

APPLICATION OF SOCIAL GROUP WORK IN PROVIDING PSYCHOLOGICAL SUPPORT TO PREGNANT WOMEN AT THE OBSTETRICS DEPARTMENT OF NINH BINH PROVINCIAL OBSTETRICS AND PEDIATRICS HOSPITAL

¹Nguyen Thanh Binh, ²Lai Thi Ngoc Anh

Hanoi National University of Education

DOI: <https://doi.org/10.5281/zenodo.22829436>

Published Date: 18-September-2026

Abstract: This study focuses on analyzing the psychological difficulties experienced by pregnant women during inpatient treatment and based on the findings, developing and implementing a small-scale social group work intervention for pregnant women who met the participation criteria. The intervention was designed to address several prominent psychological difficulties identified through the initial assessment. The evaluation of the group intervention focused on members' preliminary changes in areas directly related to the group's objectives, including perceived levels of anxiety and stress, their ability to share, recognize and cope with unpleasant emotions as well as their ability to identify and utilize available sources of support.

Keywords: social group work, psychological support, pregnant women, hospital.

1. INTRODUCTION

Pregnancy is a period characterized by substantial changes in women's physical, psychological and social lives. In addition to physiological changes associated with fetal development, pregnant women must adapt to changes in their roles and family responsibilities as well as to new demands in their everyday lives. Concerns about their own health and that of the fetus, childbirth, the ability to care for the newborn, family relationships, employment and financial circumstances may affect women's emotional well-being, adaptive capacity and quality of life during pregnancy. The World Health Organization (WHO) emphasizes that perinatal mental health should be considered an integral component of maternal and child health care. Pregnant women need a safe and respectful environment in which they can share their difficulties and receive appropriate identification and support when mental health problems arise (World Health Organization, 2022).

Studies conducted in Vietnam indicate that psychological difficulties during pregnancy affect a considerable proportion of women. A study by Pham Thi Thu Phuong, Dang Thi Minh Trang and Thai Thanh Truc (2020) involving 550 pregnant women in Ho Chi Minh City found that 24.0% of participants exhibited depressive symptoms and 16.0% exhibited anxiety symptoms. The findings also indicated that psychosocial factors, including stressful life events and the level of emotional support received from husbands were associated with pregnant women's psychological well-being. Similarly, a study by Tran Thi Truc Phuong and To Mai Xuan Hong (2021) involving 310 pregnant women at 28 weeks of gestation or later at Nguyen Tri Phuong Hospital reported that 28.7% of participants were at risk of antenatal depression. Anxiety during pregnancy, the lack of someone with whom to share personal concerns and the absence of counseling from healthcare

professionals were among the factors associated with this condition. These findings suggest that care for pregnant women should address not only their physical health but also their psychological well-being.

Among pregnant women requiring inpatient treatment, psychological difficulties may become more pronounced because they must simultaneously adapt to pregnancy and to a medical condition requiring monitoring and treatment. Hospitalization may disrupt daily routines, restrict certain activities and social interactions and increase concerns about disease progression, fetal safety, treatment outcomes and childbirth. Patients may also face difficulties related to family responsibilities, childcare, employment, treatment costs or the absence of someone with whom they can regularly share their concerns. Therefore, the needs of pregnant women receiving inpatient care extend beyond medical treatment and include the need to be listened to, to share their concerns, to receive appropriate information to obtain support in coping with anxiety and stress and to be connected with necessary resources.

In hospital settings, social work plays an important role in helping patients address psychological and social difficulties arising during the process of medical examination and treatment, strengthening their adaptive capacity, mobilizing resources from family and society and coordinating with healthcare professionals and other relevant disciplines in patient care. Circular No. 51/2024/TT-BYT, issued by the Ministry of Health on December 31, 2024, on the implementation of social work in medical examination and treatment facilities, provides an important legal foundation for needs assessment, the provision of social work services, coordinated support and referral services aimed at addressing patients' psychological and social problems. This regulatory framework provides an important basis for healthcare facilities to further develop psychological and social support interventions that are responsive to the characteristics and needs of different patient groups.

