inadequate or delayed medical treatment. Traditional customs further exacerbate these issues, as many ethnic minority women are required to give birth at home, often in unsanitary conditions. In some cases, women are forced to deliver their babies in tents or huts outside their homes without any assistance from trained medical professionals. These practices pose significant risks to both maternal and infant health, contributing to higher maternal and neonatal mortality rates in these areas. Cultural and logistical barriers, along with deeply ingrained gender norms that limit women's autonomy, continue to obstruct Vietnam's progress in achieving gender equality. These findings suggest that while Vietnam is committed to implementing the MDGs, especially in promoting gender equality and improving healthcare services, substantial challenges persist for ethnic minority women and girls in remote areas, particularly regarding reproductive health and safety.

Keywords: Gender Equality, Women's Development, Ethnic Minorities, Reproductive Health, Vietnam

1. Introduction

In pursuit of the Sustainable Development Goals (SDGs), Vietnam has made significant progress and improved its global ranking in the SDGs Index, ranking 55th out of 166 countries in 2023. The national strategy for gender equality has affirmed Vietnam's achievements in gender equality and has significantly enhanced the role and status of Vietnamese women. In 2024, Vietnam ranked 72nd out of 146 countries in gender equality. The percentage of female members in the National Assembly remains one of the highest in the Asia-Pacific region (30.26%); women constitute 46.8% of the national labour force, with a female labour force participation rate of 62.4%; and 28.2% of businesses are owned by women. Gender equality and women's empowerment are among the three MDGs that Vietnam has successfully achieved in its commitment to the United Nations. Vietnam's gender equality ranking improved by 11 places in 2023 compared to 2022. In 2024, Vietnam was officially elected to the Executive Board of the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) for the 2025–2027 term. However, Vietnam's commitments to gender equality and women's development still face significant challenges in achieving the targets outlined in the MDGs, the Beijing Declaration and Platform for Action by 2030. The 2030 agenda includes 17 goals and 169 gender-specific targets addressing various aspects of gender disparities, including poverty, hunger, health, education, water and sanitation, employment, and the empowerment of women and girls (UN Women, 2015). Some critical targets, such as Goal 2—to eliminate malnutrition in children under five, adolescent girls, pregnant and lactating women, and the elderly—are unlikely to be achieved by 2030. Similarly, Goal 3 aims to ensure access to high-quality and

comprehensive healthcare services while eliminating harmful practices that threaten women's health and well-being. Cultural and socio-economic barriers prevent some women from benefiting from modern societal advancements. Nowadays, many ethnic minority women and girls, in particular, continue to face gender biases, illiteracy, low education levels, and limited access to comprehensive healthcare services. They also remain vulnerable to gender-based and domestic violence, which remains widespread and insufficiently addressed.

Despite improvements in reproductive healthcare for ethnic minority women in developed countries, contraceptive use remains low among these groups. Challenges affecting contraceptive adoption among ethnic minorities include lack of awareness, lower socio-economic status, and cultural sensitivities. Research highlights the importance of socio-economic factors in reproductive health decisions (Gijsberts & Dagevos, 2007). Studies in the United States indicate that ethnic minority women and those with lower socio-economic status are less likely to use contraceptives compared to white women and those with higher socio-economic status (Radilaite Cammock, Patricia Priest, Sarah Lovell, Peter Herbison, 2018). This trend is also evident in developing countries. A study on knowledge, attitudes, and practices regarding family planning among Taukei women in New Zealand and Fiji revealed lower contraceptive use compared to national averages in both countries. Limited integration into mainstream society led to reduced exposure to family planning information. Studies have found that cost, language, and cultural sensitivities are major barriers to reproductive healthcare access. Even in urban areas, ethnic minority women in Taukei may struggle to comprehend family planning information due to linguistic and cultural barriers, such as traditional gender roles and taboos surrounding sexuality and reproduction, which hinder their effective interaction with healthcare services in New Zealand (Radilaite Cammock et al., 2018). Onouma Thummapol et al. (2018) emphasize that addressing health inequalities for ethnic minority women requires recognizing their roles, implementing strategies to change cultural and social norms that create barriers to equal opportunities, and better integrating gender perspectives into healthcare systems. These measures will ensure more effective use of healthcare services and reduce gender-based health disparities.