2. RESULTS

2.1. Preparation and Group Formation

In the initial draft, the practitioner initially approached 12 pregnant women receiving inpatient treatment. Following preliminary discussions and consultation with healthcare professionals regarding their health status, 10 women met the basic eligibility criteria. Two women were not invited to continue because priority needed to be given to rest and health monitoring. Of the remaining 10 women, 8 agreed to participate; however, one participant was subsequently expected to be discharged very soon and was therefore not included in the formal group. The final group consisted of 7 members.

The selection criteria included being currently hospitalized in the Obstetrics Department; having at least one psychological or social difficulty or support need relevant to the group's objectives; being able to participate in basic discussions; participating voluntarily; having a health condition that permitted participation and being expected to participate in most of the group process. The Edinburgh Postnatal Depression Scale (EPDS) score was considered an additional indicator rather than the sole criterion for participant selection.

Table 1. Baseline Characteristics of Group Members

Code	Age	Gestational Age	Length of Hospital Stay at Initial Contact	EPDS	Prominent Difficulties	Primary Sources of Support
TV1	27	30 weeks	3 days	10	Concern about effects on the fetus; difficulty sleeping and frequent reassurance-seeking	Husband
TV2	32	33 weeks	4 days	8	Concern about fetal condition; simultaneous concerns about a young child at home	Husband, mother
TV3	29	25 weeks	3 days	11	Concern about pregnancy outcomes; excessive searching for information online	Husband
TV4	35	31 weeks	5 days	7	Pressure related to responsibilities toward two children; feelings of guilt about being hospitalized	Husband, grandparents

Code	Age	Gestational Age	Length of Hospital Stay at Initial Contact	EPDS	Prominent Difficulties	Primary Sources of Support
TV5	24	22 weeks	2 days	8	Concern about the pregnancy but limited disclosure because of fear of causing additional worry to family members	Mother
TV6	31	34 weeks	7 days	10	Work and income pressures; feeling a lack of control due to prolonged treatment	Husband, colleagues
TV7	38	29 weeks	4 days	12	High levels of concern about pregnancy progression; frequent need for reassurance	Husband, sister

Group records indicated that the members shared the common circumstances of being hospitalized during pregnancy and having support needs; however, their difficulties could not be clearly separated into discrete categories. A single member might simultaneously experience concerns about the fetus, sleep difficulties, worries about a young child at home or financial pressure. This description more accurately reflects the interconnected nature of psychological and social difficulties and provides a basis for addressing emotions, information needs, family relationships and resources within the group.

EPDS scores ranged from 7 to 12, indicating a relatively natural variation among members. Some participants had scores below commonly noted screening thresholds but nevertheless demonstrated clear needs for sharing, family support or assistance in coping. Conversely, participants with higher scores were monitored more closely throughout the group process. This was consistent with the study's perspective that support needs should not be determined solely on the basis of a screening score.

Following the initial discussions, the group's objectives were jointly established. These objectives were to help members articulate more clearly the issues causing them concern, identify at least one appropriate coping strategy, identify available sources of support and experience positive interactions with other women facing similar circumstances.

Table 2. Four-Session Plan for Social Group Work

Session	Focus	Main Objectives	Key Activities	Duration
1	Initiation and safety	To become acquainted, establish group rules, identify expectations and common experiences	Introductions; brief sharing; development of group rules; identification of desired outcomes	25 - 30 minutes
2	Identifying worries and coping	To identify sources of stress and distinguish between matters that can be addressed independently and those requiring assistance	Sharing situations; "what I can do/what I need support with" mapping; discussion of existing coping strategies	25 - 30 minutes
3	Mutual support, skills, and resources	To practice self-regulation strategies, learn from one another's experiences, and identify and mobilize sources of support	Slow breathing/attention anchoring; experience sharing; resource mapping; preparation of questions for healthcare professionals	25 - 30 minutes
4	Consolidation and termination	To review changes, select strategies to continue using, evaluate the intervention, and prepare for subsequent support	Feedback; self-support planning; identification of support resources; pre-post evaluation; referral and linkage where necessary	25 - 30 minutes

Before the group began, the facilitator discussed with each member the objectives, participation procedures, the right to decline to share personal information and the priorities of ongoing medical treatment. The anticipated schedule was also coordinated with healthcare professionals to minimize conflicts with medical examinations, diagnostic tests or procedures. The group setting was selected to provide a sufficiently quiet environment that was convenient for patients and allowed members to see one another during discussions.