Regarding gender-based violence, according to various researchers, there are 4 key factors that contribute to the likelihood of gender-based violence: (1) Economic inequality; (2) The use of physical violence as a conflict resolution method; (3) Male dominance and control in decision-making processes; and (4) Limited opportunities for women to participate in social and economic activities (Bhanot, S., & Senn, C. Y., 2007). These factors align with the relative resource theory of decision-making power and cultural perspectives that position men as dominant and women as dependent. There is extensive documentation on the experiences of ethnic minority women as victims and survivors of violence. While studies have consistently highlighted the urgent need to provide support for ethnic minority women, in reality, organizations dedicated to supporting these women often face resource constraints and are undervalued. Furthermore, statutory agencies frequently exhibit a lack of understanding of the specific needs of ethnic minority women. Research has shown that nine out of ten local governments do not have specific preparations in place for ethnic minority women who have experienced violence, and support services are predominantly concentrated in urban areas (Sharon Smee and Zohra Moosa, 2010). It is evident that gender inequalities affecting ethnic minority women persist across multiple countries and various aspects of social life. The primary causes of these inequalities stem from cultural norms, societal prejudices against women, and inadequate infrastructure and social services in ethnic minority regions.

2. Data Sources and Research Methodology

This study utilizes field survey data from the project on key issues of gender equality among ethnic minority groups in Vietnam, conducted from 2018 to 2021. The survey covered 2,894 household representatives, including both men and women, from 14 ethnic minority groups across eight provinces in Vietnam. Data collection methods included structured individual questionnaires, in-depth interviews, and community group discussions.

The research team adhered to ethical research principles during the interviews. All participants provided informed consent before taking part. Interviewers read the questions aloud, and respondents provided their answers to each question. Confidentiality and anonymity of personal information were strictly maintained. Group discussions and in-depth interviews were recorded and securely stored in accordance with ethical guidelines.

Indicators for analyzing gender inequality in the healthcare sector were derived from national surveys, including metrics such as the percentage of women accessing healthcare facilities for childbirth and prenatal check-ups, as well as health insurance coverage rates. Additionally, the research team developed specific indicators to assess adolescent pregnancy, healthcare access, and utilization of community-based healthcare services. For

gender-based and domestic violence analysis, the study established criteria to assess gender role perceptions, gender-based violence, and domestic violence prevalence. The research analysis was conducted using SPSS 20.0 software, employing statistical techniques such as frequency analysis, cross-tabulation (crosstabs), and regression models.

Table 1: Demographic Characteristics of Household Representatives Responding to the Survey

Demographic Characteristics	Male		Female		Total	
	%	N	%	N	%	N
Household Representative	48,9	1414	51,1	1480	100,0	2894
Age group						
<30	19,1	270	29,6	438	24,5	708
30-39	30,6	432	35,4	524	33,0	956
40-49	26,9	380	20,9	310	23,8	690
50+	23,5	332	14,1	208	18,7	540
Household Living Standards						
Well-off	9,6	136	5,8	86	7,7	222
Average	46,0	650	42,7	632	44,3	1282
Poor	44,4	628	51,5	762	48,0	1390
Ethnic Group						
Kinh	29,0	58	43,1	62	34,9	120
Patrilineal	50,0	100	43,1	62	47,1	162
Matrilineal	21,0	42	13,9	20	18,0	62

3. The Current State of Gender Inequality in Reproductive Healthcare and the Protection of Ethnic Minority Women and Children in Vietnam

3.1 Illness and Disease Conditions

Living in remote areas, most ethnic minorities engage in physically demanding labor related to agricultural production and the natural environment. As a result, their access to healthcare services is highly limited. The burden of disease remains a significant obstacle to human development, particularly for ethnic minority women. Health inequalities are widening across regions due to geographical, economic, and cultural factors.

Survey results from eight provinces in Vietnam indicate a relatively high incidence of illness among the population, with 60.2% of respondents reporting that they had been ill in the past 12 months. Among them, 65.9% were women, while 54.2% were men. The proportion of women who experienced illness in the past year was significantly higher than that of men.