At the end of the preparation phase, the group had a relatively stable composition. Members understood the objectives and procedures for participation, the four-session plan had been established and individual issues requiring attention had been documented by the facilitator. These conditions provided a basis for moving into the initial stage of group development.

2.2. Initial Stage

As members began introducing themselves, the facilitator observed not only the content of their sharing but also how they responded to one another. Some participants looked directly at the person speaking, whereas others primarily directed their attention toward the facilitator. Invitations for members to respond directly to one another were introduced gradually to avoid creating pressure. Nonverbal responses, such as nodding, smiling and attentive listening, were also regarded as indicators of emerging interpersonal connections.

A notable characteristic of the first session was the relatively strong need for reassurance. When one participant expressed concerns related to the pregnancy, others tended to respond with reassurance such as “It will probably be fine”. The facilitator did not dismiss the positive intention behind such responses but encouraged members to respond through shared experiences or attentive listening, because excessively rapid reassurance may cause the person sharing to feel that her concerns have been minimized.

The initial stage therefore involved more than simply “getting acquainted.” It was a critical period for establishing group norms, boundaries, a sense of safety and patterns of interaction. The quality of this stage directly influenced members’ ability to engage in deeper sharing during Sessions 2 and 3.

The first session focused on creating a sense of safety and helping members begin to perceive themselves as part of the group. Rather than asking participants to immediately disclose sensitive experiences, the facilitator used brief questions concerning what made the hospitalization period more difficult, what kind of support they hoped to receive and what was currently helping them feel more reassured.

The initial stage indicated that the group had begun to establish the necessary conditions for a supportive group: shared rules had been developed, common experiences had been identified and direct responses among members had begun to emerge. At this stage, the facilitator’s primary roles were to maintain safety, observe participation, create opportunities for interaction and establish appropriate boundaries.

2.3. Working Stage

The working stage focused on a coherent sequence of core activities: identifying sources of worry, examining current coping patterns, practicing several brief self-regulation strategies and utilizing mutual support and resources outside the group. This organization was appropriate for a short inpatient stay and helped prevent the group from becoming merely a series of information-sharing sessions.

During Session 2, the facilitator invited each member to select a situation that frequently caused her stress and categorize it into two areas: “What I can do” and “What I need support with”. This activity helped members distinguish between aspects of their circumstances over which they could exercise some degree of control and those dependent on professional decisions or other people.

For health-related questions, the facilitator helped members reformulate their concerns into specific questions and connected them with healthcare professionals when necessary. This approach addressed their need for information while maintaining appropriate professional boundaries.

Across the two working sessions, the facilitator’s role shifted flexibly among providing structure, encouraging interaction, offering feedback, limiting inappropriate advice-giving, facilitating access to resources and observing participation. The facilitator did not attempt to become the group’s sole source of support; instead, support resources were deliberately redirected toward the members themselves and their surrounding support systems.

By the end of the working stage, four process-level changes became more apparent. Members were able to identify more specifically the issues that caused them concern; some became better able to distinguish between matters they could address independently and those requiring assistance; direct interaction among members increased and many participants developed a clearer understanding of the people or services they could approach for assistance. These changes provided a basis for moving into the termination and evaluation stage.

2.4. Termination Stage

The facilitator began preparing members for termination toward the end of Session 3 by clearly informing them that the following session would be the final session. This provided members with time to reflect on what they wished to retain from the group experience and reduced the possibility of the intervention ending abruptly. In hospital-based groups, such preparation is particularly important because a member may be discharged shortly after the final session.

During Session 4, the review process was organized around members' self-assessment rather than having the facilitator recount the entire group process. Each participant was invited to identify one thing she had realized, one strategy she had tried, and one issue that remained difficult. This approach allowed outcomes to be expressed as individual experiences while leaving room for changes that had not yet been fully achieved.

Resource consolidation was undertaken through a brief plan addressing three questions: "What will I do first when my stress increases?", "Who will I talk to?" and "When do I need to seek professional support?" This plan helped connect individual coping skills with the member's support network and appropriate safety boundaries.

From a professional perspective, the termination stage enabled the facilitator to reassess the extent to which the group objectives had been achieved and to identify the limitations of the model. Some changes could be observed relatively clearly over the four sessions, particularly in interaction and coping patterns, whereas other issues required a longer period to address. These observations provided important information for evaluation and for recommendations concerning the organization of future groups.

Session 4 was used to conclude the group process. In the context of inpatient treatment, clear preparation for termination is particularly important because members may be discharged within a short period. The facilitator supported members in reviewing what had occurred, identifying what had been useful to them, selecting coping strategies that they could continue to use and identifying sources of support after the group ended.

Each member was invited to answer three brief questions: What have I understood more clearly about my own problem? What can I do when I feel worried? If I need further support, whom will I seek help from? This evaluation approach enabled members to describe their changes in their own words while also generating information that could be compared with observations made throughout the process.

At the group level, members were invited to provide direct feedback to one another regarding what they had gained from the interaction. Some participants noted that hearing from others in similar circumstances reduced their sense of isolation, while others reported that another member's way of sharing had offered them a new perspective. This was the point at which the role of mutual support became most apparent: participants were not merely recipients of services but had also become sources of support for one another.

The facilitator also reiterated the boundaries of the intervention and the sources of support available after the group ended. Continuing health-related concerns were to be discussed with healthcare professionals; psychological and social difficulties could be addressed with social workers; and concerning psychological symptoms required assessment by an appropriately qualified professional. This approach to termination helped maintain continuity of support rather than leaving members with the impression that they were expected to manage all difficulties independently after the group ended.

The termination stage was considered complete when members had had an opportunity to review the process, identify at least one coping strategy and one source of support that they could continue to use and understand situations in which additional assistance should be sought. The outcomes of the process were then evaluated in an integrated manner.

Evaluation combined several pre-post indicators, process observations and members' feedback. Given the small group size of seven participants and the short duration of the intervention, the study did not employ inferential statistical tests. Instead, the evaluation focused on examining patterns of change within individual members and relating these changes to developments observed throughout the group process.

Three domains were assessed: psychological state and level of anxiety; coping capacity and utilization of support resources and members' assessment of the appropriateness of the intervention. This approach was considered more consistent with the objectives of social group work than relying solely on a single psychological indicator.

Table 3. Members' Feedback on the Group Intervention

Aspect	Very Appropriate/Very Helpful	Appropriate/Helpful	Notable Comments
Small group size	5/7	2/7	Created a comfortable atmosphere for speaking and listening to one another
Duration of 25–30 minutes	4/7	3/7	Manageable; some sessions could have benefited from additional time when discussions became more in-depth
Opportunity to share with others in similar circumstances	6/7	1/7	Considered the most useful component of the intervention
Practice of self-regulation strategies	4/7	3/7	Easy to implement under inpatient conditions
Support in identifying information and resources	5/7	2/7	Helped participants understand whom to ask and what type of support to request
Overall appropriateness	5/7	2/7	Appropriate provided that the schedule remains flexible in accordance with medical treatment

Feedback indicated that the opportunity to share with people with similar experiences was the most highly valued component. This finding reinforces the view that the value of the intervention lies not only in specific techniques but also in the group mechanism itself: members recognized that they were not alone, learned from others' coping strategies and had opportunities to move from being recipients of support to becoming sources of support for others.

The 25-30-minute duration was considered relatively appropriate given the participants' health conditions, although some members indicated that sessions involving deeper discussion could have benefited from slightly more time. This finding supports the need to maintain flexibility in session scheduling rather than imposing an absolute duration. The group size of seven also facilitated participation among less vocal members without creating the pressure associated with a larger group.

A limitation identified jointly by members and the facilitator was the strong dependence of the group schedule on ongoing medical treatment. Accordingly, the four-session model with relatively short sessions was considered more feasible than the initially planned six-session format. Each session needed to have sufficient standalone value while maintaining continuity across the overall process so that the intervention would not become a series of disconnected group meetings.

Overall, the evaluation indicated that the group intervention was appropriate for the participating members and generated observable changes at both the individual and group levels. However, participants' health status, treatment-related information and family support were simultaneously evolving during the same period. Therefore, the observed outcomes should be interpreted as changes documented within a specific practice process rather than as evidence establishing a causal effect of the intervention.