Table 2: Illness Status of the Population in the Past 12 Months by Gender, Ethnicity, and Living Standards

	Overall (n=2894)	Male (n=1414)	Female (n=1480)
Overall	60,2	54,2	65,9***
Ethnicity	***		
Tay (n= 150)	60,7	54,2	64,8
Nung (n= 175)	59,4	57,6	61,4
Muong (n=250)	58,8	47,1	73,2***

	Overall (n=2894)	Male (n=1414)	Female (n=1480)
Dao (n= 200)	55,0	52,2	60,6
Hmong (n=442)	35,3	36,2	34,4
Khmu (n=155)	74,8	73,3	76,2
Thai (n=250)	48,4	35,6	59,8***
Co Tu (n=93)	78,5	69,4	88,6*
Ta oi (n=124)	78,2	75,4	80,6
Xo Đàng (n=220)	75,9	61,6	87,6***
E Đe (n=226)	76,5	70,4	81,3*
Cham (n=250)	66,0	60,5	70,6*
Kho Me (n=250)	60,8	57,7	63,3
Self-Reported Living Standards	***		
Fair (n=222)	51,4	48,5	55,8
Average (n=1282)	58,0	51,5	64,7***
Poor and Very Poor (n=1390)	63,7	58,3	68,1***

Note: Statistical Significance Level: *p<0,05; **p<0,01; ***P<0,001

Source: Survey Data from the CTD 21.17 Project, 2018-2019

According to the results in Table 2, there is a clear and significant difference in the overall illness rates between men and women over the past 12 months. Among ethnic groups, women from the Muong, Thai, Co Tu, Xo Dang, and E De communities had significantly higher illness rates than men. Likewise, women in households with average and poor living standards also experienced illness at a higher rate than men.

Table 3: Disease Prevalence in the Past 12 Months Among Ethnic Minority Populations by Gender and Ethnicity

Ethnicity	Seasonal Infectious Diseases			Acute disease			Chronic illness		
	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
	***			*			***		
Tay	67,0	71,9	64,4	8,8	6,2	10,2	29,7	21,9	33,9
Dao	60,9	54,3	72,5*	11,8	15,7	5,0	35,5	34,3	37,5
Nung	70,2	73,6	66,7	13,8	13,2	13,7	27,9	22,6	33,3
Thai	50,4	50,0	50,6	16,5	14,3	17,7	30,6	35,7	27,8
Muong	47,6	44,6	50,0	14,3	16,9	12,2	36,7	35,4	37,8
Hmong	78,8	65,8	92,2***	7,1	7,6	6,5	16,0	22,8	9,1**
Kho Mu	63,8	54,5	72,1*	10,3	10,9	9,8	27,6	34,5	21,3
Co Tu	45,2	44,1	46,2	6,8	8,8	5,1	46,6	44,1	48,7
Ta Oi	50,5	51,2	50,0	7,2	11,6	3,7	49,5	41,9	55,6
Xo Dang	54,5	54,1	54,7	9,6	9,8	9,4	33,5	36,1	32,1
E De	60,7	62,3	59,6	11,0	8,7	12,5	24,3	27,5	22,1
Cham	58,8	56,5	60,4	12,1	17,4	8,3*	30,3	21,7	36,5*
Khmer	58,6	56,2	60,2	11,2	17,2	6,8*	34,9	29,7	38,6
Overall	59,6	57,6	61,1	10,8	12,1	9,7	31,5	30,1	32,6
N	1038	442	596	188	93	95	549	231	318

Note: Statistical Significance Level: *P<0,05; **P<0,01; ***P<0,001

Source: Survey Data from the CTD 21.17 Project, 2018-2019

Based on the survey on disease patterns, women from ethnic groups residing in high mountainous areas, such as the Hmong, Dao, Lo Lo, and Khmu, exhibit particularly high rates of seasonal infectious diseases. In terms of acute illnesses, women from lowland ethnic groups, who have better access to regular medical check-ups, report higher incidence rates than men (e.g., Tay, Thai, E De). Meanwhile, chronic diseases show minimal gender differences across most ethnic groups in the surveyed sample.

“Hmong women here suffer from various illnesses; nearly everyone has a health condition, yet they do not seek medical treatment. They only visit the health station if their husbands take them—going alone is seen as shameful. Most suffer from respiratory and digestive diseases. Some also experience gynecological conditions due to a lack of water and the persistently humid, foggy environment. Children, on the other hand, face severe malnutrition. Only 50% of pregnant women attend antenatal check-ups at the health station, and even then, they typically go only once or twice. The majority of women still give birth at home. Although the health station is nearby, they avoid delivering there due to customary restrictions” (In-depth interview with the head of the Giang Chu Phin Commune Health Station, Meo Vac, Ha Giang).

“Due to the geographical characteristics and population conditions, the disease pattern is highly complex. Many illnesses are closely related to local customs, such as infectious diseases and gynecological conditions...” (Focus group discussion with district-level officials, A Luoi, Thua Thien Hue)

A gender-based comparison of acute and chronic disease prevalence in the survey sample across eight provinces reveals that chronic diseases are more prevalent among women than men. Notably, chronic illness rates are significantly higher among women from poor and very poor households. When comparing disease patterns among ethnic groups, the survey results indicate that in ethnic communities with higher socioeconomic development, people are more proactive in seeking medical care and diagnosing illnesses than those in communities with higher poverty rates. For instance, acute disease prevalence is considerably higher among the Khmer, Muong, Thai, and Cham ethnic groups compared to the Hmong, Xo Dang, and Co Tu. Conversely, ethnic groups with higher poverty rates experience significantly higher seasonal infectious disease burdens than lowland ethnic groups with better living conditions.

3.2 Maternal Care During Pregnancy and Childbirth

Antenatal care and maternal healthcare are crucial indicators for achieving the Millennium Development Goals and advancing gender equality for ethnic minority women. According to the Vietnamese government's 2014 assessment, ethnic minority groups had significantly lower access to maternal healthcare services, with only 79% of women attending at least one antenatal check-up and 32.7% receiving the recommended four check-ups in 2014. In contrast, these rates among Kinh women were 99.2% and 82.1%, respectively (*UN Women, 2015*).

In ethnic minority areas, women often lack adequate nutritional care and do not receive sufficient rest during childbirth, adversely affecting both maternal and child health. The coverage of antenatal care among ethnic minority women remains lower than the national average. In some ethnic groups, more than 70% of women give birth at home, including the Hmong, Lo Lo, Ha Nhi, and Phu La. Moreover, ethnic minority households tend to allocate a disproportionately higher share of their income to healthcare services compared to Kinh households, often exceeding their financial capacity (Ministry of Health, 2015).

Among ethnic minority women, the practice of not attending regular antenatal check-ups during pregnancy remains prevalent, with many relying on natural childbirth. This trend is particularly common in remote and isolated communes, where access to healthcare facilities is limited due to geographical distance from town centers. For certain ethnic groups living in these remote areas, poor transportation infrastructure and a lack of available means of travel—often requiring long-distance walking—further hinder access to antenatal care, resulting in unmanaged pregnancy and childbirth. The highest rates of women who do not receive antenatal check-ups are recorded among the Hmong (63.5%), Kháng (55.9%), Dao (41.3%), Hre (30.1%), Bru-Van Kieu (28%), and Ta Oi (11.5%) ethnic groups (National Committee for Ethnic Affairs & General Statistics Office, 2017).

There are significant disparities among ethnic minority groups regarding the proportion of women receiving antenatal care at healthcare facilities and those giving birth at home. Some ethnic groups, such as the Khmer, Cham, and Co Ho, have relatively high antenatal care coverage, reaching up to 84%. Correspondingly, home birth rates among these groups remain low, at 8.2% for the Khmer, 15.7% for the Cham, and 18.4% for the Co Ho. In contrast, among certain ethnic groups in the Central Highlands and the northern mountainous regions, the proportion of women receiving regular antenatal check-ups is below 36%, while home birth rates are alarmingly high, reaching 77.4% among the Hmong. Particularly concerning is the case of the La Hu ethnic group, where

only 9.1% of women attend antenatal check-ups, and home births account for as much as 95%. Ensuring maternal and neonatal safety remains a major challenge due to a severe shortage of trained village-level healthcare workers and a lack of essential medical equipment necessary for safe childbirth (see table 4).

Table 4: Percentage of Ethnic Minority Women Giving Birth and Receiving Antenatal Care at Healthcare Facilities

No.	Ethnic Group	Percentage of Ethnic Minority Women (Aged 15–49) Receiving Antenatal Care at Healthcare Facilities (%)	Percentage of Women Giving Birth at Healthcare Facilities (%)	Percentage of Women Giving Birth at Home (%)
Overall		70,9	63,6	36,3
1	Thai	65,4	42,6	57,3
2	Hmong	36,5	22,4	77,4
3	Dao	59,7	54,5	45,3
4	Gia Rai	58,1	47,2	52,3
5	Ba Na	64,5	43,3	56,5
6	Xo Dang	66,3	31,8	68,0
7	Hre	66,9	34,3	65,2
8	Mnong	75,0	50,6	49,1
9	Kho Mu	47,4	26,6	73,3
1	Co	62,4	36,0	63,5
1	La Hu	9,1	4,5	95,1
1	Ro Mam	63,8	46,4	53,6
1	Brau	75,9	55,1	44,9

Source: Vietnam National Committee for Ethnic Affairs & General Statistics Office, 2017. Survey on the socio-economic situation of 53 ethnic minorities, 2015.