3. CONCLUSION

This study implemented a short-term supportive group consisting of seven members over four sessions, with each session lasting approximately 25-30 minutes. The process focused on establishing safety, identifying sources of anxiety, examining coping patterns, practicing brief coping skills, promoting mutual support, facilitating access to appropriate information and mobilizing available resources. Reducing the intervention to four sessions was more consistent with the actual duration of inpatient stays while maintaining the fundamental stages of social group work.

One notable outcome of the intervention was the development of interaction and mutual support among members. Whereas most communication initially tended to be directed toward the facilitator, direct responses, experience sharing, empathy and reciprocal support gradually emerged among participants. Members who were initially hesitant became more actively engaged, while those who tended to provide direct advice were supported in shifting toward sharing experiences and listening. This demonstrates the distinctive value of the group method, in which members are not only recipients of support but can also become resources for one another.

The preliminary evaluation indicated that most members showed a tendency toward reduced anxiety and demonstrated changes in their ability to identify problems, use coping strategies, access information, and identify sources of support. However, the degree of change was not uniform and some difficulties rooted in social circumstances, such as employment and income-related concerns, persisted. These findings suggest that group work may facilitate the process of adaptation but cannot replace interventions addressing practical problems or the provision of specialized services.

Given the small group size, short intervention period and absence of a control design, the observed changes should not be interpreted as evidence of a causal relationship. Changes in health status, treatment-related information and family support also influenced members' well-being during the intervention. The value of this practice-based component therefore lies in demonstrating the feasibility, potential and limitations of social group work within a specific hospital context.

Taken together, the findings suggest that social group work has the potential to serve as an appropriate complementary form of support for some pregnant women receiving inpatient treatment when it is organized on the basis of needs assessment, voluntary participation, a small group size, brief and flexible sessions and multidisciplinary coordination. This approach should be embedded within a multi-level support system in which group work, individual support, family support, social work services, medical care and specialized mental health services are connected according to patients' needs.

REFERENCES

- [1] Barnett, B., Matthey, S., & Gyaneshwar, R. (1999). Screening for postnatal depression in women of non-English speaking background. *Archives of Women's Mental Health*, 2(2), 67–74. <https://doi.org/10.1007/s007370050038>
- [2] Bedaso, A., Adams, J., Peng, W., & Sibbritt, D. (2021). The relationship between social support and mental health problems during pregnancy: A systematic review and meta-analysis. *Reproductive Health*, 18, 162. <https://doi.org/10.1186/s12978-021-01209-5>
- [3] Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders*, 191, 62–77. <https://doi.org/10.1016/j.jad.2015.11.014>
- [4] Byatt, N., Hicks-Courant, K., Davidson, A., Levesque, R., Mick, E., Allison, J., & Moore Simas, T. A. (2014). Depression and anxiety among high-risk obstetric inpatients. *General Hospital Psychiatry*, 36(6), 644–649. <https://doi.org/10.1016/j.genhosppsych.2014.07.011>
- [5] Clauson, M. I. (1996). Uncertainty and stress in women hospitalized with high-risk pregnancy. *Clinical Nursing Research*, 5(3), 309–325. <https://doi.org/10.1177/105477389600500306>
- [6] Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782–786. <https://doi.org/10.1192/bjp.150.6.782>
- [7] Fang, Q., Lin, L., Chen, Q., Yuan, Y., Wang, S., Zhang, Y., Liu, T., Cheng, H., & Tian, L. (2022). Effect of peer support intervention on perinatal depression: A meta-analysis. *General Hospital Psychiatry*, 74, 78–87. <https://doi.org/10.1016/j.genhosppsych.2021.12.001>
- [8] International Association for Social Work with Groups. (2006). *Standards for social work practice with groups* (2nd ed.). IASWG.
- [9] Ketten Edis, E., & Kurtgöz, A. (2023). Care experiences and care expectations of hospitalized high-risk pregnant women: A qualitative study. *Women & Health*, 63(9), 704–712. <https://doi.org/10.1080/03630242.2023.2262614>