One of the key indicators for assessing progress in reducing maternal mortality related to pregnancy and childbirth is the proportion of births attended by skilled healthcare personnel. The prevalence of home births without medical assistance, coupled with multiple contributing factors, has significantly impacted infant and under-five mortality rates among certain ethnic groups, including the Bru-Van Kieu, Co Tu, Ta oi, Chut, and Gie Trieng. According to a survey conducted by the Committee for Ethnic Minority Affairs, the child mortality rates among these ethnic groups are nearly twice as high as the national average, with an infant mortality rate of 14.9‰ and an under-five mortality rate of 22.44%. Challenging living conditions, the long distances to district hospitals, and cultural barriers remain significant obstacles to addressing malnutrition and disease prevalence among ethnic minority children under five. To date, little progress has been observed in improving these conditions (Committee for Ethnic Minority Affairs, General Statistics Office, 2015).

According to ethnic customs, childbirth is considered a significant life event that profoundly impacts daily life and health, requiring strict adherence to various traditional taboos and practices during pregnancy and delivery. Consequently, some ethnic minority groups prefer home births to align with their cultural traditions. Among the Hmong people, women in labor are required to give birth in a secluded room within the house, witnessed by family members, as part of a spiritual ritual acknowledging the newborn as a new member of the community. As a result, despite having access to commune health stations, most Hmong women continue to give birth at home. For the Bru-Van Kieu and Ta Oi ethnic groups in certain areas of Thua Thien Hue and Quang Tri provinces, childbirth is considered impure. Therefore, women are required to give birth in temporary shelters outside their homes to avoid contaminating their living spaces. This practice remains prevalent, as husbands build makeshift huts next to their homes when their wives go into labor. During childbirth, Bru-Van Kieu and Ta Oi women must deliver their babies unassisted, cut and dress the umbilical cord by themselves, perform personal hygiene, and take care of their newborns without external support.

3.3 Adolescent Pregnancy and Preterm Birth, low Birth Weight

Adolescent pregnancy is also linked to economic status, place of residence, and ethnicity, with higher rates among the poorest quintile and among women in the Northern Midlands and Mountainous Areas and the Central Highlands. These regions have a high concentration of ethnic minorities and an adolescent birth rate approximately three times higher than in other areas due to the prevalence of early marriage and child marriage practices (GSO, UNICEF, 2015). According to the birth registry of Sung Mang Commune Health Station, among the 77 childbirth cases of Dao women in Sung Mang Commune, Meo Vac District, in 2016, 29 women were under the age of 19 (adolescents). Among these 29 mothers, three had already given birth to their second child before turning 19. Additionally, as many as 18 girls aged 16 or 17 had given birth to their first child. Due to early marriage, pregnancy, and childbirth during adolescence, these mothers often lack basic knowledge about reproductive health and rely heavily on the advice and guidance of older women in the family. Their reproductive health and nutritional care practices are largely dependent on others, and they have limited knowledge or autonomy in making personal decisions regarding their well-being.

According to field surveys conducted in several localities, the incidence of preterm birth and low birth weight is relatively high in upland districts, particularly in those classified as extremely difficult under the Government's 30a Program.

"A Luoi District is a highland district of Thua Thien – Hue Province. In recent years, low birth weight among newborns and the miscarriage rate among mothers have been quite common in the area. Many cases of preterm birth occur when the mother is an adolescent. Notably, in recent years, the rate of preterm birth has surged, leading to a significantly high neonatal mortality rate" (Group discussion at A Luoi District Health Center).

"In my village, there is a tradition of early marriage. Girls as young as 14 or 15 have already given birth. In my community, some households have teenagers who have given birth at a very young age, having three or four children in a row. If they can't work to earn a living, their maternal grandmother takes care of babies. She gets frustrated—while other people bring home money, her own daughter just comes back pregnant. After giving birth, they have nothing to eat, not even enough rice. Some families survive only on salted food. Very few households can afford meat after childbirth. If they do, it's just for one meal right after delivery, and then it takes months before they can eat meat again" (In-depth interview, female, Xo Dang ethnic group, 42 years old, Dak Lak)

It is evident that maternal healthcare during pregnancy, childbirth, and neonatal care is significantly influenced by cultural perceptions and traditional practices of ethnic groups. Fundamental indicators such as attending at least four prenatal check-ups during pregnancy, giving birth at medical facilities, and ensuring timely and complete immunization for children depend not only on household economic conditions and government healthcare support policies but also largely on the awareness and behavioral changes in healthcare practices among ethnic minority communities, particularly among men as the heads of households.

3.4 Early Marriage

Early marriage refers to the act of getting married when either one or both parties have not yet reached the legal marriage age as stipulated in the 2014 Law on Marriage and Family (under 20 years old for males and under 18 years old for females). Early marriage can lead to difficulties for young couples in securing a stable life for themselves and their children, as well as negatively impact maternal and child health due to early childbirth.

Early marriage is a reality in Vietnam, and ethnic minority groups have a higher early marriage rate than the Kinh majority. According to the 2015 survey on 53 ethnic minority groups, the overall early marriage rate among these groups in Vietnam was 26.6%.

The Results of the Survey on the Socio-Economic Situation of 53 Ethnic Minority Groups in Vietnam, 2015 show that some ethnic minorities have extremely high early marriage rates (above 50%). These include the O Du at 72.73% (72.73% for both males and females), the Hmong at 59.66% (66.19% for males and 53.46% for females), the Xinh Mun at 56.34% (61.25% for males and 51.35% for females), the La Ha at 52.76% (56.43% for males and 49.35% for females), as well as the Ro Mam and the Brau, both at 50%. Ethnic minority groups with early marriage rates ranging from 40% to 50% include the Lu, Co Lao, Mang, La Hu, Kho Mu, Lo Lo, Ha Nhi, Si La, Gia Rai, Phu La, Chut, Khang, and Chu Ru.

The survey results of the research project "Key Issues of Gender Equality in Ethnic Minority Areas of Vietnam (2018-2021)" indicate that a significant proportion of ethnic minority people still marry below the legal age

(under 20 for males and under 18 for females). Specifically, the proportion is 23.7% for males and 19.2% for females. Notably, the rate of underage marriage is significantly higher among patrilineal ethnic groups compared to matrilineal groups, for both men and women. A comparison of marriage periods reveals a progressive shift towards later marriages for both genders. However, the decline in the rate of underage marriage is more pronounced among men than women. The difference in underage marriage rates from the 1969-1986 period to the 2011-2019 period is approximately 15 percentage points for men but only around 6 percentage points for women.

Table 5: Percentage of Women Married at Age 17 or Younger and Men Married at Age 19 or Younger by Social Groups

Social Group	Male	N	Female	N
Overall	23,7	2872	19,2	2875
Ethnic Group	***		***	
Patrilineal	30,6	1799	23,8	1804
Matrilineal	12,2	1073	11,4	1071
Marriage Period	***			
1969-1986	33,6	289	24,0	288
1987-2000	23,6	948	19,1	946
2001-2010	24,7	916	19,0	915
2011-2019	18,7	717	17,6	723

Note: Statistical Significance Level: ***P<0,001

Source: Survey Data from the CTD 21.17 Project, 2018-2019

Child Marriage Among Ethnic Minority Groups: the Survey on the Socio-Economic Situation of 53 Ethnic Minority Groups in Vietnam, 2015 revealed that there were still 2,991 cases of ethnic minority children under the age of 16 who had married. Among them, the number of girls was 3.4 times higher than that of boys (685 boys and 2,306 girls). A total of 42 out of 53 ethnic groups had cases of child marriage. Among these, six ethnic groups had over 100 cases, 13 ethnic groups had between 10 and 100 cases, and 23 ethnic groups had between 1 and 10 cases of child marriage. The survey data from 2018-2019 shows that, overall, approximately 2.0% of males still married at a child age. However, there has been a gradual decline from the 1969-1986 marriage period to the present. During the 2011-2019 period, only 0.7% of males married at a child age, compared to 4.4% in the 1969-1986 period.