- [10] Kent, R. A., Yazbek, M., Heyns, T., & Coetzee, I. M. (2015). The support needs of high-risk antenatal patients in prolonged hospitalisation. *Midwifery*, 31(1), 164–169. <https://doi.org/10.1016/j.midw.2014.08.003>
- [11] Kim, H., & Park, H. (2018). Health-care needs of high-risk pregnant women hospitalized in maternal-fetal intensive care units: A mixed-methods design. *Korean Journal of Women Health Nursing*, 24(2), 196–208. <https://doi.org/10.4069/kjwhn.2018.24.2.196>
- [12] Kozinszky, Z., & Dudas, R. B. (2015). Validation studies of the Edinburgh Postnatal Depression Scale for the antenatal period. *Journal of Affective Disorders*, 176, 95–105. <https://doi.org/10.1016/j.jad.2015.01.044>
- [13] Mai Thi Hue, Nguyen Hang Nguyet Van, Phung Phuong Nha, Ngo Tuan Vu, Pham Minh Duc, Nguyen Thi Van Trang, Phan Thi Ngoc Thinh, Le Ngoc Anh, Le Thanh Huyen, & Nguyen Huu Tu. (2020). Factors associated with antenatal depression among pregnant women in Vietnam: A multisite cross-sectional survey. *Health Psychology Open*, 7(1), 2055102920914076. <https://doi.org/10.1177/2055102920914076>
- [14] Manolova, G., Waqas, A., Chowdhary, N., Salisbury, T. T., & Dua, T. (2023). Integrating perinatal mental healthcare into maternal and perinatal services in low and middle income countries. *BMJ*, 381, e073343. <https://doi.org/10.1136/bmj-2022-073343>
- [15] National Association of Social Workers. (2016). NASW standards for social work practice in health care settings. <https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Social-Work-Practice-in-Health-Care-Settings>
- [16] Nguyen, A. T., Nguyen, K. D., Le, H. M., Nguyen, T. D., Meyrowitsch, D. W., Bygbjerg, I. C., Søndergaard, J., Nguyen, H. T. T., Vinter, C. A., Linde, D. S., Gammeltoft, T. M., & Rasch, V. (2024). Social support and symptoms of antenatal depression among women screened for gestational diabetes mellitus: A cross-sectional study in Northern Vietnam (the VALID II study). *PLOS ONE*, 19(12), e0314608. <https://doi.org/10.1371/journal.pone.0314608>
- [17] Nguyen, L. H., Nguyen, L. D., Ninh, L. T., Nguyen, H. T. T., Nguyen, A. D., Dam, V. A. T., Nguyen, T. T., Do, H. P., Vu, T. M. T., Tran, B. X., Latkin, C. A., Ho, C. S. H., & Ho, R. C. M. (2022). COVID-19 and delayed antenatal care impaired pregnant women's quality of life and psychological well-being: What supports should be provided? Evidence from Vietnam. *Journal of Affective Disorders*, 298, 119–125. <https://doi.org/10.1016/j.jad.2021.10.102>
- [18] Petrucci, L. J., Ayala, S., Abraham, A. E., Haiman, M. D., Vetter, I., Sampson, M., Miller, E. S., Parra-Medina, D., & Valdez, C. R. (2026). Can social work interventions improve perinatal mental health outcomes? A systematic review. *Women's Health Issues*, 36(2), 93–105. <https://doi.org/10.1016/j.whi.2025.12.005>
- [19] Sufredini, F., Catling, C., Zugai, J., & Chang, S. (2022). The effects of social support on depression and anxiety in the perinatal period: A mixed-methods systematic review. *Journal of Affective Disorders*, 319, 119–141. <https://doi.org/10.1016/j.jad.2022.09.005>
- [20] Tran, T. D., Tran, T., La, B., Lee, D., Rosenthal, D., & Fisher, J. (2011). Screening for perinatal common mental disorders in women in the north of Vietnam: A comparison of three psychometric instruments. *Journal of Affective Disorders*, 133(1–2), 281–293. <https://doi.org/10.1016/j.jad.2011.03.038>
- [21] Vui, L. T., Quy, L. X., Thi, L. M., Cronin de Chavez, A., Manzano, A., Lakin, K., Kane, S., Ha, B. T. T., Hicks, J., Mirzoev, T., Ha, N. T., Trang, D. T. H., & Chi, N. T. Q. (2024). Health systems responsiveness towards needs of pregnant women in Vietnam. *BMC Health Services Research*, 24, 1618. <https://doi.org/10.1186/s12913-024-12040-6>
- [22] World Health Organization. (2022). WHO guide for integration of perinatal mental health in maternal and child health services. <https://www.who.int/publications/i/item/9789240057142>