3.5 Domestic Violence

The results show that both husbands and wives can be victims of domestic violence. However, violent acts against wives tend to be more severe, as the majority of physical violence cases involve wives as the victims.

Table 6: Husband-to-Wife and Wife-to-Husband Violence in the Past 12 Months (%)

	Violence Committed by Husband Against Wife	Violence Committed by Wife Against Husband
1. Insulting or humiliating	12,5	10,4
2. Threatening or intimidating in any way (such as glaring, yelling, destroying property, or threatening to use a weapon)	13,4	9,7
3. Slapping, hitting, punching, kicking, pushing, choking, pulling hair, or throwing objects	5,9	1,8
4. Using force to coerce sexual intercourse when the other person has refused	0,9	0,3
5. Using or taking part of the other person's income/savings without their consent	1,8	0,6
6. Preventing contact with friends	1,7	2,6

	Violence Committed by Husband Against Wife	Violence Committed by Wife Against Husband
7. Restricting contact with one's own family	0,5	0,6
8. Refusing or preventing the use of contraceptive methods	0,4	0,3

Source: Survey data from the CTD 21.17, 2018-2019 and the Ministry of Culture, Sport and Tourism of Vietnam

The dual intensity of violence affects both wives and husbands. Regarding violence committed by husbands against wives, the number of violent acts experienced ranges from a minimum of one to a maximum of seven. Specifically, 13.5% of women experienced one violent act, 5.6% experienced two acts, and 2.2% experienced three acts. The number of women who suffered four or more violent acts is very low (below 1%).

By ethnic group, psychological violence is more prevalent among matrilineal groups, while economic violence is more common among patrilineal groups. The other two types of violence show no significant differences. By province, psychological violence occurs most frequently in Dak Lak (46.0%), while physical violence is most prevalent in Hue (11.7%).

Wives who earn more than their husbands are significantly more likely to experience physical violence from their spouses compared to those whose husbands earn more or those with equal incomes. The corresponding rates are 12.1%, 5.2%, and 5.4%, respectively. Theoretically, a higher or equal income should enhance a woman's economic status, which, in turn, could reduce her risk of experiencing violence. However, the findings of this study do not support this assumption.

This phenomenon can be explained by deeply rooted traditional gender roles and family responsibilities that continue to persist. Socioeconomic changes have contributed to enhancing the wife's role in economic activities—something that was not common in the traditional family structure. However, husbands have not been able to adapt accordingly, as they remain heavily influenced by deeply ingrained patriarchal norms, including the belief in 'men as breadwinners and women as homemakers.' The expectation that men should be the primary financial providers for the family creates a sense of displacement, leading to negative reactions, including violent behavior toward their wives.

4. Remarks

Vietnam has made considerable efforts in implementing the Millennium Development Goals (MDGs) and has achieved notable progress. However, in practice, challenges remain in fully meeting these goals and fulfilling the commitments outlined in the Beijing Platform for Action on gender equality. Several key issues in Vietnam still require attention, including the following

Healthcare is always recognized as one of the key indicators of human development. Despite significant government attention and effective support policies, healthcare for ethnic minorities still faces many challenges. Maternal healthcare, home births, and child care remain particularly problematic. The percentage of ethnic minority women receiving prenatal check-ups and giving birth at medical facilities remains very low, with considerable disparities among different ethnic groups. In some communities, the shortage of skilled birth attendants is severe. Therefore, investing in healthcare support and training, including village health workers and skilled birth attendants, is crucial. Moreover, maternal and newborn care, as well as childhood immunization, are often influenced by the decisions of the male head of the household. This reality makes it difficult to achieve comprehensive healthcare coverage and meet basic maternal and child health targets in ethnic minority regions

Early marriage and consanguineous marriage still occur, although their prevalence has declined. Notably, the rate of early marriage is higher among patrilineal ethnic groups for both men and women. Domestic violence remains an issue, with violence against wives being more severe, particularly physical violence. Lower living standards are associated with higher occurrences of domestic violence. The dual burden of household chores and the need to earn income outside the home contributes to stress among women, sometimes leading to violent behavior toward their husbands. A key factor driving both husband-to-wife and wife-to-husband violence is alcohol intoxication. Reducing excessive alcohol consumption is one of the crucial measures to prevent domestic violence in ethnic minority communities.

Ethics Declaration

All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript

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Hoa Dang Thi declares that she has no conflict of interest.

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